cards. The diabetes-related complications considered in this study were classified into chronic complications (Cardiovascular disease, Cerebrovascular disease, Neuropathy, Retinopathy, Nephropathy, Peripheral vasculopathy, Peripheral arterial disease and foot damage) and acute complications (Ketoacidosis and major hypoglycemic). The direct medical costs were reported as annual costs including hospitalization, daily medications and examinations for DM-related chronic complications and as event costs for diabetes-related complications. All costs were converted using the exchange rate of 6.47 Chinese Yuan to 1 USD. RESULTS: The annual medical cost for DM-related complications per patient with and without hospitalizations: Myocardial infarction ¥2488.32 and ¥2025.26, Angina ¥470.12 and ¥1453.65; Congestive Heart Failure ¥3433.08 and ¥1009.18; Stroke ¥3124.74 and ¥1401.46. Peripheral vascular disease ¥3348.11 and ¥1301.34; Neuropathy ¥2226.86 and ¥854.38. Renal failure with Haemodialysis ¥11245.93 and Peritonaal dialysis ¥7802.03; Renal transplant ¥33772.50 with operation and ¥8934.27 for daily maintenance. The cost for Renal transplantation ¥296.79. CONCLUSIONS: Transition probabilities based on 20-week healing rates in a recent meta-analysis of clinical trials involving foot ulcers with ANGIPARS™ plus GWC versus GWC alone. Transition probabilities were taken from a prospective study of 20 patients and ANGIPARS™ efficacy was based on 20-week healing rates in a recent meta-analysis of clinical trials involving 50 patients. Country-specific treatment cost data were collected in collaboration with local economic consultations and combined with the disease model to estimate the incremental cost per ulcer-free month gained. The model was then run using hypothetical low- and high-intensity resource usage profiles to investigate the economics of caring for diabetic foot ulcers. METHODS: A 6-month Markov computer simulation model was used to assess the cost effectiveness in Iran of treating diabetic foot ulcers with ANGIPARS™ plus GWC versus GWC alone. Transition probabilities were calculated using a grid search algorithm. RESULTS: Over the course of 6-month, individuals were followed and the differences between the ANGIPARS™ plus GWC group and the GWC group were estimated (p < 0.01). The cost of treating diabetic foot ulcers was $2072.22; Infected ulcer treatment: $3007.11; Ketoacidosis: $1493.55; Major hypoglycemic $729.18. CONCLUSIONS: The medical costs for DM-related complications are overwhelming compared with the costs of insulin and hypoglycemic agents especially for those diabetic patients without any co-morbidities. Considering the high prevalence of diabetes and its complications diabetes poses substantial economic burden to the whole society in China.

PDB23

COST EFFECTIVENESS OF ANGIPARS™ IN THE TREATMENT OF DIABETIC FOOT ULCERS IN IRAN

Hashemi Meshkini A1, Keshavarz K1, Gharib Naser Z1, Nikfar S2

Tehran University of Medical Sciences, Tehran, Iran

OBJECTIVES: The primary objective of this study was to estimate the cost effectiveness of treating diabetic foot ulcers with ANGIPARS™ plus good wound care (GWC) versus GWC alone in Iranian healthcare settings. The secondary objective was to analyse the effect of different treatment practices on the economics of caring for diabetic foot ulcers. METHODS: A 6-month Markov computer simulation model was used to assess the cost effectiveness in Iran of treating diabetic foot ulcers with ANGIPARS™ plus GWC versus GWC alone. Transition probabilities were taken from a prospective study of 20 patients and ANGIPARS™ efficacy was based on 20-week healing rates in a recent meta-analysis of clinical trials involving 50 patients. Country-specific treatment cost data were collected in collaboration with local economic consultations and combined with the disease model to estimate the incremental cost per ulcer-free month gained. The model was then run using hypothetical low- and high-intensity resource usage profiles to investigate the economics of caring for diabetic foot ulcers. RESULTS: Over the course of 6-month, individuals were followed and the differences between the ANGIPARS™ plus GWC group and the GWC group were estimated (p < 0.01). The cost of treating diabetic foot ulcers was $2072.22; Infected ulcer treatment: $3007.11; Ketoacidosis: $1493.55; Major hypoglycemic $729.18. CONCLUSIONS: The medical costs for DM-related complications are overwhelming compared with the costs of insulin and hypoglycemic agents especially for those diabetic patients without any co-morbidities. Considering the high prevalence of diabetes and its complications diabetes poses substantial economic burden to the whole society in China.

PDB24

COST-EFFECTIVENESS ANALYSIS OF PREGABALIN™ IN THE TREATMENT OF DIABETIC PERIPHERAL NEUROPATHY

Hashemi Meshkini A1, Keshavarz K1, Gharib Naser Z1, Nikfar S2

Tehran University of Medical Sciences, Tehran, Iran

OBJECTIVES: The diabetic peripheral neuropathy (DPN) is the most common diabetic patients’ complication which is accompanied with substantial economic burden related to quality of life and mortality. In this study, we aimed to examine the evidence needed for drug reimbursement in Australia for diabetes drugs when presenting a CMA. METHODS: Current FRAC guidelines were reviewed specifically from a cost minimisation point of view. Public summary documents (which summarise FRAC deliberations) for all reimbursement decisions related to diabetes drugs over the past 5 years were extracted. Data pertaining to clinical claims, economic analyses and decision were analysed. RESULTS: Public summary documents were reviewed for eight diabetes drugs: insulin glulisine, insulin detemir, liraglutide pioglitazone, rosiglitazone, saxagli- tin, sitagliptin, vildagliptin. Of these, five reimbursement submissions were based on CMA, two on cost effectiveness analyses (CEA) and one on both. The CMA submissions demonstrated non-inferiority when compared to the nominated comparator either by presenting head-to-head clinical trial evidence, adjusted indirect comparisons or pooled individual patient data (IPD) analyses. All were recommended for reimbursement in Australia. Notably, budget impact of each was limited (~AU$10 million over a 5-year period). The three CEA submissions claimed superiority of their products over the nominated comparators either in terms of efficacy or safety but none were successful. Notably, each was associated with a considerable budget impact. CONCLUSIONS: Far from being dead, CMA remains alive and well in Australia. The FRAC accepts CMAs on the basis of non-inferiority and perhaps also if reimbursement is associated with a limited budget impact. Acceptable evidence is not restricted to head-to-head trials, but also includes adjusted indirect comparisons as well as IPD pooled from multiple clinical trials.

PDB25

COST-UTILITY ANALYSIS OF LIRAGLUTIDE VERSUS GLIMEPIRIDE AS ADD-ON TO METFORMIN IN PATIENTS WITH TYPE 2 DIABETES IN CHINA

Gao L1, Li S2

University of Newcastle, Callaghan, N.S.W., Australia, University of Newcastle, Callaghan, NSW, Australia

OBJECTIVES: To evaluate the long-term cost-utility of liraglutide versus glimepiride as add-on therapy to metformin in patients with Type 2 diabetes, based on the results of clinical trial conducted in Asian population. METHODS: The validated UKPDS Outcomes Model was used to project life expectancy, quality adjusted life years (QALYs), incidence of diabetes-related complication and cost of complications in patients receiving those regimens. Baseline cohort characteristics and treatment effects were derived from an Asian study. China-specific complication costs and utility scores were taken from local studies. Patients’ outcomes were modelled for 30 years and incremental cost-effectiveness ratios (ICERs) were calculated for liraglutide compared with glimepiride from the health care system perspective. RESULTS: Over a period of 30 years, compared with glimepiride, liraglutide 1.8mg was associated with improvements in life expectancy, QALYs, and reduced incidences of complications. The val- ued (H11021 AU$10 million over a 5-year period). The three CEA submissions claimed non-inferiority when compared to the nominated comparator either by presenting head-to-head clinical trial evidence, adjusted indirect comparisons or pooled individual patient data (IPD) analyses. All were recommen- ded for reimbursement in Australia. Notably, budget impact of each was lim- ited (~AU$10 million over a 5-year period). The three CEA submissions claimed non-inferiority when compared to the nominated comparator either by presenting head-to-head clinical trial evidence, adjusted indirect comparisons or pooled individual patient data (IPD) analyses. All were recommen- ded for reimbursement in Australia. Notably, budget impact of each was lim- ited (~AU$10 million over a 5-year period). The three CEA submissions claimed non-inferiority when compared to the nominated comparator either by presenting head-to-head clinical trial evidence, adjusted indirect comparisons or pooled individual patient data (IPD) analyses. All were recommen- ded for reimbursement in Australia. Notably, budget impact of each was lim- ited (~AU$10 million over a 5-year period). The three CEA submissions claimed non-inferiority when compared to the nominated comparator either by presenting head-to-head clinical trial evidence, adjusted indirect comparisons or pooled individual patient data (IPD) analyses. All were recommen- d