The influence of the TacPP administered (immediate/prolonged/extended release) and the administration route (oral/nasogastric tube), in case of immediate-release tacrolimus form was also analysed.

Therapeutic control was considered inadequate if CV30 occurred, or P5 was higher than 20%.

Statistical analysis was done using SPSS. Variance analysis and the Krukal–Wallis test were used to compare quantitative variables.

**Results** Eighty-four patients were included. The values of the variables analysed – mean FKs, P5 and CV30 observed – were 8.0 ng/mL (SD, 4.2), 19.3% (SD, 39.6) and 66.0% (DE, 46.9). Technically, 68.3% patients had poor FKs control levels.

According to TacPP, values for mean FKs, P5 and CV30 observed were:

- Immediate-release tacrolimus: 8.5 ng/mL (95% CI: 6.2 to 10.9), 28.6% (95% CI: 12.8 to 44.3) and 58.1% (95% CI: 39.7 to 76.5).
- Prolonged-release tacrolimus: 7.9 ng/mL (95% CI: 6.2 to 10.9), 10.5% (95% CI: 1.0 to 25.6) and 66.7% (95% CI: 55.0 to 78.3).
- Extended-release tacrolimus: 9.6 ng/mL (95% CI: 8.0 to 11.3), 8.3% (95% CI: 0.0 to 27.0) and 83.3% (95% CI: 58.6 to 100.0).

According to the administration route (immediate-release tacrolimus form), values for mean FKs, P5 and CV30 observed were:

- Oral: 8.5 ng/mL (95% CI: 6.2 to 10.9), 28.6% (95% CI: 6.7 to 24.9) and 58.1% (95% CI: 40.0 to 76.5).
- Nasogastric tube: 6.8 ng/mL (95% CI: 5.5 to 8.0), 32.3% (95% CI: 14.8 to 49.7) and 76.0% (95% CI: 58.0 to 94.0).

Mean FKs, P5 and CV30 observed varied widely among the TacPP and administration route: statistical differences were only achieved for P5 within TacPP (p=0.044).

**Conclusion** Taking into account the limitations of this study, our findings suggest that high IPV of FKs exist, at least within the first month after the transplant date. Moreover, the IPV of FKs after their administration through immediate-prolonged release preparations and/or a different administration route shows a wide range of variability that in concrete cases (P5) raises statistical significance.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

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No conflict of interest.

**4CPS-153 COMPARATIVE ANALYSIS BETWEEN ORIGINATOR AND BIOSIMILAR INFlixIMAB ACCORDING TO TROUGH LEVELS IN PATIENTS WITH INFLAMMATORY BOWEL DISEASE**

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**Background** The introduction of biosimilar infliximab (IFX-B) has led to a decrease in the costs of patients with inflammatory bowel disease (IBD). The molecular complexity in the manufacture of biological drugs makes it difficult to verify the similarity between the different drugs. Infliximab (IFX) therapeutic drug monitoring allows for objective decision-making in patients with IBD.

**Purpose** To compare the percentage of patients in therapeutic IFX concentrations, between originator infliximab (IFX-O)
versus IFX-B, as well as the prevalence of immunogenicity between both.

**Material and methods** We conducted a retrospective observational study (March 2017–September 2018). We included all patients with IBD who received maintenance therapy with IFX and underwent pharmacokinetic monitoring.

The variables studied were: sex, age, diagnosis, type of drug (IFX-O or IFX-B), number of serum samples collected, serum trough levels IFX, and the presence of antibodies. Blood extraction was performed in trough levels and determined by sandwich ELISA (Promonitor). The IFX therapeutic range was defined as between 3–10 mcg/mL. We used the X² test to compare the association between categorical variables and the student t-test for quantitative variables. All tests were performed using SPSS v.23.0.

**Results** We included 70 patients (65.7% were males). The average age of the study population was 41.8 (DE: 14.8) years, 74.4% had Crohn’s disease.

Concerning treatment, 49.3% were treated with IFX-O and 50.7% with IFX-B. We analysed 174 serum samples (61.5% IFX-O), 2.9 (SD: 1.1) and 1.8 (SD: 1.0) samples per patient of IFX-O and IFX-B respectively. Mean serum trough levels of IFX-O were 7.2 (SD: 4.5) mcg/mL versus 8.3 (SD: 7.8) mcg/mL with IFX-B (p=0.790), of which 61.9% and 47.8% (p=0.137) were in the therapeutic range respectively. In terms of immunogenicity, 13.1% patients presented antibodies anti-IFX (11.6% IFX-O and 15.4% IFX-B, p=0.43).

**Conclusion** In our study there was no significant difference in the mean concentration of drugs between IFX-O and IFX-B, and neither in immunogenicity, with IFX-B as a cost-effective alternative to the originator product. Pharmacokinetic monitoring represents a fundamental mainstay in the optimisation of these treatments.

**REFERENCE AND/OR ACKNOWLEDGEMENTS**


No conflict of interest.

**4CPS-154 ABSTRACT WITHDRAWN**

**4CPS-155 A NEW MULTIDISCIPLINARY MODEL WITH THE CLINICAL PHARMACIST FOR MEDICATION RECONCILIATION IN THE PATIENT WITH ADVANCED RENAL DISEASE**

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**Background** Most of the patients with advanced chronic kidney disease (ACKD) are fragile due to multimorbidity and associated polypharmacy. For this kind of population, polypharmacy and potentially inappropriate prescribing are common problems that impact both on patient compliance and on drugs cost for the National Health System (NHS). For therapy with high pill-burden medication reconciliation (MR), supported by Information and Communication Technology’s (ICT) instrument, is one of the most effective tools in preventing over/under/mis-prescription and drug interaction (DI), and the clinical pharmacist is the suitable figure to support the clinician in promoting the appropriateness of therapies in the transition of care.

**Purpose** The aim was to estimate compliance and the economic impact of a multidisciplinary clinical-pharmacist-led MR process in patients with ACKD.

**Material and methods** Selection and implementation of ICT tool; identification of mistaken prescription with indicators of appropriateness, such as START/STOPP and Beers criteria;