vival (PFS) and progressive disease, using a parametric extrapolation of the NO16966 phase III trial survival data. The predicted time spent in each health state was weighted using published CRC utility scores to account for patient quality of life and to estimate the Quality Adjusted Life Years (QALYs) for both bevacizumab + XELOX and FOLFOX. One-way sensitivity analysis was performed in order to evaluate the uncertainty around the base case estimate of the incremental cost effectiveness ratio (ICER) for bevacizumab + XELOX compared with FOLFOX. Uncertainty surrounding the parameters of the model was evaluated by modifying the costs and parametric survival assumptions. RESULTS: The base case cost per QALY was estimated to be £25,806. The highest ICER was observed when only a 2-year time horizon was taken (£35,241); this, however, does not capture all the costs and benefits of the interventions. The ICER for the scenario in which 100% of FOLFOX patients did not require an inpatient stay was £31,669 and decreased to £14,431 when full sensitivity analysis of the administration costs was performed. CONCLUSIONS: This sensitivity analysis illustrated that the combination of bevacizumab and XELOX demonstrated a stable ICER. Substantial cost savings and health benefits gain through the use of bevacizumab and oxaliplatin in combination with bevacizumab showed to be a cost-effective treatment strategy.