drugs at BRL 61 million. **CONCLUSIONS:** The responsible use of OTC medicines can reduce up to 21% of the volume of emergency attendances, and for every BRL 1 spent with OTC drugs is equivalent to an emergency of BRL 7 in the public health system by reducing emergency visits and improditable days. The self-care, if done properly, can be an important factor in the improvement of public health, increas- ing productivity and reducing costs, in addition to providing more time for health professionals in the care of more complex cases. Notwithstanding the expansion of OTC drugs usage should be conducted responsibly with quality products and effective pharmaceutical care.

**PHP103**

**PHYSICIAN PERCEPTION OF PHARMACY ADHERENCE BARRIERS IN A COHORT OF MEDICARE ADVANTAGE PLANS IN TEXAS**

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**BACKGROUND:** Prescription medication adherence is a known health related bar- rier for elderly patients, leading to insufficient disease control and negative health outcomes. Many barriers to prescription adherence have been identified in the litera- ture, but barriers physicians feel most strongly inhibit adherence among patients enrolled in Medicare Advantage Part D (MAPD) plans. **OBJECTIVES:** To identify physician perceived barriers to medication adherence among MAPD patients. **METHODS:** A survey was developed and administered to primary care physicians (PCPs) contracted within a MAPD plan in Texas. Surveys were distributed during an all-PCP quarterly meeting to increase completion and return rates, and were collected prior to the meeting's conclusion. A free response section was utilized for PCPs to indicate what they believed to be the top barriers. If PCPs did not feel a barrier they felt impact the MAPD patients. Responses were categorized into 8 distinct groups (cost- side effects, formulary, lack of patient understanding, forgetfulness, transportation, dosage changes, and other). The "other" category encompassed cultural issues, lan- guage barriers, obtaining drugs outside of the country or not using an insurance card, and problems at the pharmacy. **RESULTS:** A total of 210 PCPs (68%) across Texas completed the survey. An additional 27% of respondents failed to respond to the barrier, reported by 77% of respondents. Patient understanding was also a big concern, iden- tified by 53% of PCPs. Only 18% of PCPs indicated side effects (actual or potential) as a top barrier. Forgetfulness was cited by 22% of PCPs and transportation by 14%. Twenty percent of respondents fell within the "other" category defined above, while formulary (10%) and dosage change (2%) were the least frequently mentioned bar- riers. **CONCLUSIONS:** MAPD PCPs most frequently cite financial issues and lack of patient understanding as reasons for non-adherence in their patients.

**PHP104**

**EVALUATING THE OUTCOMES OF A HIGH-RISK MEDICATION INTERVENTION PROGRAM BETWEEN DUAL AND NON-DUAL ELIGIBLE MEDICARE ADVANTAGE BENEFICIARIES**

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**OBJECTIVES:** High risk medication (HRM) use in the elderly is a quality measure that contributes to the CMS Star Rating. Various clinical programs to target HRM use have been established. However, the impact of interventions among the dual eligible (DE) Medicare Advantage population is unknown. The objective of this study is to compare the impact of a faxed alert intervention directed at HRMs between DE and non-DE Medicare Advantage beneficiaries. **METHODS:** This was a retrospective study of pharmacy claims data among Medicare Advantage beneficiaries > 65 years of age in 2014. HRMs were defined by industry standard of the American Geriatric Society Green Cross for Potentially Inappropriate Medication use in Older Adults. The HRM Avoidance Program alerts the prescribing provider via fax regarding the HRM with recommended alternative(s). Eligible interventions were identified by the first HRM fill in the calendar year. Intervention success was defined when a recom- mended alternative medication was subsequently filled and/or no subsequent fill for the same HRM occurred for > 3 months from the index claim date. **RESULTS:** This data represents 926,585 non-DE and 178,840 DE Medicare Advantage benefici- aries. A total of 127,900 pharmacy claims were eligible for the HRM Avoidance Program of these, 113,627 (89%) were among non-DE and 14,273 (11%) were among DE Medicare beneficiaries. The HRM Avoidance Program was successful among 42% of non-DE compared to 44% of the DE Medicare beneficiaries receiving the intervention (p=0.0001). Significantly higher success rates were observed among DE compared to non-DE beneficiaries with the following medication class results: butal- bital (p=0.005), carisoprodol (p<0.0001), cyclobenzaprine (p<0.0001), ketofen (p=0.0001), indomethacin (p=0.0001), methadone (p=0.0001), and promethazine (p<0.0001). **CONCLUSIONS:** The fax interventions targeting HRM was more successful in the DE than the non-DE Medicare Advantage population. However, further research is needed to understand the factors behind the difference in success for these populations.

**PHP105**

**IMPACT OF NEW CHANGES DUE TO AFFORDABLE CARE ACT ON US MARKET ACCESS**

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**OBJECTIVES:** The Affordable Care Act (ACA) has introduced several major changes which can impact product pricing, access and uptake in the United States. The objective of this analysis was to review all major new changes due to ACA and develop a cost-effectiveness threshold for market access for novel medicines. **METHODS:** Pricing, access and coverage changes impacting the pharmaceutical and devices products were reviewed using the bill for ACA (H. R. 3590), 2011-2013 policy publica- tions, reports by the Congressional Budget Office and Government Accountability Office, and the latest Centers for Medicare & Medicaid Services (CMS) guidelines for Essential Health Benefits (EHBs). Primary discussions with US private payers and ex-CMS policy experts were conducted to understand key issues for medical products. **RESULTS:** The ACA has introduced major changes for product pricing, deductible, coverage and uptake. For pricing, major changes are a 50% discount for Part D population and an increased rebate of 23.1% for the Medicaid population. For uptake, the deductible was increased to $12,700. Additionally, an eligible population is based on expanded access to 30 million uninsured Americans, with more than half of them being under the age of 35 years (-59%). For access, the elimination of Essential Drug Benefits is likely to either expand or reduce coverage depending upon the state and class of drugs. For example, for NSAIDs in CA only 20 drugs are covered, while in NY, 40 drugs are covered. During 2012-2014 Accountable Care Organizations (ACOs) have increased to ~600 organizations covering ~8 million lives which has created a new stakeholder of an integrated provider-payer partnership. **CONCLUSIONS:** ACA has introduced major changes which will have a significant impact on coverage, pricing and access of pharma- ceutical and device products.

**PHP106**

**ARE EUROPEAN PATIENTS READILY ADOPTING SIMILARITY-PRICED AND REIMBURSEMENT OPPORTUNITIES TO OPTIMIZE TREATMENT PAYMENTS?**

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**OBJECTIVES:** Determine if EU pricing and reimbursement (P&R) bodies have revised their P&R approval processes for biosimilar medicines to enable faster access and optimize the potential healthcare savings. This study analyzed the biosimilar P&R procedures across Europe to determine how these differed to the standard and provide recommendations. **RESULTS:** GPs across Europe were not solely influenced by the European countries that account for 90% of EU pharmaceutical spend. The official P&R websites for these 12 countries (France, Germany, Austria, Belgium, Ireland, Spain, UK, Norway, Denmark, Sweden, Greece and Switzerland) were identified and analyzed to determine if biosimilar P&R pro- cess followed the standard, generic or a specific biosimilar P&R approval process. If to be adopted, the P&R documentation for biosimilar guidelines followed the standard P&R approval process. **RESULTS:** Of the 12 countries reviewed, 8 require biosimilars to undergo the full standard P&R process, often requiring submission of comparative clinical data and development of health economic and/or budget impact models. In addition, 6 countries fell within the “other” category defined above, while 4 countries (UK, Sweden and Switzerland) mandated an additional bio- similar price discount be applied. 3 markets applied the generic approval process to biosimilars, enabling faster access to market. Italy was the only country having a specific abbreviated biosimilar P&R pathway, where faster access to market is achieved if a pre-specified biosimilar price discount, dependent on the sales of the reference product, is applied. **CONCLUSIONS:** In the majority of European countries biosimi- lars, unlike generics, are still required to undergo a comprehensive standard P&R process. Such processes take time consuming, resource intensive and costly for both the manufacturers and P&R bodies. The implication is that European payers have yet to consider biosimilars to be clinically comparable to their reference products or to fully recognize the potential healthcare savings from having an expedited biosimilar P&R approval process.

**PHP107**

**THE WHO-COST-EFFECTIVENESS THRESHOLD: A COUNTRY-LEVEL ANALYSIS OF CHANGES OVER TIME**

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**OBJECTIVES:** World Health Organisation (WHO)-CHOICE promotes a threshold defined as three times (3x) gross domestic product (GDP) per capita as a guide to deter- mine the price of pharmaceutical and device products. Cost-effectiveness threshold is the stability of the 3x threshold over time for different countries and the implications of this for frequency of requirements to update the threshold value. **METHODS:** GDP per capita data from 2000 to 2014 were taken from the International Monetary Fund dataset and used to calculate 3x thresholds for a range of countries considered to be representative of different sizes of economies and levels of economic development. Proportional changes in the 3x threshold across the entire period and on a year-by- year basis were analyzed, and time to doubling (and increase by other multiples) of the initial cost-effectiveness threshold was explored. **RESULTS:** The 3x threshold has increased over the period 2000 to 2014 for 99% of all countries analyzed. The average proportional increase in the 3x threshold over this period varied consid- erably by country, with Belarus having the highest proportional increase over the entire time period (94 times). Time to doubling of the 3x threshold was highly variable (range 2.1 – 450 years [median 9.1 years]) and was as low as 2 – 3 years for a number of countries. High levels of variability were observed between countries within the same WHO country groupings. **CONCLUSIONS:** The results suggest that considerable proportional changes to the value of the 3x threshold are observed for a number of countries over the short-term. For some countries, the cost-effectiveness threshold would be expected to increase dramatically even over a yearly timescale. This research highlights the need for countries looking to adopt this threshold to carefully consider requirements for updating the threshold and for managing the impact of this, in instance to relation to incentives for delayed pharmaceutical entry.

**PHP108**

**THE EFFECT OF INNOVATION LAG ON DRUG ACCESS IN TAIWAN**

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**OBJECTIVES:** The objective of this study was to examine the potential barriers to new drugs and biosimilars in Taiwan’s market access policy and how the innovation lag and reimbursement lag, and comparing Taiwan’s approval lag with selected coun- tries. **METHODS:** This study focused on new drugs reviewed by Taiwan’s NHI Drug Assessment Committee (DAC) from March, 2001 to December, 2012. Linear regression was adopted to estimate factors associated with the marketing lag. A two-part