rently employed and identify opportunities for future research. METHODS: A comprehensive literature review of reference databases, conference abstracts, journals and medical societies’ websites was performed. Publications reporting practice management efficiency measures within ambulatory oncology practices and infusion centers located in the United States were included. Search was conducted in English-language articles published between 2007 and 2010. All publication types except continuing medical education materials and letters to the editor were accepted. Evidence quality was assessed with the Completeness of Reporting Index (CORE-14) instrument. RESULTS: Forty-seven references were accepted for inclusion. Efficiency strategies were classified into 7 distinct categories, each reported at a similar frequency in the literature. Within and across these categories, common themes were standardization of care, use of best practices, and alignment between quality and financial initiatives. Most publications were recommendations without a study design type (64%) and/or did not report quantifiable outcome data (74%). Additionally, 21 publications did not define the practice type included, while the remaining articles identified 12 different practice types. Consequently, applicability is limited, since outcomes cannot be associated with a particular practice type. Thirty-four publications were assigned a CORE-14 score of 0, indicating they did not meet any criteria for methodological quality (mean score, 1.84).

CONCLUSIONS: Numerous efficacy methods are being touted in the literature, but there is limited definitive data on the successfulness of these techniques. Further research, of a high methodological caliber, is needed to support informed decisions. Specifically, registries, surveys, and economic analyses would empower oncologists and other oncology professionals with practical strategies to concurrently improve quality while maintaining profitability. 

PCN138 A REVIEW OF EXPANDED ACCESS PROGRAMS (EAP) AND THEIR CONSIDERATION BY HEALTH PLAN DECISION-MAKERS IN THE UNITED STATES

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OBJECTIVES: After failing approved treatments, patients may receive investigational therapies through participation in a clinical trial or an expanded access program (EAP). EAPs were established after the FDA decided to allow patients access to investigational drugs for treatment purposes, and since then EAPs have been set up in various therapeutic areas including oncology and infectious diseases. The current discussion, however, has less been focused on how EAPs may affect payer decision making process in drug formulary positioning. Using examples of different types of drug data including EAP, payers were asked how each type affects their decision making process.

RESULTS: Most publications were recommendations without a study design type (64%) and/or did not report quantifiable outcome data (74%). Additionally, 21 publications did not define the practice type included, while the remaining articles identified 12 different practice types. Consequently, applicability is limited, since outcomes cannot be associated with a particular practice type. Thirty-four publications were assigned a CORE-14 score of 0, indicating they did not meet any criteria for methodological quality (mean score, 1.84).

CONCLUSIONS: Numerous efficacy methods are being touted in the literature, but there is limited definitive data on the successfulness of these techniques. Further research, of a high methodological caliber, is needed to support informed decisions. Specifically, registries, surveys, and economic analyses would empower oncologists and other oncology professionals with practical strategies to concurrently improve quality while maintaining profitability.

Gastrointestinal Disorders – Clinical Outcomes Studies

PG1 INCIDENCE OF ANEMIA AND NEUTROPHIN FOLLOWING HCV TREATMENT INITIATION AND RELATED DRUG TREATMENT COSTS IN THE UNITED STATES

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OBJECTIVES: Conventional peginterferon-ribavirin antiviral treatment of chronic hepatitis C virus (HCV) often leads to anemia and neutropenia. Based on US claims data, we explored the incidence of both adverse events (AEs) and the associated risk factors, and assessed the related erythropoietin/granulocyte colony stimulating factor (G-CSF) costs in daily clinical practice. METHODS: Commercially insured patients with a diagnosis of HCV infection (ICD-9 50.70) or HCV-related anemia (ICD-10 070.73) (all genotypes), who initiated any combination of peginterferon and/or ribavirin were identified in a large US claims database (Thomson 2006–2009). Time to first onset of anemia and neutropenia was analyzed using Kaplan-Meier and Cox proportional hazard regression. Incidence of anemia and neutropenia was defined based on ICD-9-coding (280.20 for anemia and 991.0 for neutropenia) and ICD-10-coding of HCV-infected patients (mean age 51.1, 63% male) initiated HCV treatment. 86% of the patients initiated a combination of peginterferon and ribavirin. Mean treatment duration was 245 days. Regardless of time on treatment, 32%/17% of the cohort experienced anemia/neutropenia, respectively. Age, female gender, Charlson co-morbidity index and liver cirrhosis were predictive for both AEs. 20%/3.13% of the cohort received erythropoietin/G-CSF respectively, on average for 131/126 days. The mean cost for the entire cohort to manage both AEs was $2,263 (erythropoietin) and $1,004 (G-CSF). Patients with weight reported having been diagnosed with hepatitis C by a physician were included for analysis (n = 1279). Patients currently, or ever, taking a prescription medication for hepatitis C (n = 579) were compared with patients who never took a prescription for hepatitis C (n = 700). Group membership was predicted with a logistic regression model, including age,