LYG for Estonia. Sensitivity analyses showed that time horizon, discounting and follow-up cost of stroke are sensitive factors. Difference in co-payment for workers and retired patients (Estonia) marginally impacted ICERs. Probabilistic sensitivity analysis showed that the probability for 0-3EE to be cost-effective is higher than 95% in Estonia (threshold €32,000/LYG). One-way sensitivity analyses showed strong robustness in Ireland (threshold €20,000/QALY). CONCLUSIONS: The incremental cost-effectiveness ratio (ICER) and incremental cost-effectiveness ratio (ICUR) per QALY of 1g O-3EE versus standard treatment was €2,140 (95% CI: €1,214 to €3,607) in the range likely to be considered cost-effective in Ireland and Estonia.

PCV66
PHARMACOECONOMIC ANALYSIS OF AZISLARTAN MEDOXOMIL IN PATIENTS WITH ARTERIAL HYPERTENSION: COMPARISON WITH VALSARTAN, TELMISARTAN, AND LOSARTAN IN THE CONTEXT OF THE MEXICAN CONTEXT
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OBJECTIVES: To compare the incremental cost-effectiveness ratio (ICER) and incremental cost-effectiveness ratio (ICUR) of the angiotensin II receptor antagonist Azilsartan vs current treatments of the same drug class as valsartan, telmisartan, losartan and irbesartan. METHODS: Cost-effectiveness analysis was conducted using a Markov model with a 35-year temporal horizon for patients over the age of 50 and hypertension as a condition for inclusion to calculate the ICERs of each treatment. The model adopts the Mexican public health institutions’ perspective. Four health states were incorporated: alive and healthy, hypertensive with non-fatal acute myocardial infarction (AMI), hypertensive with non-fatal stroke, and end-stage renal disease (ESRD). Transition probabilities (TP) were estimated based on the risk of having a stroke or AMI and the probability of having a vascular complication depending on blood pressure levels (in mmHg). Costs and effectiveness data were taken from health institutions, producer pharmaceutical companies or extracted from published literature. Outcome measures included ICER and ICUR. Cost-effectiveness was determined according to the 1USD/capita-hospital stay threshold established by the National Health Council in Mexico. RESULTS: Azilsartan was found to be dominant when compared with telmisartan, valsartan and irbesartan. Azilsartan was also more effective when compared with losartan (10.76 vs. 10.47 life years gained) although more costly (USD $6,118.92 vs. USD $4,192.71). The ICER was USD $1,922/quality-adjusted life year gained. According to the cost-utility analysis, the ICUR per quality-adjusted life year gained was USD $3,458.09. CONCLUSIONS: The ICER and ICUR are well below 1USD (USD $3,550, 95% CI) per capita versus losartan. Both azilsartan and losartan were feasible to be dominant strategies in comparison with the other included treatments. Azilsartan is therefore a very cost-effective intervention for the Mexican population over 45 with systemic arterial hypertension.

PCV67
MIND THE GAP! GEOGRAPHIC TRANSFERABILITY OF ECONOMIC EVALUATION IN HEALTH
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OBJECTIVES: Transferring cost-effectiveness information between geographic domains offers the potential for more efficient use of analytical resources. However, it is difficult for decision makers to know when they can rely on cost-effectiveness evidence produced for one geographic area to another location Whilst controlling for baseline characteristics within, and across, a set of economic evaluation studies. Explanatory variables were derived from a list of factors suggested in the literature as possible constraints on the transferability of cost-effectiveness evidence. We illustrated our approach using published estimates of the cost-effectiveness of statins for the primary and secondary prevention of cardiovascular disease (CVD). 2094 estimates of the costs and effects of statins trans were abstracted from 67 studies related to 23 geographic domains, together with 23 country-specific data, study and country-level. RESULTS: The proportion of variation at the country-level observed depends on the appropriate multi-level model structure and never exceeds 15% for incremental effects and 21% for incremental cost respectively. Key sources of variance are patient and disease characteristics, intervention cost and a number of co-morbidities defined on the data level. There were fewer significant covariates on the study and country-level. CONCLUSIONS: Our analysis suggests that variability in cost-effectiveness data is primarily due to differences between studies, not countries. Further, different methodological models suggest that the cost-effectiveness data and to further explore the appropriate set of covariates.

PCV68
ECONOMIC EVALUATION OF INITIATION WITH ENDOThELIN RECEPTOR ANTAGONISTS IN THE TREATMENT OF PULMONARY ARTERIAL HYPERTENSION IN SPAIN
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OBJECTIVES: To evaluate health outcomes and costs of initiation with endothelin receptor antagonists (ERA) monotherapy (ambrisentan or bosentan) followed by sequential combination with phosphodiesterase-5 inhibitors (PDE-5) and prostanoids in the treatment of pulmonary arterial hypertension in Spain. METHODS: A Markov model was developed based on New York Heart Association functional classes. Transition probabilities (TP) for ERA initiation were gathered from pivotal clinical trials. The Markov model was developed based on New York Heart Association functional classes. The Markov model was developed based on New York Heart Association functional classes. The Markov model was developed based on New York Heart Association functional classes. Transition probabilities (TP) for ERA initiation were gathered from pivotal clinical trials. OUTCOME: Average per-patient and year pharmacological costs [95% CI] were [35,550 [€34,944-€36,196] and €40,224 [€39,644-€41,212] for initiation with ambrisentan and bosentan, respectively. Average costs associated with AE management was [€0.6853 [0.6836-0.6870] and €0.6903 [0.6885-0.6921], respectively. This agrees with published meta-analyses and a priori expert judgment. Initiation with ambrisentan would bring about cost savings of €4,727 [€3,903-€5,620]. From a cost-minimization perspective, if the same TP were considered for both initiation alternatives, initiation with ambrisentan would provide comparable cost savings of €4,952 [€4,898-€5,007] (using ambrisentan’s TP) and €4,770 [€4,718-€4,819] (using bosentan’s TP). CONCLUSIONS: Initiation with ambrisentan mono-therapy followed by sequential combination with PDE-5 inhibitors yields comparable health outcomes and costs at lower cost than initiation with bosentan. These results might be considered in hospital pharmacy budget allocation decision making.

PCV69
ECONOMIC EVALUATION OF THROMBO INCODE, A GENETIC PLATFORM FOR THE ASSESSMENT OF VENOUS THROMBOEMBOLISM (VTE) RISK IN PATIENTS WITH A PATTERN OF VTE OR A CONDITION THAT SUGGESTS A HEREDITARY COMPONENT
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OBJECTIVES: To conduct an economic analysis of the risk assessment of VTE with Thrombo incode, a genetic platform, in patients with a pattern of VTE or a condition that suggests a hereditary component, compared with the standard methods so far used (Factor V Leiden and prothrombin G20210A mutation). METHODS: A Markov model was developed with 7 states of health (thrombophilia, no thrombophilia, VTE, major bleeding, intracranial hemorrhage, no intracranial hemorrhage, and death). The predictive ability of VTE from the identification of thrombophilia with Thrombo inCode and the standard method, was obtained from three studies of method validation performed in three different patient populations (4,696 patients in total). It was assumed that patients with thrombophilia positively identified undergo a preventive treatment of VTE, which involves both reducing the number of VTE as the increase in major bleeding. The utilities and costs of Markov states were obtained from an interview of 25 stakeholders from the National Health System perspective, for a time horizon of 5 years and lifetime. An annual discount rate of 3% for costs and benefits was applied. RESULTS: For a Thrombo inCode price of 290 €, this genetic platform would be the dominant option for any time horizon from 5 years. The ICER of Thrombo incode to reach the incremental cost-effectiveness ratio (ICER) threshold generally accepted in Spain (30,000 €/QALY) would range between €1,069 and €1,284. Probabilistic analyses indicate that Thrombo inCode assessment is dominant in 97.6% of the 1,000 hypothetical patients. CONCLUSIONS: Thrombo inCode is a cost-effective genetic option in VTE risk assessment compared with the standard method.

PCV70
COST-EFFECTIVENESS OF SMOKING CESSATION INTERVENTIONS IN SMOKERS WITH CARDIOVASCULAR DISEASE IN THE NETHERLANDS
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OBJECTIVES: Limited pharmaceutical options are available for smoking cessation interventions for smokers with a history of cardiovascular disease (CVD). METHODS: The objective of our study was to assess the cost-effectiveness of varenicline versus nicotine replacement therapy (NRT) in such a population. RESULTS: A lifetime horizon Markov model was developed to compare the cost-effectiveness of smoking cessation therapies from the societal perspective. Efficacy data (continuous abstinence rates) for each therapeutic option was obtained from an indirect comparison of available clinical trials. The population of smokers with cardiovascular disease was divided into three cohorts: those with a history of coronary heart disease (CHD), stable CHD, and patients with chronic obstructive pulmonary disease (CVD). In the model, the cohorts are followed as they progress through potential disease states including CHD, stroke, PVD, COPD, mouth cancer and lung cancer. Transition probabilities depend on age (35-65, 65+), gender and smoking status (current, former or never smoker) allowing for variations in the patient populations. Following the Dutch pharmacoeconomic research guideline, costs and effect were discounted at 4% and 1.5%, respectively. Univariate and probabi-
OBJECTIVES: To determine the cost-effectiveness of lipid lowering therapy in the secondary prevention of cardiovascular events in the Philippines. METHODS: A cost-utility analysis was performed using Markov modeling in the secondary prevention setting. The models incorporated efficacy of lipid lowering therapy demonstrated in randomized controlled trials and mortality rates obtained from local life tables. Average and incremental cost-effectiveness ratios (ACERs and ICERs) were obtained for Simvastatin, Atorvastatin, Pravastatin, and Gemfibrozil. The costs of the following were included: medications, laboratory examinations, consultation (professional fees) and related expenses and purchase losses. The costs were expressed in current or nominal prices as of the 1st quarter of 2010 (Philippine peso). Sensitivity analyses were performed using variations in the cost centers, discount rates, starting age and differences in utility weights for stroke. RESULTS: In the analysis using the lower-priced generic counterparts, therapy using 40 mg Simvastatin daily resulted in 26.6% fewer life-years gained QALYs compared to the other therapies. Pravastatin 40 mg daily was the most cost-effective alternative if the higher-priced innovator drugs were used. In all sensitivity analyses, Gemfibrozil was strongly dominated by the statins. CONCLUSIONS: In the primary prevention setting, Simvastatin or Paraciplatin were the most cost-effective options compared to Atorvastatin and Gemfibrozil in the Philippines. Gemfibrozil was strongly dominated by the statins.

**PCV72**

**COST-EFFECTIVENESS OF RIVAROXABAN VERSUS ACENOCUMAROL IN THE STROKE PREVENTION IN PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION IN SPANISH SETTING**

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OBJECTIVES: To assess the cost-effectiveness of rivaroxaban versus acenocumarol in the Spanish NHS setting. METHODS: A Markov model was developed and adapted to the Spanish settings. The model consists of health states covering the management and outcomes of AF. Costs and utilities were assigned to each health state as well as to each transition between health states. Transition probabilities were obtained from clinical studies and registries. Incremental cost-effectiveness ratios were calculated. **CONCLUSIONS:** The model suggests that rivaroxaban therapy in people with CVD is cost-effective and provides value for money compared to NRT.

**PCV73**

**ASSESSMENT OF ISCHEMIC HEART DISEASE RISK RECLASSIFICATION OF PATIENTS WITH INTERMEDIATE RISK ASSESSMENT OF ISCHEMIC HEART DISEASE RISK RECLASSIFICATION OF PATIENTS WITH INTERMEDIATE RISK**

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OBJECTIVES: To conduct an economic analysis of the risk assessment of ischemic heart disease (IHD) with Cardio inCode (adding risk score to the thresholds of REGICOR and Framingham) compared with the standard method using (only the functions). METHODS: A Markov model was developed with 7 states of health (low, intermediate, high IHD risk; IHD event, recurrent IHD, chronic IHD and death). The reclassification of IHD risk derived from genetic information and transition probabilities of IHD risk. RESULTS: The greatest benefit occurred in the subgroup of patients with intermediate-high risk, with a high risk reclassification of 22.8% of patients and an ICER of 1,650/QALY and 5,893/QALY (REGICOR and Framingham cohorts). Sensitivity analyses confirmed the stability of the results. CONCLUSIONS: Cardio inCode is a cost-effective genetic option in IHD risk assessment compared with the standard method.

**PCV74**

**COMPLEMENTARY DATA FOR RARE DISEASES - COMPARING DATA FROM NATIONAL REGISTRIES TO A EUROPEAN CHART ABSTRACTION STUDY FOR PATIENTS WITH CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION**

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OBJECTIVES: To combine and supplement public national registries and patient level chart data in order to describe and compare demographics, treatment patterns and mortality in patients with chronic thromboembolic pulmonary hypertension (CTEPH), a rare disease. METHODS: Using the national Swedish prescripion, inpatient and cause of death registries, CTEPH patients were identified via algorithms about drug prescriptions and diagnostic/procedural codes. A second cohort, identified from medical charts of diagnosed CTEPH patients treated in specialized treatment centers across five European countries was abstracted retrospectively. Descriptive statistics and potential areas of complementary information are described. RESULTS: Basic data on demographic and clinical characteristics, medication and selected health resource consumption data were found to have sufficient overlap to allow the comparison between cohorts. From Swedish registries, 94 CTEPH patients were identified. In the medical charts, 116 patients were included. Mean age of 41.1 ± 14.5 years, 61 patients were older than 61 years younger than the chart cohort (67.5 ± 12.3). Both cohorts were predominantly female (registry 52%, chart cohort 61%). Medications for pulmonary arterial hypertension were common in both datasets: endothelin receptor antagonists were 45% in both cohorts versus 60% in chart data. Concomitant medications included diuretics (43%) and beta-blockers (32%). Concomitant medications included diuretics (43%) and beta-blockers (32%). Concomitant medications included diuretics (43%) and beta-blockers (32%).