ies, as well as demonstrating homogeneity and consistency among studies. Regarding to the probabilistic analysis the Bucher's method is not recommended by most HTA bodies for indirect comparisons. Nevertheless, some HTA bodies (e.g. HAS, SMC), EU-HTA and ISPOR Task Force on Indirect Treatment Comparisons consider that even if some direct evidence is available it is appropriate to validate the results using MTCs. This may be owing to the Bucher's method being not appropriate for the analysis of complex networks, while Bayesian approach is a more comprehensive method that can include meta-regression and study-level covariates. The use of the meta-analytical methods can derive to biased results. CONCLUSION: Methodology used for NMA should include all available evidence. Due to the increasing complexity of network patterns, Bayesian analysis better meets HTA needs than the Bucher's method, and is also a stronger evidence–deriving tool.

PHP177
SCANDINAVIAN DRUG REIMBURSEMENT AND COVERAGE DECISIONS: THE ROLE OF HTA.
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OBJECTIVES: To examine and explain differences and similarities in coverage decisions for outpatient pharmaceuticals in Denmark, Norway and Sweden, and to provide a better understanding of the current and future role of HTA in these countries. METHODS: A comparative analysis of all outpatient drug appraisal cases was carried out between 2009 and 2012, including an analysis of divergent coverage decisions for outpatient drug-indication pairs appraised by all three countries was performed. Agreement levels between HTA agencies were measured using kappa scores. Primary data collection through consultation with decision makers and academics in the three countries was carried out to obtain insight on how coverage decisions are made and why reimbursement outcomes differ in the three countries. RESULTS: A total of 19 outpatient drug-indication pairs appraised in each of the three countries were identified, of which six pairs (32%) had divergent coverage decisions. An uneven distribution of coverage decisions was observed, with the highest number of overlap in appraisals in Norway and Sweden (freemarginal kappa score 0.89). Similarities were found in the criteria for reimbursement and the reasoning for coverage decisions. Differences in the appraisal methods applied and the interpretation of the evidence considered may explain divergent decisions. CONCLUSIONS: The study suggests that pathways and Sweden and Denmark employ similar methods for outpatient drug appraisals and have less divergent reimbursement outcomes, while health economic evaluation is less prominent in Danish outpatient drug appraisal, leading to a lower percentage of reimbursements with restrictions or criteria.

PHP178
THE IMPORTANCE OF SAFETY ASPECTS IN THE AMNOG PROCESS IN GERMANY: IS THE G-BA ASSESSMENT CONSISTENT WITH THAT OF THE CHMP?
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OBJECTIVES: To assess the role of safety aspects in the overall AMNOG benefit assessment in Germany. Special attention was given to two aspects: (1) Are adverse events (AE) used systematically to change the benefit assessment in any direction? (2) Are safety aspects considered in the assessment in accordance with the scientific CHMP opinion? METHODS: Twenty-nine benefit assessments decided and published by the Federal Joint Committee (G-BA) between Jan 1st 2011 and Jun 6th 2013 were analyzed regarding the extent of harm. For each drug the extent of harm included in the G-BA decision compared to the CHMP opinion. RESULTS: In 11 of the 29 cases (38%) the CHMP opinion was neglected and a greater harm or less harm was estimated compared to the CHMP assessment. For example, the CHMP recommended a greater harm vs. the comparator which negatively impacted the overall rating. Similarly, in 10 cases (34%) the CHMP recommendation was downgraded. CONCLUSIONS: The CHMP recommendation should be given full consideration during the AMNOG process.

PHP179
ARE MONOCLONAL ANTIBODIES STILL CONSIDERED INNOVATIVE BY THE FRENCH HEALTH CARE SYSTEM? A RETROSPECTIVE ANALYSIS 2000-2012
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OBJECTIVES: To understand the dynamics of the Transparency Committee (TC) assessments of monoclonal Antibodies (mAbs) through the improvement in therapeutic indications (TIs) for mAbs, from 2000 to 2012. AsMabs are divided into two main groups by the French health care system. ASMA I to III allow manufacturers to notify price to the pricing committee based on the innovative characteristics of the product and on the reimbursement includes of the comparator. ASMA IV and V are given to non-innovative products adding at best minor improvement to standard of care. METHODS: mAbs (excluding radiotherapeutics) online published reports from the TC from 2000 to 2012, including new indications and reassessments, were analyzed. The TC has to ASMA I to III and only after to ASMA IV or V (n = 6). During the following period, from 2006 to 2012, the TC granted only 30% (n = 6) of the assessments with an ASMR I, II or III. 70% (n = 49) of the remaining evaluations were assigned to ASMA IV or V. CONCLUSIONS: In the first six years mAbs were perceived as a disruptive innovation to a significant proportion of ASMRs between I and III as a reward for research and development efforts of the manufacturer. This research suggest that mAbs manufacturers no longer benefit from a ‘first mover’ advantage and that the greater price pressure from the French pricing committee.

PHP180
HEALTH TECHNOLOGY ASSESSMENTS OF MEDICAL DEVICES: IS HELP OUT THERE?
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OBJECTIVES: Small-Medium Enterprises (SMEs) should assess the potential profitability of new medical devices early in their development. This can be achieved via early-stage health care technology assessments (HTAs). However, SMEs will not have the skills necessary to undertake these HTAs, so tools and frameworks that aid this process are likely to be beneficial. A systematic review of the literature was undertaken to identify resources that can facilitate early-stage HTAs.
RESULTS: Of the 4729 papers identified, ten were included in the final analysis. Only one interactive tool, a decision analytic model which is operational via Microsoft Excel, was identified. Of the remaining nine articles, five were classified as frameworks. Of these five articles, the most comprehensive outlines a multi-criteria decision analysis (MCDA) value matrix. The final three articles included in the final analysis contained descriptive methods with information that was considered useful.
CONCLUSIONS: The resources available to aid the undertaking of early-stage HTAs is very limited. Ideally, an interactive spreadsheet tool that generates feedback would be available. However, the one identified tool is too inflexible and most users would struggle to find accurate data to populate it.

PHP181
THE NICE MEDICAL TECHNOLOGY EVALUATION PROGRAMME (MTEP) – INSIGHTS FOR MANUFACTURERS CONSIDERING NOTIFICATION
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OBJECTIVES: The Medical Technologies Evaluation Programme (MTEP) was established to promote the uptake of innovative medical technologies through the publication of Medical Technology Guidance (MTG) by the National Institute for Health and Care Excellence (NICE) to the National Health Service (NHS) in the UK. The objective of this analysis is to report data on the MTEP, which are not currently collated on the NICE website, in order to provide insights to manufacturers on the process, outcomes and implementation of guidance. METHODS: Information published on the NICE website was used to identify notified technologies, the proportion routed to the MTEP, and the subsequent NICE recommendations. RESULTS: Between January 2010 and December 2012, 102 technologies were notified to the MTEP. Of these notifications, 21 technologies were routed to MTEP and 15 were routed to the diagnostic assessment programme (DAP), giving a routing rate of 20% and 15%, respectively. Of the 21 technologies routed to MTEP, 13 technologies had had guideline issued: 10 (77%) had a positive recommendation and 3 (23%) were not recommended for use in the NHS. Whilst a positive recommendation for use is likely to encourage uptake, it is not guaranteed. Following a positive MTEP recommendation for CardioQ-oesophageal doppler monitor (OQDM), the implementation levels were relatively low (31% increase in use). CONCLUSIONS: Many of the notified technologies are not selected at notification stage. However, once selected and routed to MTEP, most technologies receive some form of positive recommendation. Evidence on implementation levels following a positive recommendation by the NICE MTEP indicates that the implementation of guidance by the NHS may not always be optimal. The new NICE Health Technology Adoption Programme should help to improve implementation levels in the future. To ensure optimal implementation, manufacturers should consider developing tools to support the uptake of technologies alongside a NICE positive recommendation.

PHP182
NUMBER OF SUBMISSIONS NEEDED TO REACH A POSITIVE REIMBURSEMENT DECISION FROM SMC, CADTH, AND PBAC
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OBJECTIVES: Often positive reimbursement decisions are only achieved after multiple submissions. Multiple submissions can delay patient access to necessary therapies and be costly for the manufacturer. This study analyzes the number of submissions needed to gain a positive decision and determines the lag time between the first submission and the positive decision. METHODS: The data covered three agencies: SMC, PBAC, and CADTH’s Common Drug Review. The results spanned 23 disease conditions and included 396 Health Technology Assessments (HTAs). RESULTS: A positive decision was achieved after the first submission in 50% of the HTAs analyzed. At 1.57 submissions, PBAC had the highest average number of submissions needed to achieve a positive decision. PBAC’s average was statistically higher than both SMC and CADTH (p<0.001). Overall, SMC and CADTH and SMC needed 1.7 and 1.16 submissions, respectively, to obtain a positive decision. Also, for drugs that were submitted, it took on average 430, 924 and 1,189 days to gain a positive decision from SMC, CADTH, and PBAC. For CADTH and SMC, there appears to be a modest linear relationship between the number of submissions needed for