maintained treatment effect from long-term evidence in other T2DM populations. Responder were primarily defined using a composite end-point that based on an HbA1c≤7.0% threshold AND no weight gain AND no documented symptomatic hypoglycemia. The NNT was calculated to determine the average number of patients needed to be treated in order to gain one additional successful responder. Sensitivity analyses were performed to examine the robustness of results. ***Results:*** For the primary composite end-point, cost per responder results were 136,290 CNY for lixisenatide group, 231,487 CNY for Basal-Plus group, and 222,424 CNY for Basal-Bolus group. The NNT analysis showed that there was approximately one additional responder for every 7.65 and 8.74 patients treated with lixisenatide combined with basal insulin compared to Basal-Plus and Basal-Bolus, respectively. The sensitivity analysis proved the robustness of results. ***Conclusions:*** Lixisenatide combined with basal insulin is a cost-effective treatment alternative compared with Basal-Plus and Basal-Bolus for T2DM patients inadequately controlled by basal insulin in China.

PDB62
INCIDENCE AND COST OF DIABETES RELATED EVENTS IN AN ADULT TYPE 1 DIABETES POPULATION FROM A U.S. PAYOR PERSPECTIVE

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Objectives: Approximately $^{3}/_{4}$ of adults with type 1 diabetes mellitus (T1DM) do not meet glycemic goals and therefore are at risk of developing diabetes-related com-

PDB64
ASSOCIATION BETWEEN CARDIOVASCULAR DISEASE RISK FACTORS AND HYPOGLYCAEMIC EVENTS IN TYPE 2 DIABETES USING THE IQVIA CORE DIABETES MODEL

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Objectives: There is clinical evidence that having a hypoglycemic event increases the risk of cardiovascular disease and mortality. In version 9.5 of the IQVIA Core Diabetes Model (CDM), an association relative risk factor (RR) of developing Cardiovascular Disease (CVD) and CVD mortality events related to non-severe (NSHE) and severe (SHE) hypoglycemic events over an adjustable duration were included. CVD conditions are Myocardial Infarction (MI), Stroke, Congestive Heart Failure (CHF) and angina. The current study compared the model outcomes obtained with and without applying a variable RR. ***Methods:*** The observational EDGE study comparing metformin + vildagliptin (M+V) versus metformin + sulphonylurea (M+S) was used as a base case. Basal insulin rescue therapy was applied to both arms when an HbA1c level of 7.5% was reached. Mean age at study start was 57.8 years and duration of diabetes 6 years. NSHE and SHE rate were applied as 13.94 per 100 patient-years (100 pt/year), 2.46 (100 pt/year) for M+S and 1.785, 0.315 (100 pt/year) for M+V. A RR of 1.1 was applied for all CVD conditions over a five-year period. UK 2018 costs were applied; costs and health benefits were discounted at 3.5%. ***Results:*** Using RR increase of 1.1 for CVD and mortality due to SHE and NSHE, changed life expectancy (LE) and QALY with -1.68 and -1.55% (LY: from 11.961 to 11.760; QALY: 8.335 to 8.91) for M+V and -1.55 and -1.50% (LY: from 11.959 to 11.716; QALY: 8.217 to 8.052) for

PDB63

THE IMPACT OF HEART FAILURE ON DIABETES-RELATED HEALTHCARE UTILIZATION AND COSTS IN ADULT PATIENTS WITH TYPE 2 DIABETES

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Objectives: Heart failure (HF) is a common comorbidity of type 2 diabetes (T2D). Patients with both HF and T2D face increased mortality and greater all-cause healthcare utilization (HCU) and costs, compared to those with only one of the two conditions. However, little is known about how HF contributes to the economic burden of diabetes, given the fact that HF negatively impacts glycemic control. This study aimed to examine and compare diabetes-related HCU and costs in T2D patients with and without HF. ***Methods:*** This was a retrospective cohort study using Truven Marketscan® Commercial and Medicare Supplemental Claims data from 2014 to 2016. Adult men and non-pregnant women with T2D and HF were compared with those without HF in diabetes-related HCU and costs, including inpatient visits and length of stay, emergency room (ER) visits, overall outpatient visits, general practitioner visits, specialist visits, and prescription drugs. A 1:1 greedy propensity score matching (PSM) algorithm was performed to adjust for demographic characteristics. Multivariate regression models were built to adjust for comorbidities and baseline HCU. ***Results:*** A total of 864,330 patients met study criteria. After PSM, 22,026 subjects remained in each cohort. The HF cohort had higher proportion of diabetes-related inpatient visits (13.45% vs. 4.13%), ER visits (4.75% vs. 2.11%), outpatient specialist visits (7.35% vs. 6.03%) and more insulin prescriptions (1.61 vs. 0.75) during a 12-month follow-up period, all $P < 0.0001$. Patients with HF incurred higher per-patient-per-year diabetes-related medical costs ($5,755 vs. $1,831) and prescription costs ($1,657 vs. $1,348). Overall, patients with both T2D and HF spent $4,233 more in managing diabetes annually, compared to those with T2D only. ***Conclusions:*** Heart failure increased the economic burden of managing T2D. Future studies should explore the impact of HF or other cardiovascular diseases on specific diabetes complications to understand the driving characteristics of this impact.

treatment. Top unmet needs included stopping disease progression and improving diagnosis. Payers are monitoring the development pipeline to prepare for drug launches. Drug data expectations included impact on fibrosis progression, budget impact, and cost offsets in a defined patient population. Payers anticipate drugs to be priced around $1000/month, depending on fibrosis stage indication, and may allow open access or implement prior authorization restrictions. ***Conclusions:*** Payers recognized a high clinical burden in NASH. Though economic burden was currently considered modest, payers believe this will increase with treatment approvals. In the absence of guidelines, diagnosis is not standardized and is a high unmet need. Payer education on disease burden, clinical data, and a clear rationale for patient population targeting will highly influence pricing and market access.

Diabetes/Endocrine/Metabolic Disorders - Epidemiology & Public Health

PDB66

ASSESSMENT OF RISK OF TYPE 2 DIABETES IN HEALTHY VOLUNTEERS USING SIMPLIFIED INDIAN DIABETES RISK SCORE TOOL: A CROSS-SECTIONAL STUDY IN NORTH INDIA

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Objectives: The large contribution of the world's diabetic population resides in India making India as diabetic capital of the world. There is large burden of undetected diabetic cases in community, which prompts to assess the early diabetes risk in vulnerable population. Madras Diabetes Research Foundation (MDRF) has developed Indian Diabetes Risk Score (IDRS) to detect undiagnosed Type 2 diabetes. This study was aimed to assess the risk of diabetes in North Indian population. ***Methods:*** This community-based cross-sectional study enrolled adult population aged between 20 to 55 years. Simple random sampling was performed to select the participants. The assessment of risk of diabetes was carried out in and around Chandigarh by