physicians $3.2 billion (95% CI: $2.88–$3.49 billion) in 2006. CONCLUSION: Medicaid PDLs for statins and antihypertensives have generated considerable costs for physicians. Physicians would incur substantial additional costs if Medicare adopted similarly-structured PDLs for Part D.

PODIUM SESSION I: WOMEN’S HEALTH

WH1

BREAST CANCER PATIENTS’ PREFERENCES FOR LOCAL AND SYSTEMIC THERAPY

Cooke JL1, Mullins CD2, Tkaczuk K1, Baquet CR1

1Xavier University—Louisiana College of Pharmacy, New Orleans, LA, USA; 2University of Maryland School of Pharmacy, Baltimore, MD, USA; 3University of Maryland Greenebaum Cancer Center, Baltimore, MD, USA; 4University of Maryland School of Medicine, Baltimore, MD, USA

OBJECTIVES: To determine the predictors of breast cancer patients’ (BCPs) willingness to accept local and systemic therapy. METHODS: Cross-sectional survey of BCPs ages 36–80 at the University of Maryland Greenebaum Cancer Center, Baltimore, MD. Since “treatment” is considered a “short-term” health state, the chained procedure for the time trade-off (TTO) was used to assess TTO. Willingness to accept therapy was determined using “minimum cancer-free years to accept therapy” (CFYs) as the dependent variable. The number of CFYs was calculated based upon BCPs TTO responses for mastectomy (MRM), breast-conserving therapy (BCT), chemotherapy (CTX) and tamoxifen (TAM). Demographic and clinical data were abstracted from medical records. Tobit regression models were used for multivariate analyses. RESULTS: Mean age was 56.0 years (SD ± 9.43, n = 77); 38.2% were white; 75.6% had early stage cancer. BCPs required more CFYs (median = 4) to accept MRM than to accept BCT, CTX, or TAM (median 1 year for each). For all forms of therapy, the mode = 0, suggesting that BCPs were willing to accept therapy even if it provided no additional CFYs. Late stage patients required more CFYs to accept TAM (β = 6.61, p = 0.0489); similarly late stage patients in good physical health required more CFYs to have MRM (β = −0.50, p = 0.0322). Treatment-experienced BCPs were more willing to accept that type of therapy than those who were treatment-naive. Younger patients (<65) required fewer CFYs to accept chemotherapy (age group 50–54, β = −4.77, p = 0.0403; 55–59, β = −7.25, p = 0.0019). Being non-white and having less education were associated with requiring fewer CFYs to accept CTX (β = −3.86, p = 0.0087; β = −5.10, p = 0.0193, respectively). CONCLUSION: BCPs required relatively few CFYs to accept treatment. Willingness-to-accept fewer CFYs for CTX among those with less education and of younger age is consistent with treatment patterns previously-published. The fact that non-whites (primarily African Americans) required fewer CFYs to accept CTX appears in contrast to observed underutilization of CTX among African American BCPs.

WH2

STANDARD GAMBLE TECHNIQUES FOR THE MEASUREMENT OF TREATMENT-RELATED TOXICITY IN ONCOLOGY: APPLICATION TO BREAST CANCER

Simons WR

Global Health Economics & Outcomes Research, Inc, Summit, NJ, USA

OBJECTIVES: To assess women’s preferences/utilities for health states specific to advanced stage breast cancer including baseline diagnoses of advanced stage breast cancer (ABC), treatment response, no treatment response, disease progression and especially their point of indifference between treatment-related toxicities and treatment response. METHODS: FACT-B QOL data from patients with ABC were used to compose health narratives consisting of physical, social, emotional, functional well-being, additional concerns content domains. Toxicities were described separately. 100 peri/post menopausal women were interviewed by a woman using Visual Analogue (VA) standard gamble techniques (SG). Baseline ABC, treatment response, no treatment response and disease progression were conducted using SG as usual with oscillating risks of perfect health (1) and immediate death (0) as anchors OR the HS narrative with 100% certainty. For toxicity, however, the trade-off is treatment response with an associated risk of toxicity OR no treatment and remaining with 100% certainty at baseline ABC. This allows one to measure how much chance of response a woman needs to be indifferent to the corresponding chance of toxicity. RESULTS: Mean age was 55.76, 64% were postmenopausal, 11% had breast cancer while 16% had another type of cancer previously. VAS scores were 51.8 (p < 0.01) for baseline ABC, 82.5 (p < 0.01) for response, 57.5 (p < 0.01) for no response and 38.4 (p < 0.01) for disease progression. SG regression results were 0.64 (p < 0.01) for baseline, 0.76 (p < 0.01) for treatment response, 0.67 (p < 0.01) for no response, and 0.50 (p < 0.01) for disease progression. The trade-off between a chance of response with a corresponding chance of toxicity yielded a value of 0.34 (p < 0.01) or utility score of 0.66 (p < 0.01). CONCLUSION: Women need at least a 34% chance of treatment response to be indifferent to treatment-related toxicity. These measured values are more appropriate for Quality-adjusted Time Without Symptoms of disease and Toxicity (Q-TWiST) analysis to value oncology treatment.

WH3

REDUCED WORK LIMITATION WITH IMPROVEMENT IN MOOD, SLEEP AND VASOMOTOR SYMPTOMS IN POSTMENOPAUSAL WOMEN

Bobula JD, Yu H1, Olivier S2

Wyeth Research, Collegeville, PA, USA

OBJECTIVES: To determine whether vasomotor symptom reduction is associated with improved work productivity using pooled data from 2 clinical trials for the relief of menopausal hot flushes with desvenlafaxine succinate (DVS). METHODS: A total of 843 postmenopausal women experiencing 50 or more moderate-to-severe hot flushes per week received 100 or 150 mg/day DVS or placebo in 2 randomized, double-blind, placebo-controlled trials. Subjects kept daily hot flush and sleep diaries and completed the Profile of Mood States (POMS) and Work Limitations Questionnaire (WLQ) at baseline and week 12. To control for multiplicity, the data were analyzed using multivariate analysis of covariance (MANCOVA), adjusting for age, race, type of menopause, and baseline values. RESULTS: At both 100- and 150-mg doses, DVS reduced the number and severity of hot flushes from baseline to week 12 compared with placebo (all comparisons, P < 0.0001). DVS reduced the number of nighttime awakenings due to hot flushes (P < 0.0001) and improved self-perceived sleep quality (P < 0.05) at both doses compared with placebo. The 100 mg dose also significantly increased the daily number of minutes slept (P < 0.05). POMS total mood disturbance score improved significantly in both DVS dose groups compared with placebo (P < 0.001). Work limitation, measured by WLQ total index score, decreased significantly from baseline to week 12 in subjects treated with 100 mg DVS (adjusted mean [SE] reduction = −3.3 [0.9]; P = 0.0115) compared with placebo (−1.4 [0.9]). The 100-mg dose group had significant improvement on the time management (P = 0.0354), mental-interper-