effectiveness, it will be important to evaluate the value of new treatments against existing comparators based on clinical and health economic and outcomes research evidence. The purpose of this study is to provide a comparative review of the clinical, economic, and patient-reported outcomes for selected targeted late-stage NSCLC therapies and explore pharmacoeconomic trends. METHODS: Sixteen targeted therapies, currently approved or late pipeline, were identified for inclusion herein. A systematic review of peer-reviewed literature for Phase III studies and US pharmacoeconomic evaluations in support of these products was conducted using PubMed, related articles, and ancestral searches. To capture preliminary/occasional studies, conference proceedings from clinical and pharmacoeconomic research conferences were hand-searched. An extraction grid was built to record key comparable attributes of each study type (e.g., study origin, methods and results) and identify trends in health economic evaluations. RESULTS: We identified 70 original clinical, economic, or patient-reported outcomes evaluations that meet the inclusion/exclusion criteria. Phase III trials showed that progression free survival (PFS) varied by 1–2 months across treatments and most commonly reported adverse events varied, ranging from reports of pulmonary hemorrhage (bevacizumab) to rash and diarrhea (erlotinib and gefitinib). Few economic studies have been conducted in support of current treatments in the US; available studies have examined the cost-effectiveness of EGFR testing (erlotinib) and budget impact of adding new treatments to plan (erlotinib and pemetrexed). Inclusion of quality of life endpoints (e.g., lung cancer scale, FACT-L and EORTC) in trials is increasingly common. CONCLUSIONS: To date, few pharmacoeconomic evaluations have been published or presented at conferences in support of targeted NSCLC agents but current pharmacoeconomic platforms are useful for establishing future benchmarks for new entrants.

OBJECTIVES: To address this gap, we developed a regulatory and market access requirements framework, this research seeks to provide a better understanding of what payer expectations are and what is driving those expectations. METHODS: Oncology analog analysis and targeted primary research to assess the success of recently launched oncology value propositions, defined to include multiple drug classes and treatment modalities. CONCLUSIONS: For cost-effectiveness thresholds £25,000–£32,000 per QALY, decisions about how best to improve care for mHRPC patients differ between the alternative analytic approaches. Based on sequential analysis, Mitoxantrone/Prednisone is deemed cost-effective, without actively implementing this guidance. An integral analysis reveals that active implementation of Docetaxel/Prednisone (3 weekly) is the cost-effective option, yielding an additional 0.05 QALY per patient. By combining uncertain evidence on treatment regimens, their usage and active implementation, allowance is made for all uncertainty associated with resource allocation in mHRPC. CONCLUSIONS: For the analysis of the related decisions about 1) issuing, and 2) actively implementing clinical guidance, an integral approach is preferred over a sequential one. As the application of OPC demonstrates, integral analysis provides better options for improving patient management, more comprehensive insight in decision uncertainty and, consequently, an efficient allocation of resources.

OBJECTIVES: To evaluate the relationship between the average out of pocket cost (OPC) paid and the total prescription volume (TRx) for oral antineoplastics compared to a market basket of commonly utilized oral drugs. Is drug utilization more sensitive to OPC changes when there is greater competition and/or when the aliments treated by those drugs are less acute? We hypothesized an inverse proportional relationship of immunostimulants—in 1999 (3.76), in 2003 (10.15) and in 2008 (5.06), and a moderate increase in consumption of immunosuppressants—in 1999 (0.31), in 2003 (0.62) and in 2008 (1.29) can be seen from this analysis. Results showed a dramatic increase in consumption from the financial perspective—antineoplastic agents in 1999 (£5,440,000), in 2003 (£6,399,000) and in 2008 (£97,913,000), endocrine therapy in 1999 (£3,292,000), in 2003 (£6,779,000) and in 2008 (£14,186,000), immunosuppressants in 1999 (£24,848,000), in 2003 (£15,538,000) and in 2008 (£24,178,000), immunosuppressive agents in 1999 (£3,867,000), in 2003 (£8,109,000) and in 2008 (£3,28,000). Both section of the Slovak drug policy must be viewed realistically with regard to chemotherapy regimens, which cause huge financial expenditures within the Slovak health care budget.

OBJECTIVES: To evaluate the relationship between the average out of pocket cost (OPC) paid and the total prescription volume (TRx) for oral antineoplastics compared to a market basket of commonly utilized oral drugs.

We obtained monthly OPC data and TRx data from SDI’s VONA and VOPA databases from January 2007-April 2009. We provides a transparent record of how evidence and values are assessed during the decisionmaking process. Further testing and validation is needed to advance MCDA approaches in health care decisionmaking.

OBJECTIVES: To identify the preferred approach to the analysis for addressing decisions about issuing and actively implementing clinical guidance. APPLICATION: The relation applies to the allocation of resources to metastatic hormone-refractory prostate cancer (mHRPC) in the UK. METHODS: An integrated Bayesian approach to decision modeling and evidence synthesis is adopted. Evidence on the costs and QALYs of all possible treatment regimens is combined with estimates of treatment usage and population size. Implementation factors and effects rates are assumed to vary between treatment options and multi-criteria decision analysis (MCDA) is used to combine clinical, economic, and patient utility evidence. The purpose of this study is to provide a transparent record of how evidence and values are assessed during the decisionmaking process. Further testing and validation is needed to advance MCDA approaches in health care decisionmaking.

APPLICATION: The relation applies to the allocation of resources to metastatic hormone-refractory prostate cancer (mHRPC) in the UK. METHODS: An integrated Bayesian approach to decision modeling and evidence synthesis is adopted. Evidence on the costs and QALYs of all possible treatment regimens is combined with estimates of treatment usage and population size. Implementation factors and effects rates are assumed to vary between treatment options and multi-criteria decision analysis (MCDA) is used to combine clinical, economic, and patient utility evidence.