## 4CPS-118 HEALTH OUTCOMES IN A COHORT OF HIV+ PATIENTS STRATIFIED USING THE KAISER PERMANENTE PYRAMID POPULATION-BASED RISK STRATIFICATION MODEL

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**Background and Importance** In recent years, hospital pharmacists have been approaching population-based risk stratification models for selected groups of patients. The implementation of these strategies as routine would facilitate the adequation of the pharmaceutical care to patient complexity.

**Aim and Objectives** To analyse the health outcomes of HIV+ patients on Antiretroviral Therapy (ART) in a comparative manner according to their classification in the Kaiser Permanente Pyramid (KPP).

**Material and Methods** Retrospective observational study including all HIV+ patients with active ART on 2022/01/03 followed up in the outpatient pharmacy of a tertiary hospital. The results extracted on 2022/01/03 from the clinical history were analysed according to the KPP risk stratification model. Data collected: sex, age, HIV Viral Load (VL), CD4+, polypharmacy (≥6 drugs, ART included), ART cost/patient/Undetectable VL (UVL; <50 copies/mL), Emergency Department Attendances (EDA)/previous year, and stratum of KPP (General population: Promotion and Prevention (PP); Chronic patients: Self-management Support (SS); High-risk patients: Illness Management (IM); Patients with severe complications: Case Management (CM)).

**Results** 947 (68% men) with a median (IQR) age of 54 years [46-59] were included. 92% had UVL and 2% >200 copies/mL. 5% had <200 CD4+/µL, 23% 200-500 CD4+/µL and 72% >500 CD4+/µL. 39% of patients had polypharmacy. EDA/previous year was: 0, 67% patients; 1-3, 29% patients; 4-8, 3.5%; >8, 0.5%.

Classification according to KPP: 3.5% unclassified, 3%PP, 45%SS, 33%IM and 15.5%CM. 4% of PP, 16%SS, 88%IM and 85%CM had polypharmacy.

91% of PP, 93%SS, 93%IM and 87%CM had UVL. No PP patients, 2%SS, 1% IM and 5% CM had CV>200 copies/mL.

No PP patients, 3% SS, 4% IM and 10% CM had <200 CD4+/L. 82% of PP patients, 79% SS, 71% IM and 57% CM had >500 CD4+/L.

EDA/previous year was 0, 77% PP-75% SS-65% IM-38% CM; 1-3, 23% PP-23% SS-33% IM-44% CM; 4-8, No PP-1% SS-2% IM-16% CM; >8, No PP or SS-1% IM-2% CM.

The ART/patient/UVL cost was the same as the overall cost in PP and IM patients, 9% lower in SS and 22% higher in CM.

**Conclusion and Relevance** The study shows a worsening in HIV health outcomes and an increase in resource consumption as patient complexity enhances.

The KPP model allows us to identify patients at greater risk of sickness-related complications and with a potentially high consumption of resources, who may require an individualised and more specific pharmaceutical care in our setting.

### REFERENCES AND/OR ACKNOWLEDGEMENTS

**Conflict of Interest** No conflict of interest

## 4CPS-119 PNEUMONOLOGY-PHARMACY COLLABORATION IN THE PHARMACOTHERAPEUTIC OPTIMISATION OF MONOCLONAL ANTIBODIES IN PATIENTS WITH SEVERE UNCONTROLLED ASTHMA

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**Background and Importance** In chronic diseases, concern about safety and economic implications of treatment with biological drugs have raised, the need to adapt, by reducing doses, the treatment used once reached the individualised therapeutic goal for each patient.

**Aim and Objectives** Implementation of a pharmaceutical care consultation for patients with Severe Uncontrolled Asthma (SUA).

To establish a collaboration with the Pneumology Service for the referral of candidate patients for pharmacotherapeutic optimisation.

**Material and Methods** Pharmaceutical care consultations were scheduled for all SUA patients.

Candidates for optimisation were those treated with any monoclonal antibody for more than 1 year, had no exacerbations in the last 12 months, ACT score >20, FEV1>80%, withdrawal of oral corticosteroids, had good adherence to treatment measured by the Test of Adherence to Inhalers and the pharmacy dispensing record.

If a patient met these requirements was referred to pneumologist with a treatment optimisation proposal (lengthening the interval between doses or reducing the dose). Pneumologists were able to accept the optimisation proposal or not. If there was worsening after dose optimisation, the initial prescription was returned.

**Results** During a 2-year period, from May 2020 to May 2022, 38 patients received Mepolizumab, 20 Benralizumab, 14 Reslizumab and 59 Omalizumab. 125 patients came to pharmacy consultation.

35 patients that met the criteria for optimising treatment and were proposed to pulmonologist, with acceptance of the proposal: 9 with mepolizumab every 5 weeks, 1 with benralizumab every 9 weeks, 5 with benralizumab every 5 weeks, and 20 with omalizumab at half initial dose.

In September 2022, 25 patients continue to be optimised, 10 patients have returned to the usual dose because they were not fully controlled with the optimised regimen, none of whom had asthma exacerbations.

**Conclusion and Relevance** Pharmacotherapy optimisation exposes patients with total control of asthma to less drug and less probability of developing adverse effects, while minimising costs in the health system.

**Abstract 4CPS-119 Table 1**

| Monoclonal antibody | N patients | N optimisation | % optimisation |
|---|---|---|---|
| Mepolizumab | 38 | 9 | 23,7% |
| Benralizumab | 20 | 1 | 5% |
| Reslizumab | 14 | 5 | 35,7% |
| Omalizumab | 59 | 20 | 33,9% |
| Total patients | 131 | 35 | 27% |

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