erlotinib). Efficacy data were based on the TORCH and TAX317 randomized controlled trials. All costs were obtained from NHS Reference Costs, British National Formulary list prices and other publically-available sources. RESULTS: In the base-case analysis, the estimated incremental cost-effectiveness ratio exceeded the NICE willingness-to-pay threshold of £20,000 per quality-adjusted life year gained. However, the cost-effectiveness was sensitive to the uncertainty and variability around the parameters. CONCLUSIONS: Our model suggests, that from the perspective of the UK, NSCLC with mutast-guided treatment strategy across first- and second-line treatment of NSCLC is not cost-effective compared with a strategy dependent on mutational status.

PCN124
COMPARATIVE COST-EFFECTIVENESS STUDY OF MODERN RADIATION THERAPIES IN HUNGARY FOR LOCALIZED PROSTATE CANCER
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OBJECTIVES: To review the cost-effectiveness studies of chronic lymphocytic leukemia (CLL) treatment, in combination and in comparison with fludarabine and cyclophosphamide chemotherapy (R-FC) in refractory patients or patients who had been previously treated. METHODS: Search and analysis of scientific evidence: the basics of The Cochrane Library, Centre for Reviews and Dissemination (CRD), Embase, MEDLINE, Database of the Brazilian Foundation for Technology (FUNDACIO NISIKERAT), and MEDLINE via PubMed were searched. Aims to meet economic evaluations (AVE), or evaluations of health technologies (ATS), comparing schemas cyclophosphamide and fludarabine (CF) and the same plus Rituximab (R-FC). Studies were only selected in second-line treatment for CLL. RESULTS: Two economic evaluations studies the treatment of patients with refractory or relapsing disease (R-FC vs FC). In the study, 24% had improvement in progression-free survival outcome (p <0.05) in the R-FC, with more patients achieving partial or complete response in this group (61% vs 49%, p <0.05). There was no statistically significant difference in overall survival. The Rituximab caused more adverse effects, but values of statistical significance were only selected in second-line treatment for CLL.

PCN125
SYSTEMATIC CRITICAL REVIEW OF ECONOMIC EVALUATIONS OF RITUXIMAB, ADDED TO CONVENTIONAL CHEMOTHERAPY REGimens IN THE TREATMENT OF PATIENTS WITH CHRONIC LYMPHOCYTIC LEUKEMIC REFRACtory
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OBJECTIVES: To review the cost-effectiveness studies of chronic lymphocytic leukemia (CLL) treatment, in combination and in comparison with fludarabine and cyclophosphamide chemotherapy (R-FC) in refractory patients or patients who had been previously treated. METHODS: Search and analysis of scientific evidence: the basics of The Cochrane Library, Centre for Reviews and Dissemination (CRD), Embase, MEDLINE, Database of the Brazilian Foundation for Technology (FUNDACIO NISIKERAT), and MEDLINE via PubMed were searched. Aims to meet economic evaluations (AVE), or evaluations of health technologies (ATS), comparing schemas cyclophosphamide and fludarabine (CF) and the same plus Rituximab (R-FC). Studies were only selected in second-line treatment for CLL. RESULTS: Two economic evaluations studies the treatment of patients with refractory or relapsing disease (R-FC vs FC). In the study, 24% had improvement in progression-free survival outcome (p <0.05) in the R-FC, with more patients achieving partial or complete response in this group (61% vs 49%, p <0.05). There was no statistically significant difference in overall survival. The Rituximab caused more adverse effects, but values of statistical significance were only selected in second-line treatment for CLL.

PCN126
WHAT IS THE MOST COST-EFFECTIVE STRATEGY FOR TREATING CHRONIC MYELOID LEUKEMIA AFTER IMATINIB LOSSES PATENT EXCLUSION IN EUROPE?
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OBJECTIVES: To analyze the cost-effectiveness of treating all chronic-phase chronic myeloid leukemia (CML) patients with imatinib initially combined with physicians choice between imatinib or the second-generation tyrosine kinase inhibitors (TKIs) dasatinib or nilotinib. Imatinib will lose patent exclusivity in 2015-2016 and its price is expected to drop 60-90% within one year throughout Europe. METHODS: A Markov model describing step-up therapy, physician’s choice, in CML in 2015 models years. The model assumes that the European societal perspective. In both approaches, if initial treatment fails, patients are switched to a second-generation TKI. Patients are assumed to stop if they fail to meet efficacy endpoints: complete cytogenetic response (CoR) or major molecular response (MRM). The model assumes stabilized prices of second-generation TKIs, but discounted 3% for first 6 months; 50% for second 6 months; and 10-30% thereafter. For each drug, tolerance, efficacy and the probabilities of treatment choice, switching and failure were drawn from published clinical trials. Quality-adjusted life years (QALYs) were based on a UK preference weights (Saltelli et al, 2010). Accidental costs including costs of managing patients with severe resource constraints. Multivariate probabilistic sensitivity analyses found step-up therapy-cost effective in 99.9% of 10,000 Monte Carlo simulations. CONCLUSIONS: When imatinib loses patent exclusivity, the optimal treatment protocol is to step-up to second-generation TKIs.