years. This sequence remained dominant or cost saving in all the deterministic sensitivity analyses, changing efficacy data, utility weights, or discount rates. Resultsetor were more sensitive to changes in the time horizon of the analysis. The probabilistic sensitivity analysis confirmed that the apremilast sequence was dominant or cost saving in a large majority of the simulations. CONCLUSIONS: This study showed that apremilast before biologic drugs is a cost-saving strategy for the NHS in the treatment of moderate to severe plaque psoriasis who have failed to respond to, have a contraindication to, or are intolerant of biologic drugs. The current analysis reported here is limited by the lack of utility data for apremilast. Sensitivity analyses ensured that the conclusions were robust.

PPS32 COST-EFFECTIVENESS ANALYSIS OF IVRAL for the TREATMENT OF MODERATE TO SeVERE PsORIASIS IN SPAIN

Carrascosia JM,1 Vanaclochoc F,1 Calato T,1 Echave M,1 Oyayigee I, Tencer T2
1Department of Dermatology, Germans Trias i Pujol University Hospital, Barcelona, Spain, 2Department of Dermatology, 1Z Reina Sofia University Hospital, Málaga, Spain

OBJECTIVES: This study investigates the cost-effectiveness of IVRAL for the treatment of patients with moderate to severe plaque psoriasis. This analysis was conducted utilising clinical data from head-to-head randomised clinical trials of IVT-IVRAL 2g vs. ranibizumab 0.5q4, and an indirect comparison of IVT-IVRAL 2g with ranibizumab 0.5q4. A de novo health economic model combined these clinical inputs with Dutch-specific costs associated with treatment, monitoring, and indirect caregiving, and utility inputs relevant to a Dutch population. Total quality-adjusted life-years (QALYs) and costs were calculated over a 15-year horizon. There was no discount on the outcomes and the analysis was conducted using a Dutch perspective.

RESULTS: Compared with ranibizumab 0.5q4, a 2-year treatment IVT-IVRAL is associated with a significantly lower cost of €1,737 (95% CI: €1,724–€1,755) over the 15-year horizon. There was no difference in QALYs (95% CI: –0.0057 to 0.0001). IVT-IVRAL 2g also statistically significantly lower total costs than ranibizumab 0.5q4 (€2,450 [95% CI: €2,349–€2,549]), with a nonsignificant gain of 0.0007 QALYS (95% CI: –0.0033 to 0.0036). Probabilistic analyses showed that, due to its lower costs, IVT-IVRAL 2g treatment had an estimated >99% probability of being cost-effective compared with both of the ranibizumab treatment strategies at a willingness-to-pay threshold of €200 per QALY, the proposed informal Dutch threshold. This analysis did not alter the conclusions.

CONCLUSIONS: The analysis showed that IVT-IVRAL 2g treatment is associated with cost savings versus ranibizumab 0.5q4 or 0.5q2. There is no significant difference in total QALYS between the treatments. Due to lower overall costs, IVT-IVRAL is a cost-effective treatment option for wAMD patients in the Netherlands.