incremental net monetary benefit of €16 ($1,406 to $329) at a willingness to pay of €20,000 per QALY. Dagoozeh and asparin had an incremental net monetary benefit; €3-20 ($2,844 to €38) and €8-€€ ($4,528 to €2,662) respectively. CONCLUSIONS: Rivaroxaban had the highest net monetary benefit at a willingness to pay threshold of €20,000 for primary prevention (THR and TFR). However, there was substantial uncertainty around these results in both populations.

C3 A COST-EFFECTIVENESS ANALYSIS OF NIVOLUMAB COMPARED TO IPILIMUMAB FOR THE TREATMENT OF BRAF WILD-TYPE ADVANCED MELANOMA IN AUSTRALIA

Bohansky M1, Pasupathi R2, Gorrelia A2, Kim HP3, Harrison JP3, Liew D4
1Melbourne University, Parkville, Australia, 2Royal Melbourne Hospital, Parkville, Australia, 3Bristol-Myers Squibb Australia, Mulgrave, Australia

OBJECTIVES: To evaluate the cost-effectiveness, from an Australian health system perspective, of nivolumab versus ipilimumab in previously-untreated, BRAF wild-type (WT) advanced melanoma (AM), comprising unresectable and/or metastatic melanoma. METHODS: A state-transition Markov model with 3 health states (Alive, Pre-progression, Alive, post-progression* and Dead) was constructed to simulate the history of Braf-WT Australian patients with AM. A 5% annual discount rate was applied to costs and health measures. A 10-year time horizon was selected to capture the long-term survival and the immunotherapy agents. For the Nivolumab Group, risks of progression and death were based on those observed in the Nivolumab arm of study CA209-066 (nivolumab versus dacarbazine). Resource use (management and event costs) and utilities were determined using EQ-5D data from study CA209-066. Probabilistic sensitivity analyses were undertaken using variations to key input parameters.

RESULTS: Compared to ipilimumab, nivolumab therapy over 10 years would improve quality-adjusted survival by 0.014 QALYs, with costs ranging from $41 to $135. The incremental cost-effectiveness ratio of nivolumab compared to ipilimumab was $1,350 to $2,315 per QALY gained, with a 95% CI of $848 to $2,662. CONCLUSIONS: Nivolumab costs were based on the expected reimbursed price under the PBS per 1 mg for nivolumab and $12 per mg for ipilimumab. Utilities were determined using EQ-5D data from study CA209-066 (nivolumab versus dacarbazine). Log-logistic functions were used to model progression and death were based on those observed in the Nivolumab arm of study CA209-066. In the ACLIFORM and AUGMENT trials. Resource use (management and event costs) and utilities were determined using EQ-5D data from study CA209-066. Probabilistic sensitivity analyses were undertaken using variations to key input parameters.

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We identified 11,602 patients receiving chemotherapy in public hospitals. During 2017, 147 patients (1.3%) received at least one expensive drug, consisting mostly of pemetrexed (55.7%), bevacizumab (16.9%), and topotecan (7.2%). These patients were significantly more likely women and younger than the rest of the cohort (p < 0.0001). Conversely, all selected comorbidities were associated with lower rates of metastatic lung cancer in the French National hospitals databases (PMSI) during 2017. Patient data were linked to allow a two-year follow-up period. Because extra-DRG data were not available for private hospitals, our analysis was restricted to patients benefiting from chemotherapy in public hospitals only. In addition of demographic characteristics, comorbidities, and treatment, we assigned each patient to social deprivation index based on their postcode of residence.

** RESULTS:**

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** METHODS:** HF registries were identified through a systematic search of Embase and PubMed databases. Inclusion criteria were data on HF patients from EUS countries (France, Germany, Italy, Spain, and the UK) and patient counts ≥ 1000. Registry publications and websites were assessed for availability of information on HF patient characteristics, disease management, resource use, treatment outcomes and funding agency. **RESULTS:** Of 23 identified registries reporting data for HF patients, 43% were level I registries, 21% were level II registries, and 14% were level III registries. Twelve registries each collected data from Spain, Germany, and Italy and eight and six registries from France and the UK, respectively. Data was collected for patients with acute HF only (31%), chronic HF only (43%), and both acute and chronic HF (26%) in the identified registries. Variations in the follow-up range from 3–53 months. Data was available for patient demographics (in 100% registries), comorbidities (87%), diagnosis and disease classification (78%), mortality (78%), hospitalisation (96%), prescribed drugs (100%), and patient-reported outcomes (17%). Registries also collected data on specific diagnostic tools (blood pressure, ECG, blood tests, biomarkers, imaging, and renal function tests), treatment procedures (vascularisation, catheterization, and transplant), resource use, adverse events, costs, and mortality. We included only registries that reported data on at least 10 years and 61% were industry-funded. **CONCLUSIONS:** Registries are a rich source of real-world information on HF patients which can be turned into actionable insights for important health-care decisions. Rise in the number of HF registries in recent years and industry funding indicates increased interest of stakeholders in these registries’ data.

** EQUITY & ACCESS STUDIES **

**EA1 HOW READY ARE EUROPEAN PAYERS FOR EMA ADAPTIVE PATHWAYS? Macaulay R**

**OBJECTIVES:** In April 2014, the European Medicines Agency (EMA) announced an adaptive pathways pilot enabling initial approval of a medication for a restricted patient population with very high unmet need based on early clinical studies. Programmatic adaptations in the marketing authorization would expand access to broader patient populations based on subsequent data. However, such an adaptive license may pose a problem for payer bodies, many of which currently require a long time period to review medicines under strict clinical and economic assessments. This review aims to evaluate how ready European major payer systems would be to encompass EMA adaptive pathways. **METHODS:** Key European payer bodies from the EUS (NICE, SMIC, HAS, IQWiG/Q-BA, AIFA and AEMPS) were scored by the EMA’s Commercialization panel of pricing and reimbursement experts on four key criteria: (1) speed of appraisal, (2) flexibility to clinical data appraisal approach, (3) flexibility to economic data appraisal approach, and (4) additional local/regional access criteria. Data was scored (0–5) on a 5-point scale in the range of (0) no points to (5) full points. **RESULTS:** Out of a possible 8 points, HAS scored the highest (7) followed by SMIC (6), AIFA (5), AEMPS (5), IQWiG (4) with NICE the lowest (2). Low scores for NICE were driven by high criteria: (1) speed of appraisal, (2) flexibility to clinical data appraisal approach, (3) economic appraisal criteria, and a reduction of public expenditure on publicly covered medication (979). On the other hand, there are two negative factors from increasing privately funded drugs (1.165) and the cost of improving self-care (35). Sensitivity analyses confirm overall results (p < 0.01). **CONCLUSIONS:** Under increasing budgets constraints, switching drugs for mild conditions may be a solution with positive societal net effects, although the distribution of the impacts among stakeholders might make the initiative unpopular.

**EA2 ACCESS TO INNOVATIVE DRUGS IN PATIENTS WITH METASTATIC LUNG CANCER IN FRENCH PUBLIC HOSPITALS (THE TERROIRE STUDY) Scherpoere A1, Fernandez P2, Cotte F1, Blein C1, Debevere D2, Durand-Zaleski P1, Gaudin A2, Oxan N1, Saitta B2, Souquet P1, Vinainchot A1, Westeel V1, Chouaid C6, Falissard B3, Toumi M4, Tavella F5, Vainchtock A4, Souquet P7, Westeel V8, Chouaid C9**

**OBJECTIVES:** Lung cancer survival is socioeconomically patterned, and socioeconomic inequalities in receipt of treatment have been demonstrated in several countries. In France, many innovative anticancer drugs are too expensive to be covered through a Diagnosis-Related Group (DRG) of chemotherapy administration. In France, such drugs are fully reimbursed up to national reimbursement tariffs (extra-DRG). However, the general public equity of such a system was to assign access to patient to innovative drugs according to social deprivation index. **METHODS:** A retrospective cohort study was constituted with all patients having a diagnosis of metastatic lung cancer in the French National hospitals databases (PMSI) during 2017. Patient data were linked to allow a two-year follow-up period. Because extra-DRG data were not available for private hospitals, our analysis was restricted to patients benefiting from chemotherapy in public hospitals only. In addition of demographic characteristics, comorbidities, and treatment, we assigned each patient to social deprivation index based on their postcode of residence. **RESULTS:**

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** HEALTH TECHNOLOGY ASSESSMENT STUDIES **

**HT1 ACCESS TO NEW THERAPIES IN ROMANIA THROUGH THE SCORECARD HTA SYSTEM Radu PC, Chiriac NC, Pravat MA, Raile Romana Srl, Bucharest, Romania**

**OBJECTIVES:** The objectives of this study are to present the scorecard HTA system used in Romania from July 2014 and the results in terms of access of new therapies at reimburse. **METHODS:** The authors studied the scorecard HTA legislation and the relationship between the health-care environment from the last 2 years considering: the evolution of the Romanian HTA methodologies, the HTA process and the implications in other