incremental quality-adjusted life years (QALYs) while ESAs were administered and discontinued. HB “normalisation period” following cancer treatment. Incremental long-term QALYs were accrued solely through extrapolated overall survival. Short-term mortality and HRQoL associated with adverse events and RCTs were not modelled. Costs included: ESA acquisition (list prices, British National Formulary) and adverse events (Malaria, RBC, additional blood draws with ESA therapy) and event costs. RESULTS: All ESAs except epoetin beta and darbepoe tin alfa were cost-effective versus using RBCCT only at an upper cost-effectiveness threshold of £20,000/QALY. In 15.9% of simulations it was clinically effective but not cost-effective and in 31.4% of simulations it was dominated by RBCCT only. Additional sensitivity analyses demonstrated that overall survival was one of the most influential and uncertain parameters. When the cost of ESAs (not statistically significant) was removed, the ICERs for all ESAs were over £100,000/QALY. CONCLUSIONS: There is substantial uncertainty regarding the impact of ESA therapy on overall survival, which leads to significant uncertainty about the cost-effectiveness of ESAs in CIN.

**PCN158**

**QALY WEIGHTINGS BASED ON THE BURDEN OF ILLNESS APPLIED TO A UK COST-EFFECTIVENESS ANALYSIS OF NAB-PACLITAXEL + GEMCITABINE VERSUS GEMCITABINE ALONE FOR THE TREATMENT OF METASTATIC PANCREATIC CANCER**

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OBJECTIVES: To demonstrate the impact of QALY weightings based on the burden-of-illness (BoI) in patients with pancreatic cancer on the incremental cost-effectiveness of nab-paclitaxel plus gemcitabine (NPG) versus gemcitabine (G). METHODS: A markov model using data from the MPACT trial plus resource use data and costs from NHS Scotland, US and Canadian sources. Clinical data was obtained from the Southwest Oncology group. The base case ICER was £52,885/QALY based on a cost of £3,232 and a QALY gain of 0.156 (SMD). QALY weightings up to a maximum of 2.5 distributed across six modifier factors, including BoI, have been proposed (Nice consultation on Value Based Assessment), with high economic burden of grade 3 + 4 adverse events providing proportional QALY shortfall associated with the condition. The estimated 98% loss of healthy life (proportional QALY shortfall) in pancreatic cancer (Hutchings 2014) represents an almost complete loss of life, and thus a very high BoI. A BoI weighting of 3 (maximum weighting allocated entirely to BoI or Bo FULL) and an alternative BoI weighting of 1.417 (maximum weighting shared equally between six modifiers, 1/6th of 2, or Bo PARTIAL) were therefore applied to the QALY gain of NPG versus G. RESULTS: The Bo FULL weighting gives an adjusted QALY gain of 0.156 and a cost of £3,592 per QALY compared with the base case. The Bo PARTIAL weighting gives an adjusted QALY gain for NPG of 0.221 and a corresponding ICER of £37,249/QALY CONCLUSIONS: Various ways of accounting for QALY loss from disease can be estimated and made workable by HTAs, including QALY weightings according to proportional QALY shortfall. The adjusted QALY gain and corresponding ICERs of NPG versus G in pancreatic cancer show that the value of medicines for life-threatening ‘end-of-life’ conditions with a high relative shortfall can be reflected by an appropriate system of QALY weightings.

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**ECONOMIC EVALUATION OF LAPATINIB IN HER-2+ POSITIVE METASTATIC BREAST CANCER PATIENTS IN EGYPT**

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OBJECTIVES: The objective of the current analysis was to assess the cost-effectiveness of lapatinib plus capcitabine versus capcitabine alone in human epidermal growth factor receptor-2 positive metastatic breast cancer patients from the third party payer perspective. The timeframe of the analysis was for clinical trials of lapatinib and for six cycles of capcitabine (CEC6). A half cycle corrected Markov chain model comprising 3 health states (stable, progression and death) was developed to estimate the projected clinical and economic implications of lapatinib. Transition probabilities were estimated based on the results of the EGF100151 clinical trial of Lapatinib. Health state utilities and major adverse events were obtained from published sources. Direct medical costs were obtained from the third party payer list. Costs (in 2013 €GP) and effects were discounted at 3.5% annually. One way sensitivity analyses were conducted. RESULTS: The economic evaluation of lapatinib plus capcitabine as combination therapy resulted in additional cost of 1,597,796 €GP, with an incremental positive effect of 0.7 quality adjusted life years (QALY) or an incremental cost-effectiveness ratio (ICER) of 277,169 €GP/QALY gained. The overall survival of the two arms was found to be the greatest impact on the results. CONCLUSIONS: Compared with our willingness-to-pay threshold of £35,000/QALY, lapatinib plus capcitabine is an economically attractive alternative to paclitaxel and docetaxel in MBC, providing an economically attractive alternative to palitaxel and docetaxel in MBC, providing an economically attractive alternative to paclitaxel and docetaxel in MBC, providing a substantially lower cost per QALY. Additionally in the patient preference survey, patients were willing to pay up to £55,933 more for a substantially lower cost per QALY. Compared with our willingness-to-pay threshold of £35,000/QALY, lapatinib plus capcitabine is an economically attractive alternative to paclitaxel and docetaxel in MBC, providing an economically attractive alternative to paclitaxel and docetaxel in MBC, providing an economically attractive alternative to paclitaxel and docetaxel in MBC, providing a substantially lower cost per QALY. Additionally in the patient preference survey, patients were willing to pay up to £55,933 more for a substantially lower cost per QALY. Additionally in the patient preference survey, patients were willing to pay up to £55,933 more for a substantially lower cost per QALY. Additionally in the patient preference survey, patients were willing to pay up to £55,933 more for a substantially lower cost per QALY. Additionally in the patient preference survey, patients were willing to pay up to £55,933 more for a substantially lower cost per QALY.