This analysis aimed to assess if the early switch from IFNB to fingolimod impacts MS clinical outcomes. This promotes better resource utilization from a Portuguese hospital perspective. METHODS: This analysis was based on TRANSFORMS phase III trial extension data. A cost-effectiveness model was developed to calculate the cost per relapse avoided with 4.5 years of continuous treatment with fingolimod (early treatment) versus 1 year of treatment with IFNB followed by a 3.5 years of treatment with fingolimod (delayed treatment). A Portuguese hospital perspective was adopted addressing only direct costs: drug, monitoring and relapses’ treatment. Costs were based on Portuguese list prices, while in a Dutch cost of each complication was obtained from the Diagnosis Related Groups tariff. The costs of relapses were derived from the Portuguese literature. RESULTS: Assuming there are 819 patients treated with IFNB that are poor responders, the early treatment with fingolimod resulted in more relapses avoided when compared with delayed treatment with fingolimod (2,211 versus 1,843). The early treatment with fingolimod led to an increase of drug acquisition costs, but reduced costs associated with monitoring the patients and relapses’ treatment. The total costs per patient for early treatment versus delayed treatment for 79,257,091 for delayed treatment. This represents an average incremental investment of 1,933€ per patient per year. The early strategy resulted an incremental cost effectiveness ratio of 19,358€ per relapse avoided when compared with the delayed strategy. CONCLUSIONS: Under the Portuguese hospital perspective, early treatment with fingolimod is expected to result in better clinical outcomes associated with a more efficient health care resources allocation.

**PND21**

**COST ANALYSIS OF TWO AFTER-CARE STRATEGIES IN CHRONIC CONTINUOUS INTRATHECAL BACLOFEN THERAPY IN PATIENTS WITH INTRACTABLE SPASTICITY**

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**OBJECTIVES:** Intrathecal baclofen (ITB) therapy is indicated for use in the management of intractable spasticity. Patients treated with ITB are required to receive a pump refill at least once every three months in the hospital (standard care (SC)). Since SC can be very burdensome for both patients and informal caregivers, an alternative approach (Care4homecare) has been developed which enables patients to receive replacement infusions at home. Moreover, a role of specially trained nurse practitioners ensures that there is no reduction in effectiveness. We compared the costs of both strategies. METHODS: Resource use in both strategies was estimated using observational data of 38 adult patients with spasticity (due to g. multiple sclerosis or spinal cord injury) that are currently living at home. We then combined this data with expert opinion and the Dutch costing manual to estimate the total one-year costs from a societal perspective. RESULTS: Patients included in the in-home refill strategy manage an age of 58.2 years and patients scored on average 44±12.5 points on the Care Dependency Scale. The Care4homecare strategy involves care that is almost identical to SC and therefore can result in comparable direct medical costs. However, patients receiving Care4homecare do not incur any travel costs compared with SC patients (±849). In addition, the productivity costs of informal caregivers (SC 195; Care4homecare 40) and of patients treated with Care4homecare are less than the costs of patients receiving SC from a societal perspective. Moreover, it can be a welcome option for many patients and caregivers who want to avoid the burden of regular hospital visits.

**PND22**

**COST ANALYSIS OF THE USE OF GLATIRAMER ACETATE COMPARED TO INTERFERON-Â IN PATIENTS WITH RELAPSING-REMITTING MULTIPLE SCLEROSIS**

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**OBJECTIVES:** To analyze the costs associated with first-line use of glatiramer acetate (GA) compared to interferon-ß (INF-ß) in patients with relapsing-remitting multiple sclerosis (RRMS) and spasticity from the perspective of the National Health System in Spain. METHODS: A cost analysis of treatment and spasticity management with GA (29.79% of prescriptions) and 5 mg (29.79% of prescriptions). For rivastigmine, the cost was R41.02 per DDD and for galantamine R27.72 per DDD (using the most convenient dosage strengths). These three products were our original products. For donepezil, the originator and three branded generics were available. The cost of the originator was R27.86 per DDD, and for one of the generics the cost was R23.28 per DDD. All DDDs were used. Costs of care are quite high and have risen dramatically, e.g. >200% in Brazil and Mexico, 1 Chile). Mostly (22/27, 81%) were published as abstracts; 5 were published in the refereed literature. A cost analysis was based on TRANSFORMS phase III trial extension data. A cost-effectiveness model was developed to calculate the cost per relapse avoided with 4.5 years of continuous treatment with fingolimod (early treatment) versus 1 year of treatment with IFNB followed by a 3.5 years of treatment with fingolimod (delayed treatment). A Portuguese hospital perspective was adopted addressing only direct costs: drug, monitoring and relapses’ treatment. Costs were based on Portuguese list prices, while in a Dutch cost of each complication was obtained from the Diagnosis Related Groups tariff. The costs of relapses were derived from the Portuguese literature. RESULTS: Assuming there are 819 patients treated with IFNB that are poor responders, the early treatment with fingolimod resulted in more relapses avoided when compared with delayed treatment with fingolimod (2,211 versus 1,843). The early treatment with fingolimod led to an increase of drug acquisition costs, but reduced costs associated with monitoring the patients and relapses’ treatment. The total costs per patient for early treatment versus delayed treatment for 79,257,091 for delayed treatment. This represents an average incremental investment of 1,933€ per patient per year. The early strategy resulted an incremental cost effectiveness ratio of 19,358€ per relapse avoided when compared with the delayed strategy. CONCLUSIONS: Under the Portuguese hospital perspective, early treatment with fingolimod is expected to result in better clinical outcomes associated with a more efficient health care resources allocation.

**PND23**

**SYSTEMATIC REVIEW OF THE ECONOMICS OF MULTIPLE SCLEROSIS IN LATIN AMERICA**

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**OBJECTIVES:** To summarize published articles dealing with economic issues related to multiple sclerosis (MS) in Latin America. METHODS: We searched Medline, Embase, Scielo and LILACS using the key words “multiple sclerosis” and “esclerosis múltiple” in English and Spanish. We included articles written in English or Spanish, with the exception of a few articles published in Portuguese. The search was not restricted by date or language. All work was done in duplicate by two independent reviewers with similar training. RESULTS: We identified 1,482 papers, of which 27 were considered for analysis. There were 7 economic analyses (5 cost-effectiveness, 2 cost-utility), 5 budget impact analyses, 10 cost analyses (6 drug management studies and 4 cost of illness studies), and 1 study of drug adherence. Conclusions: the majority of studies were from the United States and Europe, and less from Latin America. The quality of studies varied widely. The studies were heterogeneous, and it was not possible to combine the results. Only one study was a randomized controlled trial. This study aimed to systematically review published estimates of direct and indirect costs associated with the use of EIAEDs compared with non-enzyme-inducing anti-epileptic drugs (nEIAEDs) in patients with focal and generalised seizures, and to evaluate methodological differences between the studies. METHODS: Comprehensive electronic searches were undertaken using MEDLINE, EMBASE, Cochrane Library, EconLit, relevant conference proceedings and cost effectiveness analysis registries. All studies reporting any direct and indirect costs of AEDs for the treatment of patients with epilepsy seizures were included. Quality study assessment was performed for each included study using a predesigned check list. RESULTS: Thirty-three references were included, and cost-effectiveness comparisons were performed between EIAEDs and nEIAEDs in several settings. The results were dominated by differences in drug costs. Conclusions: insufficient data and heterogeneity in methodology prevent valid comparisons being made between the total cost of EIAEDs and nEIAEDs, although some studies compared direct medical and indirect costs of AEDs. Conclusions: insufficient data and heterogeneity in methodology prevent valid comparisons being made between the total cost of EIAEDs and nEIAEDs, although some studies compared direct medical and indirect costs of AEDs. Conclusions: insufficient data and heterogeneity in methodology prevent valid comparisons being made between the total cost of EIAEDs and nEIAEDs, although some studies compared direct medical and indirect costs of AEDs. Conclusions: insufficient data and heterogeneity in methodology prevent valid comparisons being made between the total cost of EIAEDs and nEIAEDs, although some studies compared direct medical and indirect costs of AEDs.