products in Europe as compared to the US. CONCLUSION: While European regulatory bodies have long embraced QoL/PROs (along with efficacy and safety) as key endpoints for approval, the FDA is starting to acknowledge pharmacoconomics in their evaluations. Further research is warranted to determine if there is a correlation between pharmacoeconomic messaging and product uptake, with prescription or unit sales analysis combined with large scale physician surveys on influences of prescribing patterns.

**Abstracts**

**FACTORS ASSOCIATED WITH THE PRESCRIPTION OF ADJUVANT HORMONAL THERAPIES AMONG MEDICAID ENROLLEES WITH BREAST CANCER**

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OBJECTIVE: The purpose of this study was to examine various patient and provider characteristics associated with being prescribed an aromatase inhibitors (AI) v tamoxifen only therapy among a cohort of North Carolina (NC) Medicaid enrollees diagnosed with breast cancer. METHODS: Data was gathered using the Linked NC Central Cancer Registry-Medicaid Claims database which links NC cancer registry claims with Medicaid data. A logistic regression model was built to determine the odds of an individual ever receiving an AI during the study period. RESULTS: A total of 600 patients were included, of which 451 (75.2%) and 149 (24.8%) received tamoxifen only and AI (alone or in combination) therapy, respectively. Results showed that patients who lived in urban areas (compared to rural), were postmenopausal (based on age ≥55), had regional- or distant-staged cancer (opposed to local or unknown), had been hospitalized in the year prior to treatment index, and had breast conserving surgery (BCS) (rather than mastectomy) had 1.97 [1.29, 3.00], 2.26 [1.80, 2.83], 2.74 [1.79, 4.20], 1.87 [1.20, 2.92], 0.64 [0.41, 1.00] times the odds, respectively, of ever receiving an AI compared to tamoxifen only. Additionally, for every one-year increase in the time a patient started hormonal therapy, the odds of receiving AI therapy (compared to tamoxifen only) increased 2.26 [1.80, 2.83] fold. CONCLUSION: The differences in antiestrogenic treatment type based on whether the patient visited a hospital in the year prior to the study and in whether the patient lived in urban or rural area may represent disparities in access to advances in care. Furthermore, it may be the case that women who undergo mastectomy or who have locally staged cancer are not being treated aggressively enough with novel antiestrogenic therapies.

**DRUG UTILIZATION PATTERNS AND COSTS FOR ERYTHROPOIESIS-STIMULATING AGENTS (ESAS) IN A MANAGED CARE CANCER POPULATION RECEIVING CHEMOTHERAPY**


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OBJECTIVE: To assess current utilization patterns and costs for epoetin alfa (EPO) and darbepoetin alfa (DARB), two ESAs, in managed care cancer patients receiving chemotherapy. METHODS: Medical claims from the Ingenix Impact National Managed Care Database between January 2006 and June 2007 were analyzed. Patients included were ≥18 years old, had ≥1 claim for cancer within 90 days prior to treatment initiation, were newly initiated on EPO or DARB with ≥2 doses of either drug, and received chemotherapy during ESA treatment. Mean cumulative ESA dose was used to calculate ESA cost (based on October 2007 wholesale acquisition cost [WAC]) and dose ratio. RESULTS: A total of 2322 EPO and 4353 DARB formed the study population. EPO patients were older (57.7 vs. 55.7 years; p < 0.0001) and a lower proportion were women (65% vs. 69%; p = 0.0002), compared to DARB patients. Mean ESA treatment duration was slightly longer in the EPO group (59 vs. 55 days; p = 0.0001). The mean cumulative dose (SD) was 312.723 (255.432) Units for EPO and 1174 (833) mcg for DARB, resulting in a dose ratio of 266:1 (Units EPO : mcg DARB). Based on these doses, WAC-based ESA cost was 28% less for EPO than for DARB (EPO $3915; DARB $5434; p < 0.0001). A sensitivity analysis using January 2008 average sales price +6% also indicated lower cost for EPO (EPO $2803; DARB $3396; p < .0001). This finding was also maintained after adjusting for age, gender, treatment duration, payer type, type of malignancies, cancer treatments, and severity indicators, (adjusted cost difference: $1788, p < 0.0001). CONCLUSION: This observational study of 6675 cancer patients reported a dose ratio of 266:1 which resulted in a 28% lower drug cost in the EPO group compared to the DARB group. These findings provide greater understanding of current real-world ESA utilization in the managed care setting.

**EFFECT OF THE HUNGARIAN ORGANIZED NATIONWIDE CERVICAL CANCER SCREENING PROGRAMME ON THE COVERAGE OF WOMEN UNDER THE AGE OF 25 YEARS**


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OBJECTIVE: Organized nationwide screening programme for cervical cancer was introduced in Hungary in 2003. The aim of this study is to analyze the three year screening rate (coverage) of the organized cervical cancer screening programme in women aged less than 25 years. Although women under 25 years are out of the scope of the organized screening programme, opportunistic screening may be applied. METHODS: The data derive from the financial database of the National Health Insurance Fund Administration (OEFS) of Hungary covering the period of 2000–2002 (without organized screening) and 2003–2005 (with organized screening). We calculated the three-year screening rate for 2003–2005 according to the age-group of women less than 25 years (15–19 and 20–24). Screening is defined with cytological examination of Papanicolaou smear and includes all smears taken either within or outside of the organized programme. RESULTS: The three-year screening rate of women aged 25–64 years was 52.65 % in 2003–2005. The coverage of women under 25 years was the following in 2003–2005: 15–19 years: 31.94%; 20–24 years: 61.20%. Comparing this values to the coverage of 2000–2002 (without organized screening) we found a decreasing tendency in these two age-groups: 15–19 years: −0.06 percent point decrease (non-significant), 20–24 years: −6.28 percent point decrease (p < 0.01). CONCLUSION: We found that coverage of women aged 20–24 being out of the scope of the organized cervical cancer screening programme is higher (61.2 %) than the average of target age group of 25–64 years (52.65%). Despite of this finding, the coverage of women 15–19 and 20–24...