of how technologies are chosen. The decision criteria and its weights should represent the decision-making as well as the potential user’s perspective of the technology. METHODS: To identify relevant criteria in terms of technology acquisition, a literature review was carried out. As a second step 221 HTA-experts were confronted with key decision makers at payers and payer intermediary organizations. Respondents included medical and pharmacy directors who actively participate in pharmaceutical technology assessment (PTA). Participants were asked to describe their PTA process and to rate the importance of the sources and types of evidence they use. RESULTS: Pharmacy and medical directors from 15 national and regional health plans, prescription drug plans, and pharmacy benefit managers rated information used for PTA on a scale of 1 (not important) to 5 (very important). While preliminary results indicate that respondents rated peer-reviewed studies as the most important source of information (mean 4.7), technology assessments such as comparative effectiveness studies (e.g., from AHRQ or Hayes) and internal (health plan) data on utilization were rated almost as highly (4.2 and 4.1, respectively). Medical directors gave comparative effectiveness studies higher ratings than did pharmacy directors (4.7 vs. 3.8; p < 0.001). Among types of evidence, randomized controlled trials (RCTs) were rated the highest (mean 4.6); budget impact analyses (mean 3.1) and pharmacoeconomic studies (mean = 2.9) had substantially lower rating, although both of these received higher ratings from pharmacy vs. medical directors. There was little variation in ratings by payer type. CONCLUSIONS: While it is not surprising that key decision makers highly value RCTs from peer-review literature, other sources of information are rated as generally important in their evaluation process.

EVIDENCE USED DURING PHARMACEUTICAL TECHNOLOGY ASSESSMENT
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OBJECTIVES: The purpose of this study is to better understand the types of evidence considered and how evidence is used by health care payers and pharmacy intermediary organizations to evaluate prescription drugs and biologics for possible formulary inclusion. METHODS: We conducted semi-structured one-hour telephone interviews with key decision makers at payers and payer intermediary organizations. Respondents included medical and pharmacy directors who actively participate in pharmaceutical technology assessment (PTA). Participants were asked to describe their PTA process and to rate the importance of the sources and types of evidence they use. RESULTS: Pharmacy and medical directors from 15 national and regional health plans, prescription drug plans, and pharmacy benefit managers rated information used for PTA on a scale of 1 (not important) to 5 (very important). While preliminary results indicate that respondents rated peer-reviewed studies as the most important source of information (mean 4.7), technology assessments such as comparative effectiveness studies (e.g., from AHRQ or Hayes) and internal (health plan) data on utilization were rated almost as highly (4.2 and 4.1, respectively). Medical directors gave comparative effectiveness studies higher ratings than did pharmacy directors (4.7 vs. 3.8; p < 0.001). Among types of evidence, randomized controlled trials (RCTs) were rated the highest (mean 4.6); budget impact analyses (mean 3.1) and pharmacoeconomic studies (mean = 2.9) had substantially lower rating, although both of these received higher ratings from pharmacy vs. medical directors. There was little variation in ratings by payer type. CONCLUSIONS: While it is not surprising that key decision makers highly value RCTs from peer-review literature, other sources of information were rated as having essentially the same importance. Medical and pharmacy directors have significant differences in the importance assigned to certain information. Additional data will help to explore variations in perceived value of information among different types of PTA staff and potentially differences across payer type.