A COST CONSEQUENCE MODEL TO ASSESS THE ECONOMIC IMPACT IN GERMANY OF PATIENTS ACHIEVING KDOQITM TARGETS WITH THE USE OF A COMBINATION OF CINACALCET + TRADITIONAL THERAPY (TT) COMPARED WITH TT ALONE

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OBJECTIVES: From a German health care perspective, to evaluate the cost per patient in achieving KDOQITM targets with the use of a combination of cinacalcet + traditional therapy (combo-CF) compared with TT. The number of patients eligible for cinacalcet was derived from the Open-label, Randomized Study Using Cinacalcet HCL To Improve Achieve-ment of KDOQITM Targets in Patients With End-Stage Renal Disease (OPTIMA) Trial [1], assessing the efficacy of adding cinacalcet to a TT protocol in controlling bone metabolism parameters in dialysis patients with secondary hyperparathyroidism over a 23-week period. KDOQITM targets considered are: iPTH ≤800 pg/mL, calcium (Ca) < 9.5 mg/dL and phosphorus (P) ≤5.5 mg/dL. Resource utilization included the average dose per day, average duration of therapy, and cost per dose. The model compares the use of the combination CF vs TT and the achievement of target vs TT, using a 4-week period to maintain average dose, average duration of therapy, and average cost per dose. The combination CF achieved the target and the cost was lower than the use of a combination of cinacalcet + TT relative to TT alone or no therapy. RESULTS: At the end of the study period, 30.2% (111) of patients receiving cinacalcet + TT achieved their KDOQITM targets, compared with 2.7% (5) for TT. The cost-utility ratio of maintaining target was €491.40 per patient with no therapy and was cost-saving (minus 39.68€ per week) with cinacalcet + TT. The incremental cost per patient at target after 23 weeks was €8,595.06 for patients receiving cinacalcet + TT compared with TT. CONCLUSIONS: Patients receiving cinacalcet + TT achieved their KDOQITM targets at a significantly lower cost per patient, to 4,000 in Spain. ICERs for SMBG a day were of €22,273 vs. €34,785, p < 0.05, primarily due to lower outpatient costs (€7,567 vs. €17,584, p < 0.01). CONCLUSIONS: Duloxetine treatment appears to be associated with delayed use of opioids among patients with DPNP. Health care costs were also lower for patients initiated on duloxetine vs. SOC treatment.

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WHO ARE THEY FOOLING?: COST OF DISEASE OR COMPLICATIONS CAN SIGNIFICANTLY BIAS ESTIMATES UNLESS CONTROL (NON-DISEASED) COSTS ARE NOT ACCOUNTED FOR IN THE ANALYSIS

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OBJECTIVES: Costing studies often do not identify the excess costs incurred by the health care system for patients with a disease vs. patients without the disease. Using cohort based cost estimates without controlling for costs also incurred by a non-disease population can bias projections, long-term modeling and economic evaluation analyses. The objective of this study was to estimate the prevalence, total and excess costs attributable to diabetes and its complications in Ontario, Canada over 11 years (1995 to 2005). METHODS: Newly diagnosed type 1 and 2 diabetes cases aged 35 and over were identified from the Ontario Diabetes Database and matched 1:2 using propensity scores with controls (non-diabetes cases). The following complications were identified: myocardial infarction, stroke, angina, heart failure, blindness in 1 eye, amputation, nephropathy and cataracts. Excess costs of diabetes were estimated as the difference between costs attributed to patients with diabetes vs. those attributed to patients without diabetes. RESULTS: The prevalence of diabetes rose drastically from 6.5% to 10.5%. Excess costs were $2930 in the year of diabetes diagnosis and $1240 in subsequent years. In the year of an event, cost differences were greatest for patients with diabetes, who had an amputation ($64,133), followed closely by hyperparathyroid-ism (4117) and stroke cases (3965). Excess costs were apparent for both females and males, and the cost amount was strongly associated with increasing age. CONCLUSIONS: Results demonstrate that relying on costs from a population with only the disease (i.e. diabetes) with no control can overestimate costs of the disease and associated complications. Assessing excess costs of disease is important for costing studies, longer-term modeling and economic evaluations in general. Existing studies which do not account for excess cost may overestimate the cost and potentially bias estimates of cost-effectiveness or cost savings due to effective patient management.