OBJECTIVES: Several international studies suggest that the time between symptom onset and DMDAR initiation in RA patients is longer than is considered optimal. We sought to estimate the delay in starting therapy that this delay is in an Australian context. METHODS: The delay in DMDAR initiation was estimated from a 2005 study of 96 Australian RA patients referred to one public and four private rheumatology practices. RA-associated utilities and costs were sourced from published data. Costs on the basis of taking DMDARs were assumed to be €37,880 and €37,880, respectively. The annual direct costs of RA, excluding DMDARs, was €32,780, and of DMDAR therapy was €26,580. It was conservatively assumed that DMDAR therapy did not reduce non-DMDAR RA costs. RESULTS: In the 2005 study, the mean time from symptom onset to initiation of DMDAR therapy was 1.48 years. Over this period a mean of 0.65 QALYs would have been lived per patient and $5579 of direct health care costs incurred. Had DMDARs been commenced at symptom onset, 0.80 QALYs would have been lived per patient, and $9503 of direct health care costs incurred. Hence early initiation of DMDARs would have saved 0.15 QALYs at a cost of $3924 per person, equating to an incremental cost-effectiveness ratio (ICER) of $26,583 per QALY saved. An additional $3400 could be spent per patient to reduce the time to DMDAR initiation before the ICER breached the arbitrary threshold of $65,000/QALY. The analysis was conservative in that it did not consider the long-term health consequences associated with suboptimal treatment and permanent joint damage. CONCLUSIONS: The considerable delay in the initiation of DMDAR therapy among patients with RA leads to significant health loss. Reducing the time to initiation of DMDARs represents a cost-effective means of reducing the burden of RA.

PMS48 TOCILIZUMAB IN METHOTREXATE-INTOLERANT OR CONTRAINDI CATED PATIENTS — A COST-UTILITY MODEL FOR THE UK

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OBJECTIVES: To evaluate the cost-effectiveness of monotherapy TCZ in DMARD-IR patients intolerant of or contraindicated to MTX in the United Kingdom (UK).

METHODS: An economic model was developed to reflect the health care system and treatment pathway in the UK. In the model, disease severity is represented by the health assessment questionnaire (HAQ) score, a surrogate health outcome which can be translated to utility scores and ultimately quality adjusted life years (QALYs). The model captures the progression of the HAQ score for each individual patient. Benefits were expressed as QALYs. Costs were calculated from a National Health Service and Personal Social Services perspective. The analysis calculated incremental costs and benefits associated with the addition of TCZ in first line to the standard care pathway involving certolizumab pegol, etanercept and adalimumab. Efficacy data for comparator biologic monotherapies were available from monotherapy trials of adalimumab (van de Putte et al 2004), certolizumab pegol (Fleischmann et al 2005), and etanercept (Moreland et al 1999). TCZ efficacy was informed by results from a recent ADACTA study (Gabay et al 2012), a new head-to-head superiority trial of TCZ and adalimumab monotherapy in RA. The economic model used inputs derived through a mixed treatment comparison that indirectly compared TCZ monotherapy with the standard of care biologic monotherapy treatment (adalimumab and etanercept). The economic model was validated with an extra cost yielding to iCERs below commonly accepted thresholds in most circumstances. TCZ may improve RA outcomes at no extra cost under different circumstances or with an extra cost yielding to iCERs below commonly accepted thresholds in most scenarios.

PMS50 INDIRECT COSTS OF RHEUMATOID ARTHRITIS IN SPAIN RELATED TO WORK ABSENTEEISM, MEDICAL WELFARE AND REHABILITATION COSTS

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OBJECTIVES: To assess the impact of RA on work productivity and productivity costs. RA-associated utilities and costs were sourced from published data. Costs on the basis of taking DMDARs were assumed to be €37,880 and €37,880, respectively. The annual direct costs of RA, excluding DMDARs, was €32,780, and of DMDAR therapy was €26,580. It was conservatively assumed that DMDAR therapy did not reduce non-DMDAR RA costs. RESULTS: In the 2005 study, the mean time from symptom onset to initiation of DMDAR therapy was 1.48 years. Over this period a mean of 0.65 QALYs would have been lived per patient and $5579 of direct health care costs incurred. Had DMDARs been commenced at symptom onset, 0.80 QALYs would have been lived per patient, and $9503 of direct health care costs incurred. Hence early initiation of DMDARs would have saved 0.15 QALYs at a cost of $3924 per person, equating to an incremental cost-effectiveness ratio (ICER) of $26,583 per QALY saved. An additional $3400 could be spent per patient to reduce the time to DMDAR initiation before the ICER breached the arbitrary threshold of $65,000/QALY. The analysis was conservative in that it did not consider the long-term health consequences associated with suboptimal treatment and permanent joint damage. CONCLUSIONS: The considerable delay in the initiation of DMDAR therapy among patients with RA leads to significant health loss. Reducing the time to initiation of DMDARs represents a cost-effective means of reducing the burden of RA.

PMS49 COST-EFFECTIVENESS ANALYSIS OF ETANERCEPT AND INFILIXIMAB IN THE TREATMENT OF RHEUMATOID ARTHRITIS (RA) IN SPAIN

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OBJECTIVES: Etanercept and infliximab are two mostly used biologic disease-modifying anti-rheumatic drugs (DMARDs) for the management of rheumatoid arthritis (RA). The aim of this study was to compare the clinical and economic consequences of using either etanercept or infliximab in the management of RA in Spain. METHODS: A decision analytic model was built to compare trial-based outcomes and costs of compared options. Efficacy data was obtained from an overview of preclinical and clinical trials. Newer therapies in the analysis, other than etanercept and infliximab, were not included because of methodological differences and patients characteristics of their corresponding clinical trials. Different approaches and data sources were used to estimate QALYs from trial-based ACR outcomes and local inputs. DMDAR costs were used to model the economic consequences of using each DMARD for RA treatment for a 1-year period. Probabilistic and univariate sensitivity analyses were performed to test different dose titration, vial waste assumptions and patient weight. RESULTS: Etanercept was associated to 0.033 - 0.042 QALYs gained depending on different sources to convert ACR outcomes to utilities. Model results showed that etanercept was a dominant option (cost savings of 573 € - 10,004 € depending on patients weight) with respect to infliximab in all studied weight scenarios with-