PHP106
EXPLORING THE VARIABILITY BETWEEN DISEASE TYPE AND THE PROPORTION OF SUBMISSIONS WITH ICERS HIGHER THAN THE THRESHOLD THAT ARE ACCEPTED BY HTA AGENCIES
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OBJECTIVES: Health technology assessment (HTA) agencies use an incremental cost-effectiveness ratio (ICER) threshold, generally understood to be £30,000 for NICE (England), £30,000 for the SMC (Scotland), CAN$50,000 for CADTH (Canada), and AUS$42,000 for PBAC (Australia). To inform future submissions, we explored the proportion of accepted submissions by disease area and examined any variability in the proportion of submissions that were accepted despite the reported ICERs being higher than these thresholds. **METHODS:** All HTA appraisals from January 2000 to January 2014 from NICE, SMC, CADTH, and PBAC were included in the analysis. Multiple technology appraisals, vaccination programmes, requests for advice, and submissions for which an ICER could not be determined were excluded from analysis. Appraisals were categorized by BNF disease type and the full responses were reviewed; the submitted ICER, recommendation, and reasoning behind the recommendation were extracted. **RESULTS:** Across all four agencies, 679 submissions met the inclusion criteria and 218 submissions included a higher than threshold ICER, with 62 (28%) of these accepted. The proportion of submissions with ICERs above the threshold that were accepted varied by disease type, ranging from 0% (Cardiovascular System) to 50% (Skin). This variability was largely due to the low number of submissions with ICERs above the threshold in 14/15 disease type categories. The remaining disease type (Malignant Disease and Immunosuppression) accounted for the majority (59%) of all submissions with ICERs higher than the threshold; 36/128 (28%) of these were accepted. Key decision drivers for acceptance included unmet clinical need, and condition of participation in a patient access or risk sharing scheme. **CONCLUSIONS:** A considerable proportion of submissions were accepted despite ICERs above the threshold, but this proportion varied widely between disease types. The majority of disease types had few submissions reporting ICERs above the threshold, with the exception of Malignant Disease and Immunosuppression.

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EXPLORING THE VARIABILITY BETWEEN DISEASE TYPE AND THE PROPORTION OF SUBMISSIONS WITH ICERS LOWER THAN THE THRESHOLD THAT ARE REJECTED BY HTA AGENCIES
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OBJECTIVES: Health technology assessment (HTA) agencies use an incremental cost-effectiveness ratio (ICER) threshold, generally understood to be £30,000 for NICE (England), £30,000 for the SMC (Scotland), CAN$50,000 for CADTH (Canada), and AUS$42,000 for PBAC (Australia). To inform future submissions, we explored the proportion of rejected submissions by disease area and examined any variability in the proportion of submissions that were rejected despite the reported ICERs being lower than these thresholds **METHODS:** All HTA appraisals from January 2000 to January 2014 from NICE, SMC, CADTH, and PBAC were included in the analysis. Multiple technology appraisals, vaccination programmes, requests for advice, and submissions for which an ICER could not be determined were excluded from analysis. Appraisals were categorized by BNF disease type and the full responses were reviewed, with the submitted ICER, recommendation, and reasoning behind the recommendation extracted. **RESULTS:** Across all four agencies, 679 submissions met the inclusion criteria and 405 submissions included a lower than threshold ICER, with 126 (31%) of these submissions rejected. The proportion of submissions rejected despite ICERs below the threshold varied by disease type. Disease types where a high proportion (≥50%) of submissions were rejected despite ICERs below the threshold included 'Respiratory System' (55% rejected), 'Central Nervous System' (55%), and 'Nutrition and Blood' (55%). Disease areas with a low proportion (≤20%) of rejected submissions were 'Infections' (19%) and 'Eye' (20%). Key decision drivers for rejection these disease types were due to high levels of uncertainty regarding clinical-effectiveness, and subsequent cost-effectiveness. **CONCLUSIONS:** The proportion of submissions that were rejected varied dramatically by disease type. In some disease types over half of submissions with an ICER below the threshold were not recommended largely due to non-robust economic analyses, which may indicate inherent underlying difficulties in these disease types in submitting a conclusive data package.

PHP108
CONSISTENCY IN REIMBURSEMENT DECISIONS AT CANADIAN HTA AGENCIES: INESSS VERSUS CDR
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OBJECTIVES: To compare the positive recommendation rate and agreement between CDR and INESSS. **METHODS:** In Canada, eligible non-cancer prescription drugs approved by Health Canada are reviewed by 2 health technology assessment (HTA) agencies: the Common Drug Review (CDR) and the Institute national d'excellence en santé et en services sociaux (INESSS). CDR is part of the Canadian Agency for Drugs and Technologies in Health (CADTH), which makes reimbursement recommendations that are considered by provincial and federal plans, with the exception of Quebec, in making their formulary coverage decisions. In Quebec INESSS performs HTA and issues recommendations to the Regie d'assurance maladie Quebec (RAMQ). Prior to INESSS, HTA in Quebec was performed by the Conseil du Médicaments (CdM). Using our proprietary CDR Tracker®database we examined the recommendations by both agencies and compared recommendation positivity and congruence for all drugs which have been reviewed by CDR, up to December 31, 2013. We separately considered positive and negative recommendations by both agencies. **RESULTS:** The overall positivity rate for CDR recommendations in this period was 52%, compared to 66.9% for INESSS. Of the 275 recommendations issued by CDR, 143 were negative and INESSS agreed with CDR in 90% of these recommendations. 132 of CDR's recommendations were negative, of which INESSS agreed in 48% of cases. **CONCLUSIONS:** INESSS has a higher positive recommendation rate and, possibly due to the broader scope for funding recommendations, frequently disagrees with CDR's analysis, particularly when CDR's recommendation is negative.

PHP109
INTERNATIONAL HTA REFERENCING – A REALITY?
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OBJECTIVES: Countries already have a long history of referencing each other on drug prices through International price Referencing. However it is still unclear whether a similar kind of referencing exists for overall market access decisions. The objective of this report is 3 fold: first to identify if decision referencing exists between these countries and if yes how. Secondly to understand the extent of influence one country might have over another, and thirdly whether this process is formal or informal. **METHODS:** The research was conducted through in-depth secondary research and interviews with stakeholders in 14 countries including the UK, Ireland, Germany, France, Spain, Portugal, Italy, Sweden, Canada, Australia, The Netherlands, Austria, Hungary and Poland **RESULTS:** NICE (UK), SMC (Scotland), and AWMSG (Wales) represent the more sophisticated attempts to integrate HTA into the decision-making process and are currently the most influential HTAs in the world with over 60 countries referencing them worldwide. IQWiG (Germany), HAS (France), TLV (Sweden), and HSE (Ireland) form the medium influence HTA agencies. This can be attributed to the fact that these agencies have their own unique approach to HTA. These agencies consider clinical effectiveness and comparator studies over cost effectiveness models. Poland, Spain, Italy, Austria, Hungary, and Portugal form the low influence HTA agencies that capitalize on the lessons learned from more established international HTA systems due to lack of in-house qualified personnel and resources for HTA activities. **CONCLUSIONS:** The research indicated that there is definitely a cross-influence influence of market access decisions between countries across geographies. Decisions are referenced informally, via direct contact with other HTA agencies, through international networking platforms like EUnetHTA, and INAHTA, or accessing published assessment reports. Variance in the level of influence can be attributed to the age and maturity of the HTA, and longevity of assessment performed (specifically cost-effectiveness assessment).

PHP110
PHARMACOECONOMIC EDUCATION IN BRAZILIAN SCHOOLS OF PHARMACY
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OBJECTIVES: The Pharmacoeconomics allows economic evaluation of products and services for health and helps a lot the health care decision-making. Therefore, there is a need for training of human resources with solid knowledge in pharmacoeconomics in Brazil. However, little is known to what extent Pharmacoeconomics is taught in schools of pharmacy in Brazil. The objective of this study was to survey the pharmacy schools in Brazil to determine the extent of education in pharmacoeconomics offered during the school year 2012-2013. **METHODS:** A questionnaire based on previous studies [Rascati (1998, 2005, 2013) was developed. This was emailed to 55 pharmacy schools in Brazil during October and December 2013. The schools were selected from the Ministry of Education website. University schools of public and private (only those that have high concepts in the National Examination Performance of Students) were included. In addition, a search was made in the database directories of research groups from National Council for Scientific and Technological Development (CNPq). **RESULTS:** Results of the questionnaires sent 55, 14 went unanswered. Only one school does not address the teaching of Pharmacoeconomics in no time. Most discuss some concepts within various disciplines (see 8:0). Four schools have formal disciplines that teach only Pharmacoeconomics or health technology assessment (more than 30 hours). All agree that the education of pharmacoeconomics is important. In the search for directories of research groups were found 23 groups that develop research in the area of Pharmacoeconomics in Brazil. **CONCLUSIONS:** Pharmacoeconomics education in Brazil is still in its infancy and there is a unique opportunity for well-trained instructors and researchers to fill this gap. Provide an education in Pharmacoeconomics to pharmacy and economists students is especially important in the context of evidence-based decisions and when health issues and allocation of scarce resources is a priority for Brazilian Health System.

PHP111
AN ANALYSIS OF REAL WORLD DATA TRENDS IN GLOBAL HTA MARKETS
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OBJECTIVES: The nature and frequency of global stakeholder real world data (RWD) "ask" is growing and there is an impact of not having RW evidence upon market entry such as delayed approval, suboptimal reimbursement and unfavorable re-evaluation. We aimed to assess RWD use for market access (MA) decisions in key global markets. **METHODS:** Search of the HTAWatch database supplemented by an online search of MA stakeholders in the US, UK, Australia, and Canada for use of RWD to support of initial assessment, re-evaluation or coverage and reimbursement recommendations. Use of RWD included safety, effectiveness, economic or quality of life studies. We also assessed theevidence level required from registry to provider or patient survey data. **RESULTS:** In the UK, the National Health Service uses real-world adherence studies to update national treatment guidelines and inform reimbursement. In Australia, the Pharmaceutical Benefits Advisory Committee is willing to delay or make temporary decisions in anticipation of RWD on a product's clinical effectiveness or economic value message. The