OBJECTIVES: Establish the potential resource and cost savings from using ePTFE covered stents compared to TIPS (SG) for treatment of causeable RILD patients. Most centers have adopted SGs to treat portal hypertension because of their reduced re-intervention rate, elimination of regular monitoring of patency and improved survival. However, there is no published economic analysis identifying the relative cost-effectiveness of SGs compared to TIPS in the current financial environment. METHODS: A Markov economic model was developed to measure the incremental costs of the initial procedure and re-interventions with SG compared to TIPS. Re-intervention procedures included angioplasty (67%), introducing a balloon expandable stent (22%) or a second stent (10%). The adverse events were hepatic encephalopathy and clinical relapse. Clinical data came mainly from a published ACT (Bureau 2007), whilst health care costs were from UK national databases. RESULTS: Compared to TIPS, using SG in TIPS resulted in a cost saving of over £1,150 per patient over 2 years. Modelling 100 patients, compared to TIPS, the SG cohort had 25 fewer re-interventions including angioplasty. Savings on staff time and staff costs were higher due to fewer cases of encephalopathy (16), recurrent ascites (8), variceal bleeds (5) and a markedly reduced mortality (13). CONCLUSIONS: The model showed that ePTFE covered stent grachts for TIPS reduced mortality and re-interventions, savings on staff time and bed-days, and reduced overall costs despite the higher initial device cost.

PG125
AN ECONOMIC EVALUATION OF THE TRIPLE HCV TREATMENT REGIMEN FOR GENOME 1 NAÏVE PATIENTS IN THE GREEK HEALTH CARE SYSTEM

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OBJECTIVES: In 2011 EMA approved Boceprevir and Telaprevir with PegIFN and Ribavirin for the treatment of genotype 1 CHCV. For the needs of this analysis, a cost-consequence model was utilized, to compare the costs incurred when: i) patients with IL28B CC genotype (30%) were treated with SoC (PegIFN alfa-2a + RBV) and patients with IL28B non-CC genotype (70%) were treated with triple therapy; and ii) all patients are treated with triple therapy. The economic inputs are based on official and publically available sources while the clinical inputs are taken from published clinical trial results. The number of patients treated for each therapy was provided by local bibliography. RESULTS: The total cost to treat 509 naïve patients with triple therapy was € 13.8 million compared to € 10.9 million to treat based on IL28B allocation, maintaining the same SVR rate of 70% for either of the treatment strategies. CONCLUSIONS: This personalized approach based on a genotype predictor response of the IL28B profile was proven to be a cost-saving resource allocation choice compared to the option of treating all treatment naïve patients with triple therapy, providing SVR rates of 70% of treatment-naive patients with the Greek health care system of € 3.9 million a year (approx. 25%).

PG126
COST-EFFECTIVENESS OF EARLY Versus DELAYED HEPATITIS C VIRUS (HCV) TREATMENT WITH TELAPREVIR/PEGYLATED INTERFERON ALPHA/ribavirin TRIPLEx TREATMENT REGIMENS (AGEd 40+) IN THE BELGIAN HEALTH-STATE, RESPOND TO TREATMENT OR PROGRESS, AT PROBABILITIES DETERMINED BY DISEASE STATE, AGE AT INFECTION, CURRENT AGE, GENDER, AND TREATMENT RECEIVED. INDIVIDUALS RECEIVED TREATMENT FOR 12, 24, 48, OR 72 WEEKS. MANPOWER COSTS WERE DERIVED FROM PUBLISHED LITERATURE AND STANDARD FRENCH SOURCES. THE EFFICACY OF A NEW HYPOTHETICAL TREATMENT REGIMEN WAS BASED ON CURRENTLY PUBLISHED RESULTS; RESULTS: A treatment lag of 1, 2, and 3 years resulted in 142,777 individuals, 140,417 individuals, and 137,930 individuals being treated by the new regimen, respectively, versus 145,010 with immediate TPR treatment. The new treatment option in additional life years saved (range 11,230-27,530). QALYs gained (range 12,528-29,359), and prevented more HCV-related deaths (range 3,839-5,756). Total costs incurred were higher for the new regimen versus TPR, from the health care perspective. ICERs were €58,294, 19,573, 295,587/QALY, and €107,409/37,197/QALY gained for the 1, 2, and 3 year treatment lag, respectively. CONCLUSIONS: These findings suggest waiting for new regiments currently in development should not be the most efficient choice to be considered by French Health care system. Waiting for new treatments should yield better clinical outcomes, but with higher costs and ICERs that may be challenging for the payer.

PG28
CROHN’S DISEASE: AN ECONOMIC ASSESSMENT OF BIOLOGICAL DRUGS IN ITALY

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OBJECTIVES: This study had a dual objective: verify the improvements in quality of life reported to pharmacoeconomists and administered in 9 centers in Italy. The questionnaire was set up to detect QoL through a Visual Analogue Scale and assess patients’ profile (age, gender, job) and clinical features (time-to-first diagnosis, current treatment, duration of disease, complications of advanced HCV includ- ing decompensated cirrhosis, hepatocellular carcinoma, liver transplant, and death. During each 1-year cycle, individuals may remain in the current health state, respond to treatment or progress, at probabilities determined by disease status, age at infection, current age, gender, and treatment received. Transition probabilities, treatment efficacy, health-state utilities, resource utilization and costs were derived from published literature and standard French sources. Costs and outcomes were discounted at 4% for 30 years and 2% thereafter. Cost-effectiveness was assessed as incremental cost per lifetime horizon to compare outcomes of early versus delayed treatment. Model health state are defined by fibrosis stage (F0-F4) and complications of advanced HCV including decompensated cirrhosis, hepatocellular carcinoma, liver transplant, and death. During each 1-year cycle, individuals may remain in the current health state, respond to treatment or progress, at probabilities determined by disease state, age at infection, current age, gender, and treatment received. Transition probabilities, treatment efficacy, health-state utilities, resource utilization and costs were derived from published literature and standard French sources. The efficacy of a new hypothetical treatment regimen was based on currently published results; results: A treatment lag of 1, 2, and 3 years resulted in 142,777 individuals, 140,417 individuals, and 137,930 individuals being treated by the new regimen, respectively, versus 145,010 with immediate TPR treatment. The new treatment option in additional life years saved (range 11,230-27,530). QALYs gained (range 12,528-29,359), and prevented more HCV-related deaths (range 3,839-5,756). Total costs incurred were higher for the new regimen versus TPR, from the health care perspective. ICERs were €58,294, 19,573, 295,587/QALY, and €107,409/37,197/QALY gained for the 1, 2, and 3 year treatment lag, respectively. CONCLUSIONS: These findings suggest waiting for new regiments currently in development should not be the most efficient choice to be considered by French Health care system. Waiting for new treatments should yield better clinical outcomes, but with higher costs and ICERs that may be challenging for the payer.

PG29
COST-EFFECTIVENESS OF LINACLOLITE COMPARED TO AntIDEPRESSANTS IN THE TREATMENT OF IRITABLE BOWEL SYMPODROME WITH CONSTIPATION IN SCOTLAND

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OBJECTIVES: Presently, linaclootide is the only EMA approved indication for the treatment of irritable bowel syndrome with constipation (IBS-C). This study sought to determine the cost-effectiveness of linaclootide compared to antidepressants for the treatment of adults with moderate to severe IBS-C who have previously received antipsychotics and/or laxatives from the perspective of the Scottish National Health Service (NHS). METHODS: A Markov model was created to estimate the costs and QALYs over a 5-year time horizon from the perspective of the NHS Scotland. Health states were based on treatment satisfaction (satisfied, moderately satisfied, not very satisfied and dissatisfied). Time horizon and transition rates were based on data from the linaclootide pivotal studies (MCP-103-302 and LIN-MD-31) and Scottish general all-cause mortality statistics. Treatment costs were calculated from the British National Formulary NHS resource use and disease-related costs for each treatment. RESULTS: QALY was calculated from the economic model. Quality of life was based on EQ-5D data collected from the pivotal studies. Costs and QALYs were discounted at 3.5% per annum. Uncertainty was explored through extensive deterministic and probabilistic sensitivity analyses. RESULTS: Over a 5-year time horizon, the additional costs and QALYs with linaclootide were £659 and 0.089, resulting in an incremental cost-effectiveness ratio of £7,370 per QALY versus antidepressants. Results were most sensitive to health state transition assumptions, NHS resource use assumptions and state utility thresholds. Analysis thresholds showed that the effectiveness of linaclootide would have to be at least 11% lower than the base case to exceed a willingness-to-pay threshold of £20,000 per QALY. Based on the probabilistic sensitivity analysis, the likelihood that linaclootide was cost-effective at a WTP of £20,000 per QALY was 74%. CONCLUSIONS: Linaclootide is a cost-effective treatment for adults with moderate to severe IBS-C who have previously received antipsychotics and/or laxatives.