performed using Monte Carlo technique. RESULTS: Annual patient costs of MMF were €7,746.75, €7,993.03, €7,694.19 and €7,599.14 USD. For MPS, the WTP threshold of $7,673.35, $7,989.92, $7,605.80 and $7,920.64 USD with an incremental efficiency of 0.07 less graft rejection in APD, IPMED, IPHAM and hemodialysis respectively in one year horizon. PSA shows consistency on model results. CONCLUSIONS: MPS was a dominant alternative having lower costs and more QALYs. The base case results show possibilities to achieve cost-savings and a potential clinical benefit in renal transplants, from the perspective of the Mexican public health system, in specific from IMSS.5 IMSS (Mexican Institute of Social Security)

PUK21 A COST-EFFECTIVENESS ANALYSIS OF ONABOTULINUMTOXINA VERSUS BEST SUPPORTIVE CARE (BSC) FOR THE TREATMENT OF ANTICHOLINERGIC TREATMENT-REFRACTORY NEUROGENIC DETRUSOR OVERACTIVITY (NDO) Hamid R1, Loveman C1, Milner J1, Colacoy D1, Stanisic S1, Gulyaev D1
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OBJECTIVES: Uncontrolled NDO may lead to medical sequelae, such as upper urinary tract degeneration, renal failure. Treatment choices include BSC (comprising of behavioural therapy and pads, alone or in combination with clean intermittent catheterisation, and possibly with anticholinergics), onabotulinumtoxina, and surgery. The study’s objective was to determine the cost-effectiveness of onabotulinumtoxina 200 U vs. BSC among patients inadequately managed with anticholinergics in a UK setting. METHODS: A Markov model was developed to compare onabotulinumtoxina + BSC to BSC alone, with surgery as a downstream option. Model inputs were based on patient-level data derived from a UK preference elicitation study. Costs were obtained from various NHS sources. Model uncertainty was examined through deterministic and probabilistic sensitivity analyses. RESULTS: The incremental cost-effectiveness ratio (ICER) was £3,856, with an incremental cost of £1,692 and incremental benefits of 0.4387 quality-adjusted life-years (QALYs) for onabotulinumtoxina + BSC compared with BSC alone over 5 years. A lifetime horizon yielded an ICER of £2,739 per QALY. Univariate sensitivity analyses indicated that the main cost drivers are mean monthly use of catheters and treatment administration costs. Probabilistic sensitivity analysis suggested there would be 100% probability of the cost per QALY being £10,000.

Conclusions: The incremental cost-effectiveness of onabotulinumtoxina + BSC is a cost-effective treatment option, compared with BSC alone for patients with NDO who are inadequately managed with anticholinergics in the UK.

PUK22 COST-EFFECTIVENESS COMPARISON OF BOTULINUM TOXIN TYPE A PLUS BEST SUPPORTIVE CARE VERSUS BEST SUPPORTIVE CARE ALONE IN THE TREATMENT OF IDIOPATHIC OVERACTIVE BLADDER WITH URINARY INCONTINENCE AMONG PATIENTS NOT ADEQUATELY MANAGED BY ANTICHOLINERGIC TREATMENT AND FAILURE
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OBJECTIVES: To assess the cost-effectiveness of botulinum toxin type A (BTXA-BOTOX®) 100 U in the treatment of idiopathic overactive bladder (OAB) with urinary incontinence (UI) among patients inadequately managed by anticholinergics in France. METHODS: A 10 year Markov model divided into 3-month cycles was developed to predict the long-term costs and health outcomes of BTXA + BSC, comprising behavioural therapy, incontinence pads, continuing anticholinergic therapy, intermittent catheterisation (IC) and, where possible, BSC alone from a societal perspective (excluding productivity loss) in France. Health states were determined by daily number of UI episodes. Patients discontinuing BTXA and BSC were assigned to the next lower state (i.e., continue IC and 2 or more ICC per day). RESULTS: The estimated treatment cost per patient per year with SC and LC was 1441.75€ and 1569.50€ respectively at the low dose regimen (400 mg of SC vs. 200 mg of LC), while within the high dose regimen (6400 mg of SC vs. 3000mg of LC) it was 2306.80€ and 2354.25€ respectively. Expected cost savings (discounted) for 5 years was $9299.62 and market share was between 1 348 794€ and 2 696 431€ at the low dose regimen, while at the high dose regimen the estimated cost savings was between 501 593€ and 1 001 526€ respectively. The results of SA (discounted) show that the major cost drivers in the treatment of phosphonuria were the unit costs of SC and LC.

Conclusions: The equal efficacy and lower cost of sevelamer carbonate than lanthanum carbonate when used for treatment of hyperphosphatemia in patients with CKD-ND in Bulgaria should make the sevelamer carbonate a preferable alternative.

PUK25 A SPANISH COST-EFFECTIVENESS ANALYSIS OF SEVELAMER VERSUS CALCIUM CARBONATE IN NONDIALYSIS-DEPENDENT CHRONIC KIDNEY DISEASE (CKD) PATIENTS
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OBJECTIVES: In a 36-month, open label ACT that involved 213 patients in stage 3-4 nondialysis-dependent CKD (INDIFFERENT study), sevelamer showed lower rates of all-cause mortality and dialysis inception vs. calcium carbonate. The aim of this study was to assess the cost-effectiveness of sevelamer vs. calcium carbonate in NDD-CKD patients with hyperphosphatemia in Spain. METHODS: A Spanish National Health System perspective and lifetime horizon was chosen for the analysis. A Markov model was developed considering health states of “alive with NDD-CKD”, “alive with dialysis-dependent CKD”, and “dead”. All-cause mortality, dialysis inception, hospitalization (frequency and length of stay [LOS]), and drug dosage data were taken from the INDEPENDENT study. All-cause mortality and dialysis inception were extrapolated beyond 36 months using Weibull regression analysis. Local costs (euros, 2014) were applied to pharmaceutical, hospitalization and dialysis utilisation. Health utility data was taken from the published literature. Costs and effects were discounted at a rate of 3%. RESULTS: In the base case analysis sevelamer was associated with increased survival, delay in dialysis inception, fewer hospitalizations, shorter LOS, 2.13 life years gained (LYG) and 1.61 quality-adjusted life years gained (QALYG) vs. calcium carbonate. Increased survival translated into more treatment time and dialysis sessions vs. calcium carbonate, resulting in an incremental cost of 33 687€. The increase in LYG for sevelamer vs. calcium carbonate was 15 897€ and the incremental costs per QALYG was 20 883€. Sensitivity analysis showed that sevelamer was more effective and less costly (i.e., dominant) vs. calcium carbonate in time horizons >5 years. Results of SA showed that sevelamer is a cost-effective strategy vs. calcium carbonate for the treatment of hyperphosphatemia in patients with NDD-CKD, with cost-effectiveness ratios well below the accepted thresholds of 30-40 000-50 000€/QALYG gained.