promote market access leverage. METHODS: Across the United States, 100 medical and health care professionals and 25 market analysts in the pharmacy and medical directors completed online quantitative surveys to capture their views on BTD. RESULTS: Surveyed payers were unanimous that BTD will influence formulary decisions for oncology drugs; some 40% said BTD would result in more favorable tier placement, while 37% expect fewer prescribing controls. However, none of our surveyed payers considered themselves yet very familiar with the BTD pathway. In contrast, one third of surveyed oncologists declared themselves to be very familiar with BTD. All oncologists said that the BTD approval and priority decision making on BTD. CONCLUSIONS: BTD instills confidence in payers and prescribers, such that this accolade looks set to positively influence reimbursement conditions, trigger uptake, and promote market access for a given agent. Moreover, associating BTD with accelerated approval and priority review likely further inspires positivity towards BTD agents. However, that payer respondents are at least somewhat unfamiliar with the BTD pathway must be considered. Manufacturers with BTD may therefore need to take a proactive role in ensuring that payers are fully aware of the benefits and advantages that secured this classification.

PCN142 OPIOID PRESCRIPTION TRENDS IN THE RURAL US: EVIDENCE FROM THE NATIONAL AMBULATORY MEDICAL CARE SURVEY (NAMCS) DATA 2006-2010

METHODS: We used the National Ambulatory Medical Care Survey (NAMCS) data available for the years 2006-2010. The NAMCS is a representative sample of the provision of outpatient medical care services in the US. Main outcome measure was opioid drug prescribed. Survey weighted logistic regression models were fit to determine factors influencing opioid prescribing. RESULTS: Opioid prescriptions increased from 10% in 2006 to 12% in 2010. There was an upward trend in opioid prescribing (11% in 2006, 12% in 2007, 14% in 2008, 15% in 2009 and 2010) as compared with urban location (10% from 2006-2008, 12% in 2009 and 11% in 2010). Primary care physicians and medical professionals were more likely to prescribe opioids (13% in 2006, 12% in 2007, 16% in 2008, 17% in 2009 and 14% in 2010) as compared with surgeons (6%, 11%, 10%, 10%, 10% respectively). Multivariate analyses revealed that the over the years, younger patients (55-49 and 50-64), who did not have a cancer diagnosis, and were insured by Medicare paid for insurance were more likely to get opioid prescription, while patients seen by surgeons were less likely to get opioids. CONCLUSIONS: Our study poses significant implications for healthcare professionals and policy makers. Our study results not only demonstrated that rural residents were more likely to be prescribed opioids but it showed an upward trend in rural opioid prescribing which was significantly different from urban locations. Increased prescribing of opioids, has led to a growing problem of prescription drug abuse especially among rural residents. Further research is warranted to study the extent of over prescribing and abuse in rural communities.

PCN143 PCDR – THE POINTLESS CANADIAN ONCOLOGY DRUG REVIEW

OBJECTIVES: To understand the trends in opioid prescribing and to determine whether rural residency impacts opioid prescribing. METHODS: We used the National Ambulatory Medical Care Survey (NAMCS) data available for the years 2006-2010. The NAMCS is a representative sample of the provision of outpatient medical care services in the US. Main outcome measure was opioid drug prescribed. Survey weighted logistic regression models were fit to determine factors influencing opioid prescribing. RESULTS: Opioid prescriptions increased from 10% in 2006 to 12% in 2010. There was an upward trend in opioid prescribing (11% in 2006, 12% in 2007, 14% in 2008, 15% in 2009 and 2010) as compared with urban location (10% from 2006-2008, 12% in 2009 and 11% in 2010). Primary care physicians and medical professionals were more likely to prescribe opioids (13% in 2006, 12% in 2007, 16% in 2008, 17% in 2009 and 14% in 2010) as compared with surgeons (6%, 11%, 10%, 10%, 10% respectively). Multivariate analyses revealed that the over the years, younger patients (55-49 and 50-64), who did not have a cancer diagnosis, and were insured by Medicare paid for insurance were more likely to get opioid prescription, while patients seen by surgeons were less likely to get opioids. CONCLUSIONS: Our study poses significant implications for healthcare professionals and policy makers. Our study results not only demonstrated that rural residents were more likely to be prescribed opioids but it showed an upward trend in rural opioid prescribing which was significantly different from urban locations. Increased prescribing of opioids, has led to a growing problem of prescription drug abuse especially among rural residents. Further research is warranted to study the extent of over prescribing and abuse in rural communities.

PCN144 PRIORITY ACCESS FOR THE BIGGEST – VARIABLE PROVINCIAL ACCESS TO ONCOLOGY DRUGS IN CANADA

OBJECTIVES: To be considered for funding at a provincial level, all oncology drugs are appraised at a national level by the pan-Canadian Oncology Drug Review (pCODR), except in Quebec. This research aims to explore whether there are any differences between the speed of provincial oncologic access and whether this varies by provincial wealth and/or population. METHODS: All publically available provincial funding summaries were extracted from the Government of Canada statistics website. Statistical comparisons were performed using one-way ANOVA and Student’s t-tests. RESULTS: The average delay between pCODR recommendations and provincial funding decisions was 8.9 months, which significantly varied by province (p<0.001), with the lowest being British Columbia (8.2 vs 15.1 months, p<0.0001). The provinces with populations lower than 1 million experience significantly greater delays to access versus the 5 provinces whose population exceeded 1 million (12.4 vs 6.1 months, p<0.001). The 4 provinces with populations > 1 million experience significantly faster time to access than the 5 provinces whose GDP is lower than this (5.1 vs. 12.0 months, p<0.005). However, this relationship does not reach significance when GDP is examined on a per capita basis (top 4 provinces: 7.2 months vs. 9.6 months for the bottom 5, p=0.11). CONCLUSIONS: There are significant variations in time to access for oncology drugs between different provinces. This is significantly related to the province population and overall wealth but not wealth on a per person basis. Further research can define whether these differences reflect provincial assessments or whether pharmaceutical companies are prioritising larger provinces where better market returns can potentially be realised.