chronic pulmonary disease. The sunitinib cohort had less time between diagnosis and index event (19 vs. 22 months, p=0.037). Proportions of patients with treatment continuation, discontinuation, switching, or interruption were NS different. Before imputation, adjusted mean [SD] daily medication costs during persistence were higher for sunitinib ($218.19 [37] vs. $177.07 [45-76], p=0.001), but NS before imputation (sunitinib > pazopanib at least $44.26, p=0.21). Twelve-month adjusted RCC-related medical costs were significantly lower for sunitinib than pazopanib before imputation ($36,638.96 [$25,199.38] vs. $45,219.75 [$34,883.70], p=0.021) and after imputation ($36,393.90 [$26,549.85] vs. $45,622.93 [$35,226.83], p=0.015). The RCC-related prescription costs were NS different between the two drugs before and after imputation.

CONCLUSIONS: Treatment patterns and persistence with sunitinib or pazopanib were NS different. Sunitinib daily cost was NS different from pazopanib after imputation. Further analysis is needed regarding dosing schedule, days supply, and related calculations.

PCN43
A COST COMPARISON OF SPLIT-DOSE REDUCED-VOLUME ORAL SULFATE SOLUTION (OSS) AND POLYETHYLENE GLYCOL WITH ELECTROLYTES SOLUTION (PEG-ELS) 1Braintree Laboratories, Braintree, MA, USA, 2Analysis Group, Inc., Boston, MA, USA, 3Boston Medical Center, Boston University School of Medicine, Boston, MA, USA

OBJECTIVES: The objective of this review was to summarize and characterize the literature on the types of cancer and to make more accurate comparisons between them. Additional research is required to better understand the absenteeism costs of various patient groups. Most studies on the economic burden of cancer have focused on cancer-related morbidity and mortality worldwide. Approximately 25% of patients present metastatic disease at diagnosis and about 50% will develop metastatic disease. Patients with metastatic colorectal cancer receive targeted therapies, and KRAS is eligible for sequential treatments, including monoclonal antibodies as first or second-line regimens. Use of bevacizumab (BEV) through multiple lines (TML) may benefit patients with mCRC. Considering the economic implications, it is important to understand these differences in terms of costs for the Brazilian private healthcare system. Our objectives were to compare economic outcomes of different sequences of therapy including monoclonal antibodies for the treatment of mCRC. METHODS: Eight scenarios were compared: (1) first-line bevacizumab TML (first-line and beyond first progression) was compared in each scenario with another sequence without bevacizumab TML. To compare the economic outcomes, the monthly cost and the total cost of the sequence per patient were calculated, according to the first, second and third-line combinations. RESULTS: Considering a standard time of treatment of 12.8 months and progression-free survival (PFS) varying from 17 to 20.6, all scenarios with bevacizumab TML were less costly than multiple lines without bevacizumab. The lowest monthly cost was related to bevacizumab TML (1stline bevacizumab 5mg+FOFOX → 2ndline bevacizumab 5mg+FOFOX → 3rdline best supportive care [BSC]). This sequence represents a monthly cost of R$ 18,192.41 per patient while the same scenario with cetuximab in first-line (1stline cetuximab 250mg+FOFOX → 2ndline bevacizumab 10mg+FOFOX → 3rdline BSC) represents R$ 23,640.57 per month. We investigated several scenarios of TML in mCRC is less compared with sequences of biological therapy that starts with cetuximab in the first-line followed by bevacizumab in second-line treatment. Resource savings with sequential bevacizumab have the potential to optimize third-line treatment strategy for mCRC patients with wild-type KRAS in Brazil.

PCN44
CHOICE OF SEQUENTIAL BIOLOGICAL THERAPIES IN METASTATIC COLORECTAL CANCER (mCRC): A COST COMPARISON ANALYSIS FOR WILD-TYPE KRAS mCRC PATIENTS IN BRAZIL

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OBJECTIVES: Colorectal cancer (CRC) is a major cause of mortality and morbidity worldwide. Approximately 25% of patients present metastatic disease at diagnosis and about 50% will develop metastatic disease. Patients with metastatic colorectal cancer receive targeted therapies, and KRAS is eligible for sequential treatments, including monoclonal antibodies as first or second-line regimens. Use of bevacizumab (BEV) through multiple lines (TML) may benefit patients with mCRC. Considering the economic implications, it is important to understand these differences in terms of costs for the Brazilian private healthcare system. Our objectives were to compare economic outcomes of different sequences of therapy including monoclonal antibodies for the treatment of mCRC. METHODS: Eight scenarios were compared: (1) first-line bevacizumab TML (first-line and beyond first progression) was compared in each scenario with another sequence without bevacizumab TML. To compare the economic outcomes, the monthly cost and the total cost of the sequence per patient were calculated, according to the first, second and third-line combinations. RESULTS: Considering a standard time of treatment of 12.8 months and progression-free survival (PFS) varying from 17 to 20.6, all scenarios with bevacizumab TML were less costly than multiple lines without bevacizumab. The lowest monthly cost was related to bevacizumab TML (1stline bevacizumab 5mg+FOFOX → 2ndline bevacizumab 5mg+FOFOX → 3rdline best supportive care [BSC]). This sequence represents a monthly cost of R$ 18,192.41 per patient while the same scenario with cetuximab in first-line (1stline cetuximab 250mg+FOFOX → 2ndline bevacizumab 10mg+FOFOX → 3rdline BSC) represents R$ 23,640.57 per month. We investigated several scenarios of TML in mCRC is less compared with sequences of biological therapy that starts with cetuximab in the first-line followed by bevacizumab in second-line treatment. Resource savings with sequential bevacizumab have the potential to optimize third-line treatment strategy for mCRC patients with wild-type KRAS in Brazil.

PCN47
HEALTHCARE RESOURCE UTILIZATION AND MEDICAL CARE COST ASSOCIATED WITH NEW BIO-SURGICAL HEMOSTOSIS IN CHINA

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OBJECTIVES: To investigate patterns of hemostat methods in surgeons and evaluate the healthcare resource utilization and economic burden of patients in China. METHODS: All articles related to the costs of cancer-related absenteeism, which we defined as any type of workplace absence. Additional eligibility criteria included the evaluation of costs per patient and the presentation of absenteeism endpoints in monetary terms. Studies were characterized according to cancer type, healthcare setting (U.S., EU, Asia), value-related outcomes, study type, period, absenteeism endpoints, and cost results. All costs were adjusted to 2013 dollars and Euros using consumer price indexes and exchange rate data. RESULTS: We found 16 articles that met our inclusion criteria. Seven cancer or pre-cancer types were studied, with breast cancer (7 studies) and colorectal cancer (3 studies) being the most common. Absenteeism endpoints used by study authors varied considerably and included terms such as “absenteeism” (the actual term), “sick leave,” “short-term disability,” and “permanent disability (reduced hours or workplace departure).” For U.S. studies, total annual absenteeism costs per patient ranged from $3,225 (precancerous cervical lesions) to $59,241 (colorectal cancer). For European studies, total mean absenteeism costs per patient based on time until retirement age of 65 ranged from $3,235 (precancerous cervical lesions) to $59,241 (colorectal cancer). Overall, colorectal cancer was associated with the highest absenteeism costs. CONCLUSIONS: Based on the literature, it is apparent that cancer-related absenteeism poses a significant economic burden to patients, employers, and society. Additional research is needed to better understand the absenteeism costs of various types of cancer and to make more accurate comparisons between them.

PCN45
COST COMPARISON OF FIRST LINE METASTATIC RENAL CELL CARCINOMA TREATMENTS USING A RETROSPECTIVE CLAIMS DATASET

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OBJECTIVES: To examine and compare costs and cost drivers for various meta- static renal cell carcinoma (mRCC) drugs. METHODS: A retrospective study used administrative healthcare claims from MarketScan® Commercial and Medicare Supplemental Databases to identify patients newly diagnosed with mRCC (index event) from 1/2006 to 3/31/2014, with continuous health plan enrollment prior to and after the index date. Treatment with approved mRCC products on or after the index date was required. Patients were followed until death, health plan enrollment end, initiation of a new mRCC therapy, or study end. The study focused on total costs of drugs, physician visits, and hospitalizations for patients with mRCC. The primary outcome was the cumulative medical costs of all drugs and cost drivers of patients with mRCC from diagnosis to 30 days of the index date. Treatment with approved mRCC products on or after the index date was required. Patients were followed until death, health plan enrollment end, initiation of a new mRCC therapy, or study end. The study focused on total costs of drugs, physician visits, and hospitalizations for patients with mRCC. The primary outcome was the cumulative medical costs of all drugs and cost drivers of patients with mRCC from diagnosis to 30 days of the index date.