curves were constructed. RESULTS: Eplerenone added incremental benefit on mortality and morbidity above placebo. Costs was $US1279.70 higher in the eplerenone treatment (CI 95%, $US604-1992) because of the drug cost. For eplerenone versus placebo, the incremental cost—effectiveness ratio (ICER) was $US13,169.8 per LY and $US19,753.4 per QALY gained. Using a willingness-to-pay threshold of $US20,000 per LY or QALY gained, 64.3% of estimates fell below this threshold. CONCLUSION: Eplerenone compared with placebo in the treatment of heart failure after AMI is effective in reducing mortality and is cost—effective with a threshold of $US20,000 per LY in Mexico. These results should be taken into account by Mexican decision makers and clinicians in the management of patients with left ventricular systolic dysfunction and heart failure following AMI.

**PCV22**

**A CARDIOVASCULAR DISEASE COST-EFFECTIVENESS MODEL BASED ON CTT META-ANALYSIS**

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OBJECTIVES: To evaluate the cost-effectiveness of lipid-lowering therapy for cardiovascular disease based upon the event risk and LDL-C reduction relationship observed in the Clinical Treatment Trials (CTT) meta-analysis. METHODS: A simple Markov model comparing the incremental cost-effectiveness for two lipid-lowering therapies was developed using TreeAge® software. The addition of ezetimibe to simvastatin 40 mg was compared to doubling the simvastatin 40 mg dose from the UK health plan perspective. Patients enter the model as a primary or secondary CHD prevention patient. Patients experience a fatal or non-fatal CHD event, die from another cause, or remain event-free in each annual cycle. Transition probabilities were determined by a patient’s baseline risk, age and LDL-C reduction. Lipid therapy was assumed to provide a 23% reduction in major coronary events for 1 mmol/L reduction in LDL-C. Costs and utilities for health states were adapted from the NICE report on statin therapies and were discounted at 3.5%. Base case analyses were performed for a 55 year old individual, with or without a history of CHD, annual CHD risk of 3%, and a baseline LDL-C value of 4 mmol/L. Probabilistic sensitivity analysis (PSA) was performed and acceptability curves were generated. RESULTS: The incremental cost per QALY gained of simvastatin/ezetimibe co-administration was estimated at ≤$14,618 and ≤$18,549 for those with and without a history of CHD, respectively. PSA based upon 10,000 iterations suggest that the ezetimibe co-administration was below a threshold of ≤$30,000/QALY gained in over 95% of the simulations. Additional analyses suggest that cost effectiveness of the addition of ezetimibe improves relative to doubling of statin dose with increasing baseline CHD risk and/or LDL-C levels. CONCLUSION: The model developed provides a simple method to compare two treatments based on their effects on LDL-C. Although the model has several simplifying assumptions it provided results consistent with other CHD models.

**PCV23**

**EVALUATION OF DYSLIPIDEMIA THERAPIES FOR TREATMENT OF LOW HDL AND HIGH LDL: A COST-EFFECTIVENESS ANALYSIS BASED ON NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY III**

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OBJECTIVES: Cholesterol management guidelines recommend management of elevated low-density cholesterol (LDL-C) followed by management of low high-density cholesterol (HDL-C) and elevated triglycerides in patients with dyslipidemia. The objective of this study was to conduct a population-based cost-efficacy analysis of dyslipidemic agents using data from the National Health and Nutrition Examination Survey III (NHANES III). METHODS: A 6-month, cost-effectiveness analysis, from a MCO perspective, incorporating dose escalation and adverse drug effects (ADEs) associated with pravastatin, simvastatin, ezetimibe/simvastatin, and extended release (ER) niacin/lovastatin was conducted. Patients with high LDL-C and low HDL-C from NHANES III were included to estimate population values for lipids, while product labeling was used for lipid changes. Goals for LDL-C were <100 mg/dL and <130 mg/dL based on cardiovascular risk; and, HLD-C > 40 or 50 mg/dL (males and females, respectively). Medication (WAC), physician office visits, and laboratory costs (Medicare’s allowance fees) were included. Monte Carlo simulations were conducted for probabilistic sensitivity analyses testing key assumptions of drug efficacy, ADEs, and costs. RESULTS: Rates of lipid goal achievement was a function of sex, age and treatment. Accounting for dosing and ADEs, the lowest cost for 180 days of treatment was ezetimibe/simvastatin ($561), followed by ER niacin/lovastatin ($655), pravastatin ($698), and simvastatin ($742). Attainment of LDL-C and HDL-C goals was highest for ER niacin/lovastatin (77.8%), followed by for ezetimibe/simvastatin (50.1%), simvastatin (44.2%) and pravastatin (29.5%). Cost/patient achieving combined goals was $842 for ER niacin/lovastatin, $1120 for ezetimibe/simvastatin, $1677 for simvastatin, and $2364 for pravastatin. Both pravastatin and simvastatin were dominated by ezetimibe/simvastatin, while the incremental cost-effectiveness for ER niacin/lovastatin at $341 per additional patient reaching goal was on the cost-effective frontier. CONCLUSION: This analysis suggests among patients with high LDL-C and low HDL-C treatment with ezetimibe/simvastatin and ER niacin/lovastatin are cost-effective strategies compared to either pravastatin or simvastatin.

**PCV24**

**USE OF A DECISION ANALYTIC MODEL TO EVALUATE COST PER PATIENT TREATED TO GOAL WITH HIGH POTENCY ANTILIPIDEMICS**

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OBJECTIVES: To estimate the cost per patient successfully treated to NCEP ATP-III goal with high-potency statins or statin/combinations. METHODS: We constructed a decision analytic model (from the payer perspective) comparing four statins or statin combinations: atorvastatin (40–80 mg), rosuvastatin (10–40 mg), simvastatin/ezetimibe (Vytorin; 10/10–40/40 mg), and simvastatin 80 mg. Costs were based on the available Military Health System (MHS) prices, and only included drug acquisition costs. Monte Carlo simulations were used to generate a distribution of starting LDL values for a hypothetical cohort of 1000 patients. The mean starting LDL was 189.1 (SD = 18.6), with individual patient LDLs normally distributed. The percentage of patients in each NCEP ATP-III risk group was: low risk 41% (LDL goal <160 mg/dL); moderate risk 30% (LDL goal <130 mg/dL); high risk 29% (LDL goal <100 mg/dL). Distributions of efficacy values (% LDL reduction) based on clinical literature were generated for each treatment arm. The primary outcome was the percentage of patients successfully treated to individual NCEP ATP-III goals based on starting LDL