variability in CERs for some drugs for different indications, in some cases also varying by biomarkers. Primary care drugs had lower and less variable CERs than specialty drugs. Variations also exist in methodology used by different groups in modeling cost effectiveness, especially for time horizon and comparator. Majority of primary care drugs were modeled for a time horizon of 35-40 years or lifetime to demonstrate cost effectiveness. Among the top 10 drugs, quetiapine and etoricoxib had the highest variability across different studies, and atorvastatin, salmeterol/fluticasone and clopidogrel had the most consistent ICER values across studies. CONCLUSIONS: This analysis shows the range, variability and methods used for calculation of ICER values for these high budget impact drugs and provides lessons for executives and policy makers.

A COMPARISON OF THE DISCRIMINATIVE AND EVALUATIVE PROPERTIES OF THE SF-36 AND THE SF-6D INDEX

Mutebi A1, Brazier J2, Walters S1
1University of Arizona, Tucson, AZ, USA, 2University of Sheffield, Sheffield, UK

OBJECTIVES: To examine whether the move from the SF-36 to the SF-6D entails a loss of discriminative and evaluative properties. METHODS: The study used relative validity (RV): a ratio of two F statistics, and standardized response means (SRM) to evaluate sensitivity and responsiveness of the SF-36 scales and SF-6D index. An RV of 1 reflected the most sensitive/responsive scale and the smaller the RV the less sensitive the measure would be. Combined criterion for interpreting effect sizes was used to interpret the SRMs. The data were used in a total of 10,089 subjects. No single SF-36 scale consistently had the largest RV or SRM, and there was no largest RV or SRM observed for the SF-6D index. The mean RV differences and mean SRMs differences between the SF-36 scales and the SF-6D index represented the loss or gain in sensitivity. RESULTS: Data were available from a total of 10,089 subjects. No single SF-36 scale consistently had the largest RV or SRM, and there was no largest RV or SRM observed for the SF-6D index in any condition studied. Comparisons showed the SF-6D index was more discriminative with a mean RV difference of 0.09 (95% CI 0.07 to 0.12) and more responsive with a mean SRM difference of 0.08 (95% CI 0 to 0.16) than the SF-36 scales. However, based on longitudinal RVs the index was less responsive with a mean RV difference of 0.07 (95% CI 0.01 to 0.15) than the SF-6D scales. CONCLUSIONS: Moving from the SF-36 to the SF-6D index entails a loss in evaluative strength and a loss/gain too small to matter given the merits of the index.

ELECTRONIC PRO VERSUS PAPER PRO: WHAT DO THE PATIENTS THINK?

Rous M, Murcott M
Ahm Clinical Technologies, Yardley, PA, USA

OBJECTIVES: To examine patients’ preferences and satisfaction on completing Patient-Reported Outcome (PRO) assessments in studies that compared paper and electronic data capture systems. METHODS: A literature search was conducted to gather articles that utilized ePRO. From that articles, a selected and reviewed that compared paper to ePRO and assessed for patient satisfaction/preferences. RESULTS: 119 articles were identified that utilized ePRO. 26 (21.8%) compared paper to ePRO. Of the 26, 17 (65.4%) reported on patient satisfaction/preferences. Electronic modalities consisted of handheld devices (70.6%), interactive voice response system (IVRS) (phone) (17.6%), electronic data capture system (5.9%) and both IVRS and handheld (5.9%). Patient satisfaction/preference was assessed through either interviews (41.2%) or questionnaires (58.8%). Patients reported preferring ePRO over paper in 88.2% of the articles. Positive aspects of paper included: familiarity, not dependent on technology that may malfunction and ease of reading. Negative aspects of paper included: forgetting to complete and burden. Positive aspects of ePRO included: like the diary’s appearance, convenient, ease of data entry, fast/efficient, saves trees, reminders, overall survey experience, more familiar, easier on eye, more up-to-date, and comfort in handling. Negative aspects of ePRO included: system problems/failures, difficulty to read, difficult to use, instructions could have been simpler, and inability to change reminder time or enter data late. CONCLUSIONS: As PRO are measures that come directly from the patients, it is important to identify their preferences and aspects of what makes their experiences more positive. These findings suggest that patients overall preferred ePRO and identified more positive aspects for ePRO. Both positive and negative aspects reported are equally valuable in identifying how PRO data collection can be improved to provide patients with the most positive experiences.