therapeutics, the proposed PP and its acceptance are collated in an Excel file); then discussion and validation of the results in Medicines and Sterile Medical Devices Commission (MSMDC), in particular for the not accepted PIs.

Results The flowchart criteria are kalemia, oral intake, KCl-inj concentration, KCl-inj in prevention during high-dose hypokalemic treatments, initiation of treatment. Each of the situations identified is linked to a PI or the absence of PI. 6 axes of PP have been identified including oral co-prescription, switch by electrolyte solution, and adaptation of the volume of solvent.

The study over one month gives 172 lines with a MR according to our tool. 85 prescriptions were compliant. 87 PI formulated including 6 without PP. The PI acceptance rate is 43.2%, with a maximum of 52% for the oral relay and a minimum of 0% for adaptation of the volume of solvent or electrolyte solution switch. At the end of the MSMDC, our tool is validated after an agreement on the importance of promoting the use of electrolyte solution.

Conclusion and Relevance The acceptance rate and the conclusions of the MSMDC allow us to validate the flowchart. Its use improves the relevance of PIs, their acceptance and reduces the use of KCl-inj. To facilitate the use of the tool, an Excel file that identifies the PPs according to the criteria is being developed.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-157 COMPARISON OF THE EFFECTIVENESS BETWEEN INTERLEUKIN-23 INHIBITORS FOR TREATMENT OF PSORIASIS IN A THIRD LEVEL HOSPITAL

A Merchán, SC Lucía, FM Raquel, GO María de Los Reyes, PM María, AB María Ángeles*, PJ María Del Puerto, VM Isabel, AM Mercedes, CP Lucía, VH José Manuel. *Hospital Clínico Universitario Lozano Blesa, Pharmacy, Zaragoza, Spain*

10.1136/ejhpharm-2023-eahp.156

Background and Importance Interleukin-23 (IL-23) is a cytokine involved in inflammatory and immune responses in psoriasis. Novel therapies such as tildrakizumab, guselkumab, and risankizumab inhibit the IL-23-receptor interaction.

Aim and Objectives To compare the effectiveness between IL-23 inhibitors in patients with psoriasis in a third level hospital.

Material and Methods An observational, retrospective, descriptive study was conducted in patients with psoriasis treated with tildrakizumab, guselkumab or risankizumab between August-20 and August-22. Demographic, clinical, and treatment specific variables were collected. Effectiveness was determined through the comparison of psoriasis area severity index (PASI) prior starting IL-23 inhibitor and after the first visit (between weeks 4 and 16 after start).

Results The study included 58 patients [62.1% men, median age 51 (23-83) years] out of whom 8 (13.8%) had psoriatic arthritis comorbidity, 11 (18.9%) were treated with tildrakizumab, 20 (34.4%) with guselkumab and 27 (46.5%) with risankizumab. Median of treatment line was 3 (2-5) with tildrakizumab and guselkumab, and 2 (1-12) with risankizumab. Adalimumab was the most common previous therapy (54.5%, n=6 for tildrakizumab; 40.0%, n=8 for guselkumab; 38.5%, n=10 for risankizumab) and the median time of treatment with previous drug was 58.4 (9.8-665.0), 64.5 (1.5-921.0) and 46.6 (0.0-299.0) weeks, respectively. Reasons for switching to IL-23 inhibitors were treatment failure (100.0%, n=11 for tildrakizumab; 85.0%, n=17 for guselkumab; 84.6%, n=22 for risankizumab), adverse events (15.0%, n=3 for guselkumab; 11.5%, n=3 for risankizumab) or drug interaction (3.8%, n=1 for risankizumab). Median time of treatment with IL-23 inhibitor was 41.9 (16.9-68.0), 44.1 (9.2-168.0) and 26.3 (14.9-96.1) weeks for tildrakizumab, guselkumab and risankizumab, respectively. Median PASI before switching to IL-23 inhibitor treatments vs after first visit were 7.7 (3.3-10.8) vs 1.4 (0.0-5.2) for tildrakizumab, 8.9 (1.0-29.1) vs 0.9 (0.0-6.8) for guselkumab and 7.8 (2.8-21.8) vs 1.2 (0.0-10.4) for risankizumab. 7 patients (35.0%) and 10 patients (37.0%) in treatment with guselkumab and risankizumab respectively achieved PASI 0, while only 3 patients (27.3%) in treatment with tildrakizumab did.

Conclusion and Relevance The duration of the previous treatment was prolonged. Treatment failure was the main reason to initiate an IL-23 inhibitor treatment. Data suggest that guselkumab and risankizumab could be more effective treatments between 4 and 16 weeks compared to tildrakizumab.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-158 IMPROVEMENT IN PATIENT CARE BY PHARMACIST PHONE CALL AFTER STARTING TREATMENT

J Urda Romacho, I Bretones Pedrinaci, A Jofre Peralta, MA Castro Vida*. *Hospital Universitario Poniente, Pharmacy, Almeria, Spain*

10.1136/ejhpharm-2023-eahp.157

Background and Importance Outpatient Pharmacy Unit (OPU) is the last place that patient goes within the hospital circuit. Usually, patient arrives overloaded with information and worried about his new disease, not being able to assimilate all the information that is offered to him about the new treatment that he has to start.

Aim and Objectives To develop a communication project between patients and OPU professionals to help patients understand, remember and improve adherence to treatment prescribed, detect possible medication-related problems (MRP) and increase the degree of satisfaction with the care received at the OPU.

Material and Methods Project started in April 2019, in the OPU of a regional hospital. Three profiles of patients were included; Profile 1: patients who, after a recent diagnosis, may have a greater psychological impact; Profile 2: those who start treatment with devices that require specific manipulation and Profile 3: those who, due to their special conditions (language, age...) are considered to need reinforcement of the information received in the first visit to the Pharmacy (FVP). When the patient comes to the OPU for the first time, he is offered all the information necessary to start his treatment and is included in a follow-up programme , doing a phone call 3 to 5 days after begin the new medication. On the second visit to the OPU, a satisfaction survey is given.

Results Data collected between April 2019-December 2021. Patients included: 142. Calls made to 100% of patients, 118 patients (83.1%) answered the call. 52.1% of the patients were classified as Profile 1; 37.3% Profile 2, and 10.6% Profile 3. 49 patients (34.5%) reported adverse effects, of which 41 (85.4%) evolved favorably and 8 (14.6%) changed

treatment due to poor tolerance. Regarding the satisfaction survey, 92.4% of the patients reported call was useful to them 95.8% were satisfied or very satisfied with care received at the FVP and at the phone call.

Conclusion and Relevance Phone call after starting treatment reinforces the information given in OPU during the FVP and allows early intervention in detection and resolution of MRP. A high percentage of patients consider the project useful, showing a high degree of satisfaction with the care received.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-160 REAL-WORLD PERSISTENCE WITH DOLUTEGRAVIR/LAMIVUDINE VERSUS BICTEGRAVIR/EMTRICITABINA/TENOFOVIR ALAFENAMIDE AMONG HUMAN IMMUNODEFICIENCY VIRUS PATIENTS

[1]L Martín Zaragoza*, [1]J Sánchez-Rubio Ferrandez, [1]A Onteniente González, [1]M Gómez Bermejo, [1]A Alcántara Prado, [1]L Carmona Juárez, [2]SJ Rodriguez Álvarez, [2]A Monereo Alonso, [1]T Molina Garcia. *[1]Hospital Universitario de Getafe, Pharmacy Service, Madrid, Spain*; *[2]Hospital Universitario de Getafe, Internal Medicine Service, Madrid, Spain*

10.1136/ejhpharm-2023-eahp.158

Background and Importance Persistency can provide information on the comparative effectiveness, durability and tolerability in real-world patient populations.

Little is known about comparative persistence of dolutegravir/lamivudine (DTG/3TC) and bictegravir/emtricitabine/tenofovir-alafenamide (BIC/FTC/TAF), two preferred antiretroviral treatments in our country.

Aim and Objectives To compare persistence between two preferred antiretroviral therapies and analyse reasons for discontinuation.

Material and Methods We conducted a retrospective, non-interventional, longitudinal study. All HIV patients over 18 years treated with DTG/3TC or BIC/FTC/TAF in our centre were included.

Persistence was defined as the duration of time from initiation to discontinuation of therapy (last dispensing or end of the study in March 2022). Persistence was also calculated as a dichotomous variable at the conclusion of the first year of therapy. Permissible gap (days between two prescription fills exceeding the allowable refill period) was 90 days.

Covariates collected from medical record were: age, gender, viral load (VL), CD4 count, number of previous antiretroviral medications, Charlson comorbidity index and Medication Possession Ratio (MPR).

Persistence after first year was compared using the χ^2 test. Kaplan-Meier survival analysis was performed and differences were evaluated using the log-rank test. Adjusted risk of discontinuation was assessed with Cox Proportional Hazard models. Significance level was 0.05.

Results Three hundred and sixty-two patients were included, 79.2% were male. 5.2% were naive. Age (mean ± SD) was 47 ± 12 years. 91.2% had VL<200 copies and 10.1% CD4<200/ml. Number of previous treatments was 3.5 ± 2.6. MPR was 95.4 ± 11.1 Charlson comorbidity index was 1 ± 1.66. 49.2% were treated with BIC/FTC/TAF.

97.8% vs 89.7% of patients were persistent after the first for DTG/3TC and BIC/FTC/TAF respectively [OR= 5.1 (CI95% 1.7-15.6);p=0.002].

Overall, mean persistence duration was 1.189 days (CI 95% 1.163-1.215). Persistence with DGT/3TC was 1.231 days (CI 95% 1.206-1.255) and persistence with BIC/FTC/TAF was 980 days (CI 95% 944-1.016);p=0.001. However Cox-model adjusted HR was 2.5 (IC95% 0.5-12;p=0.26).

The main reasons for discontinuation for BIC/FTC/TAF were tolerability/toxicity (n=9) and death (n=3). Only two patients withdrawed DTG/3TC, due to toxicity (n=1) and death (n=1).

Conclusion and Relevance In our study, more patients on DTG/3TC were persistent after the first year compared to BIC/FTC/TAF. However, there were no differences in overall persistence in covariate-adjusted analysis. Main reason for BIC/FTC/TAF discontinuation was tolerability/toxicity.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-162 TRIPLE WHAMMY DRUG-DRUG INTERACTION: CLINICAL RELEVANCE AND RESULTS OF PHARMACEUTICAL INTERVENTION

Á González Gómez*, JA Hernández Ramos, A Castro Frontiñán, JM Caro Teller, MD Canales Siguero, JM Ferrari Piquero. *Hospital Universitario 12 de Octubre, Pharmacy, Madrid, Spain*

10.1136/ejhpharm-2023-eahp.159

Background and Importance Acute kidney injury (AKI) is a highly prevalent condition among inpatients, usually attributed to pharmacological causes. One of the most clinically relevant drug-drug interactions (DDI) in this context is the triple whammy interaction (TWI), caused by the addition of three potential nephrotoxic groups of drugs: Non-steroidal anti-inflammatory drugs (NSAIDs), diuretics and ACE inhibitors/angiotensin receptor blockers (ARB).

Aim and Objectives To evaluate clinical significance of the TWI, as well as the role of pharmaceutical intervention (PI) in preventing possible adverse events due to this DDI.

Material and Methods Observational retrospective study that included patients who were prescribed the TWI over a period of 4 years (2018 to 2022). Data were collected using computerised medical records, nurse administration registry and PI data base. ICU patients were excluded from this study. Recommendation of monitoring serum creatinine and potassium, as well as discontinuing the triple therapy was carried out in all patients. Incidence of AKI was calculated according to AKIN criteria. Impact of PI was estimated based on average number of days patients received the combination and amount of time until complete resolution of AKI.

Results 34 patients were included and stratified according to their risk factors for developing AKI. 87,5% patients were considered at high risk. The first cause of admission was surgery in 62% of cases. Mean basal SCr was 0,99 (CI 95% 0,82–1,15). Acceptance of PI rate was estimated in 65,62%. Incidence of AKI was 29,4% (10/34), 8 of which were classified as AKIN 1. Mean duration of the triple therapy was 6,81 days (CI 95% = 3,47-10,15) in non-accepted PI group vs 3,17 days (CI 95% = 2,23-4,11) in the accepted PI group. AKI was detected more frequently in accepted PI patients (7/10). However, these patients recovered normal renal function faster than patients with no approved PI: 10 days (CI 95% = 5,41-14,58) vs 14,33 days (CI 95% = 8,52 – 20,14), respectively.