to measure quality of life. The clinical parameters used in the model take into account the results of a MTC of clinical trials (CT) on RA within the rheumatoid arthritis (RA) population. The model accounts for the presence of disease-modifying antirheumatic drugs (DMARDs), biologic agents and anti-TNF agents. The model is population-based and considers the effects of these treatments on HRQoL and costs.

OBJECTIVES: To evaluate the incremental cost-effectiveness ratio (ICER) of adalimumab (adalimumab) versus placebo for patients with rheumatoid arthritis (RA) in the first 12 months of treatment.

Methods: A Markov model was developed to model the clinical and economic outcomes of RA patients over time. The model included five health states: no RA activity, low activity, moderate activity, severe activity, and death. The model was run for 12 months, with a 3-month cycle length. The model assumes that patients receive adalimumab or placebo at the beginning of each cycle, and the effects of treatment are modeled based on the duration of treatment and the response to treatment. The model also includes the costs of drugs, hospitalization, laboratory tests, and physician visits.

Results: The annualized ICER of adalimumab versus placebo was $44,703 per QALY gained for patients in the first 12 months of treatment. This result is within the commonly accepted threshold of $50,000 per QALY gained.

Conclusions: The results of this model suggest that adalimumab is cost-effective compared to placebo for patients with RA in the first 12 months of treatment. However, further research is needed to confirm these findings and to assess the long-term cost-effectiveness of adalimumab.

PMS47 THE IMPACT OF DISEASE MODIFICATION ON THE COST-EFFECTIVENESS OF PEGLOTICASE FOR THE TREATMENT OF SEVERE DEBLITATING CHRONIC TOPHUS TOPHUS IN patients with severe chronic gout.

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OBJECTIVES: To determine the cost-effectiveness of pegloticase (Kytrystexa®) for patients with severe debilitating chronic tophaceous gout (SDCTG), from a UK health care perspective. METHODS: Severe debilitating chronic tophaceous gout (SDCTG) is defined as a debilitating high unmet medical need. Existing treatments can provide symptom relief and not modify the disease course. Pegloticase has the potential to be a disease modifying agent. A decision analytical model was built to compare pegloticase (PS) use versus usual care (UC) in patients with SDCTG with baseline chronic gout (BCG) (UC) with a Markov model used to extrapolate outcomes to a 20 year time horizon. In the base case, the disease modifying properties of pegloticase were modelled. In scenario analyses only symptomatic relief of pegloticase on acute attacks and tophi was included. RESULTS: In the base case, the cost-effectiveness of pegloticase compared to BCG was $31,197 per QALY gained. In this base case, pegloticase dramatically reduced the uric acid burden in over 60% of patients who completed a six month course of treatment. Only assumed costs to the NHS included drugs, hospitalization for acute gout, and costs of hospital treatments. This was a Markov model based on international RA treatment recommendations, it was concluded that there is a $12 million incremental cost-effectiveness ratio (ICER) of $44,703 per QALY gained for patients with severe chronic gout. This model is population-based and considers the effects of these treatments on HRQoL and costs.

OBJECTIVES: To evaluate the incremental cost-effectiveness ratio (ICER) of adalimumab (adalimumab) versus placebo for patients with rheumatoid arthritis (RA) in the first 12 months of treatment.

Methods: A Markov model was developed to model the clinical and economic outcomes of RA patients over time. The model included five health states: no RA activity, low activity, moderate activity, severe activity, and death. The model was run for 12 months, with a 3-month cycle length. The model assumes that patients receive adalimumab or placebo at the beginning of each cycle, and the effects of treatment are modeled based on the duration of treatment and the response to treatment. The model also includes the costs of drugs, hospitalization, laboratory tests, and physician visits.

Results: The annualized ICER of adalimumab versus placebo was $44,703 per QALY gained for patients in the first 12 months of treatment. This result is within the commonly accepted threshold of $50,000 per QALY gained.

Conclusions: The results of this model suggest that adalimumab is cost-effective compared to placebo for patients with RA in the first 12 months of treatment. However, further research is needed to confirm these findings and to assess the long-term cost-effectiveness of adalimumab.