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¿FROM THE NICE NEW APPRAISAL PROCESS FOR LIFE-EXTENDING END-OF-LIFE TREATMENTS?

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OBJECTIVES: In January 2009, the National Institute for Health and Clinical Excellence (NICE) adopted an evaluation process for life-extending end-of-life treatments. While eligible drugs, QALYs are weighted to favour the incremental cost-utility ratios (ICUR). Also, patient access scheme (PAS, pricing agreements) are sometimes established between the NHS and drug manufacturers to lower the economic impact of costly drugs. The purpose of this study was to document the effectiveness of the end-of-life evaluation process needed for PAS and NICE recommendations. METHODS: NICE website was searched to identify published technology appraisal guidances of anticancer drugs issued between January 2009 and May 2011. We documented EOL and PAS status, the listing recommendation and the supporting ICURs. Positive and negative recommendations were stratified by EOL and PAS status. RESULTS: We retrieved 32 recommendations among which 50% were approvals. The proportion of accepted drugs tends to be higher among those evaluated with the EOL (9/16, 56%, p=0.8). The ICURs of positive recommendations associated with drugs not eligible or not considered for the EOL were more frequently approved than approved EOL drugs (21/30, 70% and 30,000/QALY gained). On the other hand, ratios of positive recommendations for drugs eligible to the EOL were higher and varied from 30,350/QALY to 54,366/QALY gained. Among drugs evaluated with the EOL, the proportion of accepted drugs analysed with PAS (9/10, 90%, p=0.01) tended to be higher than for drugs approved without PAS. Despite the small number of evaluations since its implementation, we observed with the EOL a higher ICUR threshold that may have led NICE to recommend to list more anticancer drugs that it would have been without the EOL. When the EOL was considered, PAS also seems to have contributed to a higher rate of positive listing. These findings have raised questions about the economic evaluation of anticancer drugs in Canada.

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CANCER DRUG PRICES IN THE UNITED STATES AND THE UNITED KINGDOM: IMPLICATIONS FOR PRICING STRATEGY AND DRUG ACCESS

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OBJECTIVES: To understand relative price differential for cancer drugs in the US and the UK. Develop implications for pricing strategy and patient access for cancer drugs. METHODS: Ten branded cancer drugs were selected and their prices for similar dose and packaging were compared in the US and the UK. Prices were analyzed for the end of 2010 and early 2011. Historical exchange rates were used to convert British pounds to US dollars. Relative price discount was calculated for all selected cancer drugs. KOLs and payers were interviewed to understand current and future implications of this price differential. RESULTS: The median price discount for selected ten branded cancer drugs in the UK versus the US was —50%. The range of discount for 10 branded cancer drugs was 27%-61%. The price discount for oral small molecule drugs was higher than for biologics (55% versus 45%). Since UK is one of the few remaining free pricing markets in Europe, other European markets are likely to have even higher discounts relative to the prices in the United States. Due to rising co-insurance of specialty products, US cancer patients bear significantly higher cost than patients in the UK. KOL and payer interviews suggest that short US pricing trends for cancer drugs are unlikely to be sustained at this level in the future. CONCLUSIONS: US cancer drug prices are significantly higher than the prices in the UK. This price differential is unlikely to be sustained in the future.

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ASSESSMENT OF REIMBURSEMENT PROCESSES AND OUTCOMES FOR CANCER TREATMENTS IN CROATIA – COMPARISON TO NICE AND NCCN GUIDELINES

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OBJECTIVES: Objective of this study was to assess reimbursement outcomes and patient access to oncology drugs in Croatia. National Institute of Clinical Excellence (NICE) guidelines and National Comprehensive Cancer Network (NCCN) guidelines were used as benchmark. NICE is known for being committed to complying with legal obligations on equity and human rights, conducting their work based on identified cost effectiveness thresholds and known to be restrictive in their recommendations. On the other hand, NCCN professional guidelines are key international recommendations followed worldwide. METHODS: Reimbursement processes, specific indications and restrictions for 23 studied cancer drugs, ATC L01 class (antineoplastic agents) have been analyzed and compared to UK NHS funding and reimbursement recommendations.RESULTS: The NCCN guidelines are clear and allow clear decisions to be made. However, the NICE recommendations were more restrictive and followed world-wide. RESULTS: Studied cancer drugs were used for the treatment of 14 different tumor locations: breast, colon, lung, leukemia, renal, GIST, ovary, lymphoma, glioblastoma, prostate, liver, gastric, myeloma. Among 57 registered indications, Croatian Health Insurance Fund has in total reimbursed 43 (75%) while NICE has issued positive recommendations for only 35 (60%). On the other hand, all investigated drugs and relevant indications except of one partially