HCV prevalence, study perspective, discount rate, screening and antiviral treatment mode varied. The incremental effectiveness of HCV screening and early treatment compared to no screening and standard care varied from 0.0004 LYG to 0.066 LYG (0.0001–0.072 QALY). Incremental cost-effectiveness ratios (ICER) of HCV screening versus no screening ranged from 18,300 to €1,151,000/QALY. HCV screening seems to be cost-effective in populations with high HCV prevalence (€18,300–46,700/QALY), but is associated with higher ICER in populations with an average HCV prevalence. CONCLUSIONS: Based on current evidence, HCV screening and early treatment has the potential to improve life-expectancy and quality-adjusted life-expectancy, but should focus on populations with elevated HCV prevalence in order to be cost-effective. Further research on the long-term health-economic impact of HCV screening when combined with appropriate monitoring strategies in different European health care systems is needed.

**PIN30**

**COST-EFFECTIVENESS ANALYSIS OF DROTRECOGIN ALFA (ACTIVATED; DAA) AS A TREATMENT FOR SEVERE SEPSIS WITH MULTIPLE ORGAN FAILURE (MOF) IN POLAND**

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OBJECTIVES: To determine cost-effectiveness and cost-utility of DAA added to standard care compared to standard care in the treatment of severe sepsis with MOF from public payer's perspective in Poland. METHODS: Results of a systematic review of published clinical trials conducted according to Polish HTA Guidelines were used to assess effectiveness and safety of DAA. Data on reduction of 28-day all-cause mortality and probability of adverse events for patients treated with DAA or standard treatment reported in this study, baseline mortality of sepsis patients in Poland, probability of death during four years following intensive care and life tables for general population were incorporated into the decision tree model. A 24-year analytic horizon was established as life expectancy in general population of the same age and gender characteristics as sepsis patients. Epidemiology data were obtained from Polish Sepsis Registry. Cost-utility analysis was performed using utilities for sepsis patients and general population—derived from published literature. Costs of treatment valid from public payer’s perspective were taken into account. Costs of DAA, intensive care unit hospitalization, parenteral nutrition, physician consultations, bleeding and thrombotic events were included. All calculations were performed for 2007 (1EUR = 3.8PLN). Only effects were discounted (at 5% rate), as no costs occur beyond 1 year. Sensitivity analysis was conducted assuming range of cost for DAA, length of ICU stay, length of parenteral nutrition and discount rate for effects. RESULTS: Adding DAA to standard therapy of patients with severe sepsis and MOF significantly reduces 28-day mortality. Cost-effectiveness ratios are below the established thresholds (ICER = 42,517PLN, ICUR = 58,615PLN). Sensitivity analysis showed that these results are robust. CONCLUSIONS: DAA added to conventional treatment of severe sepsis with two or more organ dysfunctions is cost-effective from polish public payer’s perspective.

**PIN31**

**COST-MINIMIZATION ANALYSIS OF ETRAVIRINE AND RALTEGRAVIR, TWO NEW HIV TREATMENTS FOR TREATMENT-EXPERIENCED PATIENTS**

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OBJECTIVES: According to international HIV treatment guidelines, the goal of highly active antiretroviral treatment (HAART) is to reduce viral load to undetectable levels (<50 copies/mL). Two therapies have recently been introduced in the US with similar indications for treatment-experienced patients: etravirine (TMC125, ETR) and raltegravir (RAL). This analysis compares the relative cost of each therapy to reach the treatment goal. METHODS: The proportion of patients reaching undetectable viral load (<50 copies/mL) was reported in the phase II trials that compared each drug to placebo in the presence of optimized background regimen (OBR): DUET 1&2 (ETR) and BENCHMRK 1&2 (RAL). No head-to-head trials comparing ETR and RAL are available, so an indirect comparison at week 24 was made. The trials studied similar treatment-experienced HIV-1 infected patients, but the composition of the OBR differed. All patients received background darunavir/ritonavir (DRV/r) in the DUET trials, while less than half received background DRV/r in the BENCHMRK trials. Subgroup data from the BENCHMRK trials provided a 'prior' estimate of the treatment effect modification due to DRV/r use. A Bayesian analysis was used to adjust for differences in background DRV/r use between trials. The current analysis estimated the treatment effect assuming that all patients received background DRV/r. After adjusting for differences in the trials, efficacy and wholesale acquisition drug costs were analyzed. RESULTS: The two new agents demonstrate a similar treatment effect when adjusting for differences in OBR. Mean odds ratios (95% CI) vs. placebo are: ETR 2.08 (1.64–2.6) and RAL 1.92 (0.98–3.42). The annual drug costs are $7957 for ETR and $9855 for RAL. CONCLUSIONS: Based on the results showing similar efficacy rates in reaching the treatment goal of <50 copies/mL, a cost-minimization approach can be taken when evaluating the addition of ETR or RAL to a HAART regimen for treatment-experienced patients.

**PIN32**

**COSTS OF INTERMITTENT VERSUS CONTINUOUS ANTIRETROVIRAL THERAPY IN PATIENTS WITH CONTROLLED HIV INFECTION. A SUBSTUDY OF THE ANRS 106 WINDOW TRIAL**

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OBJECTIVES: To test the hypothesis of a reduction in total medical costs we conducted a cost-study analysis in the setting of a randomized open-label study comparing an intermittent to a continuous antiretroviral regimen. METHODS: A total of 403 HIV-1-infected adults who were well tolerating HAART were randomly assigned to switch to a fixed 8-week off 8-week on regimen with or without placebo monotherapy. RESULTS: Complete cost data were available for 391 patients (194 patient in the CT and 197 in the IT arms). The mean cost per patient over the 96 weeks follow-up (excluding protocol-driven costs) was €16,162 in the CT arm versus €9738 in the IT arm, a €6424 difference almost entirely due to the difference in HAART cost. Protocol-driven costs represented €280 in the CT versus €290 in the IT arm. The use of IT achieved a 40% reduction in the total cost of HAART. CONCLUSIONS: Reducing by 40% the cost of HAART medications in a treatment