with breast cancer in the UK. METHODS: A previously published decision tree model was populated and developed with the Vial et al. and Brown et al. trial data to assess the cost-effectiveness of using the branded Taxotere® versus its generic counterpart docetaxel from the UK NHS perspective. RESULTS: If the branded Taxotere® was promoted as the first-line therapy, it would cost the UK NHS £411.54 per vial per patient with 0.434 QALY (Quality-Adjusted Life Years) gain compared to £412.98 with the generic docetaxel. Taxotere® was promoted instead and failed the therapy. Although the acquisition cost of docetaxel is more than 50% less than that of Taxotere®, promoting the generic docetaxel based on its lower acquisition cost, only, would result in increasing the total health care cost compared to Taxotere®.

CONCLUSIONS: Based on the decision tree model generated in this study, promoting the branded Taxotere® is more cost-effective compared to its generic counterpart docetaxel. This should be considered for implementation in practice and for future guidelines.

PCN46

COST-EFFICACY ANALYSIS OF LICENSED DRUGS FOR THE TREATMENT OF METASTATIC CAstrate RESISTANT PROSTATE CANcer POST DOCETAXEL BASED ON HOSPITAL DRUG EVALUATION METHODOLOGY IN SPAIN

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OBJECTIVES: To estimate which is the dominant treatment between the two drugs that had been able to demonstrate overall survival (OS) improvements in patients with metastatic castrate resistant prostate cancer (mCRPC) that have progressed on or after docetaxel treatment, and that were approved by the EMA in 2011 (AA: Abraxana® (GW): cabazitaxel (AA) and abiraterone acetate (AA)).

METHODS: We replicated the methodology most commonly used by Spanish hospitals to estimate the cost-effectiveness of oncologic drugs (OS gains and incremental costs vs. those of comparators) by: (i) taking the perspective of the Spanish NHS (ii) estimating treatment costs based on the product labels (i.e. main medication, co-medication, premedication, and primary prophylaxis) at ex-factory prices, and the cost of administering such medications; and (iii) the OS data from the respective pivotal phase III trials: for CBZ vs. mitoxantrone + prednisone (MP) OS was 15.1 vs. 12.7 months; For AA vs. MP: OS was 15.8 vs. 11.2. Input for the base case analysis comes from Phase III randomized clinical trials and from publicly available cost data. Sensitivity analysis was performed on: (i) length of treatment; (ii) median OS; and (iii) G-CSF usage and drug administration costs.

RESULTS: In our base case scenario the cost per cycle of CBZ was 4,711.52€ vs. 78.20€ for MP. The cost per cycle of AA was 3,179.26€ vs. 116.20€ for CBZ. The cost per cycle of AA was 5,350 for prostate cancer. The average disease-specific costs were estimated to be £2,391.706, with a further £189,106 paid for carcinoma in situ of the penis. Per patient, mean costs were approximately £3,743 and £2,392支付 for invasive penile cancer and carcinoma in situ, respectively. Outpatient costs were considerably lower, due to the majority of care being delivered in an ingpatient setting and issues with HES outpatient data collection. Further research into outpatient costs is currently ongoing.

CONCLUSIONS: The burden of penile cancer in the UK has cost implications, the full extent of which cannot yet be ascertained due to underestimation of outpatient costs. Any preventive intervention aimed at decreasing this burden should be carefully considered.

PCN49

ECONOMIC BURDEN OF MELANoma IN Russia

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OBJECTIVES: To estimate the costs associated with melanoma in Russia for 2009.

METHODS: Prevalence-based cost-of-illness analysis (COI) was performed by the payer’s point of view (national and regional governments). Direct medical costs (hospital and outpatient services, and drug expenditures) and indirect medical costs (monetary payments in social benefits) were calculated to estimate total costs.

RESULTS: The total costs of melanoma in Russia in 2009 was 771,2 million RUR (£818,8mln), or 1 314 RUR (£275,9) as average cost per patient per year. Almost half of total costs (48.3%) occur in patients during the 1st year after diagnosis. The direct medical costs accounted for 52,41% of total spending, direct non-medical costs – for 34,9%, and indirect costs – for 12,69%. Direct medical costs represented 72,8% of total spending in melanoma patients within the 1st year after the diagnosis; during the subsequent years the direct costs reduces to 34,9%.

CONCLUSIONS: Our analysis of melanoma patients demonstrates that the most significant part of medical costs for melanoma occur during the 1st year after diagnosis that corresponds with the results of other COI studies in oncology; in subsequent years the main costs are outside the scope of health care system.

PCN50

TREATMENT PATTERNS, HEALTH CARE UTILIZATION, AND COSTS OF OVARIAN CANCER IN CENTRAL AND EASTERN EUROPE USING A DELPHI PANEL BASED ON A RETROSPECTIVE CHART REVIEW

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OBJECTIVES: Despite the considerable disease burden of ovarian cancer (OC), there were no cost studies in Central and Eastern Europe. This study aimed to describe treatment patterns, health care resource utilization and costs associated with OC in Hungary, Poland, Serbia and Slovakia.

METHODS: Overall clinical practice for management of epithelial ovarian cancer was described through 9 Delphi rounds based on the results of 15 expert panel consisting of 15 global experts. Experts completed a survey based on patient records (N=1,542). The survey was developed based on clinical guidelines and the FIGO Annual Report. Means, ranges and outlier values were discussed with the experts during a telephone interview. Finally, consensus estimates were obtained in face-to-face workshops. Based on these results, overall cost of OC was estimated using a Markov model. RESULTS: The patients included in the chart review were followed pre-surgical diagnosis and in each phase of treatment, i.e. primary surgical staging and surgery, chemotherapy and chemotherapy monitoring, follow-up and palliative care. Overall treatment patterns were similar but regimens in second and subsequent lines of chemotherapy varied across the countries. The