METHODS: We conducted a retrospective cross-sectional study of adult HF patients presenting to PVAMC as outpatients between 1/1/12 and 12/31/12 with symptoms consistent with CAP. Patients were excluded if differential diagnoses included neither ADHF nor CAP. Medical records were reviewed to identify imaging, laboratory tests, medications, chief complaint, primary diagnosis, and patient outcomes (including subsequent hospital admissions and outpatient visits within 30 days). The proportion of patients who received treatment for ADHF and CAP was calculated.

RESULTS: Of 2,760 potentially eligible encounters, 132 have been screened to date and 32 met inclusion criteria. Primary chief complaints were shortness of breath (69%) and chest pain (16%). Chest x-rays were performed for 91%, sputum cultures for 6%, blood cultures for 25%, NT-proBNP levels for 59%, and CBC for 78%. Overall, 21.9% of encounters received both antibiotics and HF medications either during the visit or as a discharge prescription. Only 9% ultimately had a primary diagnosis of pneumonia, with an additional 9% having a primary diagnosis of obstructive chronic bronchitis; no other infectious diseases were identified among primary diagnoses. Overall, 66% of encounters were admitted directly to PVAMC, and among the remainder, 33% were admitted in the subsequent 30 days.

CONCLUSION: In outpatient settings, inconsistent use of diagnostics and laboratory tests, along with ambiguity in interpreting results, can result in excess medication use due to treatment for both CAP and ADHF. Patients may thereby be at increased risk for adverse outcomes.

449. Chronopharmacology of valsartan and amlodipine *Sephorah Falzon, M.Pharm.*[1], Louise Grech, M.Phil.[2], Anthony Serracino-Inglott, Pharm.D.[1], Lilian M. Azzopardi, B.Pharm.(Hons), M.Phil., Ph.D., MRPharmS[2]; (1) Department of Pharmacy, University of Malta, Msida, Malta (2) Department of Pharmacy, Faculty of Medicine and Surgery, University of Malta, Msida, Malta

PURPOSE: To test the effect on 24 hour blood pressure (BP) profile of valsartan and amlodipine and to compare the effects of morning versus evening dosing on circadian BP.

METHODS: Sixty two patients aged 40–75 years had their 24 hour BP measured using an ambulatory BP monitor (ABPM). Patients suffering from essential hypertension who were prescribed valsartan (n = 21) or amlodipine (n = 8) as monotherapy were monitored twice, 7 days apart and were asked to change the time of dosing of their medication for a week for the second measurement. Patients suffering from hypertension but taking no medication (n = 14) and normotensive patients (n = 19) were recruited as controls.

RESULTS: Whole day systolic BP (SBP) and diastolic BP (DBP) means following both morning and evening valsartan administration were lower than the 140/90 mmHg limit (123.91/77.94 mmHg and 121.31/76.06 mmHg respectively). Compared to morning administration, evening valsartan dosing resulted in a non-significantly lower BP during the early morning and day time periods and significantly lower BP during the night ($p = 0.146$, 0.905 and 0.012 respectively for SBP and $p = 0.079$, 0.880 and 0.003 respectively for DBP; Mann–Whitney). Whole day BP means following both morning and evening amlodipine dosing were lower than the 140/90 mmHg limit (126.23/77.35 mmHg and 127.75/78.71 mmHg respectively). Compared to evening dosing, morning amlodipine administration resulted in a non- significantly higher BP during the early morning period and non-significantly lower BP during the day and night time periods ($p = 0.330$, 0.483 and 0.091 respectively for SBP and $p = 0.480$, 0.961 and 0.065 respectively for DBP; Mann–Whitney).

CONCLUSION: Valsartan and amlodipine were effective for 24 hour BP control irrespective of their dosing time. Evening dosing of valsartan was preferred to morning administration as it was more effective at lowering early morning and night time BP.

450. Revisiting niacin at the VA Portland Health Care System (VAPORHCS): are we in compliance with the guidelines? *Matt J. Glaus, B.S.*[1], Laura R. Davis, B.S.[1], Lynnette R. Klaus, Pharm.D.[1], Jessina C. McGregor, Ph.D.[2], Harleen Singh, Pharm.D.[2]; (1) VA Portland Health Care System, Portland, OR (2) Oregon State University/Oregon Health & Science University College of Pharmacy, Portland, OR

PURPOSE: Current cholesterol guidelines recommend optimizing statin therapy for atherosclerotic cardiovascular disease (ASCVD) rather than adding niacin, which has not been proven in trials to reduce cardiovascular events. The purpose of this project is to evaluate niacin prescribing at the VAPORHCS in high cardiovascular risk veterans.

METHODS: VAPORHCS patients with active niacin orders as of 03/13/2015 were electronically identified. Chart review was conducted to collect patient demographics, lipid-lowering regimens, and comorbidities. Patients with discontinued/expired niacin orders, who were deceased, or no longer with VAPORHCS were excluded. The frequency of niacin patients at high cardiovascular risk, on optimized statin therapy, and indications for niacin were calculated. The VAPORHCS Institutional Review Board approved this as a quality improvement project.

RESULTS: Of 480 patients identified with active niacin orders, 196 charts were reviewed to date; 144 (73.5%) met inclusion criteria. Of the 52 excluded, 48 (92.3%) were for niacin expiration or discontinuation, 3 (5.7%) were deceased and 1 (1.9%) was no longer a VAPORHCS patient. Of included veterans, the average age was 67.1 years, 98.6% were male, 115 (79.9%) had hypertension and 79 (54.9%) had diabetes. Documented niacin indication was present in 114 (79.2%) and was most commonly for hyperlipidemia (57.9%) and hypertriglyceridemia (36.8%). Among patients initiated due to hypertriglyceridemia, 22/42 (52.4%) were initiated for triglycerides <500 mg/dL (average = 333.9 mg/dL). Among 134 niacin-receiving veterans with ASCVD or risk ≥7.5%, 78 (58.2%) were on a moderate- or high-intensity statin, while 56 (41.8%) were on no statin or a low-intensity statin and of those patients 23/56 (41.1%) had no documented statin intolerance.

CONCLUSION: Niacin use persists among VAPORHCS patients despite a lack of optimization of statin therapy, particularly in the highest cardiovascular risk group. These results highlight the need to optimize statin regimens before initiating non-statin therapies.

451. Alemtuzumab induction versus conventional immunosuppression in heart transplant recipients *Areerut Leelathanalerk, Pharm.D. Candidate*[1], Thammasin Ingviya, M.D.[2], Vijay Ivaturi, Ph.D.[1], Brent N. Reed, Pharm.D., BCPS-AQ Cardiology[1]; (1) Department of Pharmacy Practice and Science, University of Maryland School of Pharmacy, Baltimore, MD (2) Bloomberg School of Public Health, The Johns Hopkins University

PURPOSE: Induction therapy in the setting of heart transplantation remains an area of controversy. The purpose of this retrospective analysis was to compare alemtuzumab induction and conventional immunosuppression in heart transplant recipients.

METHODS: We included patients aged 18–89 years who underwent heart transplantation at our institution, received alemtuzumab induction, and had at least 6 months of follow-up (n = 10); this cohort was compared to an equal number of patients who received conventional immunosuppression (n = 10). The primary endpoint was time to ≥ Grade 2R rejection at 6 months; other endpoints included time to any rejection as well as differences in laboratory parameters and immunosuppression use. Baseline characteristics were compared using t-test, chi-squared, or Fisher's exact test as appropriate. Follow-up data were compared using Kaplan–Meier, Wilcoxon, or Fisher's exact as appropriate.

RESULTS: Baseline characteristics were similar between the two groups except higher mean serum creatinine concentration in the alemtuzumab group (1.65 mg/dL vs. 0.94 mg/dL in the conventional therapy group, $p < 0.001$). At 6 months, there was no