policy making. METHODS: A published decision-analysis tool (the GeDeForCTEM) was employed to assess cost-effectiveness of GSM by comparing costs and averted disability-adjusted life years (DALYs) with no GSM. As modeling inputs, costs for GSM screening and antenatal care, incidence and cost of GD perinatal adverse effects (PAE) were based on an investigation on 6 tertiary hospitals from different cities in China as part of this analysis. Cost for postpartum care was calculated based on literature and adjusted for China. PAE-DALYs, lifetime cost for postpartum T2DM, and effectiveness of interventions were collected from local and national guidelines, which were mainly based on a European study aimed to identify the impact of adding SvAG to MF vs adding sulphonylureas (SU) to MF for the treatment of T2DM patients with inadequate glycometric control. METHODS: A published individual-level simulation model was developed to compare pre-defined medical cost, diabetic complications, drug-related adverse events, life expectancy and quality adjusted life years (QALYs) associated with Sitagliptin add-on therapy versus SU add-on therapy. The model is based upon the UKPDS 68 risk equations to project long-term complications which was a major consideration of drug use. Sensitivity analyses were conducted on a key parameter: results. CONCLUSIONS: GSM screening and interventions are cost-saving in an urban Chinese setting by IADPSG standards. Sensitivity analyses conducted from T2DM prevention, China should pay more attention to providing postpartum care for GD women in the future.

PD6B1 COST-OF-REACHING DEFINED HBA1C TARGET USING CANAGLIFLOZIN COMPARED TO DAPAGLIFLOZIN AS ADD-ON TO METFORMIN IN PATIENTS WITH TYPE 2 DIABETES MELLITUS (T2DM) IN THE UNITED ARAB EMIRATES (UAE) Schubert A1, Nielsen AT2, El Khoury A1, Kamal A1, Taebi VM1
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OBJECTIVES: Improving glycaemic control is the primary goal of T2D management and can help to reduce the risk of micro- and macrovascular complications. Guidelines from the American Diabetes Association and European Association for the Study of the Diabetes recommend lowering glycosylated haemoglobin (HbA1c) levels ≤ 7.0% as a treatment target. This analysis compared the cost of reaching this target (HbA1c < 7.0%) using canagliflozin versus dapagliflozin, two compounds that inhibit sodium-glucose co-transporter (SGLT)2 in the kidney. It was added as add-on therapy to metformin from the payer perspective in the UAE. METHODS: A Bayesian network meta-analysis (NMA) was conducted to compare the efficacy of canagliflozin 100 and 300 mg versus dapagliflozin 10 mg in terms of the percentage of patients that achieved the HbA1c goal of ≤ 7.0% at 1 year. Based on the NMA results and the acquisition cost of dapagliflozin in the UAE ($1.77 per day), we calculated what the daily acquisition cost of each dose of canagliflozin would be if the costs of a patient reaching the target with canagliflozin 100 and 300 mg were equalized to the cost of reaching the target with dapagliflozin 10 mg. RESULTS: In dual therapy as add-on to metformin, patients using canagliflozin 100 and 300 mg were more likely to achieve HbA1c < 7.0% compared to those using dapagliflozin 10 mg, with odds ratios of 1.9 (95% CI: 1.8-2.1) and 1.7 (95% CI: 1.5-1.9), respectively. The cost per patient per month for canagliflozin 100 and 300 mg that equalized the cost of reaching HbA1c < 7.0% with dapagliflozin 10 mg were $2.11 and $2.45 per day, respectively. CONCLUSIONS: These results suggest that adding canagliflozin 100 or 300 mg instead of dapagliflozin 10 mg in patients inadequately controlled on metformin would result in a more efficient use of resources with costs per day up to break-even levels.

PD6B2 COST-EFFECTIVENESS ANALYSIS OF VILDAGLIPTIN VS. GLIMEPIRIDE AS ADD-ON TO METFORMIN IN THE MANAGEMENT OF TYPE 2 DIABETES MELLITUS IN GREECE Koussoulakou H1, Kalogeropoulou M2, Panitti E2
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OBJECTIVES: Metformin is the first-line treatment for type 2 diabetes mellitus (T2DM) in the management of T2DM in Greece achieves defined glycaemic control targets. When treatment with metformin (MF) fails to control T2DM patients, add-on therapies are needed. Sitagliptin is indicated as second-line therapy in Greece, after treatment with MF has failed and is a valid option in the proposed national therapeutic protocols. The primary objective was to assess cost-effectiveness of Sitagliptin (SIT) vs glimepiride in terms of both cost per LY and cost per QALY gained. When treatment with SIT or glimepiride (GLI) fails to control T2DM patients, add-on therapies are needed. SIT was associated with add-on therapy versus SU add-on therapy. The model is based upon the UKPDS 68 risk equations to project long-term complications. Sensitivity analyses were performed on 17 parameters. Analysis based on Greek payer perspective. RESULTS: Sitagliptin strategy is projected to cost 355 EUR more than SU strategy per patient over lifetime. Sitagliptin showed reductions in diabetes-related complications and adverse events. The incremental QALY for Sitagliptin strategy is 0.042, primarily due to improved outcomes associated with hypoglycaemia, body weight change, and MI. The incremental cost-effectiveness ratio (ICER) is 8,582 €/QALY gained. Sensitivity analysis conducted varied multiple parameters. ICER ranges from 4,873 to 12,173 €/QALY gained. The results are robust and never exceeded the 30,000/QALY threshold. CONCLUSIONS: Sitagliptin add-on strategy could be cost-effective, compared to SU, for the Greek healthcare setting. Furthermore, it remains cost-effective in all types of sensitivity analysis.

PD6B4 ECONOMIC EVALUATION OF SAXAGLIPTIN IN COMBINATION WITH METFORMIN VERSUS VILDAGLIPTIN IN COMBINATION WITH METFORMIN IN PATIENTS WITH TYPE 2 DIABETES IN RUSSIA Krysanov P1, Tiapinka M2
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OBJECTIVES: to assess the cost effectiveness of saxagliptin (SAXA) vs sitagliptin (SITA) or vildagliptin (VILDA) as add-on therapy to metformin (MET) in patients with T2DM and inadequate glycaemic control on metformin alone. METHODS: the Cardiff Diabetes Model was adapted to the Russian healthcare setting. We modeling events, efficacy, total costs for managing patients with T2DM. 1st-line – monotherapy metformin alone, 2nd-line (target group) – SAXA or SITA or VILDA plus metformin, 3rd-line – insulin rescue therapy. The model simulated the disease progression and treatment effects for 40 years (8-26-6 years for 1-2-3 lines respectively). The effectiveness measure was quality-adjusted life years (QALYs) with cost as a primary outcome. The estimated ICER of 1% cost-effectiveness ratio (CER) for SAXA+MET was the lowest: $835 per QALY. When compared with SITA+MET for the long-term efficacy (40 years), SAXA+MET was the dominant strategy, i.e. less costly ($505) and more effective (+0.16 QALY). When compared with VILDA+MET, SAXA+MET was more costly (+$364), but more effective (+0.14 QALY). The incremental cost-effectiveness ratio (ICER) per responder for SITA+MET vs VILDA+MET was estimated at $2,566 per QALY gained and would be cost-saving at the will to pay (WTP) threshold for SV for Russia in 2014. If we used combined medicines: Kombiglyce (SAXA+MET), Janumet (SITA+MET) and Galvus Met (VILDA+MET), then Kombiglyce interventions were also more efficacious than Janumet and Galvus Met, but were associated with increased total costs. The ICERs per responder for Kombiglyce were estimated at $3,216/QALY (vs Janumet), $3,269/QALY (vs Galvus Met) and would be cost effective at the WTP threshold of $37,000/QALY. CONCLUSION: for Russian patients with T2DM, a willingness-to-pay threshold of $36,373/QALY SAXA+MET and Kombiglyce is likely to be a cost-effective option for the treatment of T2D in adult patients in Russia.

PD6B5 ECONOMIC EVALUATION OF SECOND LINE ORAL ANTIDIABETICS FOR TYPE 2 DIABETES IN COLOMBIA Quiliano H1, Aschner P1, Muñoz O1, Iragotti N1, Girón D1, Gomez-Restrepo C1, Rosselli D2
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OBJECTIVES: to establish incremental cost-effectiveness ratio (ICER) in cost per additional patient with glycosylated control for all the oral antidiabetic medications available in Colombia, as a second-line treatment for patients with type 2 diabetes (DM2), who do not reach therapeutic targets with metformin and are not yet considered candidates for insulin therapy. METHODS: oral antidiabetic medications were divided into drug classes: sulfonylureas (divided between glimebride, other sulfonylureas), thiazolidinediones, GLP-1 receptor agonists, and DPP4 inhibitors. Systematic review of the literature was done to obtain transition probabilities in a Markov model (monthly cycles, time horizon one year) designed to represent the Colombian health system perspective. The main outcome considered was glycemic control, but data on adherence and adverse events were also collected. RESULTS: for GLP-1 receptor agonists, 1 euro /QALY was assigned from base cases obtained from multidisciplinary expert panel meetings, with local costs applied from national tariff manuals and official drug price registries. Sensitivity analyses were performed by varying primary drug classes. When ranging from $116 for glimebride, and $98 for other sulfonylureas, to $12,025 for GLP-1 receptor agonists. Number of patients with glycemic control (per 1000 people) were glimebride 1465, sulfonylureas 265, thiazolidinediones 472, GLP-1 receptor agonists 60, and 158 for DPP4 inhibitors. Compared to metformin, glimebride was dominated, while ICERS per additional patient with glycemic control per year would be $156 for DPP-4 inhibitors, $712 for thiazolidinediones and $66,790-0,00-156 for GLP-1 receptor agonists. Critical variables in the sensitivity analyses were drug costs (particularly for GLP-1 receptor agonists), but also patient