Adu (Zydex) exceeds £38,000/QALY. The results were robust in a wide range of sensitivity analyses and did not change when costs were discounted. In the sensitivity analyses, the cost-effectiveness of IRA was £10,492 and 0.32, respectively. Discount rate was 3.5% for both cost and outcomes.

The clinical effectiveness of IRA in this patient group was demonstrated in a Phase III RCT (‘study 116’). The cost-effectiveness of IRA in this patient group is unknown. Therefore, the treatment effect observed in the trial was assumed not to continue beyond trial follow-up. Data from published literature and UK treatment practices and patterns were used to inform costs and utility in the post-progression health state. In the model, the lifetime costs and utilities were calculated as follows:

RESULTS: The base-case incremental cost-effectiveness ratio (ICER) was £32,950 per QALY gained, with incremental discounted costs and QALYs of £10,492 and 0.32, respectively. Discount rate was 3.5% for both cost and outcomes. The probability of cost-effectiveness at a willingness-to-pay threshold of £30,000 per QALY was 43%. Univariate sensitivity analyses indicated that the proportion of patients who received active therapy after progression following first-line treatment decreased the cost-effectiveness ratio, while the proportion of patients who were unable to continue treatment increased the cost-effectiveness ratio. In the sensitivity analyses, the cost-effectiveness ratio increased to £49,476 per QALY gained when discounted at 3.5%.

OBJECTIVE: To evaluate the effectiveness of opatumumab plus chlorambucil (OCh) versus chlorambucil (Chl) for the first-line treatment of chronic lymphocytic leukemia (CLL) in patients not eligible for fludarabine-based therapy from the United Kingdom health care payer perspective.

METHODOLOGY: A Markov decision model was developed with a lifetime time horizon of 25 years and a 3-month cycle length. The COMPLEMENT-I trial provided estimates of overall response rates (ORR), progression-free survival (PFS), overall survival (OS), safety data, and progolatitis update analyses for the number of patients with “progressive disease,” “death,” and “any other cause” at the end of each cycle was determined by parametric survival functions for PFS and OS. Long-term predictions for OS were guided by a survival analysis from a large database of patients with CLL treated with IRA. The transition to the trial model was assumed to occur after 3 months of IRA treatment. The model was run for 25 years and the Markov model was used to simulate the progression of patients with advanced CLL.

RESULTS: The base-case incremental cost-effectiveness ratio (ICER) was £32,950 per QALY gained, with incremental discounted costs and QALYs of £10,492 and 0.32, respectively. Discount rate was 3.5% for both cost and outcomes. The probability of cost-effectiveness at a willingness-to-pay threshold of £30,000 per QALY was 43%. Univariate sensitivity analyses indicated that the proportion of patients who received active therapy after progression following first-line treatment (responder, active second-line treatment) had the largest influence on the ICER. However, none of the variables considered generated an ICER exceeding £38,000 per QALY gained. CONCLUSIONS: The improved ORR, PFS, and OS for OCh compared with Chl translated to improved long-term health outcomes in the base-case analysis, and the results were robust in a wide range of sensitivity analyses and did not exceed £38,000/QALY.

PCN143
A SCOTLAND BASED COST-EFFECTIVENESS ANALYSIS OF IDELALISIB (ZYDELIG®) IN COMBINATION WITH RITUXIMAB FOR THE TREATMENT OF ADULTS WITH CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

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OBJECTIVES: Idebitalsib/rituximab (IR) is licenced for the treatment of adults with CLL who either have received at least one previous therapy and as first-line therapy with del17p/TP53 mutations. Prior to the availability of IR, individuals in these patient groups received best supportive care (BSC). The clinical efficacy of the IR in these patient groups was demonstrated in a Phase III RCT (study 116). The cost-effectiveness of IR in this patient group is unknown. Therefore, the treatment effect observed in the trial was assumed not to continue beyond trial follow-up. Data from published literature and UK treatment practices and patterns were used to inform costs and utility in the post-progression health state. In the model, the lifetime costs and utilities were calculated as follows:

RESULTS: The base-case incremental cost-effectiveness ratio (ICER) was £32,950 per QALY gained, with incremental discounted costs and QALYs of £10,492 and 0.32, respectively. Discount rate was 3.5% for both cost and outcomes. The probability of cost-effectiveness at a willingness-to-pay threshold of £30,000 per QALY was 43%. Univariate sensitivity analyses indicated that the proportion of patients who received active therapy after progression following first-line treatment (responder, active second-line treatment) had the largest influence on the ICER. However, none of the variables considered generated an ICER exceeding £38,000 per QALY gained. CONCLUSIONS: The improved ORR, PFS, and OS for OCh compared with Chl translated to improved long-term health outcomes in the base-case analysis, and the results were robust in a wide range of sensitivity analyses and did not exceed £38,000/QALY.

OBJECTIVE: To evaluate the cost-effectiveness of iftarabine in the treatment of previously treated anaplastic lymphoma kinase-positive (ALK+) non-small cell lung cancer (NSCLC) in the United Kingdom

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OBJECTIVE: To assess the cost-effectiveness of ceritinib versus other therapies in the treatment of anaplastic lymphoma kinase-positive (ALK+) non-small cell lung cancer (NSCLC) from the UK National Health Service (NHS) and Personal Social Service (PSS) perspective. METHODS: A partitioned survival model with three health states (progression-free, progressive, and death) was developed to compare ceritinib versus other treatments in patients with ALK+ NSCLC who were previously treated with chemotherapy (post-C), or with an ALK inhibitor, regardless of prior chemotherapy (post-ALK). The comparator arms included crizotinib, dacomtex, and pemetrexed in the post-CP population and best supportive care (BSC, docetaxel), and pemetrexed in the post-ALK population. Progression-free survival and overall survival for ceritinib were estimated using the GRID study data (NCT01825163, ASCEND-2 (NCT01695060), and ASCEND-3 (NCT01695138) trial data). Parametric models were used to extrapolate outcomes beyond the trial period. Survival data for comparators were obtained from published clinical trials. Drug acquisition, administration, monitoring, and adverse event management algorithms were used in the model.

RESULTS: Over 10 years, ceritinib was associated with 2.69 QALYs and total direct costs of £80,445 for post-CP population. The incremental cost per QALY was £30,536 comparing ceritinib vs. crizotinib, £4,847 vs. docetaxel (both post-CP), and £38,966 vs. amrubicin (both post-ALK). Total direct costs for ceritinib vs. crizotinib, £75,600 vs. docetaxel and £40,145 vs. amrubicin (both post-ALK). Sensitivity analysis results were consistent with the base-case findings. CONCLUSION: Based on the willingness-to-pay threshold for end-