utilities for pazopanib and placebo were from PALETTE. Lacking a connected evi-
dence network, estimates of relative effectiveness for trabectedin and ifosfamide were from an unadjusted indirect treatment comparison pazopanib vs. placebo. Costs were from NHS reference costs and other published sources. RESULTS: Compared with placebo, pazopanib is estimated to increase QALYs by 0.130 and costs by €8,072; the incremental cost-effectiveness ratio (ICER) for pazopanib vs. placebo is estimated to be €26,261/QALY gained. For most parameters, the ICER changed < ±50% in the parameter value. Compared with trabectedin and ifosfamide, pazopanib provides equal or more QALYs at a lower cost. CONCLUSIONS: From a UK health care system perspective, pazopanib may not be cost-effective vs. placebo in patients with advanced/metastatic STS based on criteria typically used to evaluate therapies in the UK. Pazopanib may be cost-effective vs. trabectedin and ifosfamide, although there is substantial uncertainty associated with these compari-
sions.

PCN84

ABIRATERONE ACETATE VERSUS CABAZITAXEL IN THE TREATMENT OF METASTATIC CAstration-RESISTANT PROSTATE CANCER: AN ECONOMIC EVALUATION IN THE GREEK HEALTH CARE SETTING

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OBJECTIVES: The purpose of this study was to explore the cost-effectiveness of abiraterone acetate (abiraterone) vs. cabazitaxel in metastatic castration-resistant prostate cancer (mCRPC) patients who progressed after docetaxel from the Greek health care perspective. METHODS: As no head-to-head trial data were available for abiraterone versus cabazitaxel, an indirect cost-effectiveness analysis was developed using clinical data (progression free survival [PFS], overall survival [OS], ad-
verse events [AEs]) from the pivotal Phase 3 clinical trials COU-AA-301 (abiraterone) and TROFIC (cabazitaxel). The basic assumption in the model was that both compar-
ators arms in the trials were ‘palliative’ and therefore equivalent. Resource use, particularly for the management of AEs, was estimated based on data from Alex-
andra University Hospital in Athens. For validation purposes, a secondary analysis was conducted using UK resource use data. Both analyses used local 2012 costs, undiscounted. Costs of hospitalisation, day hospital visits, drug administration and laboratory tests were taken from officially published public tariffs. Drug acqui-
sition costs came from the latest Price Bulletins. Since abiraterone and cabazitaxel are not yet marketed in Greece, respective prices were estimated based on avail-
able publications in April 2012. Calculations were based on the median treatment duration for each arm. RESULTS: Total treatment cost was lower for abiraterone (€25,847) compared to cabazitaxel (€26,648). Higher drug acquisition costs for abi-
ra terone (€24,899 vs. €23,886 for cabazitaxel) were offset by lower administration costs (€1,290) and lower median total resource use (0.75 QALYs) in the abiraterone arm. Total treatment costs of abiraterone were €12,924 and €5,619 per incremental month of PFS and OS compared to palliative care, respectively; treatment costs for cabazi-
taxel were €19,034 and €11,103 per additional month of PFS and OS against pallia-
tive care, respectively. RESULTS were validated by the sensitivity and threshold analyses. CONCLUSIONS: Abiraterone appears to be a potentially cost-effective option compared with cabazitaxel in the Greek health care setting.

PCN85

ECONOMIC ASSESSMENT OF THE ONCOTYPE DX BREAST CANCER ASSAY

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OBJECTIVES: To perform an analysis, from a public financing viewpoint, of the economic impact and efficiency of the Oncotype DX (ODX) assay as a guide to providing chemotherapy to women with early breast cancer compared to guiding this decision using the Adjuvant! Online (AO) prognostic index. METHODS: Markov model was constructed to assess three alternatives: chemotherapy provision to women with a high risk recurrence score (RS) (i.e., >30 with ODX, to women with an intermediate/high risk score (RS >18) and to those as indicated by the AO. For the base case, a price of €230 was set for ODX plus €236.12 for treatment with tamoxifen for 6 months, plus €340.50 for 6 cycles of chemotherapy. RESULTS: Mean cost associated with AO to guide the provision of chemotherapy was €8994.02 per patient (with ODX RS >30), Guidance with ODX was €11,521.56, and for AA it was €12,070.03. The incremental cost-effectiveness ratio for ODX RS >30 compared to AO was €9659.28 per QALY, while for ODX RS >18 was €1705.80. When treatment was guided by AO, a mean of 16.80 QALYs were obtained per patient, ODX was associ-
ated with 17.06 QALYs. Compared to guiding an RS of >30 and 17.13 QALYs per patient for RS of >18. In probabilistic sensitivity analysis, assuming a willingness to pay of €10,000/ QALY, providing chemotherapy to patients with an ODX RS of > 18 became the best alternative. Probability of this being the best choice was 60% for a willingness to pay of €20,000/QALY and 70% for €30,000/QALY. CONCLUSIONS: Compared to guiding the provision of chemotherapy with AO, the ODX would appear to be cost-effective. In the Spanish setting, for a willingness to pay €30,000/QALY, the best option would appear to be to prescribe chemotherapy for patients with ODX RS of >18.

PCN86

COST-EFFECTIVENESS ANALYSIS OF ABIRATERONE FOR THE TREATMENT OF ADVANCED PROSTATE CANCER UNDER THE BRAZILIAN PRIVATE HEALTH CARE SYSTEM

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OBJECTIVES: To estimate the cost-effectiveness of once-daily abiraterone acetate (AA) plus prednisolone for the treatment of advanced metastatic castration-resis-
tant prostate cancer (mCRPC) after failure of taxane-based chemotherapy such as docetaxel, under the Brazilian Private Health System perspective. METHODS: A cost-effectiveness analysis was developed based in a Markov model and the disease progression and patient mortality. A systematic revision of the literature was developed over the efficacy and safety of the use of AA and cabazitaxel (C), both combined with prednisolone (P), in patients diagnosed with advanced mCRPC. Efficacy data is informed by the Phase III trials (C + P versus P and AA + P versus P). Data is combined and adjusted via a mixed treatment compari-
son network meta-analysis to determine the relative efficacy of each compar-
or front a controlled therapy used as efficacy reference for the clinical trials (HR for overall survival: (C - P vs M = 0.703 (CIS: 0.59-0.83); AA - P vs B = 0.649 (CIS: 0.54-0.768). It was assumed that M + P is equal to P alone. The costs and consequences of the disease treatment were computed for each disease alter-
native. Only direct medical costs were considered. Costs and outcomes were dis-
counted at 3% per year. MCS considered were life years (LY) and quality adjusted life years (QALY). RESULTS: The incremental cost-effectiveness analysis demonstrated that AA is the most economically attractive medication. When the incremental cost-effectiveness ratio (ICER) for LY and QALY gained was evaluated, AA was dominant with regards to C, being more effective (LY: 1.1895 vs 2.885; QALY: 0.6744 vs 2.2818) and lower costs (€97,594 vs €80,005). CONCLUSIONS: AA is the best therapeutic option, with the best cost-effectiveness ratio, versus C for the treatment of patients diagnosed with advanced mCRC under Brazilian public private perspective.

PCN8 COST EFFECTIVENESS EVALUATION OF VEMURAFENIB, AN ORPHAN DRUG FOR BRAF MUTANT METASTATIC MALIGNANT MELANOMA
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OBJECTIVES: To identify the cost effectiveness ratio of Vemurafenib in the treat-
ment of patients of the public health care institutions in Mexico, with BRAF positive mutation (BRAF+) metastatic or advanced melanoma, compared with dacarba-
zine, bendamustine or chemotherapy. The Markov model was developed with monthly cy-
cles, with 4 health states: clinical benefit, stable disease, disease progression and death, considering the adverse events as transitory stages, during a 5 year time horizon. A cost effectiveness analysis was developed, where the transition prob-
abilities were used to calculate the final budget. The current LAF was used to calculate the final budget. The clinical and survival data were used instead of medians.

RESULTS: The Markov model was developed with monthly cycles, with 4 health states: clinical benefit, stable disease, disease progression and death, considering the adverse events as transitory stages, during a 5 year time horizon. A cost effectiveness analysis was developed, where the transition probabilities were used to calculate the final budget. The current LAF was used to calculate the final budget. The clinical and survival data were used instead of medians.

CONCLUSIONS: AA was dominant with regards to C, being more effective (LY: 1.1895 vs 2.885; QALY: 0.6744 vs 2.2818) and lower costs (€97,594 vs €80,005). CONCLUSIONS: AA is the best therapeutic option, with the best cost-effectiveness ratio, versus C for the treatment of patients diagnosed with advanced mCRC under Brazilian public private perspective.