HT2
APPLICATION OF COST-EFFECTIVENESS LOGIC TO US MANAGED CARE DRUG FORMULARIES: LONG-TERM OUTCOMES OF A VALUE-BASED FORMULARY
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OBJECTIVES: Cost-effectiveness analysis (CEA) is explicitly used for informing drug coverage decisions in many countries but not in the United States. Evidence suggests that failure to incorporate value considerations in drug coverage decisions may lead to reduced economic efficiency in the form of increased costs or worsened health outcomes. Yet the use of CEA in the context of binary coverage decisions (yes or no) may not be politically or socially feasible in the US. In 2010, Premera Blue Cross implemented a value-based formulary (VBF) that uses CEA to determine formulary level-not binary coverage-for each drug in the formulary, drugs with lower incremental cost-effectiveness ratios (ICERs) are assigned lower copayments, drugs with higher ICERs are assigned higher copayments. The objectives were to: assess the impact of Premera’s VBF on healthcare costs and outcomes. METHODS: We utilized an interrupted time series design with concurrent control group in order to examine the impact of the VBF on both pharmacy and medical costs for enrollees and the VBF plan separately and to examine the impact of the VBF on both emergency department visits and acute hospitalizations. In order to accomplish these aims, we utilize segmented regression models with two-part generalized estimating equations for analysis. RESULTS: Preliminary descriptive analysis suggests that over the 4 years of observation, comparing the period before VBF implementation to the period after VBF implementation, both medical and pharmacy costs increased more in the control group ($38.37 and $4.79 per member per month (PMPM)) than in the VBF group ($16.14 and $3.28 PMPM). The number of ED visits and acute hospitalizations did not change in either group. CONCLUSIONS: Preliminary analyses suggest that the use of cost-effectiveness principles in the US context may lead to greater efficiency. Subsequent analyses utilizing greater control for confounding will establish more valid estimates of outcomes and costs.

HT3
ANALYSIS OF NICE DRUG TECHNOLOGY APPRAISALS (2001-SEPTEMBER 2014)
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OBJECTIVES: This study was the National Institute for Health and Care Excellence (NICE) provides guidance and advice to improve health care in the UK. This study assessed the NICE Drug Technology Appraisals published in the period 2001-September 2014. METHODS: The list of NICE guidance, including published guidance, in development and consultations was extracted from NICE webpage. Descriptive statistics and chi-square were used in the analysis. RESULTS: In September 2014, NICE listed 594 guidance documents, including 246 technology appraisals (TA), of which 158 were excluded due to the TA associated with different drugs, combinations or drug classes. 75.8% of the drug TA evaluated was recommended by NICE in the NICE Drug Technology Appraisals published in the period 2001-September 2014. CONCLUSIONS: Most of the TA resulted in a positive recommendation by NICE. Women with ovarian cancer were eligible to receive first-line maintenance treatment for ovarian cancer and estimate benefit-risk trade-offs. In the United States with self-reported physician diagnoses of ovarian cancer and eligible for maintenance therapy completed an online discrete-choice experiment (DCE) survey. The survey presented nine choice questions involving medical outcomes, efficacy, tolerability, and risks of side effects. Each profile was described and respondents who had been diagnosed within the last 2 years compared to those diagnosed more than 2 years ago. In total, 142 patients and 150 physicians completed the TTO questions. Among clinically-relevant levels of the health states for patients, cardiopulmonary arrest had the lowest utility (0.68), with serious hemorrhage (0.74), GI perforation (0.79) and rash (0.91) having higher levels of utility. Utility values for patients showed a similar pattern: cardiopulmonary arrest (0.75), serious hemorrhage (0.76), GI perforation (0.82) and rash (0.92). CONCLUSIONS: Results add to previously published literature regarding utilities for health states outcomes from patients' and physicians' perspectives. Results show that patient and physician ratings of health states were largely consistent, suggesting agreement in the perceived impact of these adverse events.

PT2
PATIENT PREFERENCES FOR FIRST-LINE MAINTENANCE TREATMENTS FOR OVARIAN CANCER
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OBJECTIVES: Elicit medicine preferences of women eligible to receive first-line maintenance treatment for ovarian cancer and estimate benefit-risk trade-offs. Women with ovarian cancer were included in the United States with self-reported physician diagnoses of ovarian cancer and eligible for maintenance therapy completed an online discrete-choice experiment (DCE) survey. The survey presented nine choice questions involving medical outcomes, efficacy, tolerability, and risks of side effects. Each profile was described and respondents who had been diagnosed within the last 2 years compared to those diagnosed more than 2 years ago. CONCLUSIONS: Women with ovarian cancer were willing to trade-off efficacy (PFS) for improvements in side effects and risk. The lack of differences across subgroups suggest consistent preferences across the attributes within our sample. Funded by GSK.

PT3
PATIENT VERSUS GENERAL POPULATION PREFERENCES IN ANTICOAGULANT THERAPY
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OBJECTIVES: To estimate health-state utilities for adverse outcomes associated with metastatic colorectal cancer. METHODS: Patients and physicians completed time-trade-off (TTO) questions. Health states were defined and refined based on literature review, and patient and clinician interviews. Four adverse conditions were considered, and respondents were paid a papouleopapshur rash (rash), severe bleeding, severe heart attack, and gastrointestinal perforations. Respondents estimated the risk of serious bleeding, heart attack, and gastrointestinal perforation. Three event risk levels were randomized across events and respondents. Rash was presented as a deterministic outcome, so respondents evaluated the impact of experiencing the rash, not as a risk of developing rash. Patients and physicians evaluated the health states in TTO questions that provided a range of time in the adverse health state that would leave respondents indifferent between being in the adverse health state and their life spans with perfect health. TTO data were analyzed using an interval regression model to estimate the health-state utility for each side effect. Results were used to infer the health-state utility of the most clinically relevant levels corresponding to the most commonly used targeted treatments for mCRC, VEGF and EGFRI (20% chance of rash, 5% chance of serious hemorrhage, and a 2% chance of gastrointestinal perforations and cardiopulmonary arrest). RESULTS: A total of 127 patients and 150 physicians completed the TTO questions. Among clinically-relevant levels of the health states for patients, cardiopulmonary arrest had the lowest utility (0.68), with serious hemorrhage (0.74), GI perforation (0.79) and rash (0.91) having higher levels of utility. Utility values for patients showed a similar pattern: cardiopulmonary arrest (0.75), serious hemorrhage (0.76), GI perforation (0.82) and rash (0.92). CONCLUSIONS: Results add to previously published literature regarding utilities for health states outcomes from patients’ and physicians’ perspectives. Results show that patient and physician ratings of health states were largely consistent, suggesting agreement in the perceived impact of these adverse events.