of public healthcare in Ecuador to predict the financial consequences of introducing axitinib for a hypothetical treatment in Ecuador. Cost savings were projected to be $53,270 for dabrafenib-trametinib combination, $27,043 for vemurafenib, $22,634 for dabrafenib, and $19,029 for trametinib.

**CONCLUSIONS:** The addition of user-modifiable projected reimbursement revenue valuation is a valuable tool that expands the contribution of economic modeling to hospital financial decision-making.

**PCN40**

**UNIVERSAL VERSUS TARGETED SCREENING OF COLON CANCER FOR LYNCH SYNDROME: COST AND DIAGNOSTIC EFFECTIVENESS ANALYSES BASED ON CLINICAL EXPERIENCE**

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**OBJECTIVES:** Strategies for screening incident colorectal cancer(CRC) for possible Lynch syndrome(LSh) are evolving rapidly. Our objective is to compare the diagnostic results and costs from two strategies for LS screening: Targeted Screening(TS) and Universal Screening(US) of tumors for mismatch repair(MMR) abnormalities.

**METHODS:** For 18-months in 2010-2011, we employed TS - individuals under age 40, with LS designated to the Ministry of public healthcare in Ecuador, and since it has an A1 recommendation level, it will represent an improvement in the mRCC treatment options.

**PCN38**

**BUDGET IMPACT ANALYSIS OF ENZALUTAMIDE FOR TREATMENT OF METASTATIC CARCINOID-RATIATED PROSTATE CANCER FROM A U.S. PAYER PERSPECTIVE**

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**OBJECTIVES:** Prostate cancer is the second leading cause of cancer death in American men and has a high economic burden. Enzalutamide drug cost, size of chemotherapy-naïve mCRPC patient population of 115 mCRPC patients, adopting the new enzalutamide indication was calculated. One-way sensitivity analyses were performed.

**RESULTS:** In an estimated population of 115 mCRPC patients, adopting the new enzalutamide indication had modest annual plan impact ($510,641 incremental aggregate BI, $4,426 PFPY, $368.83 PPPM and $0.04 PMPM). Enzalutamide acquisition cost was partially offset by the percentage of the patients with progression. The model considers two scenarios: 1) The current market of treatment without Axitinib, 2) The current market of treatment with Axitinib.

**CONCLUSIONS:** Real-world results were more complicated than anticipated. Results from US with IHC were often atypical, not diagnostic of LS. Economic analysis using our costs suggests that TS is less costly than US, but it cases of mildly penetrant LS. US identifies changes that are currently of unknown significance but that have potential to contribute to future research into the mechanisms of CRC tumorigenesis.

**PCN41**

**CANCER RISK FACTORS IN ARGENTINA: COSTS, MORTALITY AND READMISSIONS**

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**OBJECTIVES:** Little is known about cancer (CA) in hospitalization, cost and outcomes in an additional country. We studied this in a multicentric hospital study in Argentina. **METHODS:** Adult CA, hospital direct costs, re-admissions (ReH < 30 days) and deaths in 1 year of 3 academic hospitals. Cost and results, harmonized according to HUCPS (USA) terminology groupers, of primary (1DX), and secondary (2DX) for each C3 code (Clinical Classification Software-CCS single level: SL), 2009. Total costs (CT$), mean costs (SD) and median per discharge (C$, 25%-75%-percentiles), in hospital (H), and outpatient (O), Cost analysis (C$) using Generalized Linear Modeling (GLM) for mean value parameter. Sensitivity analysis assessed impacts of imputing days supply for sunitinib’s 42-day dosing for prescription differences.

**CONCLUSIONS:** Real-world data may inform decisions regarding treatment for renal cell carcinoma (RCC). We compared treatment population and healthcare costs for sunitinib and pazopanib using cycle difference analysis method. **METHODS:** This retrospective cohort study used the Truven MarketScan® database. Inclusion criteria were KCC diagnoses, age ≥ 20 years, ≥ 1 index prescription within 60 days of start date, and ≥ 1 index prescription within 90 days of start date. Patients were followed up to 6 months after index. We compared demographic and clinical characteristics and treatment patterns, using Chi-square, Student t-test, and Wilcoxon signed-rank test (α = 0.05). Costs were compared using generalized linear modeling to account for demographic and medical differences. Sensitivity analysis assessed expected impacts of imputing days supply for sunitinib’s 42-day dosing for prescriptions with 28 or 30 days supply. **RESULTS:** Among 466 patients (77% receiving sunitinib), the cohorts were not significantly (NS) different in demographic or Medicare Comorbidity Index. More sunitinib patients (46 vs. 6 pazopanib patients; p = 0.038) had
chronic pulmonary disease. The sunitinib cohort had less time between diagnosis and index date, and the pazopanib cohort had more time (p < 0.0001). Proportions of patients with treatment continuation, discontinuation, switching, or interruption were NS different. Before imputation, adjusted mean [SD] daily medication costs during persistence were higher for sunitinib ($218.19 [34.73] vs. $177.07 [45.76]; p < 0.0001), but NS previous discontinuation (sunitinib vs. pazopanib; p = 0.213). Twelve-month adjusted RCC-related medical costs were significantly lower for sunitinib than pazopanib before imputation ($36,638.96 [$25,199.38] vs. $45,219.75 [$34,887.70]; p = 0.021) and after imputation ($36,395.90 [$26,549.89] vs. $45,622.95 [$35,226.83]; p = 0.015). The RCC-related prescription costs were NS different between the two drugs before and after imputation.

CONCLUSIONS: Treatment patterns and persistence with sunitinib or pazopanib were NS different. Sunitinib daily cost was NS different from pazopanib after imputation. Further analysis is needed regarding dosing schedule, days supply, and related calculations.

**PCN43**

A COST COMPARISON OF SPLIT-DOSE REDUCED-VOLUME ORAL SALT FREE SOLUTION (OSFS) AND POLYETHYLENE GLYCOL ELECTROLYTE SOLUTION (PEG-ELS)

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OBJECTIVES: The study aimed to (1) develop a cost model for colonoscopy prepa-
ration among patients referred for colonoscopy using split-dose reduced-volume oral salt free solution (OSFS) and generic polyethylene glycol with electrolytes solu-
tion (PEG-ELS); (2) examine cost-savings associated with OSFS versus PEG-ELS; and (3) assess the robustness of the cost model.

METHODS: Clinical efficacy of each agent was based on the results of a 541-patient clinical trial comparing OSFS to PEG-ELS. Clinical agent and colonoscopy procedure costs were calculated from OptumHealth Reporting & Insights claims data for 2010-2013. In the cost model, patients’ colonoscopies were tracked until the patient reached age 75. The different colonoscopy years (PPY) in total colonoscopy procedures costs over the time horizon between the OSS and PEG-ELS cohort was calculated. One-way sensitivity analyses were also conducted to test the robustness of the cost model.

RESULTS: The cost model showed that OSS patients had fewer procedures, and the time horizon and wild rates and wilds were ($143; p<0.001). Total FFFY were $280.34 for the OSS cohort and $296.36 for the PEG-ELS cohort, resulting in a cost-saving of $16.01 to the payer for the OSS cohort. Varying the annual colonoscopy completion rate, surveillance intervals, time horizon, and proportion of high risk patients did not change the observation of cost-savings under OSS. Cost-savings switched from the OSS to the PEG-ELS cohort in three cases: (1) base case of a completed colonoscopy decreased by 75%, (2) base case cost of $41.07 of OSS and 103.07 of PEG-ELS. Total FFFY were $280.34 for the OSS cohort and $296.36 for the PEG-ELS cohort, resulting in a cost-saving of $16.01 to the payer for the OSS cohort.

CONCLUSIONS: Colonoscopy (CRC) is a major cause of morbidity and mortality worldwide. Approximately 25% of patients present metastatic disease at diagnosis and about 50% will develop metastatic disease. Patients with metastatic colorectal cancer (CRC) who are treated are more costly in terms of costs for the Brazilian private healthcare system. Our objective was to compare economic outcomes of different sequences of therapy including monoclonal antibodies for the treatment of CRC.

**PCN46**

CHOICE OF SEQUENTIAL BIOLOGICAL THERAPY IN METASTATIC COLORECTAL CANCER: A COST COMPARISON ANALYSIS FOR WILKIN-THIRD LINE KRAS MUTATION-PATIENTS IN BRAZIL

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OBJECTIVES: Colorectal cancer (CRC) is a major cause of morbidity and mortality.

RESULTS: We found 16 articles that met our inclusion criteria. Based on the literature, it is apparent that cancer-related absenteeism has been less well studied.

**PCN47**

HEALTHCARE RESOURCE UTILIZATION AND MEDICAL CARE COST ASSOCIATED WITH NEW BIO-SURGICAL HEMOSTOSIS IN CHINA

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OBJECTIVES: To investigate patterns of hemostat methods in surgeons and evaluate the healthcare resource utilization and economic burden of patients in China.

METHODS: All patients using oxidized regenerated cellulose (OCR), microfibrillar collagen hemostat (MCH), resorbable oxidized cellulose (ROC), and microporous polysaccharide hemespheres (MPH) after cholecystectomy, hysterectomy or other related surgeries in tertiary hospitals were identified from the 2012 dataset of the China Health Insurance Research Association (CHIRA) claims database which includes a nationwide, cross-sectional sampling of inpatients. Direct medical costs including medication, hemostat, and other related care consumables cost. Descriptive statistics were used to describe patient profiles, healthcare resource utilization and direct medical cost. Two-tailed tests were performed at 95% confidence level (α = 0.05) in the use of hemostats in patients who were missing the length of stay (LOS) was used to compare the median values that may influence inpatient costs thus providing patient selection criteria for a third-line best supportive care (BSC) were compared in each scenario with cetuximab in first-line (1st-line cetuximab 25mg +FOLFOX 4→ 2nd line bevacizumab 5mg +FOLFIRI → 3rd line best supportive care [BSC]). This sequence represents a monthly cost of $18,192.41 per patient while the same scenario with cetuximab in first-line (1st-line cetuximab 25mg +FOLFOX 4→ 2nd line bevacizumab 10mg +FOLFIRI → 3rd line BSC) represents $23,640.57 per month/patient.

CONCLUSIONS: The sequence of therapy that starts with cetuximab in first-line followed by bevacizumab in second-line treatment. Resource savings with sequential bevacizumab have the potential to optimize third-line treatment strategy for mCRC patients with wild-type KRAS in Brazil.