Limited information was available linking disease severity to QoL. CONCLUSIONS: In studies of patients receiving treatment for current or recent SCD/CML, median OS did not differ significantly among populations receiving regimens containing cetuximab, docetaxel, methotrexate, or paclitaxel. Among platinum-refractory patients, no treatment was identified as having demonstrated significant improvements in QoL.

PCN26 LEUKOTRIENE KETOSTRAIN FOR REDUCTION OF CHEMOTHERAPY-INDUCED NEUTOPENIA RELATED EVENTS: A META-ANALYSIS

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OBJECTIVES: The purpose of the current meta-analysis was to compare the effec- tiveness of leucotriene ketosterain (LKS) to pegfilgrastim prophylaxis. METHODS: EMBASE was searched for head-to-head trials examining the efficacy of LKS, pegfilgrastim, or filgrastim. Outcomes included incidence of febrile neutropenia (FN), incidence of severe neutropenia (SN), duration of SN (DSN), and time to recovery of absolute neutrophil count (ANC) in patients receiving daily G-CSF were prescribed 5 or less doses in at least one PCN28 cycle with pegfilgrastim prophylaxis. This comparative effectiveness analysis showed a significantly higher likelihood of metastatic status, cycle number, chemotherapy FN-risk and history of anaemia and primary/secondary diagnosis of neutropenia (D70.1*, D70.7). Odds ratios (OR) for those cycles with G-CSF administration initiated for breast cancer or NHL from January 1, 2009 to December 31, 2013 were included in Germany. Patients receiving first-line, high/intermediate FN-risk chemotherapy for breast cancer or Non-Hodgkin lymphoma (D70.1*, D70.7) were included in the analyses. The Relative Dose Intensity (RDI) method compared the intensity of dose received per day of treatment against expected dose (recommended dose) intensity. RDI values and total number of eribulin administrations were calculated for each patient based on the presence of either dose reduction and/or dose delay. Data was analyzed using an independent samples t-test. RESULTS: An analysis of patient distribution revealed the mean number of eribulin administrations was 13.4 with a mean RDI of 85%. Persistence was statistically higher in patients that had eribulin therapy managed through dose delay and dose reduction strategies. Patients with no modification (100% RDI) received an average of 8.1 eribulin administrations. Patients with dose modification (81% RDI) received an average of 8.7 eribulin administrations. CONCLUSIONS: Management of eribulin therapy in patients with MBC via dose delay and/or reduc- tion resulted in a statistically significant increase in persistence among responding patients.

PCN29 A SYSTEMATIC LITERATURE REVIEW TO IDENTIFY AND COMPARE CLINICAL TRIAL EFFICACIES OF CHEMOTHERAPEUTIC AGENTS IN POST-GENCITABINE ADVANCED PANCREATIC CANCER

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OBJECTIVES: There is currently no FDA-approved therapy for advanced pancreatic cancer (APC), including locally advanced and metastatic disease, who progressed following first-line therapy. Available treatment options have been limited to patients who had eribulin therapy managed through dose delay and dose reduction strategies. Patients with no modification (100% RDI) received an average of 8.1 eribulin administrations. Patients with dose modification (81% RDI) received an average of 8.7 eribulin administrations. CONCLUSIONS: Management of eribulin therapy in patients with MBC via dose delay and/or reduc- tion resulted in a statistically significant increase in persistence among responding patients.

PCN30 A REAL-WORLD ANALYSIS OF KOREAN NATION-WIDE DATABASE: PATTERNS, ASSOCIATION, AND RELATED HEALTHCARE COSTS OF IMATINIB AMONG PATIENTS WITH CHRONIC MYELOID LEUKEMIA

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OBJECTIVES: This study aimed to determine the demographic features, treat- ment pattern, medication adherence, survival rates associated with healthcare costs in patients with newly diagnosed Ph+ CML from Korean National health Insurance (NHI) claims database. METHODS: We conducted a longitudinal analy- sis of patients with newly diagnosed Ph+ CML (ICD-10: C92.1) and started treatment with imatinib in 2005 enrolled in the Korean NHI program. Patients were excluded if they had 2 or more diagnoses of other cancer during the follow-up period. The time of analysis, the only Phase 3 RCT to evaluate a new therapeutic agent in post-gemcitabine APC was the NAPOLI-1 trial (nanoposomial irinotecan (MM-398, nal-IR) + 5-fluorouracil and leucovorin (SFU/LV) versus SFU/LV), which was a large, global study that demonstrated a statistically significant improve- ment in overall survival in patients with metastatic disease, including heavilypretreated patients. CONCLUSIONS: The present review highlights the limited number of RCTs evaluating new therapeutic agents in patients with APC who progressed following first-line therapy. New agents fail to be evaluated beyond small, uncontrolled trials of APC. Despite much research in this difficult-to-treat patient population with high unmet medical need, only one Phase 3 RCT of a new agent (nal-IR) + SFU/ LV demonstrated significant improvement in overall survival in patients with APC who had progressing gemcitabine-based therapy.

PCN31 ABSOLUTE RISK REDUCTION AND CLINICAL SIGNIFICANCE OF NEWER THERAPEUTIC AGENTS IN METASTATIC BREAST CANCER

A434 V A L U E  I N  H E A L T H  1 8  ( 2 0 1 5 )  A 3 3 5 – A 7 6 6
A 352) and 0.385(0.248, 0.596) respectively for OS and PFS. Survival extrapolation provided an overall survival of 8 months and additional OS gain for Lenvatinib vs sorafenib, with MAIC extrapolation showing largest gain and a good model fit. CONCLUSIONS: This analysis demonstrated that in absence of head-to-head trials, MAIC is an important methodology to adjust for population and trial differences, especially in orphan diseases, where limited data available. MAIC enables reliable comparison of effectiveness data and support patients decision making.

PCN34
A DESCRIPTION OF REAL-WORLD TREATMENT WITH ABRITADERINE ACETATE IN METASTATIC CARCINOST-RESISTANT PROSTATE CANCER PATIENTS IN THE POST-CHEMOTHERAPY SETTING IN FRANCE AND THE NETHERLANDS

Methods:
In this retrospective study, we reviewed medical records of mCRPC patients progressing after docetaxel chemotherapy compared to placebo with either abiraterone acetate (AA). Eligible mCRPC patients were aged ≥ 18 years, previously treated with docetaxel and naive to prior AA treatment. The methods chosen were descriptive summary statistics and survival analyses were performed for AA treatment duration, overall survival (OS) and time to prostate-specific antigen (PSA) progression endpoints. RESULTS: A total of 68 patients (France and the Netherlands) reported data on 269 mCRPC patients treated with AA. Median PSA (ng/mL) of patients from France and the Netherlands was 55.8 (interquartile range [IQR]: 28.0-102.0) and 74.5 (IQR: 69.5-371.5), respectively. The median time between mCRPC diagnosis and AA initiation was 12.6 (IQR: 7.0-22) in France and 18.3 (IQR: 9.6-36.0) in the Netherlands. Median (months) AA treatment duration, median OS and median time to PSA progression in France was 11.3% (95% confidence interval [95%CI]: 8.3-13.7), 21.6% (95%CI: 14.5-%) and 13.8 (95%CI: 11.1-15.5), respectively. In the Netherlands, it was 4.9 (95%CI: 3.4-6.4), 11.0 (95% CI: 7.3-13.0) and 4.9 (95% CI: 3.0-7.3), respectively. CONCLUSIONS: Here we describe the real-world treatment of mCRPC patients receiving AA in the post-chemo-therapy setting in mCRPC in EU countries. This study suggests that initiating AA earlier in the post-chemical therapy setting may result in better health outcomes.

PCN35
REAL-WORLD ANALYSIS OF TYROSIN KINASE INHIBITOR TREATMENT PATTERNS AMONG PATIENTS WITH CHRONIC MYELOID LEUKAEMIA IN KOREA

Methods:
To assess relative efficacy and safety of second-line treatments in mCRPC patients, significantly higher than dasatinib and nilotinib (p < 0.0040). No comparative bosutinib or ponatinib studies were identified. Efficacy outcomes were reported using various definitions and different time points. Compared with nilotinib, significantly fewer imatinib patients treated with complete cytogenetic response (CCyR) at baseline, achieved complete molecular response (CMR) (15% vs 11%, p = 0.021) by 24 months and in patients without major molecular response (MMR), CMR by 12 months was 12% vs 36%, p = 0.006 and 24 (83% vs 53.6%, p = 0.0342) months. Compared with imatinib, significantly more dasatinib patients achieved CMR (16% vs 40%, p = 0.004, 18% vs 44%, p = 0.0025), MMR (4% vs 16%, p = 0.038), CML-1 CR (2% vs 12%, p = 0.029) and complete haematologic response (82% vs 93%, p = 0.034; 82% vs 93%, p = 0.0341) at 15 and 24 months, respectively Interpretation of safety data was inconclusive due to its limited availability and treatment exposure. Therefore, the present analysis provides potential guidance for NMA and site management because of missing network links, significant differences between trial populations, and varying follow-up times. CONCLUSIONS: Review of all published comparative studies on second-line treatment of CML confirms that, based on direct efficacy results, imatinib is the choice for the second line agents of choice. NMA comparing nilotinib and dasatinib was not feasible.

PCN33
MATCHING-ADJUSTED INDIRECT TREATMENT COMPARISON AND SURVIVAL EXTRAPOLATION IN RADIOIODINE-REFRACTORY DIFFERENTIATED THYROID CANCER (RAI-REFRACTORY DTC): UPDATED ANALYSIS

Methods:
A total of 304 patients were identified. The 184imatinib patients, the 70 dasatinib patients, and 51 nilotinib patients were similar in mean age, gender and comorbidity at baseline. Based on the 180-day gap definition of discontinuation, the cut-off was not significantly different. Mean PFS (imatinib 91.2%, nilotinib 91.6%, p-value=0.4763) and persistence (imatinib 78.7%, dasatinib 88.5%, nilotinib 95.3%, p-value=0.411) was also not significantly different among three groups. However, switch to TKI therapy from index TKI in imatinib group was significantly higher than dasatinib and nilotinib (p<0.001). Patients with Good MFR showed higher survival rate (p=0.0039) and patients who do not switch to other TKIs showed higher survival rate (p=0.0040). CONCLUSIONS: In a retrospective assessment of patients with CP-CML treated with imatinib, Nilotinib and Dasatinib, using NHI claims data have shown that imatinib was used more frequently than other TKI in the first-line setting. Furthermore adherence and discontinuation was not different among patients receiving TKI. It would be needed to develop how treatment decisions for patients with CML are changed over time in routine clinical practice in Korea.

PCN36
NEW DRUGS IN ADVANCED MELANOMA: DISPARITY IN REQUIREMENTS FOR POST-LAUNCH REAL-WORLD EVIDENCE IN EUROPE

Methods:
We conducted an extensive review of post-launch real-world evidence in Europe, covering four advanced melanoma EMA approved drugs, for the purpose of answering a key gap in current evidence with regard to advanced melanoma. General perception suggests that RWE is crucial for demonstrating clinical utility in routine clinical practice in mCRPC patients in four European countries. Treatment sequencing and survival data were assessed to place the treatment duration into context. Results for France and the Netherlands are reported. METHODS: The study was designed as a retrospective chart review. Patients were identified through treating oncologists and urologists. Eligible mCRPC patients were aged ≥ 18 years, previously treated with docetaxel and naive to prior AA treatment. Baseline patient characteristics were described using summary statistics. Survival analyses were performed for AA treatment duration, overall survival (OS) and time to prostate-specific antigen (PSA) progression endpoints. RESULTS: A total of 68 patients (France and the Netherlands) reported data on 269 mCRPC patients treated with AA. Median PSA (ng/mL) of patients from France and the Netherlands was 56.0 (interquartile range [IQR]: 28.0-102.0) and 74.5 (IQR: 69.5-371.5), respectively. The median time between mCRPC diagnosis and AA initiation was 12.6 (IQR: 7.0-22) in France and 18.3 (IQR: 9.6-36.0) in the Netherlands. Median (months) AA treatment duration, median OS and median time to PSA progression in France was 11.3% (95% confidence interval [95%CI]: 8.3-13.7), 21.6% (95%CI: 14.5-%) and 13.8 (95%CI: 11.1-15.5), respectively. In the Netherlands, it was 4.9 (95%CI: 3.4-6.4), 11.0 (95% CI: 7.3-13.0) and 4.9 (95% CI: 3.0-7.3), respectively. CONCLUSIONS: Here we describe the real-world treatment of mCRPC patients receiving AA in the post-chemo-therapy setting in mCRPC in EU countries. This study suggests that initiating AA earlier in the post-chemistry therapy setting may result in better health outcomes.