PHARMACOECONOMIC ANALYSIS OF ERLOTINIB COMPARED WITH DOCETAXEL FOR THE TREATMENT OF RELAPSED NON-SMALL-CELL LUNG CANCER (NSCLC) IN TURKEY
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OBJECTIVES: To perform a cost-utilty analysis of erlotinib compared with docetaxel for treatment of advanced NSCLC following the failure of prior chemotherapy from the perspective of the Turkish health care system. METHODS: A cost-utilty analysis was performed using a transition model with three health states (progression free, progression, death); primary endpoint was QALY gained. The model compared the impact of erlotinib or docetaxel therapy over a 2-year period (cycle length of 1 month) in patients with stage IIIb/IV NSCLC who had failed at least one prior chemotherapy regimen. Clinical data from the BR.21 (erlotinib) and TAX317 (docetaxel) phase III studies were used; for the purposes of this analysis, it was conservatively assumed that overall survival was equivalent for the two interventions. The time spent in each health state was adjusted for quality of life, including the impact of adverse events (AEs). Costs included were: resource utilisation for each health state and AE (including hospitalisation, physician visits, outpatient examinations, concomitant medicines and required tests), drug administration and administration. RESULTS: The total discounted cost of erlotinib was €11,943, compared with €12,037 for docetaxel. Erlotinib was associated with higher QALYs than docetaxel (0.258 versus 0.206; incremental QALYs = 0.053), mainly due to the lower incidence of AEs and the administration route (oral, versus intravenous for docetaxel). Erlotinib was dominant versus docetaxel, with an incremental cost-effectiveness ratio of –3277 YTL (–€1792) per QALY gained. CONCLUSION: This is the first pharmacoeconomic modelling analysis performed for the setting of the Turkish health care system. The results show that erlotinib is dominant versus docetaxel for the treatment of relapsed advanced NSCLC, providing higher QALYs at a lower cost. A major contributing factor to the cost-savings observed with erlotinib is its favourable AE profile, particularly its lack of haematological toxicity.

PODIUM SESSION III: HEALTH CARE USE & POLICY STUDIES

HEALTH SYSTEM CORRELATES OF RECEIPT OF RADIATION AFTER BREAST CONSERVING SURGERY IN LOW-INCOME MEDICAID-ENROLLED WOMEN
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OBJECTIVES: Breast-conserving surgery (BCS), followed by radiation therapy (RT) is a safe and effective alternative to mastectomy for most women with early stage breast cancer based on evidence from prospective randomized trials, and has become the preferred surgical option. Omission of RT after BCS, however, is increasingly common and leads to poor outcomes. Few studies examine patient and health system correlates to receipt of RT after BCS, especially in a low income population. This study described patient and health care systems correlates of receipt of recommended care with BCS in North Carolina (NC) indicated by receipt of adjuvant RT. METHODS: Subjects were women diagnosed with primary breast cancer in 1998 and 1999 who were classified as alive at least 12 months post-treatment with BCS (N = 344). Medicaid claims were obtained to supplement central cancer registry data on adjuvant RT; state county data were obtained on health provider shortage regions. RESULTS: Of 344 women in NC enrolled in Medicaid and treated with BCS during the period of study, one third did not receive RT. The following factors were associated with lack of receipt of RT after BCS older age (65 > years), residence in a low population density county, receiving BCS at a smaller-sized hospital, and living in a county classified as whole-county specialist scarcity area (all p < 0.05 in multivariate analyses). CONCLUSION: Some low income women do not access RT following BCS, placing them at risk for recurrence. We identified geographic isolation and scarcity of health care as possible leverage points for interventions.

ASSESSING THE IMPACT OF A NATIONAL DRUG BENEFIT PROGRAM ON THE USE OF GENERIC DRUGS AND DIFFERENT THERAPEUTIC CLASSES
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OBJECTIVES: To examine changes in the utilization of prescription medicines from 16 therapeutic classes from 2005 to 2006.