min vs. 23.3 min, -65%). CONCLUSIONS: Time savings associated with Dimab SC injection were seen for all outcome measures. Owing for Dimab SC injection instead of Zol IV infusion should free up the hospital capacity to treat more patients, and decrease patients’ treatment burden in Italy.

PCN313
DESCRIPTION OF BASELINE CHARACTERISTICS OF PATIENTS PROVIDED CANCER CARE WITHIN A NOVEL COMMERCIAL HEALTH PLAN CANCER CARE QUALITY PROGRAM IN THE FIRST YEAR
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OBJECTIVES: The HIRE – Oncology contains clinical oncology data captured as part of the Cancer Care Quality Program (CCQP), a novel program by Anthem health plans designed to align reimbursement with evidence-based, cost-effective oncology treatment, that is integrated with administrative claims data in the HealthCore Integrated Research Database (HIRD). This study updates prior research describing the baseline characteristics of patients within oncology practices participating in the CCQP.

METHODS: Breast, colon, and lung cancer patients from HIRE-Oncology were identified between 6/23/2014 and 6/30/2015 (Intake Period). Patients were characterized by the following medications (Index Date) during the Intake Period, analyses included patients with ≥6 months of continuous pre-index eligibility. Baseline characteristics were stratified by cancer type/stage and included: pathology biomarkers, health care costs, and Deyo-Charlson Index (DCI).

RESULTS: A total of 2,206 breast, 554 colon, and 796 lung cancer patients were identified with mean (SD) ages of 64(10), 65(10), and 61(9) and 5(3.2), 7(2.6), and 7.8 (2), respectively. Stage distributions indicated the greatest proportion of breast cancer patients were stage II (36%, 73%), and 74% among breast, colon, and lung cancers patients. Pathology results among lung cancer patients demonstrated 78% and 22% with non-small cell and small cell cancers, respectively. 36% of breast cancer patients had HER2 positive status and 34% of lung cancer patients were detected with KRAS mutation, and 32% of colon cancer patients were detected with KRAS mutation among those reporting test results. Across all stages, total all-cause mean (SD) baseline health care costs were $503,000, $587,625, and $76,505(SD 59,064), respectively.

CONCLUSIONS: This updated analysis provides valuable initial insight into the demographic and clinical characteristics of patients within participating practices during the first year. HIRE-Oncology provides a comprehensive picture for commercially-insured oncology patients and baseline data for future program evaluation.

PCN314
ONCOLOGIST SUPPORT FOR AMERICAN SOCIETY OF CLINICAL ONCOLOGY (ASCO) CONSOLIDATED PAYMENTS FOR CANCER CARE MANAGEMENT IN THE UNITED STATES (US)
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OBJECTIVES: To assess physician support of the 2014 ASCO payment reform proposal, focusing on four components: 1) new patient payments- single payment for any new patient until treatment begins; 2) treatment month payments - each month the patient is treated; 3) active monitoring month payments - during months when the patient is not actively treated but receiving care and support; and 4) transition of treatment month payments from the patient to coverage before and after cross-over. RESULTS: 231 physicians participated (87% physicians, 13% medical directors; 67% hematologist/oncologists, 32.5% medical oncologists). Mean practice duration: 15yrs; 53% practice in an academic/community, 47% in group/solo private practice; geographic distribution: South:32%, Northeast:29%, Midwest:23%, West:17%. Only 7% rated the reimbursement climate as “excellent” (good:32%, satisfactory:42% not very good:20%); 18% rated the financial status of their cancer program as “excellent” (good:41%, satisfactory:13% not very good:7%, bad:4%). Physicians reporting that they “strongly” or “somewhat” support the components of the 2014 ASCO proposal: 1) new patient payments:47%; 2) treatment month payments: 57%; 3) active monitoring month payments: 55%; and 4) transition of treatment payments: 54%. Physician rating of “strong or somewhat support” based on perception of reimbursement climate (excellent:good vs. satisfactory/not very good:bad): 1) new patient payments:55%/42% 2) treatment month payments:66%/51% 3) active monitoring payments: 65%/48% 4) transition of treatment payments: 63%/50%. Strong/“somewhat” support based on perception of financial status of their cancer program (excellent/good vs. satisfactory/not very good:bad): 1) new patient payments:49%/44%, 2) treatment month payments: 61%/52%, 3) active monitoring month payments 60%/47%, 4) transition of treatment payments: 59%/47%.

CONCLUSIONS: About half of the physicians in the study supported the components of ASCO’s 2014 proposed payment reform, especially if they already considered the current reimbursement climate and financial status of the cancer program to be positive.

PCN315
G-BA DOES NOT ADJUST EVIDENCE REQUIREMENTS IN EARLY BENEFIT ASSESSMENT IN CASES OF PRE-DEFINED, EFFICACY-BASED CROSS-OVER DECISIONS IN ONCOCYRIOLOGY Trials
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OBJECTIVES: In Germany, an early benefit assessment (EBA) by the Federal Joint Committee (G-BA) is compulsory for all new drugs. This procedure, often called ‘cross-over’, is often seen in oncology clinical trials. Cross-over is usually employed for ethical reasons, i.e. to ensure access to a beneficial treatment for all patients, but may complicate data analysis by improving efficacy in the control arms. We aimed to analyse the impact of cross-over on evidence levels granted by the G-BA.

METHODS: Oncology medicines with completed EBAs by 01 Jan 2015 for at least 2yrs and managing at least 20 patients, were randomly sampled to participate in the G-BA. RESULTS: Cross-over was frequent in oncology, concerning 14 of 28 EBAs (50%). For 6 of the 14 medicines, cross-over could be considered ethically required as significant differences in overall OS (O) and OS were demonstrated before cross-over and ii) evidence levels granted by the G-BA (proof, indication or hint). RESULTS: Cross-over was frequent in oncology, concerning 14 of 28 EBAs (50%). For 6 of the 14 medicines, cross-over could be considered ethically required as significant differences in overall OS (O) and OS were demonstrated before cross-over. An evidence level of proof was granted by the G-BA for 3 out of the 14 medicines, all of which were orphan drugs, but none were granted for medicines with ethically required cross-over.

CONCLUSIONS: The G-BA regards evidences (EBA) with proof, indication or hint. However, cross-over with a strong and subsequently ethically justified cross-over deserves an evidence level of proof.

PCN316
QUALITATIVE ASSESSMENT OF SOCIETAL PREFERENCES FOR MARKET ACCESS OF CANCER DRUGS
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OBJECTIVES: The need and price for cancer drugs will increase while budgets are becoming more constrained. Policy makers need to make hard choices about which drugs are worthwhile. Inclusion of societal preferences in resource allocation is thus recommended by acumen and policy makers. This study qualitatively assesses societal preferences for market access of cancer drugs.

METHODS: Focus group discussions (FGD) with members of the general population in Flanders Belgium (n=20). Participants were recruited through flyers distributed in the University Hospitals Leuven and social media. First, the topic of budgetary constraints and resource allocation was introduced. Next, introductory statements based on ethical and economic considerations were used to set up the following discussions: characteristics of a patient, disease and drug that they would use to prioritize if there is only money to use/treat one of them. FGD were led by one researcher, video and audio recorded, transcribed and analyzed using thematic framework analysis. FGs were repeated until data saturation. Participants received a compensation of €20.

RESULTS: Three FGD with each six participants were conducted in February 2015. The median age of participants was 43 years (22-65, N=18). When participants were asked to define criteria they would use to prioritize patients, they mention age and life style of a patient and severity of the disease. They prefer to treat the largest patient group with the best prognosis. Drugs would be prioritized by participants based on the effect on quality of life, side effects and treatment duration.

CONCLUSIONS: Participants would like to maximize the benefits within a restricted budget, but conflicts between criteria such as prognosis and severity of disease crop up. Further research will quantify the relative importance and the trade-offs between criteria that society is willing to make through a discrete choice experiment.

PCN317
PRICE STRUCTURE ASSESSMENT OF SELECTED ONCOLOGY PRODUCTS IN CHINA, TAIWAN, SOUTH KOREA, BRAZIL, AND MEXICO
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OBJECTIVES: To assess supply chain and healthcare system structure for public price on oncologics in selected emerging markets. METHODS: Review of published price data and publicly available information from health authorities, 16K peer reviewed publications, 1K0 market research, and news followed by data from current payers and healthcare for validation and gap mitigation. RESULTS: In the selected countries, when comparing to the US pharmacy price as benchmark, oral targeted oncologics were priced lower than injectable oncologics. Brazil and the Mexican private sector saw the largest disparity with difference of approximately 40% between orals and injectables. Taiwan had the smallest difference between orals and injectables with only a 4% difference. China had the highest prices among the selected countries. In countries with both a public and private market, the prices in the public sector were always lower than those in the private sector. The ex-factory prices in the selected countries were much closer, with maximum 16% difference between lowest to highest price level. Brazil has the highest ex-factory price for orals with 72% and China has the highest for injectables with 77%. South Korea had the lowest ex-factory and pharmacy prices for both orals and injectables. CONCLUSIONS: The combination of no reimbursement, a regionalized approach to pricing, and a complex distribution chain has led to highest mark-ups at pharmacy level price in China among the selected countries despite having similar ex-factory prices. Due to tougher price negotiations in the public sectors, targeted oncology products enter the Brazil and Mexico markets in the private sector first then enter the public market which allows for greater the average price differential between public and private sectors.

With universal healthcare systems in South Korea and Taiwan and international price referencing the differences between orals and injectables and the mark up from ex-factory to pharmacy purchasing price is negligible.

PCN318
ANALYSIS ON TIME GAP BETWEEN APPROVAL AND REIMBURSEMENT OF TARGETED THERAPY TO ADVANCED COLORECTAL CANCER
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OBJECTIVES: Three target therapies for advanced CRC had been approved by TFDA since 2005; only two are under reimbursement now. Long reimbursement process had prevented advanced CRC patients from prescribing target therapy. This study is to use Cetuximab, the first reimbursed target therapy to evaluate the impact of

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