class III, 47 class IV and 9 class V. Baseline serum creatinine was 82.44±29.26 μmol/L; 15 patients showed eGFR<60min/1.73m² at baseline. Immunosuppressants were taken by 70 (76.5%) patients: 47 miconolucite, 15 azathioprine and 5 ciclosporine. Sixty patients (65.9%) were on antimalarial. During follow-up 34 (37.4%) patients achieved CRR. Among them 5 (14.7%) patients relapsed and 29 (85.3%) patients maintained remission. Mean time to achieved CRR was 9.71±5.91 months.

High levels of baseline proteinuria were a negative independent predictor of CRR and PERR at 6 months (OR 0.043 CI95% 0.006-0.320 p=0.002 and OR 0.232 CI95% 0.091-0.566 p=0.002) and 12 months (OR 0.029 CI95% 0.002-0.356 p=0.019 and OR 0.056 CI95% 0.009-0.327 p=0.001). High levels of baseline creatinine were a negative independent predictor of renal response. Renal response at 6 months was a strong predictive factor of renal response at 12 and 24 months.

Conclusion: Belimumab is an effective add-on therapy in the treatment of GN in real-life practice setting.

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POS694 REAL-WORLD ECONOMIC IMPLICATIONS OF ACHIEVING LOW DISEASE ACTIVITY IN LUPUS NEPHRITIS

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Background: Lupus nephritis (LN) is a common and severe manifestation of systemic lupus erythematosus (SLE) affecting 50% of SLE patients and leading to end-stage kidney disease (ESKD) in up to 30% of patients with LN. Previous studies have reported higher healthcare costs in patients with SLE that develop LN compared to patients without LN. These studies captured overall treatment costs associated with LN, regardless of disease activity or severity, and were conducted in small patient populations.

Objectives: The aim of this study was to assess the real-world economic implications of achieving low disease activity compared to active disease or ESKD in a large LN population.

Methods: This study was a retrospective observational analysis of patients with LN within Optum’s health plan identified with ICD9 or ICD10 codes to have LN within the study period, and no use of cyclophosphamide for ≥6 months, evidence of mycophenolate mofetil (MMF) doses ≤2g/day, and no use of cyclophosphamide for ≥6 consecutive months. Follow-up time that could not be defined as low disease activity was defined as active disease periods, except for periods with evidence of ESKD. Healthcare payer costs for medical and pharmacy services were compared between periods of low disease activity, active disease, and ESKD. A univariate generalized estimating equation model accounting for interdependence was used to compare differences in costs between periods of active and low disease activity.

Results: A total of 21,251 patients with LN met study criteria with a mean follow-up time of 31.0 months. The mean age was 60.3 years; 86.9% of patients were female and 35.2% of patients were non-White race. Low disease activity was evident in 51.3% of patients with a mean duration of 275.7 months. Mean monthly medical costs were $2,523 during periods of low activity and $4,777 during periods of active disease. After factoring in pharmacy costs, mean monthly total costs were $3,584 during periods of low activity and $6,612 during periods of active disease (P<0.001). The mean monthly costs of ESKD were $4,777 during periods of low activity and $6,612 during periods of active disease (P<0.001). The mean monthly costs of ESKD were $3,584 during periods of low activity and $6,612 during periods of active disease. After factoring in pharmacy costs, mean monthly total costs were $3,584 during periods of low activity and $6,612 during periods of active disease (P<0.001). The mean monthly costs of ESKD were $4,777 during periods of low activity and $6,612 during periods of active disease. After factoring in pharmacy costs, mean monthly total costs were $3,584 during periods of low activity and $6,612 during periods of active disease (P<0.001).

Conclusion: Achieving low disease activity in patients with LN is associated with reduced economic burden to healthcare payers, with monthly medical costs averaging $2,523 less and total monthly costs averaging $3,028 less than costs during periods of active disease.

REFERENCES:
