cancer treatment ranges from €10,251 to €13,934). The national ICER was €26,361 per QALY, but the net cost per subject vaccinated differed across regions impacting the affordability to vaccinate multiple cohorts 12-years/catch-up to 16-years. CONCLUSIONS: National analyses, using national ‘average’ data, are the necessary starting point for the evaluation of new health technologies, addressing centralized regulatory agency requirements. However, in the Italian scenario, characterized by decentralization and local autonomy, a further level of detail is essential in order to describe the regional impact to budget holders thereby better informing local decision makers and facilitating the uptake of cost-effective health care interventions.

EE8 COST EFFECTIVENESS OF CAPECITABINE IN COMBINATION WITH OXALIPLATIN (XELOX) COMPARED TO FOLFOX (5-FU, LV, OXALIPLATIN) FOR THE TREATMENT OF METASTATIC CARCINOMA OF THE COLON OR RECTUM (CRC) FROM A UK NATIONAL HEALTH SERVICE (NHS) PERSPECTIVE

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OBJECTIVES: Capecitabine’s mCRC licence was recently extended supporting its use in combination therapy. This study evaluated the cost effectiveness of replacing FOLFOX, with XELOX. METHODS: Based on results from phase 3 trials, demonstrating that XELOX is non-inferior to FOLFOX4 (NO16966 1st line; NO16967 2nd line), a cost minimisation analysis was performed evaluating incremental costs from the start of treatment until disease progression. Dose, treatment duration, adverse event frequency and the probability of central venous access device (CVAD) replacement were taken directly from the NO16966/7 trials. Drug costs were based on the UK list price. Administration, pharmacy and adverse event costs were taken from NHS reference costs 2005/6, the literature, and previous technology appraisals. Clinical practice assumptions were: 10% and 100% of XELOX and FOLFOX patients receive a CVAD respectively; 25% of 5FU infusions require an overnight stay in hospital, the remaining 75% use an ambulatory pump at home; 30% of patients receive hospital funded transport. Uncertainty was explored via one-way sensitivity analysis and a scenario of FOLFOX4 being replaced in 1st line (cetiriz paribus) was also evaluated. RESULTS: Per patient, replacing FOLFOX4 with XELOX, saved (£773/£173 adverse event costs. Total savings were £9611 and £6405 1st and 2nd line respectively. In all of the scenarios evaluated in the sensitivity analysis XELOX was cost saving by more than £8636 per patient 1st line, and £5702 2nd line, compared to FOLFOX4. XELOX remained cost saving (~£6500) when compared to FOLFOX6. CONCLUSIONS: Replacing FOLFOX with XELOX offers the NHS considerable savings in terms of administration and pharmacy, and to a lesser extent drug acquisition costs, with equivalent efficacy. Additionally patients may prefer XELOX due to the reduction in hospital administration visits and probability of requiring a CVAD.

POD IUM SESSION II: MENTAL HEALTH II
(SCHIZOPHRENIA IN EUROPE)

MH5 EFFECT OF A NURSE TELEPHONE FOLLOW-UP ON THERAPEUTIC ADHERENCE OF PATIENTS WITH SCHIZOPHRENIA

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OBJECTIVES: To evaluate the effect of a nurse telephone follow-up as a strategy for improving therapeutic adherence among outpatients with schizophrenia. METHODS: A 16-week, open, multicentre, randomised controlled trial. Patients fulfilled criteria for schizophrenia (DSM-IV TR criteria). To be eligible, patients had to be ambulatory in treatment with an oral antipsychotic agent. Participants were randomised to receive monthly telephone calls from a nurse of mental health center or standard clinical follow-up. Phone calls were performed at weeks 4, 8, and 12 in the intervention arm. The calls consisted of a brief interview to assess treatment compliance and Drug Attitude Inventory (DAI-10). A compliance with ≥60% of doses was used to classify patients as compliant. Primary endpoint was the difference in the percentage of compliant patients after nurse telephone follow-up versus control group at week 16. Secondary endpoints included socio-demographic data, past mental health diagnosis, Clinical Global Impression-Schizophrenia (CGI-SCH), DAI-10, and Euroqol EQ-5D. Study protocol was approved by a local Ethical Committee and all patients provided written informed consent. RESULTS: A total of 865 patients were studied, 65% men. Mean age: 40.08 years (SD = 11.6). Baseline socio-demographic and main clinical characteristics were similar between both groups: mean time from diagnosis: 13.08 years (SD = 9.5), mean number of hospitalisations in the last 5 years: 2.23 (SD = 2.7), mean time from last relapse: 3.1 years (SD = 3.9). A total of 88.2% (374) patients in the intervention arm were compliant vs 90.0% (397) in control arm. An absolute difference of 5.5% was found between groups (CI95%, 2.3–8.6%; p = 0.0007); OR 3.57 (CI95%, 1.81–7.04). Mean global CGI-SCH and DAI-10 scores were similar in both groups. At week 16, 410 (96.7%) patients fulfilled compliance criteria in the intervention group vs 402 (91.1%) in the control group. An absolute difference of 5.5% was found between groups (CI95%, 2.3–8.6%; p = 0.0007); OR 3.57 (CI95%, 1.81–7.04). Mean global CGI-SCH and DAI-10 scores were better in the intervention arm: 3.07 vs 3.25 p = 0.009; 6.05 vs 5.19 p < 0.0001, respectively. CONCLUSIONS: Despite a high baseline rate of compliance of the studied population, nurse telephone intervention increased antipsychotic adherence. A nurse telephone follow-up could be a complementary strategy to improve therapeutic adherence in schizophrenic patients.

MH6 ADHERENCE, PERSISTENCE, COSTS AND QUALITY OF LIFE IN PATIENTS TREATED WITH ANTIPSYCHOTIC DRUGS: RESULTS FROM THE COMETA STUDY

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OBJECTIVES: To assess adherence, persistence, costs and Health-Related-Quality-of-Life (HRQoL) in patients undergoing