clinical and quality of life benefi ts of iron defi ciency treatment in CHF patients using
Chronic heart failure (CHF) is associated with poor quality of life
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CABG. We also calculated the mean cost per case based on the total length of stay (LOS) for CITU, HDU, ward and
patiemnter implantation. We also calculated the mean cost per case based on the total length of stay (LOS) for CITU, HDU,
cardiac intensive care unit), HDU (high dependency unit), ward and pacemaker implantation. We also calculated the
mean cost per case based on the total length of stay (LOS) for CITU, HDU, ward and pacemaker implants of each of the isolated AVR and
valvular disease (AVR + CABG). The cost per TAVI case based on total LOS was £24,721 compared to £49,982 for AVR +
CABG. CONCLUSIONS: The cost consequence model was sensitive to long LOS on CITU and HDU in the
AVR plus CABG group. Using a cost consequences model cost TAVI was at worst cost neutral and at best most likely to deliver
substantial savings in this centre in this well de fined patient population. This fl nding is signifi cant in assessment of the “real”
cost impact for substituting TAVI for high risk conventional surgery patients.

HEALTH ECONOMIC ASSESSMENT OF FERRIC CARBOMMALTOSE IN PATIENTS WITH IRON DEFICIENCY AND CHRONIC HEART FAILURE IN THE FAIR-HF TRIAL
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OBJECTIVES: Chronic heart failure (CHF) is associated with poor quality of life resulting from physical and psycho-social limitations. The FAIR-HF trial showed clinical and quality of life benefi ts of iron defi ciency treatment in CHF patients using ferric carbomaltoose (FCM), an intravenous (i.v.) iron preparation. This study evalu-
cated the cost-effectiveness of iron repletion using FCM in CHF patients, from the perspectives of the statutory health insurance (Germany) and the National Health service (UK). (UK). Using data from FAIR-HF, a randomised, double-blind, controlled clinical trial (n = 459), per-patient costs and clinical effectiveness of FCM were estimated. Economic assessment was based on published costs associated with New York Heart Association (NYHA) functional classes. Effectiveness was assessed as the proportion of patients (n = 887) gained, derived from EQ-5D scores. The ICER of FCM was determined compared to placebo. Time horizon of this within-trial analysis was 24 weeks. RESULTS: In the FAIR-HF trial, NYHA classes were signifi cantly improved in the FCM group compared with placebo (P < 0.001). Estimated per-patient costs (excluding iron costs) were €262.25 and €291.99 (Germany), and €413.55 and €462.15 (UK), for FCM and placebo arms, respectively. Based on the reimbursed price for FCM in Germany and UK (£28 and £19 per 100 mg iron) and the mean iron dosage of the clinical study (1850 mg) plus administration costs, a net investment of £5374. The test
marker test which helps to decide whether patients with an intermediate risk should be treated with statins. METHODS: Prognosis of patients with an intermediate risk was simulated with a Markov chain Monte Carlo model to estimate the potential lifetime costs and effects (life-years (LY)) for three strategies: treat all with statins, treat none with status or use a test to select patients for statin treatment. Costs were calculated for the The Netherlands using a health care sector perspective. Values for all input parameter were derived from the literature. RESULTS: A strategy using a perfect test for a 35 year old man would be slightly more expensive than the treat-none option (£1966 vs. £1941) but less expensive than the treat-all option (£2819). The test and the treat-all option would be equally effective (24.45 LY) and more effective than the treat-none option (24.3 LY). An ICER of £170 versus treat-none indicates that it is a biomarker test with great potential. Results were sensitive to uncertainties regarding model parameters such as the sensitivity, specifi city and costs of the test as well as CHD risk, and the costs and effectiveness of statins. CONCLUSIONS: A test to reclassify patients in the Framingham intermediate risk group into higher and lower risk categories has the potential to optimize cost-effectiveness by preventing CHD and reducing the risk of drug side-effects. Values used in this model (e.g., test sensitivity and specifi city) can be adjusted wherever needed to determine whether continued development of a biomarker is worthwhile.

ECONOMIC PERFORMANCE OF DABIGATRAN ETEKLIATE FOR PRIMARY VTE PREVENTION FOLLOWING TOTAL HIP AND KNEE REPLACEMENT SURGERY IN ITALY
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OBJECTIVES: To estimate cost-effectiveness and costutility of dabigatran etexilate (DBG) compared to standard care for the prevention of venous thromboembolism (VTE) secondary to total hip replacement (THR) or total knee replacement (TKR) in Italy. METHODS: A decision analytic, Markov-chain based model originally
developed for the UK has been adapted to the Italian context. Clinical outcomes, including incidences of VTE and treatment-related adverse events, were extrapolated from head-to-head, phase III trials of DBG vs. enoxaparin. For the other low molecular weight heparins (LMWHs), indirect comparisons were performed on the basis of equal effectiveness assumptions. The adaptation involved cost and demographic character-
istics, leaving clinical and utility data unvaried. Costs are taken from national observa-
tional studies, where available. Otherwise, current prices and tariffs are applied. Resources consumed where derived from practice guidelines or taken from those estimated for the UK model. According to the prevalent national practice, extended prophylaxis has been considered in both surgical procedures. Time horizon of the analysis is patients’ lifetime. RESULTS: Compared to LMWHs, DBG is associated to an expected increase of 0.019 LY’s and 0.014 QALY’s per THR patient and of 0.024 LY’s and 0.019 QALY’s per TKR patient. DBG-related cost is lower than competitors in both procedures, with a mean difference ranging between £82 and £109 for THR, and 100 and 135 for TKR, depending on the considered comparator. Higher acquisition costs for DBG are completely offset and inverted by avoided administration expenses and, less importantly, by savings on VTE management. Probabilistic sensitiv-
ity analysis estimates that, for a willingness to pay threshold of £30,000 (~$43,300/ QALY, DBG is associated to a probability of being costeffective of about 98% for THR and of 90% for TKR. CONCLUSIONS: On average DBG dominates LMWHs, as it’s expected to be cost-saving and non-inferior in terms of efficacy and safety.