of the biologic agents currently utilized in the United States for this indication (adalimumab, alefacept, efalizumab, etanercept and infliximab). Model results were displayed for a time horizon of one year based on a switch to an appropriate alternate biologic agent in the event of suboptimal clinical response. Multiple one-way sensitivity analyses were conducted. RESULTS: Across all the biologics evaluated there are significant differences in PASI 75 response at 12 weeks versus longer term (ranging from 59% to 20% across the agents at the end of one quarter of treatment and at the end of four quarters of treatment, respectively). The cost per PASI 75 was observed to be $26,460, $31,191, $28,217, $30,544 and $30,983 for therapy initiated with adalimumab, alefacept, efalizumab, etanercept and infliximab, respectively. CONCLUSION: While there are significant differences in the cost of the studied biologic agents initially, the CE results tend to converge over the first year of treatment. Further research needs to be conducted to evaluate the CE of treatment beyond a one-year period.

A PHARMACOECONOMIC EVALUATION OF PEGAPTANIB FOR THE MANAGEMENT OF AGE-RELATED MACULAR DEGENERATION (AMD) IN MEXICO

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OBJECTIVE: In western countries AMD is considered one of the most important causes of blindness among persons over 65 years old. The purpose of this study was to determine the cost-effectiveness of pegaptanib vs verteporfin in the treatment of AMD from the health care payer’s perspective. METHODS: A seven-stage stochastic Markov model based on visual acuity (VA) in the better seeing-eye (stages: with clinical benefit, VA > 20/40; VA = 20/40–20/100; VA = 20/100–20/160; VA = 20/200–20/500; VA < 20/500 and legal blindness) was performed during a five-year period. Effectiveness measure used in the assessment was the probability to gain at least one level of VA at the end of the follow up period. Effectiveness data was obtained from international published literature. Comparators used in the model were pegaptanib 0.3 mg (8 sessions) and verteporfin 15 mg (10 sessions). Resource use and cost data were obtained from hospital records and official institutional databases from the Social Security Mexican Institute (IMSS). Costs and health outcomes were discounted with a 3% annual rate. The model was calibrated.

Probabilistic sensitivity analyses were performed to determine the results robustness. RESULTS: Patients who received pegaptanib experienced a higher probability to gain at least one level of VA(57.4%; CI95%:52.26%–62.54%) compared with patients treated with verteporfin (13.8%; IC95%:10.61%–16.99%) considering an initial VA state of >2040/p < 0.001). Mean total costs per patient were higher in patients who received pegaptanib compared to those who received verteporfin (US$6749; CI95%:US$6401–US$7096 vs. US$6311 CI95%:US$5948–US$6674, respectively). The ICER in patients receiving pegaptanib compared to those receiving verteporfin was US$1004 (CI95% US$926–US$1090). Sensitivity analyses found that pegaptanib is a cost-saving strategy when the numbers of sessions given to the patients are less than three. CONCLUSION: The results show that in Mexico, pegaptanib is a cost-effective therapy for AMD when is compared with verteporfin. These results should be taken into account by Mexican decision makers in the management of patients with AMD.