incidence (assuming 1 occurrence/patient/cycle), treatment usage, and 1-year prevalence of MM (2124 cases) to estimate treatment burden in Australia for a single AE occurrence. RESULTS: The most-cost-intensive AEs were all Gr 3/4. For TT, the most-cost-intensive AEs were squamous cell carcinoma (SCC) and rash, with a mean cost per event per patient of A$226 and A$232, respectively. For IT, they were neuropathy and leukenoplasia, with a mean cost of A$67 and A$33, respectively. For CT, they were neutropenia/leukopenia and anaphylaxis, representing a mean cost of A$1005 and A$381, respectively. Across all 3 treatment categories, the top 4 AEs with the highest burdens were MM and breast cancer stage, and disease progression. Existing studies suggest that although medical costs are high, overall cancer drug treatment costs only contribute 1.8–13.9% of total cancer costs, and 2.4–37.0% in breast cancer.

PCN79
LITERATURE REVIEW ON TOTAL MEDICAL COSTS AND COST COMPONENTS OF ONCOLOGY CARE IN THE UNITED STATES
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OBJECTIVES: To understand the proportion of total medical costs attributed to cancer drug treatment in oncology patients, with a focus on breast and prostate cancer.
METHODOLOGY: Literature review conducted using PubMed, Medscape and Google to identify and retrieve studies in cancer patients reporting total medical costs and cost components, particularly cancer drug treatment costs. All studies reporting data on US American patients published in English language between 2009 and 2013 were included. RESULTS: A total of 7 studies were reviewed. 14 of which were relevant and included. Total medical costs and cost components varied substantially by tumor type and location, cancer stage, phase of care, study design, payers and the timing of study. In 2011, oncology care costs accounted for $125 billion. Prescription drug costs were 1.8–13.9% of total cancer care costs, with 13.9% representing the proportion of costs during the last six months. Among patients reported in these studies, 61% had insurance and 39% were uninsured. CONCLUSION: Hospital costs were the single largest cost driver, accounting for 64.0–82.0% of total costs. Among patients receiving chemotherapy treatment, chemotherapeutic costs contributed for 25.0% and other medications (e.g., anagenesis, sedatives, anti-emetics, antidepressants) accounted for 26.0% of total costs. None of the prostate cancer studies identified met the research inclusion criteria. CONCLUSIONS: Studies on drug treatment costs are limited and results vary substantially depending on patient clinical characteristics, cancer stage, and disease progression. Existing studies suggest that although medical costs are high, overall cancer drug treatment costs only contribute 1.8–13.9% of total cancer costs, and 2.4–37.0% in breast cancer.

PCN80
TRENDS IN APPROVALS AND PRICES OF ONCOLOGY DRUGS IN THE UNITED STATES (1990-2013)
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OBJECTIVE: To assess the trends in approval and prices of oncology drugs in the United States. METHODS: 165 approved oncology therapeutic drugs (44 biologics and 121 chemical entities) in the period of analysis. RESULTS: The FDA listed 165 approved oncology therapeutic drugs (44 biologics and 121 chemical entities) in the period of analysis. The FDA approved 31 products (18% of total) before the 1980s, 11 (6.7%) in the 1980s, 50 (30.3%) in the 1990s, 48 (29.1%) in the 2000s, and 25 (15.2%) in 2010-2013. There were 45 (27.3%) products with at least one FDA approved orphan indication. There were 10 products (6.1% of approvals) discontinued. There were 45 products with complete price history from approval to January 1, 2014, and 2 had generic competition. The CPI adjusted average annual AWP price increase was 10.2%±21.0% (95%CI:8.2%-12.1%) with an average 9.18±6.59 years in the market. The average annual AWP increase was higher for products approved in the 1990s (20.9%±34.8%) than for those approved in the 2000s (4.5%±8.9%) and 2000-2013 (6.3%±9.8%). Chemical entities and drugs with orphan indications had higher AWP price increases than biosimilars and non-orphan drugs, respectively. CONCLUSIONS: Manufacturer listed prices of oncology products approved in the period 1990-2013 grew faster than the inflation. Price increases were higher for orphan drugs and chemical entities.

PCN81
TREATMENT PATTERNS AND COST OF CARE FOR PATIENTS WITH GASTROINTESTINAL STROMAL TUMOR (GIST) TREATED WITH IMatinib
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OBJECTIVES: Since approval of imatinib, systemic therapy (ST) for gastrointestinal stromal tumors (GIST) has changed considerably. This study evaluated treatment patterns and costs across 3 large retrospective databases among GIST patients receiv-
OBJECTIVES: Clinicians treating patients with advanced NSCLC have a range of potential treatment options. The objective of this study was to determine the cost-effectiveness (CE) model to compare induction-maintenance sequences approved for use in the U.S. for the treatment of advanced non-squamous NSCLC given the absence of direct head-to-head trials. **METHODS:** The modelled regimens that were licensed in the U.S. for advanced states included: paclitaxel+cisplatin→bevacizumab; pemetrexed+cisplatin→best supportive care (BSC); gemcitabine+cisplatin→BSC; gemcitabine+cisplatin→erlotinib; gemcitabine-cisplatin→pemetrexed; and pacitaxel carboplatin (EC). The model evaluated the effect of induction and maintenance on survival endpoints using data from a previous network meta-analysis. Decision analytic modelling was used to synthesise the treatment effect and baseline risk estimates for the induction and maintenance treatment arms. The model included all active maintenance therapy containing regimens, with the exception of gemcitabine-cisplatin→erlotinib, which were more costly than induction-only regimens. Gemcitabine-cisplatin→BSC was the baseline comparator and established the cost effective threshold range of $0 to $211,425. **RESULTS:** The CE model showed that gemcitabine-cisplatin→erlotinib and pemetrexed+cisplatin→BSC were cost-effective compared with gemcitabine-cisplatin→pemetrexed. Other regimens were dominated (paclitaxel+cisplatin→bevacizumab→bevacizumab or extendedly dominated (gemcitabine-cisplatin→pemetrexed). Sensitivity analyses demonstrated that efficacy data and the method of extrapolation of survival had the greatest impact on the cost-effectiveness results. For non-dominated regimens, the cost-effectiveness acceptability frontier showed that gemcitabine-cisplatin→BSC, pemetrexed+cisplatin→BSC, and pemetrexed+cisplatin→pemetrexed dominated all other regimens. The cost-effectiveness over the following threshold ranges: $0-$124,000/LY, $124,000-$220,000/LY, and above $220,000/LY, respectively. **CONCLUSIONS:** Using the specific cost-effectiveness threshold, the model showed that gemcitabine-cisplatin→BSC, gemcitabine-cisplatin→erlotinib, pemetrexed+cisplatin→BSC versus gemcitabine-cisplatin→erlotinib, and pemetrexed+cisplatin→pemetrexed versus pemetrexed+cisplatin→BSC were not cost-effective when ranking these comparators.