utilities for pazopanib and placebo were from PALETTE. Lacking a connected evidence network, estimates of relative effectiveness for trabectedin and ifosfamide were from an unadjusted indirect treatment comparison vs. pazopanib. Costs were from NHS reference costs and other published sources. **RESULTS:** Compared with placebo, pazopanib is estimated to increase QALYs by 0.130 and costs by £8,072; the incremental cost effectiveness ratio (ICER) for pazopanib vs. placebo is estimated to be £63k/QALY gained. For most parameters, the ICER changed <30% with +/−50% changes in the parameter value. Compared with trabectedin and ifosfamide, pazopanib provides equal or more QALYs at a lower cost. **CONCLUSIONS:** From a UK health care system perspective, pazopanib may not be cost-effective vs. placebo in patients with advanced/metastatic STS based on criteria typically used to evaluate therapies in the UK. Pazopanib may be cost-effective vs. trabectedin and ifosfamide, although there is substantial uncertainty associated with these comparisons.

PCN82

COST-EFFECTIVENESS ANALYSIS OF ERLOTINIB VERSUS PLATINUM BASED CHEMOTHERAPY AS FIRST-LINE TREATMENT OF NON-SMALL CELL LUNG CANCER EGFR ACTIVATING MUTATIONS

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OBJECTIVES: Eurtact trial was the first randomized phase III trial evaluating efficacy and safety of erlotinib vs chemotherapy in the first-line treatment of EGFR mut+ Caucasian patients. This trial showed an increase in the median PFS of 4,5 months with erlotinib vs chemotherapy. Based on this study, we aimed to assess the cost-effectiveness of erlotinib versus platinum based chemotherapy in the first-line treatment of advanced NSCLC patients with activating EGFR mutations. **METHODS:** A health economic cost-effectiveness analysis was developed incorporating a Markov model simulating the evolution of a cohort of advanced NSCLC patients with activating EGFR mutations. Three health states were included: Progression Free Survival (PFS), Progression and Death. The time horizon was 7 years. Outcomes were life years gained (LYG). Resource utilization related to each health state was estimated by a Spanish Expert Panel. Cost were expressed in € 2012 and include drug and administration costs, and drug-related adverse events management cost. This analysis was performed taking into account the Spanish National Health System's perspective. Patient data on progression-free and overall survival were obtained from the EURTAC study. Probabilistic sensitivity analyses were conducted to incorporate parameter uncertainties. **RESULTS:** Erlotinib treated patients achieved a mean of 2.161 LYG compared to 1.555 LYG in patients receiving chemotherapy. Total mean treatment cost with erlotinib and chemotherapy was €22,458 and €5,335 respectively. The incremental cost-effectiveness ratio (ICER) per LYG was €28,261. Since erlotinib treatment is prolonged until disease progression and chemotherapy is stopped at 4 cycles, treatment duration is one of the cost-driver of the model. **CONCLUSIONS:** Erlotinib treatment of NSCLC patients with activating EGFR mutations is associated with an increased life expectancy and is a cost-effective therapeutic option in Spain.

PCN83

COST EFFECTIVENESS ANALYSIS IN THE VENETO REGION OF CABAZITAXEL VERSUS MITOXANTRONE IN PATIENTS WITH METASTATIC HORMONE REFRACTORY PROSTATE CANCER, PREVIOUSLY TREATED WITH A DOCETAXEL CONTAINING REGIMEN

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OBJECTIVES: Hormone refractory prostate cancer has generally poor prognosis with an expected median survival of approximately 12 months. Cabazitaxel is an antineoplastic agent, recommended by NCCN guidelines in metastatic, hormone-resistant patients, after docetaxel therapy. Available alternatives are: mitoxantrone, a second docetaxel-containing regimen and other rescue chemotherapies. Although in Italy an official cost-effectiveness threshold value is not identified, the Italian Association of Health Economics (AIES) identifies a range from € 25.000 to € 40.000/QALY or LYG. The objective of the study is to evaluate the cost-effectiveness of cabazitaxel versus mitoxantrone in the Regional Health Service (RHS). **METHODS:** Survival data from the TROPIC trial were used to calculate the Incremental cost-effectiveness Ratio (ICER). The maximum hospital wholesale price allowable for Cabazitaxel and regional tender price for mitoxantrone were used to calculate costs of treatment (e.g. 6 cycles every 3 weeks). The perspective was RHS's. It was decided to develop a conservative analysis and to quantify only the cost of drugs, as other direct costs (i.e. staff, premedication, managing adverse events) were not quantifiable or highly variable. The cost of drug administration was not considered, since it was the same for both drugs. **RESULTS:** Therapy with cabazitaxel versus mitoxantrone leads to an increase of the survival (+ 0.20/years) and an increase of costs (+ €18.785). The ICER is € 93.925/LYG. **CONCLUSIONS:** The estimated ICER is similar to what is shown in the more complete analysis of the National Institute for Health and Clinical Excellence and the Scottish Medicines Consortium. Moreover, the analysis was conservative because cabazitaxel showed more adverse events than mitoxantrone. If quantified, the ICER would have been higher. The Pharmacy and Therapeutic Committee of the Veneto Region expressed a negative opinion to the inclusion of the drug in the Regional Drug Hospital Formulary.

PCN84

ABIRATERONE ACETATE VERSUS CABAZITAXEL IN THE TREATMENT OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: AN ECONOMIC EVALUATION IN THE GREEK HEALTH CARE SETTING

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OBJECTIVES: The purpose of this study was to explore the cost-effectiveness of abiraterone acetate (abiraterone) vs. cabazitaxel in metastatic castration-resistant prostate cancer (mCRPC) patients who progressed after docetaxel from the Greek health care perspective. **METHODS:** As no head-to-head trial data were available for abiraterone versus cabazitaxel, an indirect cost-effectiveness model was developed using clinical data (progression free survival (PFS), overall survival (OS), adverse events (AEs)) from the pivotal Phase 3 clinical trials COU-AA-301 (abiraterone) and TROPIC (cabazitaxel). The basic assumption in the model was that both comparator arms in the trials were 'palliative' and therefore equivalent. Resource use, particularly for the management of AEs, was estimated based on data from Alexandra University Hospital in Athens. For validation purposes, a secondary analysis was conducted using UK resource use data. Both analyses used local 2012 costs, undiscounted. Costs of hospitalisation, day hospital visits, drug administration and laboratory tests were taken from officially published public tariffs. Drug acquisition costs came from the latest Price Bulletins. Since abiraterone and cabazitaxel are not yet marketed in Greece, respective prices were estimated based on available EU prices in April 2012. Calculations were based on the median treatment duration for each agent. **RESULTS:** Total treatment cost was lower for abiraterone (€25.847) compared to cabazitaxel (€26.648). Higher drug acquisition costs for abiraterone (€24.899 vs. €23.886 for cabazitaxel) were offset by lower administration costs (€844 vs. €2.292) and lower AE management costs (€104 vs. €470). The total treatment costs of abiraterone were €12.924 and €5.619 per incremental month of PFS and OS compared to palliative care, respectively; treatment costs for cabazitaxel were €19.034 and €11.103 per additional month of PFS and OS against palliative care, respectively. Results were validated by the secondary analysis. **CONCLUSIONS:** Abiraterone appears to be a potentially cost-effective option compared with cabazitaxel in the Greek health care setting.

PCN85

ECONOMIC ASSESSMENT OF THE ONCOTYPE DX BREAST CANCER ASSAY

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OBJECTIVES: To perform an analysis, from a public financing viewpoint, of the economic impact and efficiency of the Oncotype DX (ODX) assay as a guide to providing chemotherapy to women with early breast cancer compared to guiding this decision using the Adjuvant! Online (AO) prognostic index. **METHODS:** Markov model was constructed to assess three alternatives: provision of chemotherapy to women with a high risk recurrence score (RS) (i.e., >30) with ODX, to women with an intermediate/high risk score (RS >18) and to those as indicated by the AO. For the base case, a price of €3200 was set for ODX plus €236.12 for treatment with tamoxifen for 6 months, plus €3490.50 for six cycles of chemotherapy. **RESULTS:** Mean cost associated with AO to guide the provision of chemotherapy was €8994.02 per patient, with ODX RS >30 as a guide was €11,521.56, and for RS >18 it was €12,070.03. The incremental cost effectiveness ratio for ODX RS >30 compared to AO was €9659.28 per QALY; for ODX RS >18 was €7105.80. When treatment was guided by AO, a mean of 16.80 QALYs were obtained per patient, ODX was associated with a mean 17.06 QALY with an RS of >30 and 17.13 QALY per with an RS of >18. In probablistic sensitivity analysis, assuming a willingness to pay of €10,000/QALY, providing chemotherapy to patients with an ODX RS of >18 became the best alternative. Probability of this being the best choice was 60% for a willingness to pay of €20,000 /QALY and 70% for €30,000 /QALY. **CONCLUSIONS:** Compared to guiding the provision of chemotherapy with AO, the ODX would appear to be cost-effective. In the Spanish setting, for a willingness to pay €30,000/QALY, the best option would appear to be to prescribe chemotherapy for patients with ODX RS of >18.

PCN86

COST-EFFECTIVENESS ANALYSIS OF ABIRATERONE FOR THE TREATMENT OF ADVANCED PROSTATE CANCER UNDER THE BRAZILIAN PRIVATE HEALTH CARE SYSTEM

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OBJECTIVES: To estimate the cost-effectiveness of once-daily abiraterone acetate (AA) plus prednisolone for the treatment of advanced metastatic castration-resistant prostate cancer (mCRPC) after failure of taxane-based chemotherapy such as docetaxel, under the Brazilian Private Health System perspective. **METHODS:** A cost-effectiveness analysis was developed based in a Markov model to simulate the disease progression and patient mortality. A systematic revision of the literature was developed over the efficacy and safety of the use of AA and cabazitaxel (C), both combined with prednisolone (P), in patients diagnosed with advanced mCRPC. Efficacy data is informed by the Phase III trials (C + P versus mitoxantrone (M) + P and AA + P versus P). Data is combined and adjusted via a mixed treatment comparison network meta-analysis to determine the relative efficacy of each comparator front a controlled therapy used as efficacy reference for the clinical tests (HR for overall survival (OS): C+P *vs* M = 0.703 (IC95%: 0.59-0.83); AA + P *vs* P = 0.649 (IC95%: 0.543-0.768)). It was assumed that M + P is equal to P alone. The costs and consequences of the disease treatment were computed for each treatment alter-