tivity analysis was conducted and confirmed the robustness of the results. CONCLUSIONS: Findings suggest XELOX as a cost-saving therapy for the first line treatment for mCRC under the payer perspective in Brazil when compared to FOLFOX-6, when compared to FOLFOX-6.

**PCN49**

**COST-MINIMISATION ANALYSIS OF MAINTENANCE THERAPIES FOR PROSTATE CANCER IN THE UK**

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**OBJECTIVES:** to compare the costs of maintenance therapy with currently used preparations for hormone-sensitive prostate cancer with a new leuprorelin 6-month depot (L6) preparation.

**METHODS:** Patient data were extracted from the IMS Disease Analyzer observational database. UK patients with a diagnosis of prostate cancer and three or more prescriptions for goserelin or leuprorelin were eligible. Individual prescription events were included if they were for goserelin 28-day depot (G28) or 12-week depot (G84) or for leuprorelin one month or 3-month depots (L1 and L3). Total cost included drug cost, physician and nurse visits, prostate specific antigen (PSA) testing, and payments for implant administration. The cost of treatment with a newly available L6 was estimated by varying the daily drug cost, and assuming resource use equivalent to L3. **RESULTS:** 118 patients reported 1262 prescriptions for L3 compared to 600 patients (8433 prescriptions) for G84, 36 patients (489 prescriptions) for L1 and 272 patients (2984 prescriptions) for G28. A separate visit for implant administration was required for 35% of prescriptions with L3, 29% with L1, 41% with G84 and 28% with G28. PSA testing, although recommended in the UK, occurred infrequently around the time of prescription (5% of events). The cost per patient of one year of treatment was £1656 with L3, £1507 (G84), £1949 (L1) and £2121 (G28). The cost of one year treatment with L6 if based on the daily drug cost of L3, would be £1580. Applying the daily drug cost of G28 resulted in £1169, while applying the G84 daily cost increased it to £1235. Patient drug costs ranged from 52% of the total cost (G28) to 95% (L6). **CONCLUSIONS:** The cost of maintenance therapy for hormone-sensitive prostate cancer is lower when longer-acting preparations are given, due principally to reductions in non-drug cost such as GP visit costs.

**PCN50**

**COST-MINIMIZATION ANALYSIS OF ERLOTINIB VERSUS DOCETAXEL OR PEMETREXED AS A SECOND-LINE TREATMENT OF ADVANCED NON-SMALL LUNG CANCER (NSCLC) IN THE CONDITIONS OF THE CZECH REPUBLIC**

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**OBJECTIVES:** To assess the pharmacoeconomic evaluation of erlotinib used in the second line treatment of metastatic and developed locoregional non-small lung cancer in the conditions of the Czech reimbursement policy. We compared costs of tyrosine-kinase inhibitor erlotinib with the other cytostatic agents docetaxel and pemetrexed recommended according to Czech oncological guidelines. **METHODS:** In the absence of head to head studies we used data based on clinical trials comparing docetaxel and pemetrexed (JMEI) and BR21 study comparing erlotinib and placebo. We conducted cost-minimization analysis from the perspective of the payer. We calculated costs of drugs, administration, monitoring, premedication, transport of patients and management the hematologic toxicities. Prices of drugs were based on the list of reimbursement of drugs provided by an reimbursement agency (State Institute for Drug Control) and payments for health interventions were collected from the prices of health care published by health insurance companies. **RESULTS:** The costs were calculated for four therapeutic cycles which referred to median number of cycles administered in the clinical trials and it was in a concordance with the median value of progression-free survival. The total costs associated with therapy were €207,238, €131,720 and €320,000 CZK (£8,635, £5,488 and £13 333) for erlotinib, docetaxel and pemetrexed. The acquisition cost was €310,720 CZK (£12,429) for pemetrexed, 206,565 CZK (£8,263) for erlotinib and 104,832 (£4,193) for docetaxel. Erlotinib has more favourable tolerability profile whereas the cost of adverse events in docetaxel arm was 23,388 CZK (£936) and in pemetrexed arm 5,969 CZK (£239). Also the administration, monitoring and transportation costs of erlotinib was significantly lower than for docetaxel and pemetrexed. **CONCLUSIONS:** The less costly alternative in second-line therapy of metastatic non-small lung cancer was docetaxel because of lowest acquisition price. Erlotinib has lowest toxicity, administration and transportation cost. The cost of erlotinib is partly compensated by the reduction of toxicity and management/administration costs.

**PCN51**

**POTENTIAL ECONOMIC AND HEALTH IMPACT OF GENOMICS AND PROTEOMICS TECHNOLOGY FOR THE TREATMENT OF ACUTE MYELOID LEUKEMIA**

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**OBJECTIVES:** Current technology does not adequately predict the prognosis of patients with acute myeloid leukaemia (AML). Many patients therefore undergo unneeded but costly and toxic treatment. However, innovative approaches using genomics, epigenomics and proteomics technology are being developed to ameliorate this problem. The aim of this study was to estimate the potential economic and health impact of these technologies for AML. **METHODS:** This study was based on a literature review and expert opinion regarding the epidemiology, clinical practice and costs relating to AML and its treatment. Data were subsequently analysed using decision modelling. **RESULTS:** Conventional methods help to divide patients into three categories: favourable prognosis (20% of patients, >60% chance of survival); intermediate prognosis (60%, 30–40%); and poor prognosis (20%, <20%). Improved diagnostics would reduce the frequency and costs of unneeded treatment (chemotherapy, stem cell transplantation). Specifically, it could reassign some intermediate prognosis patients to the favourable prognosis category (approx. 10%) and others to the poor prognosis category (approx. 20%). Cost-savings could be €10,000–15,000 per patient assuming average costs of €100,000. Avoidance of unnecessary therapy would also lead to reductions of side-effects. While better diagnostics would also result in some extra costs because of treating patients more intensively, these treatments would also lead to health gain. Given current diagnostic costs of €1500–5000 per patient and the high volume of tests, the cost reduction achievable by improving AML diagnostics would save millions of euros per year. **CONCLUSIONS:** Improved AML diagnostics would reduce some diagnosis, prognosis, and treatment costs. Any increased treatment costs would be coupled with health gain. In addition, rapid testing would reduce the time needed to develop a treatment plan and may thereby improve prognosis.