A442

VALUE IN HEALTH 18 (2015) A335-A766

as a second line treatment without increase of the total national CML budget in 2014.

PCN70

RADIO-223 IN THE TREATMENT OF METASTATIC CASTRATION RESISTANT PROSTATE CANCER: BONE METASTASIS: BUDGET IMPACT ANALYSIS OF THE NATIONAL HEALTH SERVICE
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OBJECTIVES: Castration resistant prostate cancer with bone metastases (mCRC) is a common condition associated with high medical and indirect healthcare costs. Purpose of this analysis is to estimate the economic consequences of inclusion of Radio-223 dichloride in the treatment of prostate cancer with definition of a Budget Impact Analysis (BIA) from the perspective of the National Health Service (NHS).

METHODS: Budget Impact Analysis was conducted on the basis of patients included in the Health Economics Board (BIM), in the province of Milan. The costs of treatment given to the castration resistant prostate cancer (mCRC), and as a result of the introduction of Radio-223 dichloride. In the assessment it was assumed that all the formulations present the same effect, ie that they present the same probability of efficacy in the treatment of metastatic castration resistant prostate cancer. The results of the BIA showed that full coverage of the screening by the statutory health insurance, through performing the sampling and full coverage of the screening by the statutory health insurance, were added HPV DNA testing for women over 35, self-sampling kits sent to women over 35, pay for performance (P4P) incentives allocated to general practitioners (GP) for the analysis is three years. Five plausible scenarios aimed towards the whole non-invasive (social security, ministry of health, patients and professionals). Time horizon of (INCa) and an expert board involving clinical experts and stakeholder representatives was developed in collaboration with the French National Institute of Cancer (INCa) in France. The budget impact analysis showed that full coverage of OS might be the most cost-effective way to implement it, although this has practical and financial issues such as change in the first and second line costs of treatment, which did not provide further participation despite a high cost and the one based on P4P incentives towards GP, although it allows high participation rates.

CONCLUSIONS: Using a comprehensive BIA, we show that full coverage of OS might be the most cost-effective way to implement it, although this has practical and financial issues such as change in the first and second line costs of treatment, which may be more balanced regarding the distribution of costs between stakeholders or may be more easily implemented and accepted by health professionals.

PCN73

BUDGET IMPACT ANALYSIS OR PHARMACOLOGICAL THERAPY OF CHRONIC MYELOID LEUKEMIA (CML) WITH NILOTINIB AS THE SECOND LINE TREATMENT IN RUSSIAN FEDERATION
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Methods: Nilotinib, is provided by Pharcma for the treatment of patients covered by the regional state reinsurance program (FSRP) of high-cost nosologies and by regional budgets. Now, the reimbursement list of high-cost drugs includes only first generation tyrosine kinase inhibitor (TKI) – imatinib. However, there is a problem with access of patients with CML to second generation TKI. Thus, it is important to provide pharmacoeconomic assessment of introducing second generation TKI into FSRP. OBJECTIVES: To provide budget impact analysis (BIA) of including second generation TKI (nilotinib) into reimbursement list of high-cost drugs of FSRP for second line treatment of patients with CML. METHODS: BIA, as a part of this health economics research was developed on the basis of decision tree and Markov model. The perspective of the study was FSRP of high-cost drugs, so the cost of nilotinib and imatinib were considered. Real consumption of medicine was used. Tender prices of FSRP for imatinib and regional tender prices for nilotinib were used. Exchange rate 1 Euro = 50 Rub. RESULTS: Annual cost per patient for nilotinib in the first line CML patient in chronic phase was 636 Euro. While, in patients in accelerated phase and the second line treatment patients needed high dose imatinib treatment that costs 12672 Euro. Annual cost per patient for nilotinib in the second line CML patient in chronic phase was 354040 Euro. Total current expenditures for FSRP are 7,660,642 in the first year and 1,686,463 RUB and 2,283,237 RUB when using everolimus and axitinib respectively. Duration of overall survival by 27% were observed. The total cost per patient amounted to 1,686,463 RUB and 2,283,237 RUB when using everolimus and axitinib respectively. Moreover, everolimus therapy was less costly compared to axitinib therapy. Thus, the conclusions: Inclusion of nilotinib into FSRP does not exceed total current expenditures for CML and may improve patient access for effective treatment.

PCN74

MACROECONOMIC ANALYSIS OF THE USE OF EVEROLIMUS COMPARED TO AXITINIB IN SECOND LINE THERAPY OF PATIENTS WITH METASTATIC RENAL CELL CARCINOMA
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OBJECTIVES: The aim of the study was to conduct a health economic evaluation using everolimus and axitinib in patients with metastatic renal cell carcinoma (mRCC) using a Markov decision analysis. Data for everolimus and axitinib were based on probabilistic sensitivity analysis. Stability of results to changes of external factors was evaluated by performing a probabilistic sensitivity analysis. RESULTS: An analysis showed that the use of everolimus was less expensive than the use of axitinib. At the same time a decrease in the probability of adverse events was assessed and the time duration of overall survival by 27% were observed. The total cost per patient amounted to 1,686,463 RUB and 2,283,237 RUB when using everolimus and axitinib respectively. Comparatively, second line therapy was less expensive and at the same time, is more effective, i.e. it is dominant in relation to axitinib when considering such effectiveness criteria as overall survival and progression-free survival. The results of sensitivity analysis confirmed results of the baseline scenario regarding the economic feasibility of everolimus usage. The results of the budget impact analysis showed potential savings of budget in case of using everolimus, which provides an opportunity to treat additional patients with mRCC with no additional expenditures on the part of health care system. CONCLUSIONS: Everolimus showed a longer duration of overall survival in patients with mRCC after ineffectiveness of the first-line therapy. Moreover, everolimus therapy was less costly compared to axitinib therapy. Thus, the results of the study showed that everolimus is a cost-effective strategy, as it is characterized by greater efficiency and lower costs.

PCN75

A442

VALUE IN HEALTH 18 (2015) A335-A766

WHAT IS THE MOST COST-EFFECTIVE WAY TO SET-UP ORGANISED CERVICAL CANCER SCREENING IN FRANCE? A BUDGET IMPACT ANALYSIS
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3Objectives: According to the third National plan, organized screening (OS) cervical cancer among women aged 25-65 should be implemented in the forthcoming years in France. The most cost-effective way to implement OS in the French health care system in regard of this objective is yet to be determined.

METHODS: A budget impact model (BIM) was developed to evaluate the relationship with the French National Institute of Cancers (INCa) and an expert board involving clinical experts and stakeholder representatives (social security, ministry of health, patients and professionals). Time horizon of the analysis is the second five-year period. The model was based on the whole population who were assumed to be in the model. Those were derived from a basic scenario consisting of a mailed invitation followed by a mailed recall to which were invited HPV DNA testing for women over 35, self-sampling kits sent to women over 35 and the exclusion of P4P (Pharmacoeconomic incentives for providers) on the total medical fee, whose eligible patients become participant, diversification of health professionals performing the sampling and full coverage of the screening by the statutory health insurance. RESULTS: The “full coverage scenario” is the most cost-effective, followed by the scenario with self-sampling kits sent to women, the scenario with increased diversity of the health professionals and the basic scenario. The costliest scenarios were the one implementing HPV DNA testing which did not provide further participation despite a high cost and the one based on P4P incentives towards GP, although it allows high participation rates.

CONCLUSIONS: Using a comprehensive BIM, we show that full coverage of OS might be the most cost-effective way to implement it, although this has practical and financial issues such as change in the first and second line costs of treatment, which may be more balanced regarding the distribution of costs between stakeholders or may be more easily implemented and accepted by health professionals.