years, 51.6% female, 97.0% commercially insured). Unadjusted 1-year post-failure costs increased from 2004 to 2009. Cardiac-related severe renal disease (41.0% vs 31.6%), and medical services (i.e., non-pharmacy) (31.5% vs 26.6%) and pharmacy costs (58.5% vs 48.6%) were the highest costs of NCSLC in stage I. The analysis has been conducted based on the perspective of health insurance companies, therefore only direct medical costs were evaluated. The price of drugs and medical services have been averaged from the price-list of some major hospitals in Vietnam. The cost of disease for the whole society of Vietnam has been evaluated based on epidemiological data analysis used to train Health Analytics MarketScan® commercial and supplemental Medicare databases from January 2005 through August 2012. Eligible patients were those with Medicare benefit and continuous enrollment over at least 6 months prior to diagnosis. All patients received ≥1 dose of one of the following 5 regimens: fludarabine, cyclophosphamide, and rituximab (FCR); bendamustine plus rituximab (BR); fludarabine, cyclophosphamide, and rituximab (FCR); rituximab; and chlorambucil (Chl). Than, regression analysis was performed to identify predictors of clinical outcomes using a generalized linear model (GLM), which controlled for differences in baseline characteristics across treatment groups. RESULTS: Of 2,035 patients, 497 received FCR, 130 received BR, 449 received chlorambucil, 297 received FR, and 662 received rituximab. Mean age was 69.5 years (SD: 12.4) and 64% were male. Comorbidities included diabetes (19%), COPD (16%), and cardiovascular (14%) disease. AE results (frequency, adjusted cost, and 95% CI) were as follows: infection reaction (40%, $4,642; $4,141-$5,120), hospitalization (5.5%, $8,894-$10,650), and death (5.4%) and prescription drug (part D event) claims (43.7%). In adjusted analyses, both PC and HNC patients incurred higher Medicare carrier ($6,330), DME ($328), HHA ($647), outpatient ($19,041), and prescription drug ($5,814), hospice ($475), pharmacy ($1,144) and total costs ($35,008). CONCLUSIONS: Patients who were enrolled in Medicare and diagnosed with PC had high utilization of Carrier and outpatient services, as well as frequent comorbid conditions, resulting in considerable health care expenditures.

PCN64 COST OF BREAST CANCER IN VIETNAM
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OBJECTIVES: In recent years, breast cancer remains the leading cause of death in women worldwide. Evaluating the economic burden of breast cancer is very important in the perspective of the health care system and society. In Vietnam related studies has not been conducted until now. This is also the aim of this study. METHODS: The cost of breast cancer has been evaluated using pharmacoeconomic method “cost of illness” by following formula: COI = DC + IC in which: COI = cost of illness, DC = direct cost, IC = indirect cost A tree-decision model has been developed to evaluate the cost of different stages of breast cancer. This analysis was conducted based on the perspective of health insurance companies, therefore only direct medical costs were evaluated. The price of drugs and medical services have been averaged from the price-list of some major hospitals in Vietnam. The cost of disease for the whole society of Vietnam has been evaluated based on epidemiological data analysis used to train Health Analytics MarketScan® commercial and supplemental Medicare databases from January 2005 through August 2012. Eligible patients were those with Medicare benefit and continuous enrollment over at least 6 months prior to diagnosis. All patients received ≥1 dose of one of the following 5 regimens: fludarabine, cyclophosphamide, and rituximab (FCR); bendamustine plus rituximab (BR); fludarabine, cyclophosphamide, and rituximab (FCR); rituximab; and chlorambucil (Chl). Than, regression analysis was performed to identify predictors of clinical outcomes using a generalized linear model (GLM), which controlled for differences in baseline characteristics across treatment groups. RESULTS: Of 2,035 patients, 497 received FCR, 130 received BR, 449 received chlorambucil, 297 received FR, and 662 received rituximab. Mean age was 69.5 years (SD: 12.4) and 64% were male. Comorbidities included diabetes (19%), COPD (16%), and cardiovascular (14%) disease. AE results (frequency, adjusted cost, and 95% CI) were as follows: infection reaction (40%, $4,642; $4,141-$5,120), hospitalization (5.5%, $8,894-$10,650), and death (5.4%) and prescription drug (part D event) claims (43.7%). In adjusted analyses, both PC and HNC patients incurred higher Medicare carrier ($6,330), DME ($328), HHA ($647), outpatient ($19,041), and prescription drug ($5,814), hospice ($475), pharmacy ($1,144) and total costs ($35,008). CONCLUSIONS: Patients who were enrolled in Medicare and diagnosed with PC had high utilization of Carrier and outpatient services, as well as frequent comorbid conditions, resulting in considerable health care expenditures.