were performed on key variables and different vaccination scenarios. RESULTS: With 20% screen coverage and 20% vaccination among those screened positive, the incremental cost-effectiveness ratio (ICER) was $18,851 per QALY gained compared to baseline coverage and vaccination, and was cost-effective ($6,668 per QALY gained) assuming a willingness to pay of $100,000/QALY.

CONCLUSIONS: The model suggests that cervical cancer screening and vaccination programs are cost-effective compared to the base case, and can achieve much health benefit compared to screening alone. The coverage of the screening and the vaccination serve as a crucial factor of variations in the cost-effectiveness of different strategies. CONCLUSIONS: HPV vaccinations integrated into the current cancer screening programs are cost-effective compared to the current cancer screening programs, and can achieve much health benefit compared to screening alone. The coverage of the screening and the vaccination serve as a crucial factor of variations in the cost-effectiveness of different strategies. CONCLUSIONS: HPV vaccinations integrated into the current cancer screening programs are cost-effective compared to the current cancer screening programs, and can achieve much health benefit compared to screening alone. The coverage of the screening and the vaccination serve as a crucial factor of variations in the cost-effectiveness of different strategies.

PCN7 USE OF ABIRATERONE IN THE MANAGEMENT OF CASTRATION-RESISTANT PROSTATE CANCER: A REAL-LIFE COST-EFFECTIVENESS STUDY Rachael J. Vanhuyse, M. Aprikian, C. Curry, F. Kassouf, W. Dragomir A McGill University Health Centre, Montreal, QC, Canada Abiraterone acetate (Abi) therapy showed survival and clinical benefits in the treatment of metastatic castration-resistant prostate cancer (mCRPC) in Phase III trials. In Quebec, Abi reimbursement was approved for docetaxel-naive and refractory patients in 2014 and 2012, respectively. OBJECTIVES: Evaluate the cost-effectiveness and reimbursement of Abi treatment in the management of mCRPC/docetaxel. METHODS: The study cohort was selected from the public healthcare insurance programs: Régie de l’Assurance Maladie du Québec (RAMQ) and Med-Echo databases. It consisted of patients with mCRPC who received at least one line of chemotherapy and were treated with Abi from 2009–2010 (docetaxel), defined as pre-Abi era, and 2012–2013 (docetaxel + Abi), defined as Abi era. Survival was evaluated by Kaplan-Meier and the difference in survival between Abi and pre-Abi era was by log-rank test. Resource-utilization data were based on expert opinions through an expert panel. Mean survival was 114.7±15.11 vs 15.26±0.85; N=67 months in the pre-Abi vs Abi era (p<0.001). Mean treatment duration for Abi was 163 days (±108.7) and for docetaxel ± Abi was $49,650. As expected, the addition of Abi resulted in a cost increase of $645,976 per patient and a survival increase of $65,560 per life-year gained. CONCLUSIONS: Our real-life study indicates that patients receiving Abi plus docetaxel had a survival benefit when compared to chemotherapy alone. Addition of Abi was associated with an important increase in CRPC therapy costs.

PCN8 COST-EFFECTIVENESS OF IDRALISIB PLUS RITUXIMAB VERSUS PLACEBO PLUS RITUXIMAB FOR RELAPSED CHRONIC LYMPHOCYTIC LEUKEMIA: A COST-EFFECTIVENESS ANALYSIS Wu B., Seil B., Carlson J.T.1 1University of Washington, Seattle, WA, USA; 2Bayer HealthCare Pharmaceuticals, Whippany, NJ, USA BACKGROUND: No published economic evidence currently exists with regards to idelalisib for relapsed chronic lymphocytic leukemia (CLL). Given its recent approval, comparable products on the market, and the high cost of care in this setting, there is a need for additional information on the clinical and economic effectiveness of this agent. METHODS: We performed a partition survival model to evaluate idelalisib plus rituximab versus placebo plus rituximab. The study was conducted in three countries: the United States – Pre-Progressed, Progressed, and Death. The pivotal trial Study 116 (Furnman et al., 2014) served as the basis for this study by providing data on Progression-Free Survival (PFS) and Overall Survival (OS) duration, and adverse events. We used longer-term data from a trial of bendamustine plus rituximab in CLL plus Weibull cumulative distribution functions to extrapolate incomplete PFS and OS curves. Cost data was derived from Wolters Kluwer Health, Centers for Medicare and Medicaid Services databases, and publicly available literature. One-way and probabilistic sensitivity analyses were performed to evaluate uncertainty. We used a lifetime horizon, payor perspective, and a 3% discount rate. RESULTS: Total costs were $955,664 and $944,530 for idelalisib plus rituximab and placebo plus rituximab, respectively. The ICER was $6,668 and $698. The ICER for idelalisib plus rituximab was $3.02 to $6.06 per QALY gained. CONCLUSIONS: Idelalisib plus rituximab treatment was not cost-effective compared to placebo plus rituximab. If approved by payors, idelalisib plus rituximab may be an additional therapy for patients who have demonstrated treatment failure with a B-cell receptor tyrosine kinase inhibitor and for whom no alternative therapy is available.

PCN9 COST-EFFECTIVENESS OF EML4-ALK GENE TARGETED FIRST-LINE CERTINIB TREATMENT AMONG PATIENTS WITH ADVANCED ALK-POSITIVE NON-SMALL CELL LUNG CANCER Udaybhuja N., Atreja N. University of Houston, Houston, TX, USA OBJECTIVES: Mortality associated with the lung cancer is maximum among all cancer deaths. EML4-ALK gene is present in 3% of non-small cell lung cancer (NSCLC). Of these NSCLC patients, 5% are EML4-ALK gene positive patients. In these patients, standard therapy [platinum doublet (cisplatin and gemcitabine) as first-line therapy, pemetrexed as second-line therapy, and erlotinib as third-line therapy] has shown poor efficiency. In 2013, Crizotinib (MK-0427) was approved as a first line therapy based on the results from phase one study, under the orphan drug category for ALK+ NSCLC. This study aims to evaluate the cost-effectiveness of EML4-ALK fusion targeted crizotinib treatment as compared to standard therapy for ALK+ NSCLC. PROPOSED STUDY: Cost-effectiveness of ALK+ NSCLC patients with first-line treatment. The patients were divided into two groups: standard therapy and crizotinib therapy. CONCLUSIONS: This study suggests that the treatment by Crizotinib compared to the standard therapy was cost-effective based upon the decision analysis model. Study limitation includes non-inclusion of the cost of EML-ALK gene testing, which could change the total cost significantly.