required ethics approvals, yet the level of information required varied considerably. Six of ten sites required the protocol, case report form and an explanatory letter only. One of these sites subsequently requested additional information resulting in a delay of over two months. Another site allowed an expedited review, but required supplementary forms totaling 42 pages. Three sites required full ethics submissions. At six sites, a contract was required, necessitating legal review and negotiation. The remaining sites required a letter outlining the financial arrangements. The cost of the ethics processes ranged from AU$500 to AU$3700. CONCLUSIONS: There is considerable variability in the processes followed by Australian hospitals when conducting chart audits which impacts on time and cost, and must be taken into account when planning such a study. Nevertheless, implementation of a well-planned chart audit provides valuable information that will allow the development of a strong cost-effectiveness argument.

A BUDGET IMPACT MODEL FOR THE INTRODUCTION OF PANITUMUMAB, A NEW THERAPY FOR THE MANAGEMENT OF METASTATIC COLORECTAL CANCER (mCRC) IN GREECE

Yfantopoulos I1, Christodouloupolou A2, Bracco A1, Yfantopoulos I1
1University of Athens, Athens, Greece, 2Amgen Hellas, Athens, Greece.

OBJECTIVES: Despite treatment advances, mCRC, the second-leading cause of cancer-related deaths, imposes a substantial burden to patients and public health. Panitumumab, a novel therapeutic agent, is the first fully human anti-EGFR monoclonal antibody and is currently approved as monotherapy for patients expressing wild type (wt) KRAS, after failure of fluoropyrimidines-, oxaliplatin-, and irinotecan-containing chemotherapy regimens. Panitumumab has introduced the concept of individualised therapy in mCRC as it is indicated for patients with specific KRAS gene, wt KRAS. This study evaluated the overall budget impact (BI) of panitumumab on the total health care budget in mCRC management in Greece. METHODS: A decision analytic model estimating the cost associated with panitumumab treatment and Best Supportive Care (BSC) was developed for the assessment of the BI for the Greek health care system. Treatment costs included primary drug costs, infusion costs, concomitant medications, clinic visits, hospitalisations and radiation therapy. In the absence of local cancer registry, an expert panel was used to map mCRC patient flow. The cost calculations were separately carried out for public and private sectors. RESULTS: Out of 470 potentially eligible patients for panitumumab monotherapy, the decision analytic model targets 268 (57%) patients with wt KRAS, according to the indication. Panitumumab was calculated in addition to BSC. In the public setting, the total panitumumab cohort budget was €4.8 million and the average cost/patient treated €17,998. In the private setting, the total panitumumab cohort budget was €5 and the average cost/patient treated €18,716. CONCLUSIONS: Panitumumab improves treatment outcomes and reduces unnecessary exposure to therapy, with a modest health care budget impact. By identifying the population of wt KRAS patients who are most likely to benefit, panitumumab increases patient-level clinical outcomes and may lead to the rational use of health care resources in Greece.

PCN104

MEDICARE PART D'S MARKET IMPACT ON UTILIZATION, AVERAGE RETAIL PRICE AND OUT-OF-POCKET SPENDING FOR ORAL CHEMOTHERAPEUTICS AND A COMPARATIVE MARKET BASKET OF DRUGS

Horwicz-Mehler N, Sepulveda B, Doyle JJ
Quantiles Global Consulting, Hawthorne, NY USA

OBJECTIVES: To determine whether Medicare Part D coverage of prescription oral chemotherapeutics and a comparative market basket of non-oncologics impacted trends in prescription volume, retail price, and out-of-pocket costs. To assess these trends over the 2005–2008 period, including the January 1, 2006 implementation of Medicare Part D. To investigate geographic trends for states with and without major accredited cancer centers (MACCs). METHODS: The top five prescribed oral chemotherapeutics (capecitabine, imatinib, temozolomide, chlorambucil, cyclophosphamide) and a comparative market basket consisting of the top two prescribed anticonvulsants (clonazepam, gabapentin), antidepressants (escitalopram, fluoxetine), antipsychotics (quetiapine, risperidone), HIV/AIDS (emtricitabine/tenofovir, ritonavir) and immunosuppressants (azathioprine, mycophenolate) were selected based on total prescription (TRx) between January 2005 and April 2008. For that time frame, TRx, average retail price (ARP) and out-of-pocket costs (OPC) per prescription for both Medicare Part D patient and non-Part D Medicare patients were collected. Finally, average TRx and ARP were compared in MACC states versus non-MACC states over that time. Parameters were collected using the Verispan’s VONA and VOPA databases. Statistical analyses were performed using one-way ANOVA.

RESULTS: Quarterly imatinib TRx increased significantly more than the other chemotherapeutics, >50% between Q1 2003 and Q1 2008 (p < 0.05). This increase was mostly attributable to an increase in refills, which was significantly greater than the other chemotherapeutics (p < 0.05). Interestingly, average TRxs were significantly higher in MACC states (p < 0.05). The ARP significantly increased for capecitabine, imatinib and temozolomide (33% average), while half of the comparative market basket drugs saw an increase in ARP (30% average increase for those 6; p < 0.05). With the exception of imatinib, the average OPC only increased significantly for Medicare Part D patients than for non-Part D patients (p < 0.05). Nonetheless, over time, the OPC only increased significantly for capecitabine and for two of the market basket drugs (p < 0.05). CONCLUSIONS: The introduction of Medicare Part D did not appear to impact ARP or utilization for the top oral chemotherapeutics. One possible explanation is Medicare Part B coverage of certain oral chemotherapeutics prior to January 1, 2006. Secondly, there may be some drug classes that are more sensitive than others to changes in health care policy. We observed a positive correlation between MACC designation with utilization and ARP patterns.

PCN106

PROSTATE CANCER DIAGNOSIS IN SPAIN: HOW IS IT PERFORMED? HOW MUCH DOES IT COST FOR SPANISH NHS?

Herranz F1, Bovio H2, Cordero L3, Sobreviela E3, Ampudia R1
1Gregorio Marañón General Hospital, Madrid, Madrid, Spain, 2AstraZeneca Farmacéutica Spain S.A, Madrid, Madrid, Spain

OBJECTIVES: Determine how prostate cancer (PC) is diagnosed in Spain as well as its economical impact on NHS budget. METHODS: Cross sectional multicenter study conducted in urology and specialized units in Spain during 2006. Information, retrospectively compiled, from >18 years, 3 months—2 years