1, 2005 through December 31, 2011 for patients with commercial or employer-sponsored supplemental Medicare insurance. Bevacizumab claims were excluded if the claim was for a diagnosis related to macular degeneration or other eye disease. Claims for both drugs were excluded from the payment analysis if the reimbursed amount was less than $100. All claims were identified as occurring in an office-based setting (OHS), an outpatient hospital setting (OH) or other. The percent of bevacizumab reimbursed in OHS increased from 6 to 37% among Medicare claims, and from 15 to 42% among commercial claims from 2005 to 2011. For trastuzumab, the increases were 9 to 33%, and 17 to 37% in Medicare and commercial claims, respectively. Median commercial claims from 2005 to 2011. For trastuzumab, the increases were 9 to 33%, and 17 to 37% in Medicare and commercial claims, respectively. For Medicare claims, the increases were 88% ($2284 to $4298) and 11% ($228 to $4627) for OHS and OH, respectively. For trastuzumab commercial claims, median reimbursement increased 47% ($2037 to $2996) and 88% ($2749 to $1571) for OHS and OH, while for Medicare the increases were 68% ($1697 to $2854) and 67% ($1570 to $2567) respectively. Claims for both drugs were excluded from the payment analysis if the claim had a diagnosis related to macular degeneration or other eye disease. The direct costs of cancer patients is not restricted only to hospital insuffations and their admissions, but also outpatient expenditures such as oral medications and palliative treatments.

PCN58
DIRECT COST OF CANCER PATIENTS ON BRAZILIAN HOSPITAL AND MEDICINES (CHEMOTHERAPY AND PALLIATIVE CARE)
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OBJECTIVES: To analyze the cost of care in oncology inpatients in private hospitals and their spending on medication (chemotherapy and palliative care). METHODS: We selected patients who consume antineoplastic medicines in Orizon database (16 million lifes) within a 12-month period and analyzed their medical bills including: admissions, hospitalizations (direct costs) and also medicines for palliative treatment. RESULTS: We identified 1244 patients who consume an annual average of R$ 6,342.51 in outpatient use of anticancer drugs per patient and outpatient hospital US$2,70-78 in expenses with a mean hospital stay of 4.60 days with 4.48 consultations per patient to the cost of R$210.56 and the cost of medicines for palliation of R$2.777.16. All patients were identified as being from the base case analysis. In addition, an indirect comparison was used. The base case analysis total costs were estimated to be 699.176 SEK for VATS procedures and 18.033 open procedures were identified. LOS (3.0 – 17.3 days (VATS) versus 5.0 to 23.8 days (open)), hospital costs (US unadjusted: $10.084 to $23.826 (VATS) versus $12.119 – $25.125 (open)) and complication rates were lower for VATS versus open procedures. Similar cost differences were reported in Korea, Japan and China. Post-discharge care and cost of patients with VATS were driven by the utilization of home health care, increased pain management costs, more frequent doctor visits and delayed return to work. CONCLUSIONS: There is wide variability in the care path options associated with management of VATS and associated complications during LVRS in emphysema patients. VATS appears to have a positive health care utilization and cost advantage versus open procedures globally. Further analyses are needed to quantify the true cost of care associated with managing LVRS in VATS patients.

PCN61
CASABINAXEL IN SECOND LINE (2L) TREATMENT OF METASTATIC CAstration-resistant prostate cancer: an economic evaluation in Sweden
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OBJECTIVES: To evaluate the cost-effectiveness of cabazitaxel in 2L metastatic castration resistant prostate cancer (mCRPC) patients who progressed after docetaxel (D) from the Swedish health care perspective in a subgroup of the TROPIC trial. METHODS: A Markov cohort model was used. Transition rates between the health states representing mCRPC disease progression (stable, progression, death) were estimated based on progression of disease and survival rates from the TROPIC trial. The efficacy and safety data is based on the results of the TROPIC trial, which compares cabazitaxel plus prednisone to mitoxantrone plus prednisone in patients previously treated with docetaxel. Resource inputs were obtained from literature, hospital data and key opinion leaders. The subgroup is defined as those patients who initially responded to D but experienced disease progression <3 months since last D dose. At the time of the trial, the combination of Mitoxantrone (M) and Prednisone (P) was considered to be an appropriate second line comparator. In the base-case, M + P is the main comparator, in accordance with the TROPIC trial design. In addition, an indirect comparison versus P alone was carried out. Costs in added life years were added in the model into the societal perspective of Swedish health care system. RESULTS: In the base case analysis, total costs were estimated to be 699.176 SEK for Cabazitaxel, 320.491 SEK for M+P and 302.726 SEK for P alone. For the TROPIC subgroup of IFL, IFL-related death, and other cause death within 100 days of IFL were 0.02 vs. 0.01, and outpatient visits (2.00 vs. 1.17) (p<.0001 for all). The shift in chemotherapy administration from OHS to OHS and related growth in reimbursement for outpatient hospital settings relative to office settings has implications for the growth in cancer costs over the past decade. Further research is warranted to understand the drivers of the shift in location and whether future policies should address reversing the shift.

PCN62
COST-EFFECTIVENESS OF POSACONAZOLE VERSUS FLUCONAZOLE/itraconazole IN THE PREVENTION OF INFUSION FUNGAL INFECTIONS AMONG HIGH-RISK NEUTROPENIC PATIENTS IN SINGAPORE
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OBJECTIVES: To evaluate the cost-effectiveness of posaconazole versus fluconazole/itraconazole in the prevention of invasive fungal infections (IFI) prevention among patients with acute myelogenous leukemia (AML), acute lymphoblastic leukemia (ALL) and other hematologic malignancies and at high risk of IFI due to chemotherapy-induced neutropenia in Singapore. METHODS: A decision-analytic model previously developed for the US and other countries, was adapted to Singapore, to estimate the cost-effectiveness of antifungal prophylaxis. In posaconazole, fluconazole/itraconazole among AML or MDS patients at high risk of IFL. Patients were assumed to receive prophylaxis with posaconazole or fluconazole/itraconazole. Probabilities of IFL, IFL-related death, and other cause death within 100 days of follow-up were estimated from clinical trial data. Trial results were extended to a lifetime horizon by modeling cancer-specific mortality, estimated from published sources, in one-month Markov cycles. In posaconazole/fluconazole and IFL treatment costs were estimated using data obtained from two hospitals in Singapore. Model