from 8.98 ± 1.44% to 7.91 ± 1.19%, decrease in BMI 0.26 ± 1.36 kg/m² and reduction in major and minor hypoglycemic events by 97% and 80% respectively. Probabilities of complications, management costs adjustments (including complications) were derived from the Czech surveys from 2007. Treatment costs were from June 2009. Future costs and clinical benefits were discounted at 3.5% per annum.

RESULTS: The short-term benefits of switching from BHI 30 to BIAP30 are projected to lead to an increase in discounted quality-adjusted life expectancy of 0.493 years (4191 ± 0.090 versus 3698 ± 0.078). Increased total lifetime cost/patient is CZK122,594 ($34,259 ± 1,992 versus 65,712 ± 21,908) with BIAP30. Combined costs and clinical outcomes result in an incremental cost-effectiveness ratio per quality-adjusted life-year (QALYs) gained were dominant. CONCLUSIONS: Core diabetes T2 patients sub-cohort simulation in 15 years perspective Czech observational study has demonstrated acceptable cost-effectiveness for patients with type 2 diabetes treated with BIAP30. BIAP30 treatment was projected to be associated with improvements in life expectancy, QALYs and cost saving compared to BHI 30. Sensitivity analyses show cost-effectiveness result to be robust.

PDB24
A PATIENT-LEVEL SIMULATION MODEL FOR ECONOMIC EVALUATION OF CINACALCET IN THE TREATMENT OF SECONDARY HYPERPARATHYROIDISM (SHPT) IN DIALYSIS PATIENTS.

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OBJECTIVES: Previous levels of parathyroid hormone (PTH), serum calcium (Ca) and phosphorus (P) are associated with an increased risk of cardiovascular death and fracture. Cinacalcet can regulate these levels in patients with SHPT. Here we describe a cost-utility analysis of cinacalcet treatment in SHPT patients in Italy. METHODS: We developed a cost-utility patient-level simulation Markov model to simulate the effect of cinacalcet on individual Ca, P, and PTH levels (based on data of a European multicenter, open-label study); to correlate these levels with mortality and morbidity (cardiovascular events, fractures, and parathyroidectomies) recently published in two reviews; and to incorporate Italian data for dialysis patients and national cost structure. Simulation horizon was patient lifetime; simulated treatment alternatives were standard treatment (mainly vitamin D steroids and phosphate binders), and cinacalcet plus standard treatment. A 3.5% discount rate was applied to life expectancy (LE), quality-adjusted life expectancy (QALE), and costs and times in ranges (95% CIs) recommended by the KDQIO initiative. Utilities were derived from a prospective cross sectional survey of 180 end-stage renal failure patients with and without co-morbidities. Costs were evaluated from the Italian National Healthcare Service perspective. RESULTS: Base case results were calculated with 10,000 iterations. Cinacalcet-treated patients had a mean (SD) increase in TiR of 5.60 (6.57), 3.45 (6.85), 1.62 (5.64) and 2.85 (5.60) discounted patient years for Ca, P, and all parameters, respectively. Mean LE extension was 1.16 (3.74) years and QALE increase 0.77 (2.63). The incremental cost-effectiveness ratio (ICER) calculated considering the TiR varied from €5,439 per patient-year in range to €18,748 per patient-year in range (limits for PTH and P, respectively). When considering LE, the average ICER results were €26,148/ly while when considering QALE, the average ICER was €39,454/Quality-adjusted life year. CONCLUSIONS: Cinacalcet treatment could be considered cost-effective but further investigation is needed.

PDB25
THE PHARMACOECONOMIC STUDY OF INSULIN GLARGINE USAGE IN TYPE 2 DIABETES IN POLAND.

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OBJECTIVES: To estimate the cost-utility of insulin glargine in the treatment of diabetes mellitus type 2, in combination with metformin, compared to the standard strategy of treatment in Poland: combination of metformin and sulphonylurea. METHODS: The cost-utility analysis is based on Markov decision model (package Tree Age Pro 2008). The following strategies of treatment were compared: vildagliptin (50 mg twice daily) versus glimepiride (mean dose 4.5 mg/day) both added to metformin (mean dose 1892 mg/day). Direct medical costs were considered: cost of oral antidiabetic drugs (OAD), cost of insulin, additional costs of treatment of type 2 diabetes (e.g. test strips, lancets), cost of general practitioner, cost of specialist visits, cost of complications of type 2 diabetes mellitus treatment. Polish cost data was used. The units of effectiveness in the analysis were quality-adjusted life years (QALY) and life years gained (LYG). The outcome of the analysis was incremental cost-effectiveness ratio (ICER), which presents the cost of gaining one additional unit of QALY or LYG in the in case of using therapy with vildagliptin instead of the comparator. Data concerning clinical effectiveness of compared interventions and also of other strategies of treatment (used after OAD treatment) were taken from RCT studies, long term studies and systematic reviews. The target population consisted of adult patients with diagnosed diabetes mellitus type 2, inadequately controlled with metformin in monotherapy. Both payer’s perspective (National Health Fund and patient) and a lifelong time horizon were assumed in the analysis. RESULTS: Cost of gaining one additional unit of QALY and one additional unit of LYG in the case of using combination therapy vildagliptin+metformin instead of therapy glimepiride+metformin is $58,483 PLN and 589,575 PLN, respectively. CONCLUSIONS: Assuming the Polish acceptable threshold which is 91,914 PLN, treatment with combination of vildagliptin and metformin is cost-effective.

PDB26
PHARMACOECONOMIC CONSEQUENCES OF LOSARTAN THERAPY IN PATIENTS UNDERGOING DIABETIC END-STAGE RENAL DISEASE.

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OBJECTIVES: Diabetic nephropathy is a frequent and serious complication in patients with type-2 diabetes mellitus (DM) and it is the most frequent cause of End Stage Renal Disease (ESRD) in industrialized countries. The global incidence of ESRD continues to rise, and ESRD patients requires intensive and costly treatments such as dialysis or transplantation; thus, the burden of illness is growing and the resources allocated to treatment are increasing. The objective of our study was to evaluate the economic impact of losartan added to the standard care administered to diabetic subjects with End-Stage Renal Disease in Italy. METHODS: We conducted a cost-effectiveness analysis comparing the economic and clinical outcomes deriving from the administration of additional losartan to standard care versus standard care alone in