and 49% were male. Patients with a VTE history (12%) had a longer duration of anticoagulant use compared to those without (9.9%). Approximately 1/3 of patients received long-acting lanreotide use may reduce costs compared with long-acting octreotide. The driver of cost savings was the longer injection interval with lanreotide during stable disease for GEP-NET. The nature of the disease implies low patient numbers.

PCN140 THE EVALUATION OF HEALTH CARE RESOURCE UTILIZATION IN PATIENTS WITH METASTATIC CASTRATION RESISTANT PROSTATE CANCER: RESULTS OF A MULTINATIONAL OBSERVATIONAL STUDY

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There is limited data available on health care resource utilization for mCRPC (mCRPC). OBJECTIVES: To assess HRU in mCRPC patients during treatment. METHODS: Observational, retrospective, year-long study conducted in 47 centres specialised in prostate cancer care (PC) in 6 countries: Belgium, France, Germany, Sweden, the Netherlands, and the UK. Patients with confirmed mCRPC diagnosis and documented disease progression were eligible. HRU data over the previous 2 years (from mCRPC diagnosis onwards if <2 years) were collected from patients’ medical records by physicians. Interim results on 212 patients, of 699 included patients, are presented below. RESULTS: Mean age was 63.0 years. Mean time since PC diagnosis was 6.6 months. At diagnosis, 35.7% of patients had metastases and 79.7% had Gleason score ≥7. At inclusion, 33.8% of patients had never been treated with any prior chemotherapy, 35.3% had been treated with chemotherapy previously and 30.8% were currently undergoing chemotherapy. Mean time since failure on androgen-deprivation therapy was respectively 1.2, 1.6 and 1.5 years. Chemotherapy consisted principally of docetaxel (82.0%). Patients without prior chemotherapy presented lower rates of PC surgery (5.9%) than patients with past (11.5%) or ongoing chemotherapy (12.9%). Palliative radiotherapy was more frequent in patients with past chemotherapy (28.2%) than in patients without prior chemotherapy (19.1%) with ongoing chemotherapy (14.5%). Higher hospitalisation rates were observed in patients with past (43.7%) or ongoing chemotherapy (43.5%) than in patients without prior chemotherapy (23.5%). Mean hospitalisation durations were roughly equivalent (respectively 30.6, 31.0 and 31.3 days). Emergency room visits were more frequent in patients with ongoing chemotherapy (14.5%) than in patients without prior chemotherapy (7.4%) or with past chemotherapy (9.9%). CONCLUSIONS: This study provides HRU information, which will be implemented into a cost analysis in order to highlight the determinants of the economic burden of mCRPC patients.

PCN141 HEALTH CARE UTILIZATION (HCU) BY BREAST CANCER (BC) AND NON-HODGKIN LYMPHOMA (NHL) PATIENTS WITH CHEMOTHERAPY INDUCED FEBRILE NEUTROPENIA (FN) IN THE NETHERLANDS

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OBJECTIVES: Chemotherapy-induced FN can result in reduced chemotherapy delivery, unplanned hospitalizations, increased mortality risk, and substantial HCU. Little is known about FN-related HCU among cancer patients in Dutch clinical practice. METHODS: Data from incident adult BC and NHL-patients from 1998–2007 were obtained from the PHARMO Record Linkage System, including pharmacy, hospital, and lab data. Eligible patients had ≥12 months medical history and received chemotherapy within 3 months after cancer diagnosis. Patients developing FN within 6 months after first chemotherapy (“FN-patients”) were matched 1:2 on gender, birth-year, and chemotherapy regimen to patients without FN (“non-FN-patients”). HCU-data (hospitalizations, medical procedures, drug use [number dispensed] was collected from entry date (date of FN or matched date for non-FN-patients) to 3 months. Only HCU-data with duration >0 (OR). RESULTS: As a result, 80/1033 (8%) BC-patients developed FN 95/486 (20%) NHL-patients developed FN. Eighty and 89 FN-patients were matched, respectively. More FN-patients than non-FN-patients were hospitalized in the first month after entry date (BC: 73% vs 14% [OR=4.23; 95%CI(3.63-7.1)]; NHL: 78% vs 33% [OR=7.6; 95%CI(3.9-15.1)]). These differences were mainly due to FN-related hospitalizations (BC: 55% vs 1%, NHL: 47% vs 4%). FN-patients also had a longer mean length of stay per all-cause hospitalization (BC: 4.6 vs 1.9 days, NHL: 10.1 vs 3.0 days). Mean number of total drugs dispensed in the first month was higher in FN-patients than in non-FN-patients (BC: 5.8 vs 3.1; NHL: 8.5 vs 3.6), as was use of anti-infectious agents (BC: 99% vs 1%; NHL: 96% vs 2% and other chemotherapy drugs. More FN-patients than non-FN-patients had medical procedures (BC: 14% vs 3%, NHL: 13% vs 4%). HCU-differences between FN and non-FN-patients were maintained for more than 3 months. CONCLUSIONS: HCU in BC and NHL-patients with FN in the Netherlands is substantial. Reduction of FN may improve quality of life and save resources.

PCN142 SUCCESS FACTORS FOR ACHIEVING REIMBURSEMENT FOR ONCOLOGY DRUGS IN AUSTRALIA

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OBJECTIVE: There has been concern that new oncology medicines may not be accepted by patients due to the requirement to demonstrate cost-effectiveness in order to gain public reimbursement in Australia. In Public Summary Documents (PSDs) reporting on the Pharmaceutical Benefits Advisory Committee’s (PBAC) decision making relating to government reimbursement of medicines has been published since July 2005. A review of PSUs reporting on oncology drugs which pre- sented cost-effectiveness analyses was undertaken to identify the success factors for achieving a positive recommendation. METHODS: Data related to history, clinical outcomes, cost-effectiveness and recommendations for oncology drugs from published PSDs between July 2005 and November 2011 were extracted and reviewed. RESULTS: Eighty-one PSUs were reviewed of which 51 were first, 18 second and 12 subsequent submissions. The PBAC recommended 26 for listing on the Australian Pharmaceutical Benefits Scheme (PBS). Of the first, second and subsequent submissions, 29%, 33% and 42% received a positive recommendation respectively. Of those that reported a AUS$/QALY, the range was: below $15k; 0% of instances, 15-45k; 67%, 45-75k; 33%, 75-105k; 0% and above 105k; 0%. The findings were generally consistent with AUS$/LYG which was reported. One product was approved with AUS$/LYG greater than $105k under the “rule of rescue”. Of the products approved with AUS$/QALY or LYG greater than $45k factors that were noted included high clinical need, risk sharing agreement and further price negotiation. CONCLUSIONS: Cost per QALY above $45k is acceptable in conjunction with factors such as clinical need and robust evidence. Nevertheless, further price negotiation may be required to gain reimbursement on the Australian PBS.

PCN143 UTILITY DATA IN APPRAISALS OF ONCOLOGY DRUGS BY THE UK NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

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OBJECTIVES: The NICE reference case requires that health-related quality of life (HRQoL) data should be reported directly from patients, preferably using the EQ-5D (2008 Methods guide, updating recommendations in 2004 Methods guide). The objective of this review was to evaluate the source of utility data in oncology appraisals since the 2004 Methods guide. METHODS: Completed NICE appraisals of oncology drugs conducted since the 2004 methods guide were reviewed. Data including model structure, utility data sources, and values reported for the main health states were extracted. RESULTS: Fifty-two completed NICE appraisals were reviewed. This included 61 separate evaluations across 46 MTAs. 43% presented patient-based data (n=39) from patients with the relevant disease for at least one of the main health states in the model. However, there was considerable variation within this – only 34% included EQ-5D data for all main health states, and in only 28% were utilities precisely matched to the indication sought (same therapy line etc.). Only 20% included EQ-5D data from patients actually receiving the drug being appraised. In total, 28% of submissions provided data from patients on the drug under consideration (either through EQ-5D or another measure). Although most appraisals were for advanced/meta- static cancer, utility values reported were reasonably high – the majority of appraisals used utilities for the initial state (typically stable disease) of between 0.65 – 0.85. CONCLUSIONS: This review highlights the paucity of available utility