AB1203

INVESTIGATING THE VIEWS OF COMMUNITY PHARMACISTS ON THEIR ROLE IN THE MANAGEMENT OF RHEUMATOID ARTHRITIS

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Background: Medicines optimisation is essential in the long-term management of rheumatoid arthritis (RA), particularly when considering combinations of conventional synthetic disease-modifying anti-rheumatic drugs (csDMARDs). Community pharmacists are ideally placed to optimise medicines use including monitoring side effects, counselling on dose and frequency and improving medicines adherence; however, in some countries, such as the UK, there are currently no community pharmacy services that address csDMARD use and little is known about the role community pharmacists play in managing RA as a long-term condition.

Objectives: The objectives of this qualitative study were to understand community pharmacists' views of their training, knowledge and current role in the management of RA.

Methods: We conducted 9 semi-structured, face-to-face or telephone interviews with community pharmacists based in the UK; all were transcribed verbatim. A topic guide, used to inform the interviews, covered four key areas: 1) knowledge and training, 2) pharmacological management 3) patients and services, 4) potential role. The transcriptions were then imported into NVivo for thematic analysis. A coding framework was developed from continual emerging themes and applied to the transcripts.

Results: Five male/4 female participants, the median age was 39 years (range 27 to 42) with a median number of years qualified as a pharmacist of 12 years (range 5 to 20) were included. The participants covered a range of roles including: pharmacist non-manager, pharmacist manager, locum pharmacist, superintendent pharmacist and relief pharmacist.

In assessing the current role of community pharmacists, 4 main themes were identified: (1) access to information about the patient's condition as a barrier, (2) their lack of knowledge in the management of RA, (3) providing practical advice about taking csDMARDs, and (4) exploring the reasons for non-adherence before taking further action. In assessing the potential role of community pharmacists, a further 2 themes were identified: improving access to information about the patient's condition before the current role can be increased and other barriers to an additional role, including time and funding.

In the theme 'access to information as a barrier' the most common point made was about the lack of information available to pharmacists on the individual indication for medicines. Pharmacists said this posed a barrier both to current practice and their potential role. No participants suggested the potential for an additional service specifically for RA, but some suggested that current services could be expanded to include RA as a target group. Participants discussed side effect counselling and ensuring access to medicines in detail with patients, but only 2 briefly mentioned discussing the benefits of csDMARDs.

Conclusion: This is the first in-depth exploration of the perspectives of community pharmacists on the management of RA in community pharmacy. This study has highlighted several important barriers both environmental and personal including time, education and resources that, if addressed, could allow community pharmacists to play a greater role in the management of RA.

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AB1204

COST-EFFECTIVENESS OF ABATACEPT IN SPAIN IN SEROPOSITIVE BIOLOGIC-NAÏVE EARLY RHEUMATOID ARTHRITIS PATIENTS WITH SHARED EPITOPE

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Background: The HLA class II Shared Epitope (SE) is a known Rheumatoid Arthritis (RA) risk allele linked to autoantibody production and disease progression. The recent Early AMPLE study suggests an enhanced treatment benefit of abatacept (ABA) over adalimumab (ADA) in SE positive patients with early seropositive RA.¹ Economic implications beyond the trial follow-up duration are unknown.

Objectives: To estimate the cost-effectiveness of ABA vs ADA in biologic-naïve RA patients seropositive for anti-citrullinated protein antibody and rheumatoid factor based on the Early AMPLE study.

Methods: We developed a microsimulation model to estimate clinical response, medical cost, quality of life and survival from a Spanish payer perspective. The model captures the patient's disease and treatment journey using response outcomes and the Health Assessment Questionnaire (HAQ) score. Patients who fail to respond switch to the next treatment line. Six treatment lines are included to capture a lifetime horizon. Responding patients (ACR50 and EULAR response) achieve an improvement in their HAQ score. Patient mortality was modelled as a function of HAQ. For both the overall Early AMPLE population and SE+ patients, incremental monthly cost per response over 2 years and incremental cost per QALY over a lifetime were estimated. Costs were based on local tariffs in Spain.

Results: Baseline characteristics for the Early AMPLE (n=80) and the SE+ (n=61) patients were well balanced between the treatment groups.² Compared to ADA, the ABA cohort had a lower cost per response and the difference was more pronounced in the SE+ population, compared to the entire Early AMPLE population for both the response criteria (Table 1). Compared with ADA, the ABA cohort showed greater quality adjusted life years (QALYs) gains, and a modest increase in cost due to a prolonged time on treatment (Table 2). The incremental cost per QALY over a lifetime fell below commonly used thresholds in Spain (25-60 thousand Euros per QALY).³

Table 1. Cost per response results

Full Early AMPLE	ACR50		EULAR	
	ABA	ADA	ABA	ADA
Cost per response (€) – 2 years	25,860	40,654	26,993	40,643
Incremental monthly cost per response (€)	-616		-569	
SE positive	ACR 50		EULAR	
	ABA	ADA	ABA	ADA
Cost per response (€) – 2 years	24,272	40,249	25,337	41,425
Incremental monthly cost per response (€)	-666		-670	

All incremental results are for ABA – ADA

Table 2. Cost-effectiveness results (discounted)

Full Early AMPLE	ACR50		EULAR	
	ABA	ADA	ABA	ADA
LYs*	30.14	30.06	30.11	30.03
QALYs	8.32	7.81	7.57	7.12
Time on treatment (years)	4.17	2.03	5.14	3.06
Costs (€)	75,547	68,157	85,122	80,933
Incremental LYs*	0.08		0.08	
Incremental QALYs	0.52		0.45	
Incremental Costs (€)	7,390		4,189	
Incremental cost per QALY (€)	14,308		9,275	
SE positive	ACR50		EULAR	
	ABA	ADA	ABA	ADA
LYs*	30.38	30.22	30.16	30.09
QALYs	8.20	7.59	7.40	6.90
Time on treatment (years)	4.48	2.02	5.38	3.02
Costs (€)	78,113	68,651	87,586	81,321
Incremental LYs*	0.15		0.06	
Incremental QALYs	0.61		0.50	
Incremental Costs (€)	9,462		6,265	
Incremental cost per QALY (€)	15,410		12,503	

*LY results are presented undiscounted. All incremental results are for ABA – ADA

Conclusion: Compared with ADA, ABA is a cost-effective alternative and is associated with a lower 2 years cost per response for both populations. The economic benefit and quality of life gain is greater in a SE+ patient population.

References:

- [1] Rigby W, et al. EULAR Annual Meeting, June 2019; Poster LB0008
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