the limited availability of databases reporting the same information in Italy, the objectives of this study were to assess the applicability of the Belgian analysis, and to estimate cost differences between ESAs in Italy. METHODS: To adapt the Belgian data for the Italian setting, costs were replaced with Italian-specific costs, and discrepancies in epidemiology and treatment patterns were examined. Adjusting for country discrepancies, costs were analyzed using a mixed-effects model stratifying for propensity score quintiles as in Spaepen et al. Sources included European national cancer registries, IMS sales data, treatment and reimbursement guidelines, and reimbursement public tariffs. RESULTS: The Italian and Belgian populations were similar in terms of age, gender, ESA use and blood transfusions. The Belgian dataset was adjusted to reflect the incidence of haematological, lung, female and venous genital cancers. No major differences between datasets were found regarding the use of ESAs or blood transfusions. In Italy, total costs (mean±SE) were €10,546±873 for DARB versus €14,063±745 and €13,274±910 for EPO-A (p=0.0001) and EPO-B (p=0.0008), respectively. Anaemia-related costs were €3,144±335, €1,033±334 and €1,083±344 for DARB, EPO-A and EPO-B (p=0.0093). ESA costs were €2,475±187 for DARB versus €4,241±115 and €3,153±205 for EPO-A (p=0.0001) and EPO-B (p=0.0139). CONCLUSIONS: Total and anaemia-related costs were lowest in patients receiving DARB compared with EPO-A and EPO-B in Italy. These findings are consistent with those from the Belgian analysis, adapting Belgian data to Italy is feasible when accounting for patient and treatment characteristics and costs.

PCN37

COST-MINIMIZATION ANALYSIS OF SECOND-LINE CHEMOTHERAPY FOR NON-SMALL-CELL LUNG CANCER (NSCLC)

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OBJECTIVES: To compare the costs associated to second-line chemotherapies for adNSCLC in France. Three therapies, docetaxel, pemetrexed and erlotinib are currently marketed in France for second-line management of advanced non-small-cell lung cancer (adNSCLC). Previous studies showed no statistically differences between these treatments in term of efficacy (median progression-free survival or survival), but there are few data on the costs of these therapies. METHODS: A cost-minimization analysis was based on an indirect comparison of the results of two prospective randomized French clinical trials (GFPC05-06 and CYTAR) and randomized controlled trials (CTA04) in second-line setting. Costs were estimated in the perspective of the French National Sickness Fund and included direct treatments costs (excluding transports) and in-patients costs both for treatment administration and potential adverse events. All costs were estimated on a 100 days period. RESULTS: Studied population included 145 patients treated with erlotinib, 75 patients treated with docetaxel and 75 with pemetrexed. Characteristics of patients were assumed to be similar. Overall, the median direct costs of the second line chemotherapies/100 management days were 9,009€ (IQR: 8,403-12,293) for docetaxel, 14,229€ (IQR: 7,178-20,099) for pemetrexed and 7,134€ (IQR: 6,752-8,669) for erlotinib. Two by two, total costs differences between compared chemotherapies were all statistically significant (p<0.001). The cost breakdowns among drug costs, in-patient stays for drug deliver-y and ambulatory visits, and potential adverse events were respectively 54%, 17%, 0%, 0%, 15% (erlotinib), 73%, 6%, 6%, 15% (pemetrexed), and 59%, 20%, 7%, 14% (docetaxel). CONCLUSIONS: Costs of second-line therapies for adNSCLC appeared to be slightly lower using erlotinib as compared with docetaxel and pemetrexed due to lower administration costs. However, this study was based only on an indirect comparison and head to head trials are required to confirm such a conclusion.

PCN38

ECONOMIC EVALUATION OF DARBEPOETIN ALPHA IN THE MANAGEMENT OF PATIENTS WITH CHEMOTHERAPY INDUCED ANEMIA (CIA) IN GREECE

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OBJECTIVES: An economic evaluation was undertaken to compare the treatment cost of patients on darbepoetin alfa (DA) 500 mcg once every 3 weeks (QW) and 150 mcg weekly (W), epoetin-alfa (EA) 40,000 IU QW, epoetin-beta (EB) 30,000 IU QW and 3-times weekly (TIW) in the management of chemotherapy-induced anaemia (CIA) in Greece. METHODS: The analysis was based on a decision tree model reflecting the local management of patients, driven primarily by their response to therapy (measured in terms of an increase in haemoglobin concentration ≥2 g/dL). As therapies are assumed to be of similar efficacy, a cost-minimisation analysis was undertaken considering National Health Services and patient transportation costs. Different on the data and cost of drugs, and frequency of therapy and response rates, were obtained from the published literature, expert opinions and registries. The model was probabilistic and was used to run Monte Carlo simulations to compensate for uncertainty. Results correspond to 2011 costs. RESULTS: The mean total cost per patient treated with DA-QW was €2951 (95% Uncertainty Interval (UI): €2912-2992), DA-QW €3192 (95%UI: €3075-3308), EA-QW €3781 (95% UI: €3643-3919), EB-QW €3749 (95%UI: €3621-3875) and EB-TIW €4036-4639). Cost-savings associated with DA-QW were: 8% relative to DA-QW, 22% to EA-QW, 40% to EB-QW, and 25% to EB-TIW. The mean cost per response to DA-QW was €3999 (95%UI: €3760-42441), to DA-QW €4326 (95%UI: €4036-4639), to EA-QW €5360 (95%UI: €5322-5790), to EB-QW €7239 (95%UI: €6699-7374) and to EB-QW €8588 (95%UI: €8575-8601). CONCLUSIONS: This analysis indicates that DA-QW and DA-QW may be associated with lower cost in comparison with other options for the treatment of patients with CIA in Greece. Of the two DA-based schemes, DA-QW appears to be associated with lower therapy cost. Research funded by Genzyme Pharma.

PCN39

BURDEN OF BRAIN METASTASIS IN AN METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) POPULATION

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OBJECTIVES: To assess the impact of brain metastasis (BMets) on health care costs and survival among metastatic NSCLC patients in a geographically diverse commercial insured US population. METHODS: Retrospective analyses were conducted using a US commercial administrative claims database linking data from a lung cancer registry and mortality records from the Social Security Administration Death Master File (2005-2010). Two cohorts were formed – a) with BMets, and b) without BMets. Healthcare costs and claims data were adjusted for age, gender, stage, and resource use (hospitalization, emergency (ER) and ambulatory visits) were compared using a generalized linear model (diagnosis –end of follow-up); A Cox proportional hazard model estimated impact on survival. All models adjusted for stage at diagnosis, age, sex, and baseline-comorbidity. RESULTS: Among 854 metastatic NSCLC patients were included (mean 60.5 years/56.3% male); 247 (42.3%) had claims-based evidence of BMets and were more likely to have been diagnosed with stage IV disease (62.8% vs. 52.2% without BMets). Overall survival was shorter among patients with evidence of BMets (median = 13.5 vs. 17.0 months; HR=1.29, p<0.001), health plan enrollment duration was similar (median = 11.7 months). With similar lengths of follow-up, average health care costs following diagnosis of