there are established agencies that evaluate new pharmaceuticals to inform health policy decisions (e.g., the HAS in France and NICE in the UK). This analysis will consider the strengths and weaknesses of European health technology bodies (HTA) and provide insight for the implementation of CER and how lessons learned from the UK and France can help improve efficacy and outcomes in oncology studies. METHODS: Secondary research will be used to review how HTA bodies evaluate oncologics and assess their impact on market access. These countries were selected as they represent the extremes of HTA assessment in Europe. Findings from this research will then be contrasted against current market access issues in the US. RESULTS: While France evaluates new products on innovation and clinical value the UK largely bases market access decisions on cost-effectiveness. Consequently, many new oncology agents available in France have been denied funding in the UK. Meanwhile, insured American patients have relatively open access. CONCLUSIONS: Cancer remains a financially leading cause of death in the US and is a growing health care burden. Therefore better informed policy decisions on the efficient use of services for oncology are critical. This analysis suggests that there is potential for the US to optimize on the European experiences when considering the adoption of a CER tool for oncology drugs management. Specifically, if the US does adopt a formal CER entity, it may wish to avoid using NICE-like economic-based outcomes to change clinical practice, but aim to play an advisory role to facilitate better informed strategic decisions (HAS-like).

PCN143

COST-EFFECTIVENESS OBSERVATIONS AND ONCODO DRUG REIMBURSEMENT RECOMMENDATIONS IN CANADA BY THE JOINT ONCOLOGY DRUG REVIEW

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OBJECTIVES: In Canada, the interim Joint Oncology Drug Review (JODR) conducts health technology assessments for all oncology products and provides funding recommendation to participating provinces. Summaries of these recommendations are publically available, however investigation of the potential factors that influence these decisions has not been conducted. Furthermore, the acceptable incremental cost-effectiveness ratio (ICER) used by the JODR has not been published. This analysis was conducted to assess the differences in the average ICER between the JODR’s positive and negative recommendations and determine the relative influence of cost-effectiveness evidence on decision-making. METHODS: A literature search for pharmaco-economic data was conducted for all 24 drugs with cancer indications reviewed by the JODR and made publicly available between March 2007 and December 2009. Cost-effectiveness data was extracted and converted into Canadian currency using CAD$4.00 = $1.00 (2009). The JODR and Ontario Public Drug Plan (OPDP) recommendations and decisions were analyzed in the context of these ICER values. RESULTS: Cost-effectiveness literature was found for 18 of the 24 drugs and of those, only 15 had published ICER values. ICER values ranged from approximately CADS10,000/QALY to CADS127,000/QALY. The average ICER of those cancer drugs considered to be cost-effective by the JODR was CADS44,269/QALY, whereas the ICER for drugs considered not cost-effective was CADS75,882/QALY (p = 0.10). Furthermore, drugs that were recommended for funding had a lower ICER when compared to those that were not recommended for funding ($57,578 vs. $81,490/QALY, p = 0.50). CONCLUSIONS: These findings suggest that while the ICER may be an important factor in the JODR decision-making process, a careful examination of all factors leading to final reimbursement decision-making is necessary. METHODS: A literature search for pharmaco-economic data was conducted for all 24 drugs with cancer indications reviewed by the JODR and made publicly available between March 2007 and December 2009. Cost-effectiveness data was extracted and converted into Canadian currency using CADS4.00 = $1.00 (2009). The JODR and Ontario Public Drug Plan (OPDP) recommendations and decisions were analyzed in the context of these ICER values. RESULTS: Cost-effectiveness literature was found for 18 of the 24 drugs and of those, only 15 had published ICER values. ICER values ranged from approximately CADS10,000/QALY to CADS127,000/QALY. The average ICER of those cancer drugs considered to be cost-effective by the JODR was CADS44,269/QALY, whereas the ICER for drugs considered not cost-effective was CADS75,882/QALY (p = 0.10). Furthermore, drugs that were recommended for funding had a lower ICER when compared to those that were not recommended for funding ($57,578 vs. $81,490/QALY, p = 0.50). CONCLUSIONS: These findings suggest that while the ICER may be an important factor in the JODR decision-making process, a careful examination of all factors leading to final reimbursement decision-making is necessary.

PCN144

COMPARATIVE KNOWLEDGE OF BREAST SELF EXAMINATION IN MIDWIFERY AND NURSING STUDENTS IN ISLAMIC AZAD UNIVERSITY KARAJ BRANCH

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BACKGROUND: Breast cancer is the most common type of cancer among women worldwide ranking second in mortality from cancer. BSE is a screening tool that should be taught to early age so as to educate women about the importance of early detection of breast cancer. OBJECTIVES: The aim of this study was to evaluate the level of knowledge of midwifery and nursing student regarding breast self–examination. METHODS: This study is descriptive on 23 midwifery and 69 nursing students. Data collection tool was a questionnaire that included questions about demographic characteristics, and 14 question about knowledge breast self examination. Data analyzed by descriptive statistics. RESULTS: Our results show that the average age bring (21±3.5), almost of them are single (%67.4) and (%29.3) twin. Our result showed, there is no significant differences in midwifery and nursing student about breast self–examination. (p > 0.5). Our result showed the students of midwifery and nursing have mild knowledge. CONCLUSIONS: It seems that despite of the importance of the BSE in early diagnosis of breast cancer the majority of women have poor knowledge and practice about BSE. Based on the study, the nurses and most women about BSE is that increasing the knowledge of women by education ways of breast cancer, especially BSE, this will be available by more attention of public health centers, TV and newspaper for increasing women awareness. Key word: breast, student, cancer, self examination.

PCN145

A COMPARISON OF PHYSICIAN AND PATIENT DECISION MAKING FOR FIRST VERSUS SECOND OPINIONS AMONG MEN WITH LOCAL STAGE PROSTATE CANCER

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OBJECTIVES: Expert groups and local stakeholders can significantly affect physician decision making. A better understanding of how patients are influenced by these factors is critical. This analysis suggests that there is potential for the US to optimize on the European experiences when considering the adoption of a CER tool for oncology drugs management. Specifically, if the US does adopt a formal CER entity, it may wish to avoid using NICE-like economic-based outcomes to change clinical practice, but aim to play an advisory role to facilitate better informed strategic decisions (HAS-like).

PCN146

REAL WORLD DATA ON MULTIPLE MYELOMA (MM) TREATMENT IN BRAZIL: GUIDANCE FOR THE PRIVATE HEALTH CARE SYSTEM (PHS)

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OBJECTIVES: New treatments in oncology frequently imply in higher costs. Historically there is a lack of statistical data on cancer treatments in PHS in Brazil. Higher costs combined to lack of information may result in waste of resources. We present here real world data (RWD) on MM treatment collected from a dedicated database of cancer treatments Evidencias® (www.evidencias.com.br). METHODS: Between November of 2007 and October 2009 we retrieved all patients with MM registered here real world data (RWD) on MM treatment collected from a dedicated database of cancer treatments Evidencias® (www.evidencias.com.br). RESULTS: Cost-effectiveness literature was found for 18 of the 24 drugs and of those, only 15 had published ICER values. ICER values ranged from approximately CADS10,000/QALY to CADS127,000/QALY. The average ICER of those cancer drugs considered to be cost-effective by the JODR was CADS44,269/QALY, whereas the ICER for drugs considered not cost-effective was CADS75,882/QALY (p = 0.10). Furthermore, drugs that were recommended for funding had a lower ICER when compared to those that were not recommended for funding ($57,578 vs. $81,490/QALY, p = 0.50). CONCLUSIONS: These findings suggest that while the ICER may be an important factor in the JODR decision-making process, a careful examination of all factors leading to final reimbursement decision-making is necessary. Further research is required to determine if there are differences in the application of the ICER in decision-making processes for oncology medications versus other disease areas.

PCN147

CHARACTERISTICS OF POSTMENOPAUSAL WOMEN INITIATING RALOXIFENE BEFORE AND AFTER AN APPROVAL OF INVASIVE BREAST CANCER RISK REDUCTION INDICATIONS

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OBJECTIVES: This study evaluated characteristics of postmenopausal women (PMW) who initiated raloxifene (RLX) treatment prior to and after the approval of invasive breast cancer (BC) risk reduction (I BCRR) indications. METHODS: PMW 50 years and older with at least one claim for RLX in 2005–2008 and continuous enrollment over the study period (Jan 2004-Dec 2008) were identified in a large national commercial and Medicare supplemental claims database. PMW on RLX were evaluated over the study period (Jan 2004-Dec 2008) were identified in a large national commercial and Medicare supplemental claims database. PMW on RLX were evaluated over the study period (Jan 2004-Dec 2008) were identified in a large national commercial and Medicare supplemental claims database. PMW on RLX were evaluated over the study period (Jan 2004-Dec 2008) were identified in a large national commercial and Medicare supplemental claims database. PMW on RLX were evaluated over the study period (Jan 2004-Dec 2008) were identified in a large national commercial and Medicare supplemental claims database. PMW on RLX were evaluated over the study period (Jan 2004-Dec 2008) were identified in a large national commercial and Medicare supplemental claims database. PMW on RLX were evaluated over the study period (Jan 2004-Dec 2008) were identified in a large national commercial and Medicare supplemental claims database.
year one evaluation of participation and compliance in a program for regional cancer care

Objectives: To examine the prescribing patterns of the recommended pharmacologic agents, immunotherapies (interferon-alpha and interleukin-2) and the newer targeted agents (sunitinib, sorafenib, bevacizumab, temsirolimus and everolimus), for the treatment of advanced renal cell carcinoma ( RCC) and metastatic renal cell carcinoma ( mRCC). The usage and sales trends show a significant increase in the use of targeted cancer therapies, chemotherapies, monoclonal antibodies, small molecules, branded and generics.

RESULTS: During the past five years the usage of targeted cancer therapies and chemotherapy drugs has increased in double digit rates. From 2005-2008, the total prescriptions for targeted cancer therapies and chemotherapies increased by 66% and 30%, respectively. While the sales of both types of these drugs are expanding, the majority of sales growth is attributed to an increasing uptake of targeted cancer drugs. The high usage of targeted cancer therapies versus chemotherapy shows the rapidly changing nature of cancer treatment regime.

Pcni148
one year evaluation of participation and compliance in a program for regional cancer care

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OBJECTIVES: The objective of this study was to evaluate the extent to which oncologist would participate and comply with a program employing clinical pathways. METHODOLOGY: A PQ4 program was enacted in five northeastern states, USA, beginning August 1, 2008. The pathways consisted of physician generated treatment (i.e., breast, hematologic, and colon-rectal cancer) and supportive care pathways (i.e., colony-stimulating factors, erythropoietin stimulating agents, and antineutrophils). Practices were informed of the program three months in advance and allowed to sign up for the program prior to and during the first year of the program. Feedback was provided to participants regarding compliance, and increased fee schedules in year 1 were adjusted in year 2 contingent on compliance in year 1. Compliance was measured through the claims submitted by participating practices on cancer patients starting a new line of therapy after August 1, 2008. Compliance was defined by provision of a drug or regimen not according to the defined pathway. RESULTS: A total of 362 physicians were eligible for participation (174 community based; 34 hospital based; 154 academic based). 49% of all physicians, 88% of community based, 44% of hospital based, and 6% of academic based physicians signed up to participate in the program. 2,119 cancer patients were eligible for compliance analysis. Overall 85.9% of patients were judged compliant to treatment pathways (90.5% breast, 90.9% colon, 72.3% lung). Overall 95.4% of patients were compliant to supportive care pathways (100% CSF, 98.6% ESAs, 91.5% antimetemics). CONCLUSIONS: This study suggests high levels of compliance with clinical pathways may be achieved. Participation varied greatly by practice type. Additional analysis should consider evaluation of alternate definitions of compliance (e.g. errors of omission rather than commission) and reasons for non-participation (e.g. overlap of compliance with potential financial advantage of participation).

Pcni149
electronic medical records: quality cancer care and cost-effectiveness

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OBJECTIVES: To examine the prescribing patterns of the recommended pharmacologic agents, immunotherapies (interferon-alpha and interleukin-2) and the newer targeted agents (sunitinib, sorafenib, bevacizumab, temsirolimus and everolimus), for the treatment of advanced renal cell carcinoma ( RCC) and metastatic renal cell carcinoma ( mRCC). The usage and sales trends show a significant increase in the use of targeted cancer therapies, chemotherapies, monoclonal antibodies, small molecules, branded and generics. RESULTS: During the past five years the usage of targeted cancer therapies and chemotherapy drugs has increased in double digit rates. From 2005-2008, the total prescriptions for targeted cancer therapies and chemotherapies increased by 66% and 30%, respectively. While the sales of both types of these drugs are expanding, the majority of sales growth is attributed to an increasing uptake of targeted cancer drugs. The high usage of targeted cancer therapies versus chemotherapy shows the rapidly changing nature of cancer treatment regime.

Pcni150
trends in usage and uptake of targeted cancer therapies versus chemotherapies

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OBJECTIVES: The oncology market has become one of the major focus areas for pharmaceutical and biotech firms. As of March 2009, 15,752 of 39,747 Phase II, II and III trials listed on clinicaltrials.gov, were related to cancer (approximately 40%). This strong interest in oncology stems from market success of cancer therapies launched in the past decade and the existence of high unmet need to treat different types of cancers. As the number of FDA approved cancer therapies increases there is a need to understand treatment patterns of these cancer drugs. METHODS: To understand the trends in usage and oncology sales we analyzed the trends from 2005-2008. RESULTS: 2005-2008 data for all FDA approved cancer drugs. Drugs were categorized as targeted cancer therapies, chemotherapies, monoclonal antibodies, small molecules, branded and generics. RESULTS: During the past five years the usage of targeted cancer therapies and chemotherapy drugs has increased in double digit rates. From 2005–2008, the total prescriptions for targeted cancer therapies and chemotherapies increased by 66% and 30%, respectively. While the sales of both types of these drugs are expanding, the majority of sales growth is attributed to an increasing uptake of targeted cancer drugs. The high usage of targeted cancer therapies versus chemotherapy shows the rapidly changing nature of cancer treatment regime.

Pcni151
clinical and socio-demographic determinants of primary prophylactic G-CSF use in elderly breast cancer medicare beneficiaries receiving chemotherapy

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OBJECTIVES: Systemic chemotherapy is a vital component of breast cancer management but early-onset toxicities like neutropenia hinder its administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia and ensures successful chemotherapy completion. Nevertheless, lack of specific guidelines for G-CSF administration in the elderly has led to unexplained geographic and racial, and counter-intuitive clinical variations. For example, older individuals with higher co-morbidities (at higher neutropenia risk) have lower probability of G-CSF receipt. This study examined the reasons for these variations and for the first time looked at variations in PP G-CSF use in relation to geographic, social and racial variations. METHODS: A retrospective observational study of newly diagnosed breast cancer patients receiving chemotherapy was performed using the 1994–2003 SEER-Medicare data. Univariable analyses and multi-variate logistic regressions were used to explore the determinants of PPG-CSF administration. Previously unexplored clinical and therapeutic characteristics (e.g. chemotherapy characteristics before the administration of PPG-CSF) were also included. RESULTS: Univariable analyses demonstrated geographic, racial and clinical disparities similar to previous studies. However, multivariable analyses revealed that controlling for chemotherapy characteristics (type and number of drugs and between cycle duration) made the correlation of age and other clinical characteristics with PPG-CSF administration insignificant. Significant geographic and racial disparities existed. Exploration of geographic variations suggested that regions with higher rates of PPG-CSF administration have higher proportion of physicians administering them; none of the physicians using PPG-CSF administered it on a significantly higher proportion of their patients. CONCLUSIONS: Physicians’ decision to administer PPG-CSF is predominantly driven by neutropenia risk associated with pre-planned chemotherapy regimen. Older, sicker women at a higher risk of neutropenia received less intense/toxic chemotherapy thus did not require PPG-CSF. Geographic variations are driven by provider-level variations in PPG-CSF administration with no evidence for overuse among the providers. Racial and geographic disparities have no clinical basis and are a matter of concern.

Pcni152
Treatment patterns in adult patients with metastatic renal cell carcinoma in the United States

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OBJECTIVES: To examine the prescribing patterns of the recommended pharmacologic treatments for metastatic renal cell carcinoma (mRCC). METHODS: A retrospective claims-based analysis was conducted that identified incident mRCC patients (18–64 years) in the Thomson Reuters MarketScan Commercial Claims Database (January 2005–September 2008). Patients were required to have at least 6 months of continuous enrollment before the index date (first metastases claim) and at least 30 days of continuous enrollment after the index date. Treatment patterns were described as proportions of mRCC patients receiving the following guideline-recommended pharmacologic agents: immunotherapies (interferon-alpha and interleukin-2) and the newer targeted agents (sunitinib, sorafenib, bevacizumab, temsirolimus and everolimus), either as initial or second-line therapies any time on or after the index date. RESULTS: A total of 11390 patients with mRCC were included in the analysis. Mean age was 55.6 years and 70.5% were male. The mean continuous enrollment after diagnosis of metastas