morbidty and mortality is highly desirable. Elevated albuminuria levels have proven to predict worse cardiovascular outcomes. The aim of our study was to estimate the cost-effectiveness and of a population-based ‘screen-and-treat’ procedures directed at albuminuria. METHODS: A formal cost-effectiveness analysis was conducted using a Markov-model for disease progression. The model consist of 8 health states defined by urinary albumine excretion (UAEx) classification (UAEx < 15 mg/day (low-normo), UAEx 15–30 mg/day (high-normo), UAEx 30–300 mg/day (micro), ≥300 mg/day (macro)), cardiovascular morbidity, cardiovascular mortality, non-cardiovascular mortality and renal disease (e.g. dialysis). Input variables for transitions between albuminuria-based Markov stages and effects of blood pressure lowering agents were derived from the observational PREVEND cohort study and PREVEND-IT clinical trial. All costs were presented in 2008 values and the cost-effectiveness analysis was performed following the Dutch guidelines for conducting pharmaco-economic research. RESULTS: Early results for screening the Dutch population on albuminuria (≥15 mg/day) and subsequent ACE-inhibitor treatment in those found positive, suggests a crude cost-effectiveness of €29,300 per life year gained (LYG). Treating only those subjects with microalbuminuria (≥30 mg/day) resulted to be more favorable with a cost-effectiveness of €9700 per LYG. Furthermore, restricting screening to only those subjects aged >50 or ≥60 years resulted in a cost-effectiveness of respectively €15,000 and €10,200 per LYG. These age-dependent figures were even more favorable in those subjects with microalbuminuria. Our preliminary results suggest a favorable cost-effectiveness outcome below the (informal) Dutch pharma-coeconomic threshold of €20,000 per LYG. CONCLUSIONS: Next to the cost-effectiveness outcomes from the PREVEND-IT economic evaluation, our results on observational data suggest favorable cost-effectiveness outcomes for a population-based ‘screen-and-treat’ procedure on albuminuria. Definite results including probabilistic sensitivity analyses will be presented during the conference.

PCV43 MODELED COST-EFFECTIVENESS OF ACHIEVING MULTIPLE LIPID TARGETS WHEN FENOFIBRIC ACID IS CO-ADMINISTERED WITH SIMVASTATIN, ROSUVASTATIN, AND ATORVASTATIN
Webb SF1, Burge RT1, Sørensen SV1
1Abbott Laboratories, Abbott Park, IL, USA; 2Abbott Laboratories, Abbott Park, IL, USA; 3United BioSource Corporation, Bethesda, MD, USA

OBJECTIVES: To compare the short-term cost-effectiveness of simultaneously achieving multiple lipid targets when fenofibric acid (FA) is co-administered with simvastatin, rosuvastatin, and atorvastatin. METHODS: A dyslipidemia outcomes model was used to estimate multiple lipid goal attainment (any 3 of 4 targets: total-C, LDL-C, HDL-C, TG) and associated costs over one year in a patient cohort with multiple lipid abnormalities. Lipid goal threshold values were based on U.S. clinical practice guidelines. Baseline lipid values and lipid efficacy data were obtained from three 12-week FA/statin studies, where FA 135 mg co-administered with atorvastatin, rosuvastatin, and simvastatin at low (20 mg, 10 mg, 20 mg, respectively) and moderate doses (40 mg, 20 mg, 40 mg, respectively) was compared to FA and equivalent doses of each statin monotherapy. Net drug costs were estimated. Drug costs were based on wholesale acquisition costs and were assumed additive. Patient copays were based on national averages. RESULTS: The predicted rate per 1,000 patients achieving 3 lipid targets with the co-administration of FA and low-dose simvastatin, rosuvastatin, and atorvastatin was 678, 814, and 723, respectively. Per member per month drug costs for each low-dose combination were estimated at $24.09, $39.63, and $41.40, respectively. The estimated per patient costs per three lipid goals achieved were $1279, $1753, and $2062 for each respective low-dose combination. The incremental cost effectiveness ratio (ICER) for one additional patient achieving 3 lipid targets when FA is combined with low-dose rosuvastatin and atorvastatin relative to simvastatin is $4,113 and $13,849, respectively. For the moderate-dose combinations, qualitative results are similar though ICERS versus simvastatin for rosuvastatin and atorvastatin were 1.4–1.2 times higher, respectively. CONCLUSIONS: Adding FA 135 mg to simvastatin 20 mg and 40 mg yields the lowest annualized cost per patient achieving 3 lipid targets compared to equivalent dose combinations of FA with rosuvastatin and atorvastatin.

PCV44 COST-EFFECTIVENESS MODEL OF IMPLANTABLE CARDIAC MONITORS (ICM) FOR PATIENTS TREATED WITH RADIOFREQUENCY CATHETER ABLATION FOR ATRIAL FIBRILLATION (PAAF) IN SPAIN
Tsintzos S1, Brosa M2, Murthy A1, Rodriguez Barbrios M1
1Medtronic International, Tolochenaz, Switzerland; 2Oblique Consulting, Barcelona, SC, Spain; 3Medtronic Iberia, Madrid, Spain

OBJECTIVES: An ICM is a programmable monitoring system that stores a patient’s subcutaneous ECG and other diagnostic information. Its features are aimed at detecting arrhythmias and their long term trending. Since long-term continuous AF monitoring is not yet used in patients with PAAF in Spain, its implications in the management of these patients (including possible OAC discontinuation) are still unknown. This study aimed to model the cost-effectiveness of OAC management using ICMs in patients treated with radiofrequency catheter ablation for atrial fibrillation (PAAF) in Spain. METHODS: A Markov model was built to simulate the outcomes and costs of Standard of Care (SOC, traditional intermittent 24H monitors) and continuous AF monitoring with an ICM (Reveal XT) Efficacy data was obtained from clinical studies showing that Reveal was able to detect asymptomatic episodes in AF patients, thus facilitating an optimized disease management that may reduce long-term complications incidence. The risks of stroke, adverse events management and utility figures where taken from international literature; local Spanish costs where used to model the economic consequences of PAAF for three years. Costs and effects were discounted at 3%. RESULTS: Model results show that the continuous long-term AF monitoring with ICMs may be associated to a gain of 0.16 at an extra cost of €6,100, showing an iCER of €37,994 per QALY gained. Sensitivity analysis showed an important uncertainty regarding the effectiveness of ICMs, with a 95% CI of QALY gains of 0.11–0.21. CONCLUSIONS: The preliminary results of this study show that ICMs may improve PAAF outcomes but extra health care costs are to be considered. Longer follow-up analyses and inclusion of eventual quality of life gains associated to the reduction of uncertainty of patients regarding their disease, may improve the economic value of this novel strategy using AF monitoring systems.

PCV45 COST-EFFECTIVENESS OF EPLERENONE IN PATIENTS WITH HEART FAILURE AFTER ACUTE MYOCARDIAL INFARCTION
Martí-Sánchez D1, Martí B1, Sánchez-Maestre C1
1Cardiology Department, Hospital Ramón y Cajal, Madrid, Spain; 2Health Outcomes Research, Pfizer, Spain

OBJECTIVES: In the Eplerenone Post-Acute Myocardial Infarction Heart Failure Efficacy and Survival Study (EPHESUS),