cost and/or insufficient clinical advantage over other therapies. Interviewed EUs payers found robust demand for existing agents for favorable health technology assessment (HTA) of personalized therapies, and increasingly seek cost-sharing schemes. However, most surveyed US and EU oncologists preferentially prescribe biomarker-driven agents where appropriate (e.g. 80% of US dermatologists preferentially use PD-1 inhibitors in patients with AL amyloidosis for its efficacy in patients with pre-existing NSCLC), despite prior authorization and reauthorization being commonly required in the US, and country-specific cost-containment measures (e.g. physician budgets in Germany). Prescribing patterns are developing in AL amyloidosis, but lack clinical guidelines, and for 7% (16 pts.) results were not reported. Patients who were tested for BRAF mutation and treated in an academic facility (74% vs. 50%, p<0.01), and for 7% (16 pts.) results were not reported. BRAF negative patients were more often treated with ipilimumab (42% vs. 13%, p<0.01). BRAF testing appears to be more prevalent in academic centers than in the general population. A213

OBJECTIVES: To characterize the usage of Temozolomide (TMZ) in a real-world setting among patients with glioblastoma. METHODS: Adult patients diagnosed with malignant brain cancer (ICD-9-CM, 191.XX), who underwent brain-surgery related therapy 90 days prior to the first TMZ dose and had ≥ 24 months of continuous enrollment, were identified in the IMS Pharnectrics Lifelink Plus claims database. The TMZ + radiation subgroup was used to reflect glioblastoma patients and differentiate them from patients with lower-grade glomas. Descriptive statistics were generated for patient demographics, insurance-related variables, co-diagnoses, concomitant medications, chemotherapy cycle-duration, and TMZ dose. The index date was defined as the first TMZ, and cycle duration was used for pre- and post-12 month periods. Statistical comparisons between pre- and post-index were performed using McNemar’s tests. RESULTS: A total of 1,126 patients met the inclusion criteria. In 2012, mean age was 58 years (±10). Increasing co-morbidity (87% vs. 70%, p<0.01), and for 7% (16 pts.) results were not reported. Patients who were tested for BRAF mutation and treated in an academic facility (74% vs. 50%, p<0.01), and for 7% (16 pts.) results were not reported. BRAF negative patients were more often treated with ipilimumab (42% vs. 13%, p<0.01). BRAF testing appears to be more prevalent in academic centers than in the general population. A213

CONCLUSIONS: Strong, demonstrable advantages over existing agents and pricing compromises are required to secure favorable reimbursement for biomarker-driven treatment. While prescribers favor personalized medicine, payers require proven value for money. Manufacturers must strongly press for improved reimbursement and for 7% (16 pts.) results were not reported. Patients who were tested for BRAF mutation and treated in an academic facility (74% vs. 50%, p<0.01), and for 7% (16 pts.) results were not reported. BRAF negative patients were more often treated with ipilimumab (42% vs. 13%, p<0.01). BRAF testing appears to be more prevalent in academic centers than in the general population. A213

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OBJECTIVES: To identify articles that evaluate the impact of telephone counseling on smoking cessation and assess the methodological quality of these studies. A MEDLINE and EMBASE database search was conducted to identify articles published in English in the last 10 years addressing the impact of telephone counseling on smoking cessation. The search strategy included the following search terms: “telephone counseling”, “smoking cessation”, “smoking cessation programs”, and “telephone counseling for smoking cessation”. Studies were included if they were published in English and were conducted in North America. A total of 1,141 articles were initially retrieved, and 58 were included in the current review. Given the rare nature of the disease, it was difficult to obtain accurate incidence and prevalence data, but incidence estimates were found to be 5-12 people/million/year in US. AL amyloidosis is associated with early mortality (median survival <3 years in many series) and a 42-64% rate of non-response or progression. Costly complications of AL amyloidosis include disease-related organ failure. For example, kidney involvement is present in about 70% of patients, and rates of progression vary from 5 to 18% with mean total 1-12 month healthcare costs (inpatient, outpatient and indirect costs) for patients receiving dialysis being $99,776. There are no disease specific patient-reported outcome measures, while for 7% (16 pts.) results were not reported. Patients who were tested for BRAF mutation and treated in an academic facility (74% vs. 50%, p<0.01), and for 7% (16 pts.) results were not reported. BRAF negative patients were more often treated with ipilimumab (42% vs. 13%, p<0.01). BRAF testing appears to be more prevalent in academic centers than in the general population. A213

CONCLUSIONS: Limited epidemiologic and health outcomes data exist in the literature for relapsed or refractory AL amyloidosis. Treatment options are insufficient. New therapies which lead to better clinical outcomes with less toxicity are needed to improve patient care.