ANALYSIS OF DOSE, COST AND USE PATTERNS OF ERYTHROPOIETIN STIMULATING AGENTS IN CANCER PATIENTS

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OBJECTIVES: Cancer patients who develop anemia are often treated with erythropoietin-stimulating agents (ESAs), including darbepoetin alfa (DA) or epoetin alfa (EA). This study compared baseline characteristics, patterns of ESA use, costs, and dosing among cancer patients as observed in a large managed care claims database. METHODS: Medical and pharmacy claims from a U.S. managed care database were used to identify 15,007 unique episodes of care (7238 with DA, 7769 with EA) in cancer patients between January 2004 and 2006. Episodes included all ESA claims within ±42 day gap between claims, plus a duration of clinical benefit based on the median days between consecutive doses for each product. The dose conversion ratio was calculated as the mean weekly dose of EA to DA. Six sensitivity analyses examined the robustness of findings to study methods. Costs were determined from plan allowed amounts for ESA claims. RESULTS: The mean (±SD) number of administrations per episode was 3.7 (±4.1) for DA and 5.3 (±6.4) for EA. The mean ESA episode duration was 55.5 (±64.7) days for DA and 59.2 (±59.2) days for EA and median time between consecutive claims was 15 and 8, respectively. The estimated mean weekly dose was 105 (±56) mcg for DA and 34,242 (±28,174) U for EA. The corresponding dose ratio is 1 : 326. In the sensitivity analyses, mean weekly doses were sensitive to the inclusion/exclusion of duration of clinical benefit (dose ratio 1 : 326 vs. 1 : 237, respectively). Patients receiving DA differed significantly in baseline characteristics compared to patients receiving EA. When DCA adjusted costs were compared, the mean weekly cost of Aranesp was lower than for Procrit. CONCLUSION: ESA use differed significantly between DA and EA. Adjustments for patterns of use are necessary to appropriately compare the drugs and their costs.

NEW SYSTEM OF COSTLY DRUG REIMBURSEMENT IN FRANCE: ASSESSMENT IN A TEACHING HOSPITAL ONCOLOGY DEPARTMENT

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OBJECTIVES: The payment of costly drugs is not included in the DRG price within the context of the French case-mix based hospital payment system (termed T2A) since 2005/01/01. These drugs will be reimbursed on an additional cost basis after implementation of a “best practices” agreement (good practice reference guidelines drawn up by scientific societies and registration agencies). The objective of this study was to assess the proportion of off-label costly anticancer drug use in terms of reference guidelines in oncology and the impact of their unreimbursability on the hospital activity. METHODS: A 18-month retrospective study (2005/01/01–2006/06/30) was performed in oncology department. 11 costly anticancer drugs were eligible for the additional reimbursement. 8416 adult patient prescriptions (943 patients) including at least one of the eleven studied drugs were analysed. For each prescription, the anticancer drug cost was calculated. The analysis of use was performed by drug: conformity to the official labelling (indication, dose, route of administration) and level of scientific evidence. The off-label anticancer drug use was discussed with prescribers in drug committee. RESULTS: The proportion of off-label costly anticancer drug use is 32% (2693/8416 prescriptions) and represents 29% (€2,020,373/€6,877,879) of oncology overall drug budget. Among these prescriptions, 43% (1153/2693 prescriptions) were supported by at least one randomized phase III trial and represent 59% (€1,191,068/€2,020,373) of the oncology costly anticancer drug induced cost. CONCLUSION: The reference guidelines should lead towards the good use of these drugs and allow the sick funds to control prescriptions. However, the official labelling of drugs is unable to answer to all clinical situations and cannot be the own references for costly anticancer drug reimbursement. The anticancer drug prescriptions from therapeutic progress (justified off label used) need to be reimbursed to maintain quality of cancer care in French hospitals.
(attendance) of this programme proved to be low. Therefore we aimed to analyze the frequency and distribution of Papanicolau smears. METHODS: The data were derived from the financial database of the National Health Insurance Fund Administration (OEP) of Hungary covering the period of 2003–2005. First we calculated the frequency of pap smears and then the distribution according to geographical regions. Screening is defined with the cytological examination of Papanicolau smear and includes all smears taken either within or outside of the organized programme. RESULTS: The age specific screening rate of women aged 25–64 years was 52.6% in 2003–2005. Distribution of Papanicolau smears according to regions was: Central-Hungary: 28.4%, Central-Transdanubia: 10.5%, Western-Transdanubia: 9.3%, Southern-Transdanubia: 10.8%, Northern-Hungary: 13.2%, Northern-Greatplane: 14.2%, Southern-Greatplane: 13.6%. Frequency (number) of Papanicolau smears per 10,000 female population according to regions: Central-Hungary: 4685, Central-Transdanubia: 4540, Western-Transdanubia: 4571, Southern-Transdanubia: 5257, Northern-Hungary: 5035, Northern-Greatplane: 4651, Southern-Greatplane: 4899. CONCLUSION: We found significant inequalities in the frequency of Papanicolau smears was the highest in the Southern-Transdanubian and Northern-Hungarian regions. To increase participation rate and to decrease within country inequalities are important aims of the Hungarian nationwide organized cervical cancer screening program.

PCN38
WITHIN COUNTRY DIFFERENCES IN MAMMOGRAPHY COVERAGE OF THE HUNGARIAN NATIONWIDE ORGANIZED BREAST CANCER SCREENING PROGRAMME
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OBJECTIVES: Nationwide organized breast cancer screening programme was launched 2002 in Hungary for women between the age of 45–65 with a 2 years screening interval. The aim of the study is to analyse the within country inequalities of mammography coverage of the organized programme. METHODS: Data derive from the database of the National Health Insurance Fund Administration (OEP) containing routinely collected financial data. The study includes all the women aged 45–64 having either screening or diagnostic mammography before (2000–2001) and after (2002–2003 and 2004–2005) the introduction of organized screening. The regional inequalities are calculated for 19 counties and Budapest as the capital (altogether 20 items). Coverage is defined as the proportion of women resident who have had a mammogram at least once in the previous 2 years. RESULTS: National mammography coverage was 26.7%, 54.6% and 51.6% in 2000–2001, 2002–2003 and 2004–2005 respectively. We found the highest coverage in 2000–2001 in counties having earlier pilot screening programme: county Tolna (59.2%), county Jász-Nagykun-Szolnok (45.1%), county Zala (39.5%). After the introduction of nationwide breast screening programme in 2002–2003 we found the highest coverage in the following counties: county Szabolcs-Szatmár-Bereg 70.8%, county Borsod-Abauj-Zemplén 64.4%, county Vas (63.9%). In 2004–2005, the following counties received the highest coverage: county Győr-Moson-Sopron (60.8%), county Szabolcs-Szatmár-Bereg 58.1% and county Vas 56.2%. The ratio of coverage between the counties with the highest and lowest coverage was 3.5 (2000–2001), 2.6 (2002–2003) and 1.4 (2004–2005). CONCLUSION: We found significant within country differences in mammography coverage, however the gap between counties with lowest and highest coverage became smaller after the introduction of organized screening programme.

PCN39
GAP BETWEEN INPATIENT TREATMENT COST OF AND MORTALITY DUE TO BREAST CANCER IN HUNGARY
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OBJECTIVES: The aim of this study is to analyze and compare the distribution of inpatient care treatment cost of and mortality due to breast cancer according to age-groups. METHODS: Data derive from the database of the National Health Insurance Fund Administration (OEP) containing routinely collected financial data. The study includes all the women who received outpatient and/or inpatient care treatment in 2001 financed from public resources of OEP. Number of deaths due to breast cancer is from the Central Statistical Office database. We compared the annual out- and inpatient care treatment cost and the annual number of deaths according to the following age groups: 0–24, 25–44, 45–64, 65–74, 75+. RESULTS: The cost distribution of out- and inpatient care treatment cost of breast cancer was the following (outp./inp.): 0–24 years: 0.1%/0.2%; 25–44 years: 12.4%/11.7%; 45–64 years: 59.2%/59.1%; 65–74 years: 20.9%/20.2%; 75 and over: 5.4%/8.7%. The distribution of deaths due to breast cancer was the following: 0–24 years: 0.0%; 25–44 years: 5.0%; 45–64 years: 37.0%; 65–74 years: 22.8%; 75 and over: 35.2%. We found that in the age-group 65–74 there is a balance between the cost distribution (20.9% and 20.2%) and the deaths (22.8%). Women in younger age groups received more treatment cost than its mortality would predict, while in older age groups (75+)—responsible 35.2% of deaths—received only 7.4% and 8.7% of out- and inpatient treatment cost respectively. CONCLUSION: There is a shift between the distribution of treatment cost of and deaths due to breast cancer in favor of younger age-groups.

PCN40
PATTERNS OF TREATMENT OF NON SMALL CELL LUNG CANCER (NSCLC) IN COMMUNITY PRACTICE
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OBJECTIVES: Evidence guiding NSCLC treatment has been derived largely from controlled trials at academic centers. Much less attention has focused on understanding NSCLC treatment by community-based oncologists. We undertook this study to better understand NSCLC treatment patterns and outcomes in community-based practices. METHODS: Ten large community-based oncology practices in the U.S. were identified. Investigators conducted chart reviews on 417 NSCLC patients treated with chemotherapy between 2001 and 2003 who were deceased at the time of the review. RESULTS: Of the 417 patients (54% male, median age 68 years, mean performance status 1.2) almost 20% had a history of radiation therapy, and 9.6% had a history of surgery. Mean survival was 10.5 months for stage IIIb patients (n = 114) and 7.9 months for stage IV patients (n = 303). In their first line of chemotherapy, 55% of patients received both carboplatin and paclitaxel (18% in combination with radiation therapy). Another 11% received carboplatin with either gemcitabine (6%) or docetaxel (5%). In contrast, monotherapy was more common in second line therapy (docetaxel 22%, gemc-