to induction cost and percentage transplants. At a willingness-to-pay threshold of 35,000€ per QALY gained, VTD has a 57.1% probability to be cost-effective in this setting. **CONCLUSIONS:** VTD induction is a cost-effective strategy for ndMM patients eligible for ASCT in Germany compared to TD.

PCN101

A COST-EFFECTIVENESS ANALYSIS OF CISPLATIN PLUS PEMETREXED DOUBLET INDUCTION TREATMENT FOLLOWED BY PEMETREXED MAINTENANCE COMPARED WITH BEVACIZUMAB PLUS CISPLATIN PLUS GEMCITABINE TRIPLET INDUCTION TREATMENT FOLLOWED BY BEVACIZUMAB MAINTENANCE FOR NON-SQUAMOUS NSCLC IN SWEDEN

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OBJECTIVES: This analysis compares the cost effectiveness (CE) of an induction and maintenance sequence of a cisplatin plus pemetrexed (cis+pem) doublet followed by pemetrexed, with that of a bevacizumab (7.5mg or 15mg) plus cisplatin plus gemcitabine (bev+cis+gem) triplet followed by bevacizumab (7.5mg or 15mg) for the treatment of non-squamous non-small cell lung cancer (NSCLC) in Sweden. **METHODS:** As no head-to-head trial data are available comparing these relevant regimens in the first-line induction and maintenance treatment settings, decision modelling and evidence synthesis were used to estimate CE. A series of network meta-analyses were performed to obtain hazard ratios for overall survival (OS) and progression-free survival (PFS) for each induction and maintenance comparator, and odds ratios for response for induction comparators. Bevacizumab doses were pooled in the meta-analyses. The CE model was structured using an area-under-the-curve approach. Costs and benefits were discounted at 3% per annum, consistent with Swedish practice. **RESULTS:** Cis+pem induction followed by pemetrexed maintenance was associated with a higher median PFS, OS, total life-years gained and quality-adjusted life-years (QALYs) than the bevacizumab triplets. Total costs were 416,478Kr for the bev(7.5mg)+cis+gem induction triplet plus bevacizumab 7.5mg maintenance sequence, 478,862Kr for the cis+pem doublet followed by pemetrexed maintenance sequence, and 541,677Kr for the bev(15mg)+cis+gem induction triplet followed by bevacizumab 15mg maintenance sequence. Total QALYs were 0.73 and 0.97 for the bevacizumab triplets and pemetrexed induction and maintenance sequence. The incremental cost-effectiveness ratio (ICER) of cis+pem followed by pemetrexed compared with bev(7.5mg)+cis+gem followed by bevacizumab 7.5mg was 260,831Kr (30,477Euro). The higher bevacizumab dose of 15mg was dominated by the cis+pem followed by pemetrexed sequence. The results of the probabilistic analysis support these results. **CONCLUSIONS:** The results of the CE analysis suggest that cis+pem doublet induction followed by pemetrexed maintenance is a cost-effective treatment sequence compared with the bevacizumab options for NSCLC in Sweden.

PCN102

A COST-EFFECTIVENESS ANALYSIS OF AXITINIB AND SORAFENIB FOR 2ND LINE TREATMENT OF ADVANCED RENAL CELL CARCINOMA AFTER FAILURE OF CYTOKINES IN THE UNITED STATES

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OBJECTIVES: To assess the cost-effectiveness of axitinib compared to sorafenib from the perspective of a US third-party payer for second-line treatment of patients with advanced RCC who failed cytokines. **METHODS:** Phase III AXIS trial reported that axitinib increased median progression free survival (PFS) compared to sorafenib (12.0 vs. 6.6 months, p<0.0001), while overall survival (OS) showed no difference (29.4 vs. 27.8 months, p=0.144) in patients failing treatment with cytokines. A cohort partition model was constructed to estimate direct medical costs and health outcomes, discounted at 3.0% per annum. Patients were apportioned into 3 health states (progression-free, progressed and dead) based on OS and PFS Kaplan-Meier curves from the AXIS trial. Active treatment was applied until progression, followed by best supportive care (BSC) thereafter. The wholesale acquisition costs and adverse event (AE) costs were obtained from published sources. AE rates and utility values were informed by the AXIS trial. US administrative claims data (MarketScan®) was analyzed to estimate routine care costs. Probabilistic sensitivity analysis (PSA) was conducted. **RESULTS:** The total per-patient lifetime costs were estimated to be $242,750 for axitinib and $168,880 for sorafenib and 84% of the cost difference was due to the higher total medication cost of axitinib. The quality-adjusted life-years (QALY) gained on axitinib vs. sorafenib was 1.3 vs. 1.2 and the incremental cost-effectiveness ratio (ICER) was $683,209/QALY. 100% of the PSA iterations showed that axitinib was more expensive than sorafenib and the QALY difference between axitinib and sorafenib was no greater than 0.7. **CONCLUSIONS:** For post-cytokine subgroup, axitinib resulted in an ICER > $650,000/QALY versus sorafenib due to high drug costs and lack of OS benefit, indicating that axitinib may not present good value for money as 2nd line treatment of advanced RCC when compared to sorafenib in the US.

PCN103

COST-EFFECTIVENESS OF COBAS® EGFR MUTATION TEST VERSUS SANGER SEQUENCING IN THE TREATMENT OF LOCALLY ADVANCED OR METASTATIC NSCLC: A PAYER PERSPECTIVE IN THE UNITED KINGDOM

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OBJECTIVES: We explored the cost-effectiveness of using the CE-IVD marked cobas® EGFR Mutation Test versus Sanger sequencing for identifying EGFR mutations in locally advanced or metastatic NSCLC patients from a UK payer perspective. **METHODS:** A decision-tree model was developed to compare testing methodologies and resulting treatment pathways in a hypothetical NSCLC population in the UK with a baseline EGFR mutation prevalence of 16.6%. Model inputs included parameters describing mutation testing accuracy, treatment response (EGFR inhibitor, standard chemo therapy or best supportive care) and adverse events arising from treatment. Inputs were based on published literature and costs in the NHS in England and Wales. The model examined cost-effectiveness over the patients' lifetime. A one-way sensitivity analysis was conducted. **RESULTS:** Using £32,500/QALY as a threshold, the cobas EGFR Mutation Test was cost-effective at an incremental cost per QALY gained of £18,394 for the target population as a result of better test accuracy and lower detection limit relative to Sanger sequencing. The cobas EGFR Mutation test was able to correctly identify more patients with EGFR mutations (lower rate of false negatives) and more appropriately direct patient treatment than Sanger sequencing. **CONCLUSIONS:** The cobas EGFR Mutation Test, by correctly identifying more patients for proper treatment, can be considered a cost-effective strategy for identification of EGFR mutations in locally advanced or metastatic NSCLC patients from a UK payer perspective.

PCN104

A CRITICAL APPRAISAL OF COST-EFFECTIVENESS ANALYSES OF HUMAN PAPILLOMAVIRUS TESTING IN CERVICAL SCREENING: MAKING APPROPRIATE COMPARISONS AND USEFULLY INTERPRETING RESULTS

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OBJECTIVES: To critically appraise published cost-effectiveness analyses (CEAs) of human papillomavirus (HPV) testing in cervical screening regarding the appropriateness of comparisons between strategies and the usefulness of the interpretation of cost-effectiveness estimates. **METHODS:** The PubMed database was searched for relevant CEAs of cervical screening using HPV testing. The identified CEAs were carefully appraised for their quality of analyses, reporting and interpretation of results. Specific examples of modelling shortcomings were selected as illustrations of what to avoid when estimating the cost-effectiveness of HPV-based screening. **RESULTS:** The review identified 29 relevant CEAs. Regarding basic errors, 11 of the 29 calculated the incremental cost-effectiveness ratios (ICERs) either partly or completely incorrectly. Ten studies failed to fully report costs and effects; either simply reporting ICERs or depicting a cost-effectiveness plane. Regarding more fundamental errors, 23 failed to include sufficient screening interval comparators against which to meaningfully estimate ICERs; effectively leading to average cost-effectiveness ratios being mistakenly identified as ICERs, which biases cost-effectiveness ratio estimates downwards. Finally, none of the studies gave specific consideration to the magnitude of the change in costs and effects of adding HPV testing to a given strategy, either with a simple graphical interpretation or with a formal interpretation using the net benefit framework. **CONCLUSIONS:** Model specification is typically the most difficult part of a model-based CEA, whereas simulating relevant strategies is relatively straightforward once the model is built. Similarly, once results have been generated, their correct presentation and interpretation is relatively straightforward. However, this analysis shows that these relatively easy aspects of CEA are being performed poorly in the HPV screening literature. Consequently, a few simple improvements to basic aspects of CEAs of HPV-based screening could greatly enhance the usefulness of such analyses to decision makers.

PCN105

COST-EFFECTIVENESS OF EML4-ALK FUSION TESTING AND FIRST-LINE CRIZOTINIB TREATMENT FOR PATIENTS WITH ADVANCED ALK POSITIVE NON-SMALL CELL LUNG CANCER IN A PUBLICLY FUNDED SYSTEM (ONTARIO, CANADA)

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OBJECTIVES: ALK-targeted therapy with crizotinib offers significant improvement in clinical outcomes for the treatment of EML4–ALK fusion positive NSCLC. We estimated the cost-effectiveness of EML4-ALK testing in combination with first-line crizotinib for ALK positive NSCLC in Ontario. **METHODS:** A cost-effectiveness analysis was conducted, using a Markov model from the Canadian public health (Ontario) perspective and a lifetime horizon in Stage IV NSCLC patients with non-squamous histology. Transition probabilities and mortality rates were calculated from the Ontario Cancer Registry and Cancer Care Ontario New Drug Funding Program (CCO NDFP). Costs were obtained from the Ontario Case Costing Initiative, CCO NDFP, University Health Network and the literature. Population-based ALK testing included initial IHC testing followed by FISH confirmation for positive cases. **RESULTS:** The strategy of genomic testing linked to targeted crizotinib treatment gained 0.11 QALYs compared to no testing or crizotinib treatment in the advanced non-squamous NSCLC population. The incremental cost was CAD $4,179 per patient compared to the previous standard of care without ALK testing; the incremental cost-effectiveness ratio for the base case was $392,538 per QALY. The incremental cost and ICER for crizotinib therapy in known ALK positive advanced NSCLC patients was $96,554 and $254,617/QALY. The cost of testing was less relevant to the ICER at a biomarker frequency of 7% and higher. The major drivers of cost-effectiveness are drug cost and low biomarker frequency in the population. **CONCLUSIONS:** EML4–ALK genomic testing in combination with crizotinib treatment for all Stage IV non-squamous NSCLC patients is not cost-effective in the setting of high drug costs and a low biomarker frequency in the general population. Modifying these key drivers will be important in improving the cost-effectiveness and accessibility to novel therapies with major clinical benefit in advanced NSCLC.

PCN106

OVERVIEW ON COST-EFFECTIVENESS RESULTS OF DECISION-ANALYTIC STUDIES FOR THE TREATMENT OF MULTIPLE MYELOMA

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OBJECTIVES: To provide an overview on published decision-analytic models evaluating treatment strategies for multiple myeloma (MM) focusing on the cost-effectiveness results. **METHODS:** A systematic literature search was performed in the electronic databases Pubmed, NHS EED and the Tufts CEA Registry to identify studies evaluating MM treatment strategies using mathematical decision-analytic models. To meet the inclusion criteria, models were required to compare different treatment strategies, to be published as full text articles in English, and comprise relevant clinical health outcomes over a defined time horizon and population. We used evidence tables to summarize methodological characteristics and economic results. For comparability, all economic results were transferred into 2012 US Dollar. We used Purchasing Power Parity to convert the currency into US Dollar of the same year. For converting US Dollar from step one into US Dollars 2012, we used Consumer Price Index rates for the relevant year. **RESULTS:** We found eleven decision-analytic modeling studies. Economic evaluations were included in all studies. Eight studies reported cost-utility results. The modeling approaches applied included a decision tree model, Markov cohort model, discrete event simulations, partitioned survival analyses and area under the curve models. Time horizons ranged from seven years to lifetime. Half of the models chose the perspective of the health care system, while other perspectives were societal, third party payer and government payer. Among others, two studies reported cost-effectiveness of autologous transplantation vs. standard-dose melphalan with an ICER of $31,263 /life-year gained (LYG) and $36,778/LYG. One study reported that bortezomib vs. lenalidomide plus dexamethasone is cost saving, while another comparable study reported an ICUR for lenalidomide plus dexamethasone vs. bortezomib of $22,301/QALY. **CONCLUSIONS:** We identified several well-designed cost-effectiveness/cost-utility models using a broad variety of different modeling approaches. Results of most of the studies were not comparable due to different treatment strategies, target population and settings.

PCN107

ECONOMIC EVIDENCE OF SURGICAL PROCEDURES IN CANCER: A SYSTEMATIC LITERATURE REVIEW

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OBJECTIVES: To examine the empirical and methodological cost-effectiveness evidence of surgical interventions for breast, colorectal, and prostate cancer. **METHODS:** Systematic searches of seven databases including MEDLINE, EMBASE, CDSR,HTA, DARE, EconLit and NHSEED, research registers, the National Institute of Health and Care Excellence (NICE) website and conference proceedings was conducted in April 2012. Studies were included if they evaluated the cost-effectiveness of a surgical procedure in either breast, colorectal or prostate cancer and reported cost per quality adjusted life-year or cost per life-year results. The quality of the studies included was assessed in terms of meeting essential, preferred, and UK specific requirements for economic evaluations. **RESULTS:** The 17 (breast=3,colorectal=7,prostate=7) studies which satisfied the inclusion criteria covered a broad range of settings with 9 set in European and 8 in non-European locations. Just a third (11/17) was published within the last 10 years. In terms of the essential quality criteria; the populations, interventions and comparators were generally well defined. However, very few studies were informed by the results of literature reviews or synthesised clinical evidence. Although the interventions had potential differential effects on recurrence and mortality rates, some studies used relatively short time horizons. Although univariate sensitivity analyses were reported in all studies, less than a third characterised all uncertainty with a probabilistic sensitivity analysis. While a third of studies incorporated patients' health-related quality of life data, only 4 of the 17 studies used social tariff values. **CONCLUSIONS:** There is very little recent robust evidence describing the cost-effectiveness of surgical interventions in these indications. Many of the more recent publications did not satisfy the essential methods requirements, such as using synthesising clinical evidence informed by a systematic literature review. Given the ratio of potential benefit and harm associated with surgery in cancer, there is an urgent need to conduct additional robust economic evaluations in this area.

PCN108

ABIRATERONE ACETATE VERSUS ENZALUTAMIDE FOR METASTATIC CASTRATION-RESISTANT PROSTATE CANCER POST CHEMOTHERAPY: COST EFFECTIVENESS ANALYSIS

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OBJECTIVES: With approvals of abiraterone acetate (AA) and enzalutamide (ENZA) in the past 2 years, the treatment landscape has shifted dramatically for metastatic castration-resistant prostate cancer (mCRPC) patients who failed docetaxel-based chemotherapy. There is increasing interest in the relative cost-effectiveness of these therapies. The objective of this study was to assess the cost-effectiveness of AA versus ENZA among individuals with mCRPC post chemotherapy from a payer perspective. **METHODS:** A survival-based Markov cohort model consisting of 3 health states, progression-free, progressed, and dead, was developed to project over 10 year period. Progression between states was determined by overall survival (OS) and radiographic progression free survival (rPFS). An indirect treatment comparison was conducted to determine the relative efficacy of AA and ENZA (data reported separately). Utilities were mapped from FACT-P to EQ-5D based on a review of the literature. Drug acquisition costs in the US were used since ENZA was approved only in the US at the time of analysis. Costs of scheduled and unscheduled follow-up visits were obtained from the Centers for Medicare Services Drug Payment Table and Physician Fee Schedule and represented in 2013 US dollars. Average wholesale prices for a 30-day supply of AA and ENZA were $7,674 and $8,940, respectively. One-way sensitivity analyses were performed against all probability, utility, and cost values incorporated into this cost-effectiveness model. **RESULTS:** In this analysis, AA provides substantial saving with $13,322 per patient versus ENZA. The main drivers of the model are drug costs, health utility values, and efficacy (OS and rPFS). The robustness of the results was supported by sensitivity analyses. **CONCLUSIONS:** Given similar OS benefits, AA is cost saving compared with ENZA for the treatment of patients with mCPRC post-docetaxel based on US data.

PCN109

COMPARATIVE STUDY OF THE COST-EFFECTIVENESS OF TRASTUZUMAB IN THE TREATMENT OF BREAST CANCER IN DIFFERENT COUNTRIES

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OBJECTIVES: Pharmacoeconomic evaluations are more critical in developing countries in which economic effects of new and expensive therapies have significant impact on patients, insurance companies and the health systems. Since cost-effectiveness studies are too costly and time consuming, in these countries new medications are often being used in daily practice before being well documented as cost-effective interventions. This would force health organizations to perform comparative studies as alternatives to cost-effectiveness analysis. Trastuzumab, an anti-cancer monoclonal antibody which was approved by FDA in 1998, is an expensive medicine introduced to the Iranian pharmaceutical market since 2003, with an annual usage cost of 308,352,730,640 Rials ($ US 25,000,000) in 2010. **METHODS:** A systematic review on electronic medical databases including the Cochrane, CRD, EMBASE, HEED, MEDLINE, and PubMed, covering the years 2000 to 2009, was performed using relevant key words to extract publications investigating cost-effectiveness and efficacy of trastuzumab in breast cancer treatment. The Incremental Cost-Effectiveness Ratios (ICERs) were compared with a criterion introduced by WHO. **RESULTS:** The reported ICERs were between $90,118/QALY to $217,264/QALY and $13,361/QALY to $65,250/QALY in metastatic and adjuvant breast cancer therapy, respectively. The metastatic ICERs were 8 to 20 folds of the GDP per Capita in Iran whereas the adjuvant phase ICERs were 1.2 to 6 folds of it. Sensitivity analysis showed the results are more sensitive to discount rate, drug regimen cost, duration of survival benefits, as well as the risk of relapse and metastasis. **CONCLUSIONS:** Trastuzumab therapy in metastatic breast cancer cannot be cost effective in Iran, however as adjuvant therapy it is still a challenging issue. Unlimited access to this medicine would not be rational and recommendations with an approach to optimize its usage, e.g. administration in younger patients with poor prognosis and higher risk of relapse or using clean rooms to reduce drug wasting, are strongly advised.

PCN110

THE COST-EFFECTIVENESS OF BENDAMUSTINE-RITUXIMAB VERSUS FLUDARABINE-RITUXIMAB FOR PATIENTS WITH INDOLENT NON-HODGKIN'S LYMPHOMA (INHL) WHO HAVE PROGRESSED FOLLOWING TREATMENT WITH RITUXIMAB OR A RITUXIMAB-CONTAINING REGIMEN IN MEXICO

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OBJECTIVES: To determine the cost-effectiveness of bendamustine-rituximab (Ben-R) versus fludarabine-rituximab (Fdb-R) in patients with iNHL who have progressed following treatment with rituximab or a rituximab-containing regimen in Mexico. **METHODS:** An economic model was constructed from the Mexican public payer perspective, with a 35-year (lifetime) horizon and a discount rate of 5%. The model included three health states, progression-free (PF), progressive disease (PD), and death, which were associated with utility weights of 0.81, 0.62 and 0, respectively. Clinical inputs (response rates, Kaplan-Meier curves, hazard ratios (HRs) and adverse event rates) were from the Stil NHL 2-2003 study. Resource use data were from interviews with Mexican hematologists treating iNHL patients. Unit costs were obtained from Mexican Social Security Institute (IMSS) and were expressed as 2013 Mexican Pesos. Univariate and probabilistic sensitivity analyses were conducted to determine the key drivers of cost-effectiveness, and uncertainty around the results, respectively. **RESULTS:** Total cost of Ben-R was $1,726,828 and total cost of Fdb-R was $1,640,024. Ben-R patients accrued more LYs (5.82 vs. 4.73), QALYs (4.22 vs. 3.29), and PF LYs (3.37 vs. 1.96) compared to Fdb-R patients. The ICERs were $79,890 (cost per LY), $92,788 (cost per QALY) and $61,486 (cost per PF LY). Univariate sensitivity analysis revealed that the ICER per LY was most sensitive to the PF survival (PFS) and overall survival (OS) HRs for Ben-R vs Fdb-R and the use of bone marrow transplants in the PD state. Probabilistic sensitivity analysis with 1,000 iterations estimated that Ben-R will be cost effective over 90% of the time at a willingness-to-pay threshold of $125,085. **CONCLUSIONS:** At a willingness-to-pay of $125,085 (GDP per capita of Mexico) Ben-R is cost effective versus Fdb-R.

PCN111

A COST-EFFECTIVENESS ANALYSES OF USING SUNITINIB (SU) IN FIRST LINE OF METASTATIC RENAL CANCER IN ROMANIAN JURISDICTION

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OBJECTIVES: In Romania the estimated incidence of metastatic renal cancer (mRCC) is about 1500 cases; less than 400 patients receive full reimbursement for