pared to the “do nothing” strategy. To collect the information needed to process to this analysis, we used: the strategy focused on evaluating equivalences (n=3333) in a representative sample of the French population and a cost-effectiveness model produced by the French National Authority for Health (HAS). RESULTS: As preliminary results, we find that antihypertensive treatments in primary prevention are efficient if the inequality aversion is 0, 1 or 2. However antihypertensive treatments are not efficient anymore if it is decided to take a stronger degree of inequality aversion of 3. Indeed, 20% of the poorest individuals would have an increase of income if antihypertensive treatment were not prescribed and reimbursed by the national health insurance given their actual participation to public health. The impact on expenses: These results may reflect issues raised by the funding of health care in the French system.

PCV44 ECONOMIC EVALUATION OF A SINGLE-PILL TRIPLE COMBINATION WITH VALSARTAN, AMLODIPINE AND HYDROCHLOROTHIAZIDE AGAINST ITS DUAL COMPONENTS IN GREECE. THE GENERIC SUBSTITUTION CASE STUDY

OBJECTIVES: The first single-pill triple antihypertensive therapy with valsartan (VAL), amlopidine (AML) and hydrochlorothiazide (HCTZ) is currently available. The aim of this study was to compare the cost-effectiveness of the single-pill triple combination with dual components in generic forms. METHODS: A Markov model evaluating the cost-effectiveness of the single-pill triple combination against each of the dual components was constructed. Two important assumptions have been considered: i) the cheaper available generics ii) effectiveness and adverse-events were the same as in the original forms. To achieve the lowest available price for the generic alternatives, three pills were necessary for the combination AML/VAL, three pills for VAL/HCTZ and two pills for AML/HCTZ. It was also assumed that adherence and Quality of Life (QoL) were similar as with single pill dual components. The time horizon was lifetime. Effectiveness and costs were discounted at 3% rate. The analysis was conducted from Greek third-party-payer perspective, in 2012€. RESULTS: The single pill triple combination was expected to increase life expectancy by 0.4%-0.6% up to 0.49 years and QALYs by 0.12-0.38, comparing with its dual components. The total cost of treatment with triple combination was estimated at 67,499 in comparison to €61,521 for AML/VAT, €14,519 for VAL/HCTZ and €11,269 for AML/HCTZ. The incremental cost-effectiveness ratio (ICER) per Quality Adjusted Life Year (QALY) gained with the triple combination versus the dual combinations VAL/AML/HCTZ and AML/HCTZ was 13,391, 28,076 and 16,541€. There was a probability of more than 80% for the triple combination to be cost-effective with an incremental cost-effectiveness rate (ICER) threshold of 20,000/€QALY gained. CONCLUSIONS: The single-pill triple combination therapy with VAL/AML/HCTZ is a cost-effective antihypertensive choice, compared to its dual components in generic forms. Moreover, this study may underestimate the cost-effectiveness of the triple combination since a single-pill formulation would improve treatment adherence and effectiveness more than the other comparators, requiring 2 to 3 different pill intake.

PCV45 LONG TERM COST-EFFECTIVENESS ANALYSIS OF TICAGRELOR IN PATIENTS WITH ACUTE CORONARY SYNDROMES FROM A TURKISH HEALTH CARE PERSPECTIVE BASED ON DATA FROM THE PLATO TRIAL

OBJECTIVES: The PLATO trial showed that in patients with acute coronary syndromes (ACS) treatment with ticagrelor compared with clopidogrel significantly reduced the rate of myocardial infarction, stroke, or death from vascular causes without a significant increase in the rate of overall major bleeding. The aim of this analysis is to estimate long-term cost-effectiveness of treating ACS patients with ticagrelor from a Turkish health care perspective. METHODS: A two-part decision-analytic model, including a one-year decision tree and a long-term Markov model, was constructed to estimate lifetime costs, LYs and QALYs of treating patients for one year with ticagrelor plus acetylsalicylic acid (ASA) compared with clopidogrel plus ASA. Event rates, health-care costs, and QALYs were estimated for the first year by using individual-patient data from PLATO. The cost was calculated by applying Turkish unit costs. For the second year onwards, necessary assumptions year by year were used. The model allowed for new or recurrent events over the lifetime of the patient. Additionally, factors such as subgroup-specific stroke risk, drug discontinuation, and time in therapeutic range (a measure of quality of anti-coagulation) were included in the model. Univariate and probabilistic sensitivity analyses were conducted on the base-case incremental cost-effectiveness ratio (ICER). RESULTS: In the base-case analysis, ticagrelor-150mg compared to VKA was associated with life expectancy of 11,758/QALY. €11,758/QALY. At an informal willingness-to-pay threshold of €50,000/QALY the probability that ticagrelor is cost-effective was approximately 0.93. Sensitivity analysis identified quality of anti-coagulation care, drug-specific stroke risk, and stroke costs as having the biggest impact on the ICER. CONCLUSIONS: Ticagrelor may be a cost-effective option compared to its components in the Netherlands. However, their use requires regular monitoring and is associated with a significant risk of bleeding, among other shortcomings. Ticagrelor is a novel oral anticoagulant associated with lower stroke and similar major hemorrhage rates compared to warfarin. This study evaluated the cost-effectiveness of dabigatran for stroke prevention in AF patients for the Dutch situation. METHODS: A Markov model was developed using efficacy data extracted from the RE-LY registry study and cost data from Dutch costing studies. The model contained the following health states: AF, atrial fibrillation, transient ischemic attack, intracranial hemorrhage, myocardial infarction, pulmonary embolism, extracranial hemorrhage, minor bleeding, and death. The model allowed for new or recurrent events over the lifetime of the patient. Additionally, factors such as subgroup-specific stroke risk, drug discontinuation, and time in therapeutic range (a measure of quality of anti-coagulation) were included in the model. Univariate and probabilistic sensitivity analyses were conducted on the base-case incremental cost-effectiveness ratio (ICER). RESULTS: In the base-case analysis, dabigatran-150mg compared to VKA has an incremental cost of €3,057 and a QALY gain of 0.26, corresponding to an ICER of €11,758/QALY. At an informal willingness-to-pay threshold of €50,000/QALY, the probability that dabigatran is cost-effective was approximately 0.93. Sensitivity analysis identified quality of anti-coagulation care, drug-specific stroke risk, and stroke costs as having the biggest impact on the ICER. CONCLUSIONS: Dabigatran may be a cost-effective option over its components in the Netherlands. Future studies may evaluate updated estimates, specifically for anti-coagulation care, stroke risk, and stroke cost in The Netherlands, would further improve and reduce uncertainty surrounding the results.

PCV46 SYSTEMATIC REVIEW OF COST-EFFECTIVENESS MODELS FOR PHARMACOLOGIC STROKE PREVENTION IN ATRIAL FIBRILLATION

OBJECTIVES: To conduct a systematic review of economic models of pharmacologic stroke prevention in atrial fibrillation (SPAF). METHODS: We searched Medline, Embase, NICEguideline and the Tuft’s Registry through May 2012. Models assessed pharmaco-economic SFAF using a Markov process or discrete event simulation (DES), calculated both costs and effectiveness, and was published in English. Two investigators independently screened models and extracted data. RESULTS: Twenty-two models, published between 1995 and 2012, were identified. One model was a DES, and the remaining Markov models. Eleven models used a structure similar to Gage et al. (1995), five were derivatives of Sorensen et al. (2009), with the remainder using unique structures. Only 5 models had a non-CNS systemic embolism health state. Models typically started at 65 or 70 years and followed patients for 20 years or more, e.g., 75 years, 75% or 100% of patients were alive at year 20. In all models, patients were classified into different risk categories on the basis of the RE-LY trial. Most models included aspirin as a first-line agent, anticoagulants (VKA), and three evaluated clopidogrel + aspirin. Comparative efficacy and safety data for warfarin vs. aspirin/control models were often derived from meta-analyses; whereas, data for newer agents came from a lone randomized trial. Models otherwise used similar sources of non-drug dependent inputs. Eighty-two percent of reported base-case incremental cost-effectiveness ratios (ICERs) were cost-effective (<$50,000/QALY). Models typically found warfarin (vs. aspirin/no therapy), dabigatran and rivaroxaban