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OBJECTIVES: MCDA allows structured consideration of the many aspects of value appraisal in healthcare. This study explored the value of lenvatinib for RR-DTC using holistic MCDA (EVIDEM framework). **METHODS:** The framework integrated 12 quantitative and 7 qualitative contextual criteria, each derived from fundamental ethical positions. By-criterion lenvatinib evidence matrices were designed for three countries (France, Italy, Spain) and two comparators (watch and wait, sorafenib) based on a systematic review and proprietary data. Value appraisal was performed by collecting weights (individual perspectives), scores (performance of lenvatinib) and qualitative inputs (impact of context) from three structured panel sessions designed to include patients, physicians, health economists and policy-decisionmakers, convened under the Chatham house rule. Value contributions (WeightsXScores) for each criterion and variability across individuals, countries and weighting methods were analyzed. Data on usefulness of the process were collected. **RESULTS:** The greatest weights were given to criteria Comparative effectiveness together with Quality of evidence (Spain and Italy) or Disease severity (France). Across all countries and comparators, four criteria contributed most to the value of lenvatinib (Comparative effectiveness [16-22%], Disease severity [16-22%], Unmet needs [14-21%], Quality of evidence [14-20%]), with contributions varying by comparator and country. Some negative contributions were observed for criteria Comparative safety (versus watch and wait) and Comparative economic consequences. The overall value of lenvatinib was positive across countries and comparators with variability across individuals, countries and weighting methods. Impacts of contextual criteria varied noticeably across countries, highlighting the importance of local consultation. Panelists reported the process contributed to their understanding of the intervention and its context and was helpful to express and share their perspectives and knowledge. **CONCLUSIONS:** Using MCDA-based holistic appraisal, the value of lenvatinib was assessed as consistently positive in the diverse treatment landscapes. The method provides a structured means to collect country-specific data and facilitates exchange across stakeholders.

PCN270

COST PER QALY AS A POTENTIAL HURDLE IN ACCESSIBILITY TO INNOVATIVE CANCER CARE IN SELECTED CEE COUNTRIES

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OBJECTIVES: Cost-per-QALY (CPQ) threshold can be a useful tool for resource allocation decisions but also may constitute an obstacle in access to the most-innovative, often life-saving but also expensive medicines. Since cancer is a major challenge for all healthcare systems, we investigated the impact of CPQ policy on new cancer drug reimbursement in 6 Central and Eastern Europe (CEE) countries: Poland and Slovakia (CPQ-driven countries), Czech Republic and Hungary (CPQ-oriented countries), Croatia and Romania (non-CPQ countries). **METHODS:** Basing on predefined criteria we selected 13 drug-indication pairs and considered their reimbursement status, time from registration to positive reimbursement decision and possible factors influencing reimbursement decision. Analyzes were performed for each selected country separately and in pairs grouped with regard to CPQ policy. The results were compared with indicators illustrating reimbursement systems, general cancer care and economics of participating countries. **RESULTS:** Generally, in all participating countries, cancer drugs generating lower CPQ values were more likely to be reimbursed. Analysis based on multinomial model adjusting for factors that might impact reimbursement decision confirmed significant role of CPQ value of a drug and GDP per capita of a country. Medicines generating higher CPQ values or evaluated in countries with lower GDP per capita are less likely to obtain positive reimbursement decisions. **CONCLUSIONS:** CEE countries have a different approach to CpQ application in reimbursement decisions. Access to oncology treatment for patients in CEE seems to be affected and not necessary improved by CPQ implementation policy. Higher CPQ value results in more constrained access to cancer drugs and prolonged time to reimbursement decision. CPQ is not the only criterion in the reimbursement process and even when met does not inevitably transfer into positive reimbursement decision. It seems that currently factors related to economy of CEE countries may affect reimbursement by far more than strictly CPQ policy.

PCN271

ARE YOU AT RISK OF CANCER? CONSIDER WHERE YOU LIVE IN ENGLAND FOR ACCESS TO THE MOST EXPENSIVE ONCOLOGY TREATMENTS

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OBJECTIVES: Access to drugs, particularly high cost oncology medicines, across England has frequently been accused to operate under a 'postcode lottery' where access varied depending on where you live. Since 2012, the National Institute of Health and Care Excellence (NICE) recommendations are mandated to be followed nationally within 90 days of issuing. Nevertheless, further regional/local restrictions upon usage are not uncommon that, along with the duration of NICE decision-making and non-universal coverage of medicines by NICE, leads to variability in prescribing levels of high cost medicines. Furthermore, NHS commissioning of specialised services is moving towards increasing co-commissioning between the local Clinical Commissioning Group (CCG) teams and regional/local NHS England bodies (formally Area Teams), with diverse models of care and service specifications being set out as part of the NHS 5 Year Forward View. This research aims to evaluate the level of regional variation in NHS prescribing. **METHODS:** All cancer drug prescribing data from the most recent NHS innovation scorecard heat map (July-September 2014) was extracted. Variations in prescribing across the 25 Area Teams per 100,000 population were identified. **RESULTS:** Data for three oncology drugs was available: denosumab, imatinib and nilotinib; NICE has issued positive guidance for all of these. Stark variations in amount prescribed between different area teams were apparent. Nilotinib, highest: Merseyside (220,385mg); lowest: Cheshire, Warrington and Wiral (12,091mg) –18.2 fold difference. Imatinib, highest: East Anglia (370,461mg); lowest: Leicestershire and Lincolnshire (71,592mg) –5.2 fold difference. Denosumab, highest: Cheshire, Warrington and Wiral (11,281DDD); lowest: Merseyside (0DDD). **CONCLUSIONS:** There are large variations in local prescribing between different NICE-approved oncology drugs, which exceeds what might have been expected from variations in local demographics. The ongoing fragmentation of the NHS particularly with respect to specialised service provision will likely further exacerbate this geographical variability in coverage and potentially fuel a greater 'postcode lottery.'

PCN272

CANCER DRUG FUNDING DECISIONS IN THE UK: INNOVATION AND VALUE IN THE BIOLOGICS ERA

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OBJECTIVES: To review evidence-based processes used in UK cancer funding decisions, using biologics in metastatic colorectal cancer (mCRC) as a case study. **METHODS:** We conducted an analysis of the peer-reviewed literature reporting overall survival (OS) in mCRC in randomised clinical trials (RCTs) and in real world studies (RWSs). Additionally, we investigated the use of RCTs and RWSs in UK cancer drug funding decisions. **RESULTS:** Recent RWSs report median OS levels in mCRC that are several months longer than those seen in pre-biologic RCTs (approximately 29.2 months in the post-biologic era versus 17.4 months pre-biologics, an incremental survival benefit of 11.8 months). The most recent data show real world median OS as long as 32 months. However, the scoring system for cancer funding decisions in the UK is currently predominantly focused on pre-launch RCT data, with no data drawn from RWSs referenced in National Institute for Health and Care Excellence (NICE) and Clinical Reference Group (CRG) evaluations. **CONCLUSIONS:** The current focus of the cancer funding scoring system on pre-launch RCTs may miss value gained from 'innovation-in-use.' Additionally, treatment holidays and sequencing steps could lead to further cost reductions that might increase value even without impact on OS. Therefore, NICE evaluations and the methodology for CRG scoring may undervalue the reality of real-world experience. The Cancer Drugs Fund (CDF) enables the UK National Health Service to realize the full scope of benefits of innovative drugs, overcoming the deficiencies currently inherent in NICE and CRG processes. Therefore, considerations for delisting of drugs from the CDF should be made in the light of data from RWSs as well as pre-launch data.

PCN273

ARE TRENDS IN SPENDING ON ONCOLOGY TREATMENTS SUSTAINABLE?: ANALYSIS OF SALES PATTERNS IN MAJOR GLOBAL MARKETS

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OBJECTIVES: Spending on oncology medications accounts for a growing share of total medical spending, raising questions about the financial sustainability of pricing regimes and continued progress against cancer. This research evaluates oncology spending across product classes, shedding light on the impact of loss of exclusivity (LOE) and new product entry in order to provide focus and an improved fact basis for discussions of financial sustainability in oncology treatment. **METHODS:** Quarterly observations on national-level sales of oncology medication in each of the five largest European markets, the US and Japan are compiled from IMS Health data from 2001 to 2013. These data are evaluated by medication type (cytotoxics, hormonals and targeted therapies) and brand/generic/biologic status, to evaluate the impact of LOE and new product entry with an eye toward projecting future oncology spending. Spending levels on oncology products by therapy type, country and exclusivity status are juxtaposed with patterns of hyperlipidemia and anti-ulcer products to assess the differences in sales patterns as product classes mature and lose exclusivity. **RESULTS:** Although there is considerable variation across countries, it is generally observed that small-molecule oncologic products experience a classic "patent cliff" around LOE. For example, total spending on cytotoxics (chemotherapy agents) in the US peaked in late 2011 and declined to 83% of peak levels by late 2013; generics comprised 12% of total spending in 2001, and 28% of total spending by late 2013. Targeted therapies, on the other hand, have experienced consistent sales growth, with much of that growth occurring for biologic therapies. **CONCLUSIONS:** Oncology spending in major global markets does not appear to be fundamentally unsustainable. Questions about future spending growth are appropriately focused on targeted therapies, particularly on biologic products, suggesting that the emergence of biosimilars will play a central role in shaping oncology spending in coming years.

PCN274

ANALYSIS OF EVALUATIONS MADE BY THE UK CANCER DRUG FUND PANEL OF BREAST CANCER TREATMENTS IN RELATION TO OVERALL SCORES AND FINAL CDF DECISIONS

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OBJECTIVES: To characterise UK Cancer Drug Fund (CDF) scoring of breast cancer drugs using the CDF prioritisation tool and to assess the final decisions made by the Chemotherapy Clinical Reference Group (CCRG) and the national CDF panel. **METHODS:** The CDF decision summaries (available online at www.england.nhs.uk/ourwork/pe/cdf/cdf-drug-sum) record the formal decisions of the CCRG in relation to drugs and drug indications that are reviewed for inclusion on the national CDF list. We reviewed the individual scoring for each treatment in the criteria using the CDF prioritisation tool. Assessed criteria included: magnitude of survival benefit (progression free survival and overall survival), quality of life, toxicity compared with existing therapies, degree of unmet clinical need, strength of evidence and total score. **RESULTS:** Between April 2013 and May 2015, 15 decision summaries assessing 7 drugs for the treatment of breast cancer were reported by the CCRG. Of these summaries, 5 saw a positive overall decision and 10 were negative. The over-