to contemplate. The question how innovative technologies can be financed is there even now. We estimated the direct medical costs of breast cancer treatment in Iran in the period of 21/03/2011-20/03/2014 and examined the fraction of total costs related to trastuzumab use. METHODS: A retrospective claims database analysis was performed using data from the Iran Social Security Organization, a health insurer which covers approximately 50% of the Iranian population. Data mining techniques helped to identify patients and determine resource use in the three stages of breast cancer (early, loco-recurrence and advanced). Using a healthcare perspective, absolute and relative costs of various medical services associated with treatment of HER2-positive breast cancer among Iranian women in both public and private healthcare systems were calculated. RESULTS: The patient population comprised 1295 women (mean SD age: 45.6 (10.3) years) and mean follow-up was 739 days (mean age: 21-107). Average costs of drugs and chemotherapy in early loco-recurrence and advanced stages were €2,707 (range: €98-€23,680, €2,751 (€31-€23,420) and €13,030 (€15-€45,813), respectively. Average costs of radiotherapy and diagnostic tests were €132 (€7-€2,054), €516 (€2-€49,840) and $8,507, respectively. Average costs of trastuzumab for the largest share of total costs (58%), followed by paracutaneous services (12%), radiotherapy (10%), and other drugs and chemotherapy (9%). CONCLUSIONS: Trastuzumab is an expensive drug which may require a substantial share of available resources and advanced stages were not adherent to SOC for patients in each risk category. The model includes realistic assumptions for physician practices and a utility analysis with Markov modeling and cohort simulation were used to model treatment decisions such as radiofrequency ablation (RFA). This study evaluated the cost-effectiveness of this new biomarker test compared with the current standard of care (SOC) surveillance and treatment of BE. METHODS: Decision analysis with Markov modeling and cohort simulation were used to model treatment costs and effectiveness (savings) from a health plan perspective. Costs were derived from Geisinger Health Plan claims data and quality-adjusted life-years (QALYs) from the medical literature. The model includes realistic assumptions for physician adherence to SOC for patients in each risk category. RESULTS: Preliminary results of a 5 year model of using the new biomarker test compared to SOC include an incremental cost-effectiveness ratio of €75,804 in U.S. 2012 dollars. Cumulative endoscopies in the biomarker test arm were 6.23% greater than with SOC and there were 73.3% fewer cumulative RFAs under SOC than with the biomarker test. Compared with SOC, the number of patients in the HGD, EAC, and death stages in the biomarker test arm were 52.5%, 60.9% and 9.83% fewer, respectively. CONCLUSIONS: Using this new biomarker test to risk stratify BE patients wA200

PCN62 ASSESSING THE ECONOMIC BURDEN AND HEALTH CARE RESOURCE UTILIZATIONS OF U.S. MEDICARE PATIENTS WITH MYELOPROLIFERATIVE NEOPLASMS

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OBJECTIVES: To examine the economic burden and health care resource utilization of myeloproliferative neoplasms (MPNs) in the U.S. Medicare population. METHODS: A retrospective data analysis was performed using the U.S. national Medicare claims from January 2008 through December 2012. MPN patients were identified using International Classification of Disease 9th Revision Clinical Modification (ICD-9-CM) diagnosis codes 284, 238, 234, 238, 738, and 289.83. The diagnosis date was designated as the index date. A comparison cohort without a MPN diagnosis was created for patients of the same age, region, gender, index year and baseline characteristics. Patients were chosen for the comparison cohort to reduce selection bias. Patients were required to have continuous medical and pharmacy benefits 1 year pre- and post-index date. One-to-one propensity score matching (PSM) was performed to compare follow-up resource utilizations between the cohorts, adjusting for demographic and clinical characteristics. RESULTS: Eligible patients (N=17,950) were identified for the MPN and comparison cohorts. After 1:1 PSM, a total of 5,546 patients were matched from each cohort and baseline characteristics were well-balanced. MPN patients had a higher percentage of health care resource utilizations, including Medicare carrier (98.6% vs. 65.9%), Durable Medical Equipment (DME; 29.5% vs. 14.4%), Home Health Agency (HHA, 12.4% vs. 5.0%), outpatient visits (76.6% vs. 67.4%), inpatient hospitalizations (27.2% vs. 6.8%) and Skilled Nursing Facility (SNF; 75.3% vs. 20.0%) visits than non-MPN patients. Patients diagnosed with MPNs also incurred significantly higher costs, including Medicare carrier ($3,872 vs. $1,283), HHA ($624 vs. $529), outpatient ($10,061 vs. $5,204), inpatient ($5,449 vs. $1,054), pharmacy ($1,069 vs. $713) and total health care costs ($23,060 vs. $7,076; p<0.0001). CONCLUSIONS: MPN patients had a higher burden of illness compared to non-MPN patients.

PCN63 SYSTEMATIC LITERATURE REVIEW OF COST OF ADVERSE EVENTS IN CANCER TREATMENTS IN THE US

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OBJECTIVES: To evaluate estimates of adverse events (AE) during cancer treatment across all types of cancer and feasibility of using an AE system. METHODS: A systematic literature search was conducted using PubMed. Selection criteria included studies published in the English language between January 2008 and October 2013, evaluating the cost of following AEs: neutropenia, thrombocytopenia, vomiting, nausea, peripheral neuropathy, sepsis, diarrhea and fatigue/stenosis, due to cancer treatment in the US. Costs were extracted for care and control cohorts (if available) and the cost difference between the cohorts was calculated to provide the additional cost due to the AEs. This difference in costs was then adjusted to 2013 USD. RESULTS: A total of 893 abstracts were screened, of which 15 unique studies were included. The distribution of studies reporting the selected AEs were: neutropenia (n=5), thrombocytopenia (n=5), vomiting (n=5), nausea/vomiting (n=3), peripheral neuropathy (n=1), sepsis (n=2), diarrhea (n=1) and fatigue/stenosis (n=1). The studies reported inpatient, outpatient, or total healthcare costs, with different units including per patient, per patient-year (PYPY), per episode, per episode or per patient. The AE cost varied vastly; the range of U.S. 2013 costs varied from $0 to $6,000 (inpatient) while the PYPY cost ranged from $9,800 (outpatient) to $21,000 (total healthcare costs). CONCLUSIONS: AEs commonly encountered in cancer treatment remain an expensive problem despite medical advances. In addition to the high cost of cancer treatment, the cost of managing AEs adds to the economic burden on patients, Payers, and society. This study highlights that the cost of AEs associated with cancer treatments are consistently high and consume a large portion of healthcare resources.

PCN64 RECEPTIONS OF BIOSIMILAR MONOCOCCAL ANTIBODIES AMONGST EUS BUDGET HOLDERS

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OBJECTIVES: Braided biologics will soon begin to face competition from incoming biosimilar monoclonal antibodies (mAbs), with many currently in development. Given the transition many markets are making towards becoming increasingly cost conscious, we sought to investigate how budget holders across the most important European markets perceived the incoming oncology biosimilar mAbs. METHODS: The research was conducted through in-depth interviews and focus groups with budget holders across EUS. RESULTS: The primary driver for biosimilars was proven clinical equivalence experience evaluating and making decisions on small molecule biosimilars (e.g. filgrastim, EPO). However, there was a lack of experience and knowledge amongst respondents on small molecule biosimilars (e.g. filgrastim, EPO). Respondents also suggested that key institutions or regions will make decisions early on while other less resourced centres/regions will adopt their decision. Conversely, clinicians are apprehensive of biosimilar mAbs and anticipate resisting