fracture incidence. For example, the published incidence_pop for spinal fractures for males age 80–84 is reported as 3.56/1,000 patient-years. Although incidence_pop is used as incidence_inc, our model predicted the fracture incidence accurately as 3.45/1,000 patient-years. CONCLUSIONS: The fracture incidence in non-risk patients in the base case is used as incident, and therefore the model may not be calculated accurately using this method based on the fracture incidence from the study population, the risk factor prevalence, and the relative risk increase associated with the risk factor.

PMS39 THE COST-EFFECTIVENESS OF ALTERNATIVE TREATMENT SEQUENCES IN RHEUMATOID ARTHRITIS

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OBJECTIVES: Many patients with rheumatoid arthritis (RA) fail to respond adequately to DMARDs and go on to failure with conventional synthetic antirheumatic drugs (cDMARDs). Biologic disease-modifying antirheumatic drugs (bDMARDs) have improved outcomes, and multiple guidelines National Institute for Health and Care Excellence (NICE) govern their prescription in England and Wales. The study aimed to determine the cost-effectiveness of alternative bDMARDs versus cDMARDs in patients who have failed to respond to at least two cDMARDs. METHODS: A discrete event simulation model was used to explore the cost-effectiveness of bDMARDs in combination with methotrexate versus cDMARDs. Populations of interest were patients with severe and moderate to severe RA who failed to respond to at least two cDMARDs including methotrexate (cDMARD-IR). In the severe population, eight alternative bDMARD strategies are compared against cDMARD-IR. In the moderate population, a single bDMARD strategy was compared against a cDMARD strategy. Strategies evaluated differed by the therapy with which the strategy began (a bDMARD or cDMARD) and the time horizon. Baseline data were derived from NICE guidance. The main outcome was the incremental cost-effectiveness ratio (ICER), expressed as cost per quality-adjusted life years (QALYs) saved. Each strategy was compared with the ICER of etanercept versus a cDMARD strategy (7 strategies strictly or extendedly dominated).

Based on the results of this analysis, a treatment strategy beginning with etanercept was considered to be the most cost-effective in patients with severe and moderate to severe RA who failed to respond to at least two conventional DMARDs.

PMS40 IMPACT OF PRICE REGULATION OF BIOLOGIC THERAPIES FOR RHEUMATOID ARTHRITIS IN COLOMBIA – A COST MINIMIZATION ANALYSIS

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OBJECTIVES: Following a recent price regulation for biopharmaceutical products in Colombia, we aimed to determine the impact on the cost of treatment with biologic therapies for rheumatoid arthritis in patients who failed to respond to oral DMARDs. METHODS: Current guidelines and evidence suggest similar efficacy and safety for all bDMARDs. Products available for the treatment of rheumatoid arthritis following DMARD failure include: abatacept, adalimumab, certolizumab, etanercept, golimumab, infliximab and tocilizumab. We compared the annual direct medical cost of treatment (including drug costs, administration and monitoring) with etanercept, golimumab, infliximab and tocilizumab. We compared the annual direct medical cost of treatment with etanercept, golimumab, infliximab and tocilizumab. We compared the annual direct medical costs of treatment with etanercept, golimumab, infliximab and tocilizumab. 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