to chemotherapy. The algorithm was validated against a PSA-based definition of CRPC (at least two PSA increases following castration or new metastases while on hormone therapy). **RESULTS:** A total of 269 patients met inclusion criteria and had 3 or more PSA measurements. The two methods agreed in 88% of patients; 220 (81.8%) were identified as CRPC by both methods and 17 (6.8%) were identified as not castration-resistant by both methods. A statistically significant comparison of the two methods yielded a Cohen’s kappa of 0.4491, indicating moderate agreement. **CONCLUSIONS:** The algorithm was concordant with a PSA-based definition of CRPC and serves as a new tool to identify CRPC patients using claims data. Future validation against a different data source is needed.

**PCN202**  
**INCREASED RISK OF CANCER INCIDENCE ASSOCIATED WITH REPEAT MEDICAL IMAGING: DESIGNING BETTER CLINICAL TRIAL PROTOCOLS**  
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**OBJECTIVES:** To assess the potential increase in lifetime attributable risk (LAR) of cancer incidence due to repeated exposure to medical imaging procedures for participants in clinical trials. **METHODS:** Medical imaging in clinical trials has grown from a minimal 1% of CT scans per year to a 30% higher risk than males, however, cancer incidence at ages 50 and 70 were similar for both sexes. At age 50 the LAR of cancer incidence increased from 31 to 151 per 100,000, while the risk increased from 15 to 71 per 100,000. The LAR of cancer incidence was one third lower in 70 year olds than in 30 year olds, and half the rate of 50 year olds. **CONCLUSIONS:** Although the LAR of cancer incidence of a single exposure seems to be relatively small, clinical trials that involve a comparably number of imaging procedures could raise significantly higher LARs. Examinations that deliver relatively high doses of radiation, such as CT, need to be clinically justified.

**PCN203**  
**TRENDS IN CHEMOTHERAPY SETTING AND COSTS FROM 2005 TO 2012: A CASE STUDY USING BEVACIZUMAB**  
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**OBJECTIVES:** The rising costs of cancer care are a major focus for clinicians, payers and patients. This analysis examines trends in bevacizumab chemotherapy administration and drug reimbursement. **METHODS:** Using the MarketScan® Research Databases, administrations of bevacizumab were identified from 1/1/2005 through 12/31/2012 for patients with commercial or employer-sponsored supplemental Medicare. Pre-existing claims with bevacizumab administration claims had a diagnosis related to eye disease or the reimbursed amount was < $100. All claiims were identified as occurring in an office-based setting (OBS), an outpatient hospital setting (OHS) or other setting. **RESULTS:** The percent of bevacizumab claims occurring in OHS increased from 6 to 34% among Medicare claims, and from 14 to 42% among commercial claims from 2005 to 2012. Medicare median drug reimbursement was $257 more for OBS than in OHS in 2005, increasing to a difference of $3,022 in 2009 and declining to $1,722 in 2011 before narrowing to $165 in 2012. Commercial differences in drug reimbursement for OBS and OHS settings continuously increased from $885 in 2005 to $3,714 in 2011, declining slightly to $3,676 in 2012. Differences in chemotherapy administration reimbursement were $176 more for OBS than in OHS in 2005, the difference decreasing to $103 in 2007 and increasing to $236 in 2012. **CONCLUSIONS:** Although the difference in reimbursements to OHS and OBS has decreased over time for Medicare, the differences across settings for commercial insurance increased over time with a slight indication that cost increases are slowing. The higher reimbursements in OBS combined with the shift from OBS to OHS over the past 7 years has implications for the growth in cancer costs over the past decade.

**PCN204**  
**NOVEL MARKET ACCESS STRATEGIES FOR CANCER DRUGS**  
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**OBJECTIVES:** Cancer drugs are the world’s highest selling category of therapeutic products. Due to their premium price and budget impact, several new drug reimbursement models have been implemented worldwide by public and private payers. These new models pose potential implications and challenges for both the development and reimbursement of all branded products. This study reviewed recent cancer drug reimbursement models and developed lessons and implications for future products. **METHODS:** Reviewed cancer drug reimbursement models and evaluated existing reimbursement models for several new drugs. Interviewed payers and KOLs to develop lessons and implications for future products. **RESULTS:** Public and private payers have implemented several new models for cancer drug reimbursement to manage budgets and control costs. In the US, payers are piloting single source compendia and third party protocols (eg. P4 Oncology) to limit off-label use of cancer drugs. In the UK, NICE has successfully negotiated lower price discounts and price caps for first few cycles of therapy. In Italy, AIFA has implemented registry based payment across for cancer drugs. In India, several manufacturers have implemented novel pricing strategy for first few cycles of therapy.

In Germany, IQWIG has proposed to use correlations between surrogate endpoints and patient-relevant outcomes to determine value of cancer drugs. Due to increased cost pressure on payers, such models are likely to inspire novel reimbursement schemes for other branded products. **CONCLUSIONS:** Cancer drug reimbursement models are setting new benchmarks for payers to manage access and control costs. These models have significant implications for other expensive branded products.
10, respectively). Similarly, patients admitted to hospital with oesophageal cancer experienced a high 90-day mortality rate, ranging from 22% to 21.9% in 2007-08 and 2009-10, respectively. However, between 2006 and 2010, no therapies were submitted for NICE appraisal for oesophageal cancer, suggesting that there may have been a lack of research interest and potentially explaining why there was no substantial decrease in mortality from 2007 to 2009, as reported in individual years. There were no therapies that had been approved, such as lung, colon and breast cancer. CONCLUSIONS: The recommendation of therapies and their uptake in the UK may at least partially explain the trends noted in this study, although other factors such as delay in therapy uptake and off-label use may also need to be taken into account.

PCN208
DO NICE EVIDENCE REVIEW GROUPS (ERG) FOCUS ON DIFFERENT ASPECTS OF MANUFACTURER SUBMISSIONS IN ONCOLOGY?

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OBJECTIVES: Evidence Review Groups (ERGs) provide a critical appraisal of the manufacturer submission in the NICE single technology appraisal (STA) process. As the academic centres may differ in experience and methodology, the objective of this study was to investigate whether the focus areas and key criticisms differed between ERGs.

The NICE website was searched for all NICE oncology STAs, published between June 2010 and June 2013. The ERG reports were retrieved, and the main critiques were categorised for the five centres that performed the most evaluations. The focus areas of the ERGs were further studied. RESULTS: A total of 27 STAs were identified with evaluations performed by 9 different ERGs. The most evaluations were performed by Liverpool (9), followed by Sheffield (4), and PentaGC, West Midlands and York (3 evaluations each). All ERG reports were related to the extrapolation and gain in overall survival (OS), maturity of data, trial comparator, and the quality of life (QoL) data. In addition, all critiques covered submission quality and disease specific challenges, yet variation was found in focus area between ERGs. For example a specific focus area of Liverpool was the OS modelling method. Proposed changes to survival modelling included separating the survival curves for pre- and post-progression, and removing any survival advantage due to progression. Conclusions: The network meta-analysis methods used to analyse relative treatment effects across relevant comparators were used to calculate the potential patient number. The results were compared with the benefit assessment was conducted to evaluate which data sources and methods for oncological drugs.

The dossier needs also scientific community and patient organizations the Federal Joint Committee (G-BA) to support decision-making by the national appraisal committee (national P&T). The rational drug list is publically available but without details of the decision or the processes of decision making. Listing of new medication is wide without indication specification or date of listing. The role of cost-effectiveness is limited and the tender prices are not linked to any type of cost-effectiveness. CONCLUSIONS: The National Agenda, the National Health Policy and the National Drug Policy tackled the high health expenditure in Jordan as an essential priority. This challenge is due to the characteristics of the Jordanian health care system that is fragmented with a divided funding system between public and private sectors. A more formalized medication selection processes empowered with drug information services will provide evidence-based decisions in the choice of medications. CONCLUSIONS: The network meta-analysis methods used to calculate the potential patient number. The results were compared with IQWIG's assessment and the final decision by G-BA, to detect possible methodological challenges and the efforts needed should not be underestimated. Authorities, industry and medical community should work on a common solution for a more valid and reliable calculation of the potential patient number in oncology.

PCN211
HEALTH TECHNOLOGY ASSESSMENT: IS IT THE RIGHT PIECE FOR THE JORDANIAN HEALTH CARE PUZZLE?
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OBJECTIVES: To study the pharmaceutical reimbursement/Coverage decision making processes in Jordan to highlight the importance of conducting formalized technology assessments.

METHODS: To review publically available data regarding the reimbursement/Coverage decision making processes in Jordan through searching the NICE website. RESULTS: NICE's assessment and the final decision by G-BA, to detect possible methodological challenges and the efforts needed should not be underestimated. Authorities, industry and medical community should work on a common solution for a more valid and reliable calculation of the potential patient number in oncology.