is more costly than BSC, it is more effective. Using the US $50,000/QALY incremental cost-effectiveness threshold, sunitinib seems to be cost-effective in the second-line treatment of mRCC in Argentina.

THE RELATIONSHIP BETWEEN SHORT-TERM RESPONSE AND LONG-TERM OUTCOMES IN PATIENTS WITH CHRONIC PHASE CHRONIC MYELOGENOUS LEUKAEMIA

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OBJECTIVES: Chronic myelogenous leukaemia (CML) is a progressive disease that is associated with significant health and economic burden. Although durable response from current treatments such as imatinib is achievable for many patients, a subset of patients develop resistant disease. This study aims to predict the impact of short-term response upon the cost-effectiveness of new interventions to treat CML. METHODS: A Markov model was developed to estimate the non-drug costs and health outcomes associated with treatments for chronic phase CML. Two hypothetical treatment options were modelled, each with a different short-term best response profile. Short-term response was defined as “no response” (NR), “complete haematological response” (CHR), partial cytogenetic response (PCR) and complete cytogenetic response (CCR). Patients progressed through the stages of the disease at different rates, based on their short-term best response to treatment. Unit costs were drawn from national databases, and were factored according to resource use to estimate total costs. Because the purpose of this study is to inform the cost-effectiveness of novel treatments, drug costs are not included in the model. Resource use and quality-adjusted life year (QALY) scores were stratified according to the patient’s current health status and response level. RESULTS: Patients who achieve no response are estimated to experience a total of 1.48 QALYs and incur costs of £39,724 over their lifetime. Those who achieve CHR, PCR and CCR experience 5.11, total of 1.48 QALYs and incur costs of £66,562 respectively. Sensitivity analyses revealed the cost premium associated with DARB Q3W therapy to be between 13% and 42%, indicating that direct medical cost of EPO QW therapy was consistently lower than that of DARB Q3W. CONCLUSION: This economic analysis demonstrated that direct medical costs for DARB Q3W therapy was consistently higher than EPO QW, with cost premiums associated with DARB Q3W ranging from 13%–42%. Drug cost was the major driver of total direct medical cost in both groups.

MEDICAL COST CONSIDERATIONS OF FIXED DOSING REGIMENS OF ERYTHROPOIETIC AGENTS IN PATIENTS WITH CHEMOTHERAPY-INDUCED ANEMIA

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OBJECTIVES: Anemia is commonly experienced by cancer patients receiving chemotherapy. Two erythropoietic agents have been FDA-approved for fixed dosing in patients with chemotherapy-induced anemia (CIA) [poetin alfa (EPO) 400 Units QW, darbepoetin alfa (DARB) 500 mcg Q3W]. The current analysis was conducted to compare medical costs between approved EPO and DARB dosages based on clinical data from two 16-week, randomized, controlled trials (Canon JNCI 2006, Waltzman Oncologist 2005). METHODS: A cost-minimization analysis was utilized to compare direct medical costs (drug acquisition and visit costs) of treating patients with EPO QW versus DARB Q3W. Drug cost was based on December 2006 U.S. wholesale acquisition cost (EPO $12.52/1000 Units; DARB $4.46/mcg). Visit cost was calculated based on physician office visit and injection cost ($53.27). Sensitivity analyses were conducted on drug cost, physician visit cost, hemoglobin monitoring, and transfusion requirements. RESULTS: Results from the base case scenario showed that direct medical costs of treating patients with DARB Q3W was $1595 more expensive (28% cost premium) than treating patients with EPO QW ($5795 for EPO QW vs. $7390 for DARB Q3W). Drug cost represented 90% of total direct medical costs in both groups (EPO: drug cost $5239, visit cost $55; DARB: drug cost $7149, visit cost $240). Sensitivity analyses revealed the cost premium associated with DARB Q3W was consistently higher than EPO QW, with cost premiums associated with DARB Q3W ranging from 13%–42%. Drug cost was the major driver of total direct medical cost in both groups.