“baseline” year served as control data. RESULTS: There were 1500 intervention and 286 control community pharmacies. The use of CER and evidence-based medicine (EBM) was evaluated using a 5-point Likert scale (5=strongly agree, 1=strongly disagree). The other products in the pipeline with established BTDs show 20-30% higher response rates than other drugs in the same category. The six approved BTDs show 36%-136% improvement in efficacy (based on active controls or comparable efficacy, and passive studies). The establishment of the BTD pathway, 55 products have been granted breakthrough therapy designations (2012-2015), of which, 42 have been publically disclosed by the manufacturers and 6 have been approved by the FDA. In terms of indications, 43% are for cancer, 14% for rare diseases, 14% are for Hepatitis C, Genotype 1. The median time to approval for these drug was >5 years, significantly shorter than the 2012 median time to approval for priority review applications (6 years). The price premium was 30-50%, compared to other drugs in the same category. The six approved BTDs show 20-30% higher response rates than other products in the same category. The other products in the pipeline with established comparators show 36%-136% improvement in efficacy (based on active controls or comparable efficacy, and passive studies). For approximately half of the products, comparative efficacy cannot be determined because of no previous evidence for a product with efficacy in the targeted indications. CONCLUSIONS: BTD is a promising pathway to shorten development time and provides early access, however, the high price could pose challenges for payers and patients.

PHP156  THE USE COMPARATIVE EFFECTIVENESS RESEARCH AND EVIDENCE BASED MEDICINE IN US FAVOR DECISION MAKING   Sax M1, Sneering J2, Brook K1  1The Pharmacy Group (TPG), Glastonbury, CT, USA, 2The TPG-NPRT, Glastonbury, CT, USA  OBJECTIVES: To understand how comparative effectiveness research (CER) is being used by US managed care plans and pharmaceutical benefit managers (PBMs) to control costs and ensure that appropriate utilization of pharmaceuticals is achieved through priority setting by pharmacy and therapeutics (P&T) committees. METHODS: Managed care (MC) and pharmaceutical pharmacy directors (MDs or PDMs) completed an online interactive survey. Topics included: advisor and planner information and current/future coverage of CER. The use of CER and evidence-based medicine (EBM) was evaluated using a 5-point Likert scale (5=strongly agree, 1=strongly disagree). RESULTS: Fifty-four percent of respondents were MDs, the remainder mostly pharmacists. Most worked for a health plan (83.6%) and 36.6% of the plans were local, 35.4% national, and 25.0% regional. Public (Medicare and Medicaid) and private (Commercial) plans were represented. When asked to select the area emerging CER is expected to affect: value of care (29.8%), optimization/improvement of clinical guidelines (27.7%), appropriate care (14.9%), pharmaceutical research and development (6.4%), medical and pharmacy benefit management (17.0%), and 4.3% uncertain. When asked about their agreement in “progress in obtaining usable information on CER of therapies the results were slightly negative with 42.5% disagreeing (34%<0.5%-completely), 38.3% agreeing (4.3%-completely, 34%-somewhat, and 19.1% neutral. When asked if they expect their plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral. When asked how much they plan to use CER regularly in formulary decision making by 2015, more than half (53.2, 14.8%-completely, 38.3%-somewhat) agreed, 27.7% disagree (23.4%-somewhat, 4.3%-completely) and 19.1% neutral.