thiazolidinediones (MET-TZD), metformin plus meglitinide (MET-MEG), and metformin plus DPP-4 inhibitors (DPP4I). Five therapy cohorts included: total therapy, alone (MET-TZD, metformin plus sulphonylurea, or metformin plus pioglitazone). For other biomarkers outcomes, the cost-effectiveness of CANA 300 mg was compared to SITA 100 mg using results from a post hoc analysis of CANA data where possible (HbA1c and weight). RESULTS: These results suggest that adding CANA 100 or 300 mg instead of SITA in patients inadequately controlled on metformin or metformin plus sulphonylurea would result in more efficient use of healthcare resources in the Spanish setting.

**PD56**

**EQUIVALENCE TESTING: THE COST EFFECTIVENESS OF CANAGLUTIN (CANAGLUTIN) VERSUS SAXA GLUTIN (SAXA) AMONG OLDER INDIVIDUALS LIVING WITH TYPE 2 DIABETES MELLITUS (T2DM) IN CANADA**


**OBJECTIVES:** To estimate the short-term cost per controlled patient with type 2 diabetes mellitus (T2DM) with liraglutide 1.2mg/day vs. saxagliptin 100mg/day in Canada.

**METHODS:** Composite endpoint defined as “HbA1c<7% AND no weight gain AND no hypoglycaemia” was adopted to describe the controlled T2DM patient. Based on data from a clinical trial (1860-Lira-DPP4) and a meta-analysis (Zinnman et al, 2012), the percentage of patients achieving the composite endpoint after 26 and 52 weeks with liraglutide and saxagliptin were estimated. In addition, responder rates after 78 weeks were obtained for patients switching at 52 weeks from sitagliptin to liraglutide and a hypothetical cohort continuing on sitagliptin. Treatment cost was calculated using available Canadian national cost data for T2DM and liraglutide. All costs were calculated with efficacy data extracted from the clinical trial (€1,460 vs. €1,820) and from a meta-analysis of available liraglutide trials (€1,593 vs. €2,234). At 52 weeks, liraglutide cost per controlled patient is also slightly lower than with sitagliptin (€2,672 vs. €2,649). At 78 weeks, in patients who have switched from sitagliptin to liraglutide at 52 weeks, the cost per controlled patient is lower than that of the hypothetical group of patient controlled with 78 weeks of continued sitagliptin treatment (€2,889 vs. €3,970). CONCLUSIONS: These results illustrate that weight-related utility changes may be a key driver of economic evaluations that compare these agents. The extreme case of no rescue therapy artificially inflated complication costs in both arms, since HbA1c drifts unabated upwards. CONCLUSIONS: Assumptions about treatment intensification matter. Unrealistic assumptions like fixing time on agents or omitting intensification had large effects, as ICERs depend on how downstream treatment choices are modeled. Consumers of T2DM economic evaluations should therefore consider these assumptions carefully.