and individual lifetime lost earnings were $1.10 million. 7.98 million YPLL. The estimated total productivity loss in 2008 was $5.49 billion annual decline in breast cancer mortality rates among blacks was smaller (-0.68%) compared with a 0.46% increase among whites, due to premature mortality. METHODS: Age-adjusted rates and rate ratios (RRs) were calculated using 1970-2012 U.S. mortality data. Changes in breast cancer mor-

effects of breast cancer mortality among younger women are limited.

Breast cancer is the second leading cause of cancer-related deaths in women. Published literature, inflated to 2014

PCN116 HEALTH AND ECONOMIC BURDEN OF BREAST CANCER MORTALITY IN YOUNGER WOMEN AGED 18-44 YEARS IN THE UNITED STATES, 1970-2012

Economic burden. Considering the effect of breast cancer on women of working-age in 2012, the age-adjusted breast cancer mortality rate among young women was

2012, the age-adjusted breast cancer mortality rate among young women was

12/100,000). Rates were higher in the Northeast (RR = 1.03, 95% CI, 1.02-1.04). The annual decline in breast cancer mortality rates among blacks was smaller (-0.68%) compared with whites (2.02%) and all race/ethnicity (1.77%). The total number of deaths from breast cancer in 2012 was 201,573 and 7.98 million YPLL. The estimated total productivity loss in 2008 was $5.49 billion and individual lifetime lost earnings were $1.10 million. CONCLUSIONS: Breast cancer mortality among young women is associated with substantial health and economic burden. Considering the effect of breast cancer on women of working-age and the disproportionate impact on black women, more aggressive interventions with multiple strategies are needed to help reduce these burdens, improve survival and to inturn reduce productivity costs associated with premature death.

PCN117 RESOURCE UTILIZATION AMONG ADVANCED SQUAMOUS AND NON-SQUAMOUS NON- small CELL LUNG CANCER PATIENTS RECEIVING SECOND- LINE TREATMENT IN FRANCE, GERMANY, ITALY, AND SPAIN: RESULTS OF A RETROSPECTIVE MEDICO-/chart review

OBJECTIVES: Across Europe, clinical and economic burden of advanced non-small cell lung cancer (aNSCLC) remains high; regional variation and cost drivers are not completely understood. The leading the evaluation of Non-squamous and Squamous NSCLC (i.e., study aimed to systematically describe aNSCLC-attributable healthcare resource utilization (HRCU) and costs within aNSCLC patients who received ≥2 lines of systemic therapy. METHODS: Patients diagnosed with aNSCLC (Stage IIIb/IV) between 07/09-08/11 who initiated second-line treat-
ment (excluding clinical trial patients) were quota sampled from 153 oncology-pulmonology practices (92 hospital-based) in France, Germany, Italy, and Spain. Medical charts were reviewed for patient characteristics and outcomes including aNSCLC-related HRCU from diagnosis through death or most recent visit (data abstracted in January-May 2014). Country-specific unit costs were obtained from national price indexes and published literature, inflated to 2014. Average lifetime costs were calculated using a Markov state-space approaches to adjust for incomplete follow-up. RESULTS: 835 patients (Non-squamous=418, Squamous=417; France=191, Germany=225, Italy=220, Spain=199; median age 65 years; 85% smoking history) were observed and tracked for a mean 20.7 months (range 2.8-57 months; 76.3% followed through death). 11.9% 6.1% had an aNSCLC-related hospitalizations/ER visits, 63.8% biomarker testing, 16.8% radiotherapy, 4.2% surgery, and 27.9% supplemental therapies. Estimated per-patient lifetime aNSCLC-attributable costs of medical care were €42,682 (France=54,536, Germany=71,508, Italy=41,847, Spain=65,424). Costs were driven by systemic treatment (systemic treatment cost=$50,737, in squamous, $28,107, non-squamous, $71,060). CONCLUSIONS: Treatment was the primary aNSCLC-related cost driver, with histology-based differences driven by lower systemic use in squamous patients. The observed levels of cost and resource use for both squamous and non-squamous management are substantial, especially considering the limited efficacy and high toxicity of existing treatments. Cost effectiveness of real-world treatment needs to be further explored.

PCN118 TREATMENT SEQUENCING PATTERNS AND COSTS OF CARE IN PATIENTS WITH RELAPSED/REFRACTORY MULTIPLE MYELOMA

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OBJECTIVES: to treat relapsed/refractory multiple myeloma (RRMM). PATIENTS: Patients with RRMM between January 2007 and September 2013 were identified from US MarketScan databases. Outcomes included treatment regimen per line (L-1, -2, -3, -4), sequence, and cost per patient line and an analysis of cost. All-cause and MM-specific monthly costs were calculated, outpatient, emergency department, and drug-related costs, adjusted for censoring. RESULTS: 4449 MM patients initiated a 2L regimen, of whom 38% (n=1696) progressed to 3L and 15% to 4L. Cost of managing progressive disease in RRMM is high, as observed by the difference in costs before and after progression.

PCN119 TREATMENT STRATEGIES, HEALTH CARE RESOURCE USE AND COSTS OF AGGRESSIVE HISTOLOGICAL TYPES OF NON-HODGKIN LYMPHOMAS IN THE SLOVAK REPUBLIC. RESULTS FROM THE CROSS-SECTIONAL SURVEY IN THE HISTOLOGY-ONCOLOGY-NATURAL HISTORY (HOST-ROM) STUDY

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OBJECTIVES: the objective of this cross-sectional survey was to measure the resource utilization and costs associated with health-care management of patients with non-Hodgkin lymphoma (NHL) in Slovakia and to provide a basis for cost-effectiveness evaluations. The latest official data on epidemiology of all NHLs are available for year 2008, prediction to 2015 indicates that high-grade NHL incidence may increase to 9.3/100,000 (n=446 cases), from that DLBCL is estimated to be 311 cases (3.1/100,000). Overall point prevalence of all NHLs is estimated to 1,404 patients. METHODS: Descriptive data of 1,298 NHLs in Slovakia from 3 hospitals were collected and analyzed. All types of health-care services, treatment management and costs were analyzed. Continuous variables were calculated using standard descriptive statistics methods. RESULTS: 98.97% of patients were treated by the 1st line (L), of which 75% of NHLs (L1=97.01%, L2=1.99%) by rituximab. Proportion of remissions after 1stL, represented 63.47%, deaths 6.76% and progression/relapse 29.77% (95%CI:29.18%-30.36%), out of them 91.99% (95%CI:91.49%-92.50%) received 2ndL therapy. Proportion of remissions after 2ndL was 26.48%, deaths 11.27% and progression/relapse 62.25% (95%CI:62.16%-62.34%), out of them 91.04% (95%CI:90.42%-91.66%) received 3rdL treatment. Proportion of remissions after 3rdL represented 7.86%, deaths 35.68%, progression/relapse 57.61% (95%CI:56.99%-58.23%), in our study 29.45% of patients (95%CI:18.50%-22.41%) are re-treated with rituximab. Overall costs of patient on active treatment during therapy represented 1,690,809 (95%CI:1,571,31-1,648,72), in the post-treatment time 31.56 (95%CI:29.36%-33.10). Costs of palliative care represented 1,283,53/28 days (95%CI=1,197.88-1,367.92) and one-off costs 4,015.96 (95%CI:4,008.88-4,101.26). Costs of adverse events management ranged in the group 2 from 0.10/58/pain (95%CI=0.55-0.10) to 103.23/ fatigue (95%CI=105.78-117.73) to €4,518.06/other malignant tumors (95%CI=14,476.87-4,559.26). CONCLUSIONS: Results of this cross-sectional survey determined the treatment strategies and average direct cost per a-NHL patient and can be used for the purposes of pharmacoeconomic evaluations.

PCN120 TREATMENT PATTERNS AND HEALTH CARE RESOURCE USE (HCRU) ASSOCIATED WITH REPEATEDLY TREATED METASTATIC SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK (SCCHN) IN THE UNITED KINGDOM (UK)

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OBJECTIVES: Recent data characterizing metastatic SCCHN treatment patterns in the UK are limited. The current study evaluated treatment and HCRU in UK patients with metastatic SCCHN who received ≥3 lines of systemic