reversal from NMB, 30% use of neostigmine), and 2) sugammadex used in all cases. The model inputs included current practice patterns derived from the survey of experts, data on the reimbursement rates for different NMB cases by 93.6% and save 70 hours in operation room due to shorter period till extubation in comparison with base case scenario. The overall spending related to general anesthesia increased by EURO 20,510. In case of rational hospital management extubation in comparison with base case scenario. The overall spending related to NMB cases by 93.6% and save 70 hours in operation room due to shorter period till extubation in comparison with base case scenario.

CONCLUSIONS: The reduction of recovery time with sugammadex and NMB reversal from NMB data.

PMS25

A BUDGET IMPACT ANALYSIS OF BIOLOGIC DRUGS FOR TREATMENT OF POLIARTICULAR JUVENILE RHEUMATOID ARTHRITIS IN RUSSIA

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OBJECTIVES: To assess impact on the 3 year health care budget of 3 biologic drugs (BD) – abatacept, adalimumab and etanercept – provided for all eligible children with poliarticular juvenile rheumatoid arthritis (JRA) not responding to the standard therapy. METHODS: The indirect comparison of the results of randomized controlled trials (RCT) demonstrated that compared BD have approximately the same effect on the rate of disease flares in children with poliarticular JRA. We developed four scenarios assessing direct costs (drugs, medical services and sick leave payments for parents) in a tertiary hospital by the average wholesale price of BD and reimbursement from Russian cost of illness analysis of JRA and RCTs on the efficacy of BD. The costs estimation was based on the average wholesale price of BD and reimbursement rates in the compulsory medical insurance system. RESULTS: The lowest costs are expected in the scenario with abatacept – EURO 63 mln in comparison with EURO 134.18 mln for adalimumab and EURO 81.62 mln for etanercept and reimbursement from Russian cost of illness analysis of JRA and RCTs on the efficacy of BD. The costs estimation was based on the average wholesale price of BD and reimbursement rates in the compulsory medical insurance system.

CONCLUSIONS: It is possible to reduce doses and associated costs of BD. It is possible to reduce doses and associated costs of BD. The follow-up of patients in a specialized outpatient clinic leads to a better patient management and a cost reduction.

PMS26

STRATAFIX™ KNOTLESS TISSUE CONTROL DEVICE: A BUDGET IMPACT ANALYSIS FROM ITALIAN HEALTH SERVICE PERSPECTIVE

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OBJECTIVES: STRATAFIX™ Knotless Tissue Control Device is a new medical device. With significantly more points of fixation than traditional sutures, STRATAFIX™ gives surgeons more control in tension control over every pass, and combine the strength and security of interrupted closure with more efficiency than continuous closure. A budget impact analysis was developed to estimate the cost saving associated with use of new technology from the Italian Health Service perspective over a 1 year time horizon. METHODS: A literature review was conducted to evaluate the time savings in different procedures: hysterectomy and myomectomy (Gynecology), breast reconstruction and abdominoplasty (Plastic Surgery), proctectomy and nephrectomy (Urology), hip and knee replacement (Orthopedics). Moreover, a survey with clinicians was conducted to estimate the number of sutures used for the different procedures. The means and 95% confidence interval (95%-CI) for the budget impact was estimated using bootstrap methods (10,000 simulations) assuming lognormal distribution for costs and time data, and beta distribution for percentage data. RESULTS: Cost savings per procedure with STRATAFIX™ would be 217 ± 227 € for hysterectomy and myomectomy respectively, 274 ± 60 € for breast reconstruction and abdominoplasty, 56 ± 230 € for proctectomy and nephrectomy, 48 ± 50 € for hip and knee replacement. Considering the evolution of annual procedures performed with the introduction of STRATAFIX™, the cost saving associated will be about 1,340 ± 129 € (95%-CI: 218.530 - 3,089.771): 30% for myomectomy, 26% for breast reconstruction and 22% for hysterectomy. CONCLUSIONS: The additional costs for this new medical device permits to see an increased efficiency and to realize an increased number of interventions.

PMS27

GLOBAL VARIATIONS IN BIOLOGICS ACCESS AND RHEUMATOID ARTHRITIS TREATMENT:

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OBJECTIVES: Biological therapy is effective at slowing disease progression in Rheumatoid Arthritis (RA), particularly in severe RA. Recent clinical trials also demonstrated efficacy of biologics for moderate RA. However, access to biologics may be limited due to different criteria of reimbursement policies. Here we investigated the proportion of patients who receive biologics, and whether eligibility criteria were correlated with total costs per RA patient across a range of countries. METHODS: Published searches were performed to establish access to biologics for RA treatment. Eligibility requirements, percentage of patients who received biologics and cost per patient were extracted from a variety of sources. Simple regression analysis was used to compare total cost per patient and severity of RA (DAS score) required for biologic access. RESULTS: Regarding eligibility criteria, 16 out of 21 countries restricted biologics to patients with severe RA (DAS score > 5.1) and/or who failed 2 previous DMARDs. Eligibility was linked to reimbursement policy for 14 countries. New Zealand had the most stringent reimbursement criteria, with only 1 biologic reimbursed and limiting eligibility to severe, active erosive RA >6 months, 4 failed DMARDs including MTX, and DAS score >5.1. Taking into account the relative prevalence of severe RA (10% of RA patients) and biologics in Norway and Belgium, 10% access to health care for public. Still optimization of workflow processes is necessary.

PMS28

ASSESSMENT OF THE COST OF BIOLOGICAL THERAPY IN RHEUMATOID DISEASES: ECONOMIC IMPACT OF DOSAGE MODIFICATION IN CLINICAL PRACTICE

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OBJECTIVES: To evaluate the real annual cost of biological therapies (BT) in rheumatoid arthritis (RA) from 2012 and to compare total cost per patient and time spending, in daily clinical practice, with theoretical costs with conventional doses. To analysis the reduction of costs after creating BT outpatient clinic. METHODS: Cost minimization analysis based on an observational, cross-sectional study. Patients received AZA in a tertiary hospital based by the usual care protocol. The economic analysis was based on data BLS, and converted to 2012 USD.

RESULTS: Annual average cost (in Euros) of BT in patients with rheumatic diseases in clinical practice compared with theoretical cost. Secondary Variables: cost reduction in Euros after implantation of a specialized outpatient clinic of BT. Dose reduction protocol: After 6 months with label dose activity is assessed, if DAS28≥2.6 or BSAEAI≥4, the reduce the standard dose and we increase every 6 months to create 60% reduction. The sample included current practice patterns derived from the survey of experts, data on the published sources. Costs were estimated on the basis of data on governmental estimates based on the average wholesale price of BD and reimbursement from Russian cost of illness analysis of JRA and RCTs on the efficacy of BD. The costs estimation was based on the average wholesale price of BD and reimbursement rates in the compulsory medical insurance system.

CONCLUSIONS: It is possible to reduce doses and associated costs of BT. The follow-up of patients in a specialized outpatient clinic leads to a better patient management and a cost reduction.

PMS29

BURDEN OF INFUSION-RELATED COSTS AND STAFF TIME FOR RHEUMATOID ARTHRITIS IN THE HOSPITAL SETTING

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OBJECTIVES: Rheumatoid arthritis (RA) is a chronic autoimmune disease affecting 0.66% of the population in the US. Current RA infusions therapy incurs substantial cost and time to the hospital and patient. The purpose of this study was to model the infusion and related staff costs within a hospital center to better understand the economic and time burden of RA infusion therapy. METHODS: We developed an Excel model to estimate the annual time and cost burden associated with RA infusions therapy in a hypothetical hospital center. We assumed patients received infusions: tocilizumab, or rituximab. We obtained the number of annual maintenance infusions (13 infusions for abatacept [30 minutes each] and tocilizumab [60 minutes each]; 4 infusions for rituximab [195 minutes each]) per patient. The model projected annual direct costs and total value of staff time for infusion drug administration, infusion-related services, facility-related services, laboratory tests, and patient/caregiver costs. Costs were derived from the literature and adjusted to 2012 USD. 29.5% allocated overhead was applied. Infusion staff costs from published sources. The number of infusions were obtained from the literature and survey data, converted to annual wages using BLS data, and adjusted to 2012 USD. RESULTS: The baseline model estimated total annual costs and drug and service cost due to be $24,646 for abatacept, $7,840 for rituximab, and $31,339 for tocilizumab. Roughly 54%, 62% and 58% of these annual costs are associated with hospital labor, respectively. Patient/caregiver costs, comprising of lost wages and indirect medical costs, were estimated to be $7873, $7744 and $3139, respectively for each infusion.

Our findings show that direct and infusion-related contribute to a substantial economic and time burden to both the hospital and patient. These findings can help decision-makers assess the relative benefits and cost implications of administering infusion drugs to RA patients.