quality of clinical evidence originating from same studies has been rated differentially by different agencies. The economic evidence in this area was primarily based on cost-effectiveness/cost utility analysis (CEA/CUA), comprising ~95% of studies (time horizon 50 years to lifetime). The incremental cost-effectiveness ratios (ICER) ranged USD15000-200000 in PBAC, USD1246-376723 in NICE, USD750-45200 in SMC, and USD11000-75000 in CADTH. More than 90% of the decisions based on ICER values were positive, with restriction being focused on cost negotiations. The primary driver of positive decisions was majorly economic analysis in NICE, PBAC, and SMC, while clinical evidence drove positive recommendations in CADTH, IQWiG, and HAS. **CONCLUSIONS:** Current landscape of CHC treatments in Canada, Australia, UK, Scotland, Germany, and France is majorly dominated by positive recommendations, considering the high unmet in this area. Most of the restrictions were around cost negotiations. The drivers of decisions fit with agency priorities, with economic analysis being the key driver in agencies with pharmacoeconomic analysis, and clinical evidence in agencies without pharmacoeconomic analysis.

PGI59
COMPARISON OF REGULATORY LABELS AND HTA DECISIONS FOR CHRONIC HEPATITIS-C THERAPIES
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OBJECTIVES: To compare the regulatory label indications and health technology assessment (HTA) recommendations for therapies indicated for the treatment of chronic hepatitis-C (CHC). **METHODS:** We reviewed the regulatory labels approved by European Medicines Agency (Europe), Health Canada (Canada) and Therapeutic Goods Administration (Australia). HTA reports for CHC therapies published by NICE (England and Wales), SMC (Scotland), HAS (France), IQWiG (Germany), CADTH (Canada) and PBAC (Australia) were assessed. Therapies with a positive HTA decision (recommended or restricted) were included in the analysis. Indication was split into four categories: age of the population (children, adults or both), fibrosis status (cirrhotic or non-cirrhotic), genotype, and prior treatment history (naïve or treatment-experienced). A match was defined as overlap of HTA and regulatory decision for any of the categories. Percentage correlation of the HTA indication with the regulatory label was calculated as the ratio of actual matches to the maximum possible matches for the parameters considered. **RESULTS:** A total of 34 regulatory approvals and 48 HTA reports were identified from the public domain. Forty-six HTA reports providing a positive decision were included. Overall, HTA decisions correlated well with the marketing authorization (89%), with the highest correlation observed for CADTH and PBAC (100% each), followed by HAS (98%), NICE and SMC (86% each) and IQWiG (63%). Across agencies, highest correlation was observed for age of the population (96% cases) and lowest for the prior treatment history (85% cases) of the population for whom the therapies were recommended. **CONCLUSIONS:** Overall, the indication approved by HTA agency almost correlated completely with the indication granted marketing authorization, except for NICE, SMC and IQWiG, indicating difference in agency priorities driving HTA decisions. Analyzing the population restriction applied by NICE, SMC and IQWiG would provide the decision drivers, allowing manufacturers to address these concerns in prospective submissions.

PGI60
TRENDS IN HEALTH TECHNOLOGY ASSESSMENT DECISIONS ACROSS THE GLOBE: A FOCUS ON HEPATITIS C
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OBJECTIVES: Recent advances in the management of hepatitis C virus (HCV) have yielded therapeutic modalities that are more efficacious, better tolerated, and have a lower pill and injection burden. Given the large population affected by HCV, decisions by health technology assessment (HTA) bodies weigh significantly in terms of societal benefits and expenditures. The objective of this analysis was to evaluate recent patterns in HCV-related HTA decisions in selected countries. **METHODS:** HTA surveillance was conducted for Australia, Canada, France, Germany, and the United Kingdom (UK) from January 1, 2012 to June 1, 2015 (42 months). HTAs for HCV treatments were evaluated by genotype, decision, and decision rationale. Decisions were categorized as favorable, unfavorable, mixed (both favorable and unfavorable), and neutral (deferral). **RESULTS:** 32 HCV-related HTAs were published in the study time frame, with 7 assessments currently in development. Among the completed assessments, the majority of decisions were favorable (24, 75%), with only 2 (6%) unfavorable and 6 (19%) mixed decisions. The most common rationales provided for a negative decision included insufficient data and/or inappropriate comparators (4), insufficient benefit to justify the high cost (ie, improperly high incremental cost-effectiveness ratio [ICER]) (3), and inadequate clinical benefit vs the most appropriate comparator (1). France and Canada had the highest percentage of favorable decisions (5 of 5 and 9 of 9, respectively, 100%), followed by the UK (3 of 4, 75%), Australia (5 of 8, 63%), and Germany (2 of 6, 33%). **CONCLUSIONS:** Based on the last 42 months of HCV-related HTAs, 75% of decisions were favorable. However, the most significant factors leading to unfavorable assessments for HCV products are related to the inability to supply advantageous clinical and cost-effectiveness data. This analysis suggests that manufacturers would have greater success with HTA decisions if more robust health economic and clinical data are generated.

PGI61
BIOLOGICS IN ULCERATIVE COLITIS (UC): TREATMENT GUIDELINES AND HEALTH TECHNOLOGY ASSESSMENTS (HTA)
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OBJECTIVES: To review clinical guidelines, recent HTA decisions, and the influence of economic analyses in HTA decisions related to biologic therapies in UC. **METHODS:** A literature review and targeted research provided information on clinical treatment guidelines (US and Europe) and HTAs (Europe) related to biologics in UC. Economic models in UC were identified and reviewed to determine how these affected HTA decisions. **RESULTS:** Since several biologics were approved after the last version of the US treatment guidelines, the US guidelines only address the use of infliximab for the treatment of moderate or severe UC. In the UK, NICE has recommended infliximab, adalimumab, and golimumab as possible treatments for adults with moderate to severe UC in whom conventional therapy hasn't worked or isn't suitable. A recent NICE HTA recommends vedolizumab as an option for treating moderately to severely active UC in adults only if the company provides vedolizumab with the discount agreed in the patient access scheme. The Scottish Medicines Consortium (SMC) recommends vedolizumab for the treatment of adult patients with moderate-to-severe UC and an inadequate response, lost response, or intolerance to conventional therapy or a TNFα antagonist; this advice is "contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower." Earlier SMC advice did not recommend adalimumab, golimumab or infliximab for use within NHS Scotland due to lack of robust economic analyses. The SMC advice is superseded by the NICE HTA decisions. **CONCLUSIONS:** In the UK and Scotland, more than 9 HTA have been performed in the 10 years since biologics have become available for the treatment of moderate-to-severe UC. Differential cost-effectiveness among specific indications, lines of treatment, and countries have resulted in a variety of recommendations as to their use which supplement clinical guidelines in UC.

PGI62
DOSE ESCALATION AMONG ULCERATIVE COLITIS PATIENTS TREATED WITH ADALIMUMAB IN SWEDEN
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OBJECTIVES: The objective of this study was to describe the real-world use of adalimumab (ADA) for maintenance treatment of ulcerative colitis (UC) on a national level in Sweden. **METHODS:** A longitudinal, retrospective cohort study was conducted using the National Drug Registry and the National Patient Registry. UC patients (age ≥18 years) treated with ADA were included. Two cohorts were selected: (1) ADA naïve patients and (2) a cross-sectional cohort. Both cohorts were followed for a 12-month period. Dose escalation among the ADA naïve patients was defined as doubling of dose (ADA 40 mg every week) or having two following filled prescriptions with average biweekly dose (ABD) ≥ 50 mg. Dosing in the cross-sectional cohort was assessed studying annual number of injections dispensed among patients on maintenance treatment. **RESULTS:** Five hundred and eighty-seven patients were identified as ADA naive during Jan 2010-April 2014. Dose-escalation by doubling of dose was observed in 273 (46.5%) patients with the median time to dose escalation being 84 days. Further analysis revealed that 191 patients (32.5%) in the ADA naive patient cohort dose-escalated defined as (ABD) ≥ 50 mg, and of these 40 (20.9%) had a subsequent dose de-escalation which occurred after a median time of 162 days. In total 992 UC patients were identified in the cross-sectional cohort, defined as filling at least one prescription during May 2013-April 2014, and of these 364 (37%) were on maintenance treatment. Out of the 364 patients on maintenance treatment dispensing at least 22 injections during the period 140 (38%) received 30 injections or more. **CONCLUSIONS:** This study demonstrates that UC patients receiving ADA in general have a patchy prescription pattern, and that the proportion of patients who dose escalate is high. This finding and the impact that dose escalation has on costs may have implications for healthcare professionals and budget holders.

PGI63
EFFECTS OF FINANCIAL INCENTIVES FOR SAVING DRUG EXPENDITURES ON PHYSICIAN PRESCRIPTION BEHAVIORS
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OBJECTIVES: The purpose of this study is to assess the impact on physician prescription behaviors of an outpatient prescription incentive program providing financial rewards to primary care physicians for saving prescription costs implemented in October 2010 in South Korea. **METHODS:** A 10% sample of clinics (N=1,625) was randomly selected from the entire clinics in the National Health Insurance claims database for the years 2009~2012, and all claims with the primary diagnosis of peptic ulcer or gastro-esophageal reflux diseases were extracted from those clinics' data. We used a clinic-level random effects model analyzing policy effects on drug expenditures and prescribing behaviors including prescription rate of medicines treating target diseases, number of drug prescribed per claim, prescription duration per claim. We also performed subgroup analyses by selected clinic characteristics, including practice type, size and specialty. **RESULTS:** We found no significant impact of the program on drug expenditure overall. Prescription rate of target medicines increased and the average prescription duration per claim decreased after the incentive program. After the financial incentive program, clinics in general medicine showed a lower prescription rate (by 0.8 percentage points), lower number of medicines prescribed (by 0.02), a lower prescription duration (by 0.15 days), and lower drug expenditure per claim after the policy (by 740 won). Small clinics had shorter prescription duration (by 0.76 days), while large clinics and clinics in group practice had a higher prescription rate (by 1.5 and 2.5 percentage points, respectively) and higher number of medicines prescribed (by 0.03 for group practice only) after the program. **CONCLUSIONS:** The financial incentive program worked as intended only in certain subgroup clinics for the target medicines. The reduction in prescription duration and the number of prescribed medicines in target claims in selected subgroups imply some margin for prescription adjustments.