status, and treatment patterns. Physicians were screened for duration of practice (active) and patient volume (≥15 HCV patients/mo) and recruited from a large panel to be geographically representative. Medical charts of the next 10 consecutive HCV patients were abstracted. G1 HCV patient data was analyzed. RESULTS: The analysis combined data published by the Italian Medicines Agency (AIFA) and Regions and national laws, to understand the impact of the applied policies on PPIs expenditure. Over the past ten years, PPI consumption increased by 280% (around 14 years), with lansoprazole reaching +533%. The number of patients ≥18 treated with PPIs in 2013 was 2.873.500 (6% of adult population), being the first class in terms of expenditure with a per capita value of 15.2€. The number of prescriptions of 74 DDD/1.000 inh./die. Consumptions and expenditure increased by respectively 6.5% and 1.6% vs 2012. AIFA also highlighted a trend to prescriptive inappropriateness over the years, where the 46.5% of patients do not meet the reimbursability criteria by law. At regional level, Regions have issued a number of regional laws to contain both consumptions and expenditure (e.g. Italy/Spain/UK) - currently treated:23%/28%/20%/17%/20%, not currently treated:16%/26%/32%/24%/32%. Treatment patterns included (France/Germany/Italy/Spanish policy)(scale: 0-100 worst-best); mean EQ-SD was 46.6±22.2 and 55±21.7 (scale: 0-100 worst-best). Over follow-up, 76% and 73% European patients consulted a GP (mean: 4.2 and 4.9 visits), and 100% and 92% a gastroenterologist (mean: 2.2 and 2.8 visits). 17% and 18% required emergency department visits/hospitalization (mean stay: 6.66±4.28±4.6 days). 51% and 65% of patients took prescription drugs for the IPS 61% and 67% took non-prescription drugs. Mean symptom severity (IBS-BSS) improved: 338.9±87.6 (baseline) to 281.5±102.6 (months) for the French cohort; 522.8±84.3 to 253.9±105.6 for the European cohort. The total mean (95%CI) annual cost for moderate-to-severe IBS-C was 4,128 (2,624-6,630) for the French cohort; €4,639 (3,733-5,598) for the European cohort. CONCLUSIONS: Moderate-to-severe IBS-C symptoms in France were similar to those other European countries, implying the need for high quality of life and the high economic burden of IBS-C continued to be a burden for both efforts with a high economic cost despite availability of therapeutic interventions.

PG57 MEDICAL RESOURCE UTILISATION OF AUSTRALIAN PATIENTS WITH GENOTYPE 1 CHRONIC HEPATITIS C: A RETROSPECTIVE OBSERVATIONAL STUDY

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OBJECTIVES: To understand medical resource utilisation (MRU) of Australian patients with genotype 1 chronic hepatitis C (GT1 CHC) including those receiving care for chronic hepatitis B (CHB) and those with hepatitis D (HD) or E (HE) co-infection before or during treatment. METHODS: Medical records were reviewed for a stratified random sample of 1681 CHC patients first attending two liver clinics between 2011 and 2013 (principal population, PP) supplemented by all GT1 CHC patients attending specialist liver transplant clinics in the same periods (transplant population, TP). CHC-related MRU (percentage and annual rate [PP] on-cost of outpatient, hospitalisation, laboratory and imaging tests) is reported for the PP by treatment status (treated/not treated) stratified by fibrosis grade; and for TP pre-transplant, year of transplant and post-transplant. RESULTS: Comprehensive MRU was collected for 276 PP patients (F0-1 n=59, F2 n=58, F3 n=53, F4 n=106; 38 were treated with treatment-naive or -resistant to first virological response; follow up 17.6±8.9 years); 50% received triple therapy. Data were collected for 112 TP patients (mean follow-up 29.9 months), 33 (29.5%) received a transplant during the study and 51 (45.5%) beforehand. MRU was higher while treated including annual rates of outpatient visits (PP: 9.67±2.91 vs 2.60±2.90, F0 3.65, F2 3.63, F4 3.33); TP: transplant 18.00 vs 2.55, p<0.05, 5.14, psychiatric visits (PP: 0.71 vs 0.18 [F0-1 0.25, F2 0.16, F4 0.20, F4 0.14]; TP: transplant 0.00 vs 0.05, p<0.01), nurse visits (PP: 1.84 vs 0.42 [F0-1 0.58, F2 0.42, F4 0.31, F4 0.32]), and the percentage with hospitalisation (PP: TP: transplant 37.3% vs 13.0% [F0-1 1.3%, F2 10.3%, F4 9.4%, F4 21.7%]; TP: transplant 100% vs pre 96.5%, post 79.2%). CONCLUSIONS: CHC-related MRU increases substantially with disease severity. To our knowledge, these are the first real-world MRU reported for GT1 CHC in Australia and will be valuable in assessing the impact of hepatitis C treatments.

PG58 HEALTH TECHNOLOGY ASSESSMENT IN CHRONIC HEPATITIS C: ASSESSMENT OF DECISION LANDSCAPE AND MANUFACTURER INPUTS IN SIX AGENCIES

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OBJECTIVES: To evaluate the landscape of health technology assessment (HTA) decisions for chronic hepatitis C (CHC) treatments in Canada (CADTH), Australia (CREA), France (PfG), England and Wales (NICE), Scotland (SMC), Germany (QWIG), and France (HAS). METHODS: Selected HTA agency websites were searched for submissions for CHC therapy and accepted for HTA: clinical and economic input provided in the submission, recommendations from HTA agencies, and drivers of HTA decisions. RESULTS: Vitekavis®, Daklinaza®, Roferon A®, Intron A®, Harvoni®, Viekirax®, Pegasys RBV®, PegIntron®, Rebetal®, Oslegra®, Botox®, Novartis. Manufacturer submissions were available across selected agencies. The number of HTA submissions with complete status reported ranged from 6-12. The percentage recommendation reported ranged from 43% in Australia to 100% in France and Canada. The number of clinical studies supporting the manufacturer submission ranged from 2-12. The
quality of clinical evidence originating from same studies has been rated different.

Economic analyses, while clinical evidence was primarily based on cost-effectiveness/cost utility analysis (CEA/CUA), comprising -95% of studies (time horizon 50 years to lifetime). The incremental cost-effectiveness ratios (ICER) ranged USD150000-200000 in FRAC, USD1246-37672 in NICE, USD750-45200 in CADTH, and USD100000-75000 in SMC. More than 90% of the decisions on the basis of ICER values were positive, with restriction being focused on cost negotia-

45200 in SMC, and USD11000-75000 in CADTH. More than 90% of the decisions on the basis of ICER values were positive, with restriction being focused on cost negotia-

tions. The primary driver of positive decisions was majorly economic analysis in NICE, PBAC, and SMC, while clinical evidence decisions related to being anticoagulants in NICE, PBAC, and SMC. The evidence driven positive recommendations in ICER values were positive, with restriction being focused on cost negotia-

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PG159 COMPARISON OF REGULATORY LABELS AND HTA DECISIONS FOR CHRONIC HEPATITIS C TREATMENTS

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OBJECTIVES: To compare the regulatory label indications and health technology assessment (HTA) recommendations for therapies indicated for the treatment of chronic hepatitis C (CHC). METHODS: We reviewed the regulatory label approvals by European Medicines Agency (EMA), Health Canada (Canada), and US Food and Drug Administration (Australia). HTA reports for CHC therapies published by NICE (England and Wales), SMC (Scotland), HAS (France), IQWIG (Germany), CADTH (Canada), and PBAC (Australia) were reviewed. HTA decisions with a restricted indication (recommended or restricted) were included in the analysis. Indication was split into four categories: (i) age of the population (children, adults, or both), (ii) fibrosis status (naïve, cirrhotic, genotype), (iii) additional indication (treatment-experienced), and (iv) treatment group (different drugs in the same class). Results: A total of 34 regulatory approvals and 48 HTA reports were identified from the public domain. Forty-six HTA reports providing a positive decision were included. Overall, HTA decisions correlated well with the marketing authorization (89%), with the highest correlation observed for CADTH and FRAC (100% each), followed by HAS (98%), NICE and SMC (86% each) and IQWIG (63%). Across agencies, highest correlation was observed for age of the population (96% cases) and lowest for the prior treatment history (96% cases) of the population for whom the therapy was recommended. CONCLUSIONS: Overall, the indication approved by HTA agency almost completely correlated with the indication granted marketing authorization, except for NICE, SMC and IQWIG, indicating differences in agency priorities driving HTA decisions. Analyzing the population restriction applied by NICE, SMC and IQWIG would provide the decision drivers, allowing manufacturers to address these concerns in prospective submissions.

PG160 TRENDS IN HEALTH TECHNOLOGY ASSESSMENT DECISIONS ACROSS THE GLOBE: A FOCUS ON GENOTYPES C AND D

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OBJECTIVES: To describe the real-world use of the world use of adalimumab (ADA) for maintenance treatment of ulcerative colitis (UC) on a national level in Sweden. METHODS: A longitudinal, retrospective cohort study was conducted using the National Drug Registry and the National Patient Registry. UC patients treated with ADA were identified. Patients treated with ADA for ≥50 mg, and of these 40 (20.9%) had a subsequent dose de-escalation which occurred after a median time of 162 days. In total 992 UC patients were identified in the cross-sectional cohort, defined as at least one prescription during May 2013 and May 2014. Policy details: Five hundred and sixty patients on maintenance treatment dispensing at least 22 injections during 2013-April 2014, and of these 364 (37%) were on maintenance treatment. Out of the 364 patients on maintenance treatment dispensing at least 22 injections during the period 140 (38%) received 30 injections or more. CONCLUSIONS: This study demonstrates that UC patients receiving ADA in general have a greater prescription pattern, and that the proportion of patients who dose escalate is high. This finding and the impact that dose escalation has on costs may have implications for healthcare professionals and budget holders.

PG161 BILOGIES IN ULCERATIVE COLITIS (UC): TREATMENT GUIDELINES AND HEALTH TECHNOLOGY ASSESSMENTS (HTA)

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OBJECTIVES: To review clinical guidelines, recent HTA decisions, and the influ-

ence of the guidelines on HTA decisions, considering the high unmet in this area. Most of the restric-
tions were around cost negotiations. The drivers of decisions fit with agency priorities, with economic analysis being the key driver in agencies with pharmacoeconomic analysis, and clinical evidence in agencies without pharma-

coeconomic analysis.

PG162 DOSE ESCALATION AMONG ULCERATIVE COLITIS PATIENTS TREATED WITH ADALIMUMAB IN SWEDEN

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OBJECTIVES: The objective was to describe the real-world use of adalimumab (ADA) for maintenance treatment of ulcerative colitis (UC) on a national level in Sweden. METHODS: A longitudinal, retrospective cohort study was conducted using the National Drug Registry and the National Patient Registry. UC patients treated with ADA were identified. Patients treated with ADA for ≥50 mg, and of these 40 (20.9%) had a subsequent dose de-escalation which occurred after a median time of 162 days. In total 992 UC patients were identified in the cross-sectional cohort, defined as at least one prescription during May 2013 and May 2014. Policy details: Five hundred and sixty patients on maintenance treatment dispensing at least 22 injections during 2013-April 2014, and of these 364 (37%) were on maintenance treatment. Out of the 364 patients on maintenance treatment dispensing at least 22 injections during the period 140 (38%) received 30 injections or more. CONCLUSIONS: This study demonstrates that UC patients receiving ADA in general have a greater prescription pattern, and that the proportion of patients who dose escalate is high. This finding and the impact that dose escalation has on costs may have implications for healthcare professionals and budget holders.

PG163 EFFECTS OF FINANCIAL INCENTIVES FOR SAVING DRUG EXPENDITURES ON PHYSICIAN PRESCRIPTION BEHAVIORS

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OBJECTIVES: The purpose of this study is to assess the impact on physician pre-

scription behaviors of an outpatient prescription incentive program providing financial rewards to primary care physicians for saving prescription costs imple-

mented in October 2010 in South Korea. METHODS: A 10% sample of clinics (N = 1,625) was randomly selected from the entire clinics in the National Health Insurance claims database for the years 2009-2012, and all claims with the primary diagnosis of peptic ulcer or gastro-esophageal reflux diseases were extracted from those clinics’ data. We used a clinic-level random effects model analyzing policy effects on drug expenditures and prescribing behaviors including prescription rate of medicines treating target diseases, number of drug prescribed per claim, prescription duration per claim. We also performed subgroup analyses by selected clinic characteristics, including practice type, size and specialty. RESULTS: We found no significant impact of the program on drug expenditure overall. Prescription rate of the medicines for target diseases, prescription duration per claim decreased after the incentive program. After the financial incentive program, clin-

ics in general medicine showed a lower prescription rate (by 0.8 percentage points), lower drug expenditure per claim (by 740 won). Small clinics had shorter prescription duration (by 0.76 days), while large clinics and clinics in group practice had a higher prescription rate (by 1.5 and 2.5 percentage points, respectively) and higher number of medicines prescribed (by 0.03 for group practice only) after the program. CONCLUSIONS: The financial incentive program worked as intended only in certain subgroup clinics for the target medicines. The reduction in prescription duration and the number of prescribed medicines in target claims in selected subgroups imply some margin for prescription adjustments.