prevalence data for 6 cancers with values ranging from < 3 to > 170 per 105were obtained from the GLOBOCAN database. Clinicaltrials.gov was searched for phase 3 trials for the cancers from 2005 to 2015; the NICE website was searched for technology appraisals concerning the cancers for the same period. **RESULTS:** Breast cancer (BC; prevalence, 174.1 per 105) had the greatest number of phase 3 clinical trials (n=333) and NICE assessments (n=10) in the period; three assessments resulted in recommendations. Prostate cancer (PC), having a similar prevalence to BC (162.5 per 105), had 60% fewer phase 3 trials (n=133) and 50% fewer NICE assessments (n=5), but also resulted in three recommendations. Multiple myeloma (MM; prevalence, 6.2 per 105) was the subject of a disproportionately high number of phase 3 trials (n=98) and NICE assessments (n=4); three assessments resulted in recommendations. In contrast, non-Hodgkin's lymphoma, having a higher prevalence than MM (15.4 per 105) was the subject of only 40 phase 3 trials and 4 NICE assessments; three resulted in recommendations. Myelofibrosis and pancreatic cancer, each having a prevalence of <5 per 105, were the subject of 11 and 25 phase 3 trials, respectively. One NICE assessment was performed for an intervention for myelofibrosis and had a negative outcome. **CONCLUSIONS:** These results suggest that while the number of NICE assessments undertaken reflects the number of phase 3 trials performed in a given cancer, there is a mismatch between the number of assessments and the prevalence of specific cancers in the UK. Further research is warranted to investigate whether a similar mismatch is evident in other countries.

PCN344

THE DUTCH MELANOMA TREATMENT REGISTRY AS BLUEPRINT FOR USING REGISTRY DATA TO IMPROVE HEALTH CARE DECISION MAKING

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OBJECTIVES: The Dutch minister of health made reimbursement of the first new melanoma drug conditional on the set-up of a population-based registry and centralisation of care. This led in 2012 to well-defined quality standards and the Dutch Melanoma Treatment Registry (DMTR) characterised by its unique collaboration between all stakeholders involved in melanoma care (public and private partnership). The DMTR aims to enhance real patient value by closing the gap of the initial uncertainty regarding the real-world value of promising drugs in everyday practice. **METHODS:** The DMTR prospectively documents detailed data of all Dutch advanced melanoma patients regarding tumour- and patient characteristics, treatment strategies, clinical, physical, social, emotional and well-being outcomes, resource use, informal care, and productivity losses. These data are used for benchmarking and outcomes research to obtain insights into real-world cost-effectiveness of treatment pathways to improve health decision making. **RESULTS:** The richness of DMTR data facilitates the assessment of multiple outcomes including quality of care, use of drugs, survival benefit, quality of life, costs and cost-effectiveness. Physicians are fortnightly provided with feedback on their delivered quality of care; manufacturers are provided with information regarding the use and performance of their drugs. This greatly enhances learning regarding the use and outcomes of treatments. First results (stage IV: N=1226; median follow-up 12.8 months) show an improved survival (2012-2015: median OS 9.3 months [IQR:4.5-17.4], one-year survival rate 40%) compared to the period before the introduction of the new drugs (2003-2011: median OS 6.8 months [IQR:3.3-18.5], one-year survival rate 33%). **CONCLUSIONS:** The DMTR provides crucial information regarding the extent to which novel treatments offer real-world value and whether scarce resources are spent cost-effectively in everyday practice. Its unique design emphasises the essential holistic view needed in cancer management and can be seen as blueprint for other registries aiming at improving health decision making.

PCN345

UPTAKE OF FILGRASTIM 'BIOSIMILARS' IN THE UNITED STATES: ANALYSIS OF A MEDICAL TRANSCRIPTION DATABASE OF PATIENT OFFICE VISITS

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OBJECTIVES: Biosimilars of filgrastim (FIL), granulocyte colony-stimulating factor (G-CSF), have been available in Europe since 2008. Now 2 FIL products are approved in the USA: tbo-filgrastim (TBO-FIL, while a biosimilar in Europe, is not technically one in the USA; approved November 2013 for a subset of FIL indications) and filgrastim-sndz (FIL-SNDZ, the first true US biosimilar; approved March 2015, but launch delayed by ongoing litigation). Our objective was to identify physician documentation and use of TBO-FIL during patient office visits. **METHODS:** Physician records were extracted (1 November 2013–18 June 2015) from RealHealthData, a US medical transcription database providing data within 72 hours of each visit to a participating provider. Records were searched for mention of TBO-FIL: "tbo-filgrastim," "Granix," or "Neutroval." Mentions of FIL ("filgrastim" or "Neupogen") and PEG ("pegfilgrastim" or "Neulasta") were also tabulated. **RESULTS:** Counts of mentions (and number of unique prescribers) were as follows: PEG: 1864 (40); FIL: 431 (53); TBO-FIL: 5 (3), with >86% from oncologists in California. TBO-FIL was reported, as "Granix," for 4 patients. Prophylactic TBO-FIL was prescribed for 1 chemotherapy patient and as interim treatment for 2 patients with chemotherapy who normally received PEG. 1 patient reported taking TBO-FIL as needed for neutropenia symptoms. Only 1 of the 4 received TBO-FIL as their main G-CSF treatment. Counts will be refreshed in October 2015 and will include FIL-SNDZ data, if launched and available. **CONCLUSIONS:** Among 2300 records reporting a G-CSF in this snapshot of primarily Californian oncologists, only 5 mentions of TBO-FIL were noted in the 18 months since launch. As awareness of 'biosimilars' improves in the USA and legal barriers are overcome, it is expected that uptake of new FIL agents will increase. If the California data reflect national trends, uptake may continue to be slow compared with more established biosimilar markets in Europe.

PCN346

FRENCH PHYSICIAN SENSITIVITY TO AND CONSIDERATION OF THE COSTS OF CANCER TREATMENT

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Expenses for anticancer treatment in France have grown substantially with an average annual cost increase of 17.7% between 1999 and 2009. This is due to access to expensive targeted therapies, higher cancer incidence rates and overall survival in patients with advanced disease.**OBJECTIVES:** To evaluate physician opinions and attitudes and their evolution between 2003 and 2013 regarding the costs of anticancer treatments **METHODS:** Conducted in France biennially, the « Cancérologie » study measures physician opinions/attitudes on today's relevant topics. Latest waves of this study included a series of questions on the cost of anticancer treatments, allowing for analysis of the evolution of responses. In 2013 315 physicians who work in French public or private hospitals and prescribe antitumor treatments for solid and/or liquid cancer participate to the study. **RESULTS:** In 2003, 54% of physicians considered cancer related budgetary issues 'very important'. Over the years, this percentage progressively decreased until dropping to 25% in 2013. However, in 2003, 68% predicted that the budgetary situation would deteriorate further compared with 73% in 2013. The contrast between the pessimistic perceptions of the future and a reality which is perceived less and less problematic demonstrates the dual mindset of physicians who are at once: - Citizens conscious of how the growth of costs can only end in an impasse, - Clinicians whose prescriptions remain guided by therapeutic goals. Thus in 2013, 62% of physicians indicated that costs had little to no impact on their choice of treatment. **CONCLUSIONS:** New molecule availability will cause costs of anticancer therapies to continue to grow at the same rate seen in recent years. If physicians do not take greater responsibility for their prescriptions' costs, the only solution would be coercive measures.

PCN347

REVIEW OF THE CURRENT STATUS OF RAS MUTATION TESTING IN PATIENTS WITH METASTATIC COLORECTAL CANCER (MCRC): FLASH-RAS STUDY

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OBJECTIVES: In 2013, it was shown that mutations in KRAS exons 3 and 4, or NRAS exons 2 to 4 had a similar effect. The primary objective was to assess the practices in conducting RAS testing in 2014. The secondary objectives were to describe the evolution of the RAS testing prescription rates from 2011, the process and time required to obtain the results, and to analyze their impact on the therapeutic strategy. **METHODS:** FLASH-RAS is an observational retrospective French multicenter study. **RESULTS:** 375 mCRC patients diagnosed and initiating a 1st line treatment (L1) between March and June 2014 were analyzed. For 90.1% of the patients (IC95%= [87.1%; 93.2%]), a genotyping request for RAS biomarkers was made in L1, i.e. a significantly increased rate compared to 2011 (81.1% in 2011, p<0.001). For 75% of the patients, the request was made before or at least one month after the diagnosis of the first metastases (1st M). No increase was observed in the median and mean times to obtain the test results between 2011 and 2014 despite the increased number of exons tested. **CONCLUSIONS:** In 2014, the rate of RAS genotyping requests has been increasing since 2011. For a majority of patients, the request is made before or at the latest one month after 1st M diagnosis. Nevertheless, for 24.5% of the patients, the request is made more than one month after 1st M diagnosis, which is not compatible with an informed treatment decision in L1.

PCN348

EVALUATION OF PATIENT-CENTERED CARE IN SHORT-TERM CANCER SURVIVORS, THROUGH THE PATIENT ASSESSMENT OF CHRONIC ILLNESS CARE QUESTIONNAIRE

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OBJECTIVES: The Chronic Care Model (CCM) is an accepted framework for delivering care to patients with chronic illnesses. The Patient Assessment of Chronic Illness Care (PACIC) is a questionnaire designed to assess the CCM from the patient´s perspective, focusing on the receipt of patient centered care. Our aim was to document patient´s assessment of chronic illness care in short-term cancer survivors, through PACIC **METHODS:** Patients with colo-rectal (CCR), breast or prostate cancer and who finished their treatment three years before answering the questionnaire were included in the study. PACIC was administered by mail and has 5 subscales, patient activation (PA), delivery system design (DSD), goal setting (GS), problem solving (PS) and follow-up coordination (FU). In addition there is a global score (G). Each subscale and the global are scored from 1 to 5 with higher scores indicating patient´s perception of greater involvement in self- management and receipt of chronic care counseling. Data are expressed as mean (standard deviation). Comparison amongst location has been carried out through analysis of variance with Scheffé post-hoc test. PACIC has been validated in Spanish. **RESULTS:** There were 645 patients included, 139 prostate, 339 breast and 167 with CCR. The mean (SD) by dimensions were: PA: 3.2 (1.4), DSD: 3.5 (1.2), GS: 2.6 (1.3), PS: 2.8 (1.5), FU: 2.2 (1.2) and global: 2.8 (1.2). There were statistically significant differences amongst cancer location in two dimensions, PS (p= 0.02) and FU (p =0.002), with best scores in CCR in both cases. **CONCLUSIONS:** To our knowledge this is the first time that PACIC is used in cancer patients. Patient activation and delivery system design have shown the best scores and follow-up, a critical point the worst score although with differences; being CCR survivors who better have evaluated this dimension