CONCLUSIONS: The reimbursement of sunitinib would bring benefits to patients may be a useful method for assessing the efficiency of new mBC treatment options replacing placebo 20,441/84,214 PLN/84,296 PLN (1.9 months at £10180), bevacizumab (H9004 3.5% for benefits were used.Discount rate of 5% for costs and logues, BSC, severe adverse events and palliative care gained (LYG) and life years gained without disease progression (LYGPF) were used as the measure of effectiveness quality adjusted life years (QALY), life years were the source of data on the efficacy of sunitinib and the health states 2011 weighted of 1.7 months at £36560), eribulin (H11001 14,188/24,162)). The 2011 weighted effectiveness in terms of median OS were included in the EFA. To perform cost-utility (CUA) and cost-effectiveness (CEA) analysis of sunitinib in combination with the best supportive care (BSC) in treatment of well-differentiated pancreatic neuroendocrine tumors (g-NE), unresectable or with metastases. OBJECTIVES: The Markov model constructed in TreeAge Pro 2009 was used in the analysis. The time horizon covered the period from start of treatment until the patient death (definite horizon). Study Raymond 2011 and porter (ishak 2011 were the source of data on the efficacy of sunitinib and the health states utility. As the measure of effectiveness quality adjusted life years (QALY), life years gained (LYG) and life years gained without disease progression (LYGPF) were used and the QALYs were cost-converted into cost-utility/effectiveness ratios (ICUR/CER. CUA and CEA analyses were conducted from the perspective of the public payer for health services (Polish National Health Fund, PNHF) and from the patient and PNHF perspective. Following direct medical costs were included: sunitinib, administration of the drug, diagnostic and monitoring, somatostatin analogues, BSC, were adverse events and palliative care. Discount rate of 5% for costs and 3.5% for benefits were used. RESULTS: The cost of gaining an additional QALY replacing placebo by BSC with sunitinib is 84,214 PLN/84,296 PLN (€20,441/ €20,461) from PNHF/PNHF-patient perspective. Similarly, the cost of gaining an additional QALY is 58,450 PLN/58,507 PLN (€14,388/€14,341, 2011) and the cost of gaining an additional LYGPF is 79,868 PLN/79,946 PLN (€19,386/€19,405). Sunitinib + BSC is more costly and more effective therapy. Obtained results are placed below the acceptability threshold in Poland (which is about 99,543 PLN (€24,162). The 2011 weighted average of Polish National Health Fund was €1 – PLN 4 1198. CONCLUSIONS: The reimbursement of sunitinib would bring benefits to patients for whom there is currently no other effective treatment option. Sunitinib in combination with BSC prolongs overall survival and time to next progression.

CONCLUSIONS: The treatment of advanced esophago-gastric cancer (gEC) in Poland. Previous clinical studies have shown the Xeloda®-based regimen, EXO, to be non-inferior to the 5-FU-based counterpart, FOLFOX4, in terms of efficacy. This study aims to compare the new concurrent combination treatment with FOLFOX4. METHODS: Thirty-seven patients were identified from the electronic records at a public tertiary hospital, with 26 and 11 received EXO and FOLFOX4 regimens respectively. Health care cost refers to direct medical costs including drugs, clinic follow-up, hospitalization, diagnostics, laboratory and non-invasive device, its placement, maintenance and removal (as required for 5-FU administration) and the continuous infusion of 5-FU via a Continuous Ambulatory Delivery Device pump or infuser. RESULTS: This economic evaluation has shown that treating advanced gEC patients with capecitabine in a triplet and a double chemotherapy combination regimen results in average cost savings of $5,291 and $2,142 respectively, when compared with 5-FU. A multi-way sensitivity analysis demonstrated that the use of capecitabine remained cost-saving from an Australian government health budget perspective.

CONCLUSIONS: Patients in the EXO group had a trend toward a greater proportion of patients with stable disease or better (49%) and a lower proportion of patients with progressive disease (37%) compared with the FOLFOX4 group (38% and 44% respectively). The time to progression was longer in the EXO group compared with the FOLFOX4 group (hazard ratio 1.6; 95% CI 1.2–1.9). The OS benefit for the EXO group over FOLFOX4 was 5.2 months (95% CI 1.0–9.4; p=0.026). Differences in the incidence of adverse events between the two treatment groups were not significant. CONCLUSIONS: The results of this study support the use of EXO as the initial treatment for patients with advanced gEC in selected Australian patients. Xeloda®-based regimen was non-inferior to FOLFOX4 in terms of OS and DFS. Compared with the FOLFOX4 regimen, Xeloda®-based regimen may be cost-saving from a societal perspective.

PCN94 FEASIBILITY OF EFFICIENCY FRONTIER ANALYSIS (EFA) IN METASTATIC BREAST CANCER (MBC) TREATMENTS: A UK PERSPECTIVE

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OBJECTIVES: EFA may be useful for assessing the efficiency of newer interventions. This study evaluated whether EFA could be useful in identifying the efficiency of mBC therapies adopted by the NHS, and to identify the efficiency frontier for newer technologies. METHODS: A literature search identified mBC treatments that underwent HTA in the UK. Reports were reviewed to identify treatment efficacy and HTA recommendations. Costs were determined for a course of treatment. The incremental costs per patient were plotted on the horizontal axis and incremental median overall survival (OS) of treatment was plotted on the vertical axis to construct the EFA line. Treatments below this line are considered inefficient. Treatments above this line have better OS and may redefine the efficiency frontier. Treatments in the upper right quadrant beyond the frontier line are in an area where ceiling price has not been defined. Treatments in the lower right quadrant beyond the frontier line are inefficient due to higher cost for lower OS. RESULTS: Ten reports that evaluated efficacy in terms of median OS were included in the EFA. The therapies are paclitaxel albumin, gemcitabine, trastuzumab, bevacizumab, lapatinib, and luteinising hormone-releasing hormone agonists. On the frontier line are paclitaxel albumin (OS of 2.3 months at £20200), gemcitabine (OS of 2.8 months at £6000), and trastuzumab (OS of 4 months at £16939), all received positive recommendations. Lapatinib (OS of 1.9 months at £10180), bevacizumab (OS of 1.7 months at £36560), eribulin (OS of 2.5 months at £4834) and fulvestrant (OS of 2.3 months at £4834) are all below the frontier line and received negative recommendations. CONCLUSIONS: EFA may be a useful method for assessing the efficiency of new mBC treatment options for clinical use. Further studies are needed to better understand value in terms of efficiency of treatments in other tumor types and disease areas.

PCN95 PHARMACOECONOMIC ANALYSIS OF DIRECT MEDICAL COSTS ASSOCIATED WITH THE TREATMENT OF ADVANCED ESOPHAGO-GASTRIC CANCER TREATMENT WITH XELODA® OR 5-FU/ORAL C5 REGIMENS: IMPLICATION FOR HEALTH CARE UTILISATION IN AUSTRALIA

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OBJECTIVES: A cost-utility analysis (CUA) and cost-effectiveness analysis (CEA) was undertaken based on real-world evidence from randomized clinical trials (RCTs) and observational studies to determine the direct medical costs associated with the use of capecitabine (Xeloda®) compared with 5-FU, or oral C5 for the treatment of advanced gEC. METHODS: Twenty-one studies were included in the CUA. Costs were calculated from an Australian healthcare payer perspective.

CONCLUSIONS: RESULTS: The costs of these therapies from both the health care and societal perspectives. 5-FU-based counterpart, FOLFOX4, in terms of efficacy. This study aims to compare the new concurrent combination treatment with FOLFOX4. METHODS: Thirty-seven patients were identified from the electronic records at a public tertiary hospital, with 26 and 11 received EXO and FOLFOX4 regimens respectively. Health care cost refers to direct medical costs including drugs, clinic follow-up, hospitalization, diagnostics, laboratory and non-invasive device, its placement, maintenance and removal (as required for 5-FU administration) and the continuous infusion of 5-FU via a Continuous Ambulatory Delivery Device pump or infuser. RESULTS: This economic evaluation has shown that treating advanced gEC patients with capecitabine in a triplet and a double chemotherapy combination regimen results in average cost savings of $5,291 and $2,142 respectively, when compared with 5-FU. A multi-way sensitivity analysis demonstrated that the use of capecitabine remained cost-saving from an Australian government health budget perspective.

CONCLUSIONS: Patients in the EXO group had a trend toward a greater proportion of patients with stable disease or better (49%) and a lower proportion of patients with progressive disease (37%) compared with the FOLFOX4 group (38% and 44% respectively). The time to progression was longer in the EXO group compared with the FOLFOX4 group (hazard ratio 1.6; 95% CI 1.2–1.9). The OS benefit for the EXO group over FOLFOX4 was 5.2 months (95% CI 1.0–9.4; p=0.026). Differences in the incidence of adverse events between the two treatment groups were not significant. CONCLUSIONS: The results of this study support the use of EXO as the initial treatment for patients with advanced gEC in selected Australian patients. Xeloda®-based regimen was non-inferior to FOLFOX4 in terms of OS and DFS. Compared with the FOLFOX4 regimen, Xeloda®-based regimen may be cost-saving from a societal perspective.

PCN97 PHARMACOECONOMIC ANALYSIS OF THE PROSTATE CANCER TREATMENT WITH GONADOTROPIN-RELEASING HORMONE ANALOGUES: LEUPRORELIN, Goserelin, Triptorelin

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OBJECTIVES: To perform an economic evaluation of prostate cancer (PC) treatment with lutetinizing hormone-releasing hormone agonists (LHRA): leuprorelin (L), gos-

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