to be 194.4 compared with 194.1 for the Aledronic acid group, which resulted in a difference of 0.33 QALYs. The total costs for the Zoledronic acid group and Aledronic acid group were LE 215,232 and LE 215,087 respectively. These costs yielded an ICER of LE 435 for the Zoledronic acid group. The odds ratio of zoledronic acid on vertebral & non-vertebral fractures was found to have the greatest impact on CER. This was compared with our threshold stated by world health organization for middle and lower income countries, Zoledronic acid is cost-effective, and most likely to result in an ICER lower than the decision threshold. Thus, the treatment (Zoledronic acid) should be recommended in the Ministry of health list.

**PMS72**

**COST-EFFICACY ANALYSIS OF CANINUAMAB IN THE TREATMENT OF PATIENTS SUFFERING FROM SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS IN RUSSIAN FEDERATION**

Yagudina B, Kulikov A, Pochuprina A

1M. Sechenov First Moscow State Medical University, Moscow, Russia

**OBJECTIVES:** To conduct the cost-effectiveness analysis (CEA) of caninumab treatment group versus tocilizumab treatment group with systemic juvenile idiopathic arthritis (sJIA). METHODS: The incremental cost-utility analysis was performed with a Markov model with 10-state Markov Chain. The Markov model was used to simulate the lifetime progression of active PsA patients following a strategy for Brazilian healthcare system. These results were shown to be robust with the Macroeconomic input parameter and alternative treatment strategies currently available for moderate to severe rheumatoid arthritis (RA) from the perspective of the Brazilian healthcare system. RESULTS: A patient-level microsimulation model with a six-month length has been developed to measure the lifetime cost and quality-adjusted life-years (QALYs). The model was based on the Brazilian Therapeutic Guidelines for RA. The costs related to drug treatment and patient follow-up were taken into consideration. For such, the list price published by the Brazilian agency was used. The model was defined as payer health agency and funded by the list price of zoledronic acid. The costs of non-pharmaceuticals, such as lost productivity costs from SUS [Brazilian Unified Health System] (SIGTAP) and the website for healthcare information (TÁBNET) from the Ministry of Health. The probability sensitivity analysis was conducted with 50 first-order iterations and 500 second-order iterations, thus yielding a total of 25,000 iterations. An amount of BRL 81,667 was adopted as a limit of willingness to pay – equivalent to three times the national GDP per capita (2014). RESULTS: In all scenarios, the treatment arm including tofacitinib was shown to be dominant with lower costs and greater effectiveness – saving up to BRL 77,271.97. The probability sensitivity analysis (PSA) was also conducted showing that tofacitinib likely to be 52% more effective, 92% more economical and 87% more cost-effective for one of the scenarios. CONCLUSIONS: The integration of tofacitinib into the treatment strategy for moderate to severe RA is a dominant strategy for Brazilian healthcare system. These results were shown to be robust after completing PSA.

**PMS74**

**COST-EFFECTIVITY ANALYSIS OF CERTOLIZUMAB PEGOL FOR THE TREATMENT OF ACTIVE PSORIATIC ARTHRITIS IN GREECE**

Tzanetakos C, Vassilopoulou D, Kourlaba G, Christou P, Maniadakis N

1National School of Public Health, Athens, Greece, 2University of Athens Medical School, Hippokration General Hospital, Athens, Greece, 3Collaborative Centre for Health Economics, Athens, Greece, 4National School of Public Health, Athens, Greece, 5UCB Pharma, Athens, Greece

**OBJECTIVES:** To evaluate certolizumab pegol (CZP) relative to the other anti-TNFs, etanercept, infliximab, adalimumab and golimumab, and standard of care (SoC), among patients with active psoriatic arthritis (PsA), previously unresponsive to conventional disease-modifying antirheumatic drugs (cDMARD) METHODS: A Markov model was used to simulate the lifetime progression of active PsA patients from a healthcare payer perspective. The model assumed that non-responders stop treatment and move to SoC. At treatment initiation, a 12- or 24-week treatment response assessment period was assumed. Long-term treatment withdrawal and patient mortality rates were obtained from the literature. SoC was defined as a mix of cDMARDs based on expert advice. Clinical efficacy was modeled in terms of change in health outcomes in the measures of the ACR criteria.