the case of expensive drugs with individualised dosing if we treated only a few patients on different days. This is the case of infliximab.

Purpose The aim of this study was to retrospectively examine the pattern of utilisation in clinical practise (clustering patients at the same day of the week or not) and the saving costs associated with the optimization of infliximab use in the treatment of rheumatoid arthritis or Crohn's disease.

Materials and Methods We collected data of patients treated whit infliximab during the first two months of 2012. We clustered patients by weeks, so we calculated the total weekly dose by adding the dose of each patient and total number of vials required of infliximab (clustering patients or not). Infliximab was given at dose of 3–5 mg/kg every 6–8 weeks. We calculated treatment costs between two alternatives.

Results Eighteen patients received at least one infliximab infusion during a selected observation period were studied. The mean infliximab dose administered to all the patients was 342 ± 80 mg per patient. The number of vials used was 67, if we cluster patients, and 71 without cluster patients Infliximab vial optimization allows us, for the whole year, to reduce the amount of vials from 486 to 458, with a significant saving of 13612€ by year.

Conclusions Clustering patients in a agreed day of week allows significant cost savings in the context of a regional hospital. The cost of treatment could be reduced by using infliximab vial optimization. These results could be applied for the vial optimization of some monoclonal antibodies and cytostatic agents.

No conflict of interest.

DSL-020 PILOT STUDY OF THE CHANGES IN THE COST OF ADULT KIDNEY TRANSPLANT TREASTMENT FOR PATIENTS IN BULGARIA

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Background There are several studies at the international level analysing the cost of immunosuppressive treatment of kidney transplant patients. In Bulgaria pharmacotherapy of kidney transplant patients is provided by the hospital pharmacy and therefore it is important to know the amount paid for immunosuppression by the hospital providing the treatment.

Purpose To analyse the changes in the cost of pharmacotherapy for kidney transplant patients in Bulgaria during the period 2006–2011.

Materials and Methods A prospective cost study of the changes in pharmacotherapy of all adult kidney transplant patients in Bulgaria during the specified period. An analysis of prescribing practise was performed, cost of pharmacotherapy was calculated. Descriptive statistics and t-test analysis were performed to evaluate the changes in the prescribing practise and the cost of pharmacotherapy.

Results In total 21 therapeutic schemes were found prescribed. The number of patients on treatment varied for each year of the observation period because of patients dropping out of treatment. The total observed population for the period was 589 individuals. Most often, the prescribed therapeutic scheme was ciclosporin + mycophenolate; in 38% to 39% of all cases. A slow increase in the average monthly costs of pharmacotherapy was observed for the period 2007–2009, after which the cost declined from 172 EUR to 138 EUR per patient per month in 2010–2011. Those variations are mostly due to changes of pharmacotherapy. During the period 2007–2009 two new substances were introduced, tacrolimus and everolimus, which led to the increase in prescribing costs. For the period 2010–2011 generic immunosuppressants were introduced and the prescribing costs declined. The drug costs of kidney transplantation vary between 17.43% and 30.66% of the hospital's drugs budget.

Conclusions To our knowledge this is the first Bulgarian study of prescribing practise and changes in the cost of drugs for kidney transplant patients. It reveals that prescribing costs are varying and dependent on the introduction of new molecules or generic products. The study shows that the introduction of the new immunosuppressive molecules leads to an increase in pharmacotherapy costs, while the introduction of generic products significantly reduces drug costs.

No conflict of interest.

DSL-021 RISK ANALYSIS OF MEDICINES PRODUCED IN HOSPITAL PHARMACY – A TOOL FOR ENSURING OPTIMAL SUPPLY

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Background The hospital pharmacy unit for the preparation of licenced sterile medicines manufactures 110 different extemporaneous preparations and licenced medicines for injection or infusion. This unit needs a tool for production planning i.e. an assessment of which medicines are critical and hence must always be in stock.

Purpose To create a tool for risk assessments for all medicines manufactured in the unit, enabling appropriate prioritising of resources from a treatment perspective.

Materials and Methods All risk assessments are executed and stored in SAID (National question and answer database). The advantages of this method are that each risk assessment is quality assured and acts as a dynamic document that can be updated regularly.

Risk assessments are based on relevant literature (e.g. Summary of Product Characteristics and Micromedex).

For each risk assessment the following is examined as a minimum:

- Which patient group will benefit from the medicine?
- Therapeutic indications and administration
- Are there any alternative treatments?
- Does a synonymous/analogous medicine exist? Any safety concerns regarding method of administration? Can the manufacturers maintain the flow of supply?

Based on the above the risk assessments are allocated a score 1 to 5, which indicates the severity of a back order.

Results The risk assessments were distributed as follows:

18% scored 5 (no alternative medicine exists)
38% scored 4 (analogous medicine exists)
24% scored 3 (synonymous extemporaneous or non-licenced medicine exists)
9% scored 2 (synonymous medicine exists)
11% scored 1 (more than one analogue/synonym exists)

The risk assessments showed that none of the medicines could be dispensed from a treatment perspective. Shorter periods of back order of some medicines can be tolerated with no effect of patient care and safety, if alternative synonyms/analogous medicines are supplied from other manufacturers.

Conclusions Risk assessments have given the unit a tool for production planning and prioritising the manufacturing of medicines.

No conflict of interest.