QALYs' outcome used utility data from other studies, of which only one used utilities
generated in Chile. Weekly cost of therapy: DCV-$2,043.15, SOF-$2,925.96. Clinical
transition inputs were obtained from a matching-adjusted indirect comparison
(adjusts for baseline differences between trials) of ALLY-3 and VALENCE: SVRs for
dCV+SOF and SOF+RBV, respectively, were 96.4% and 94.3% for treatment-naive,
82.4% and 80.8% for treatment-experienced and 88.8% and 87.5% for interferon-
ineligible intolerant patients). RESULTS: In all comparisons, dCV+SOF was pre-
dicted to be associated with reduced total costs and improved QoL versus SOF+RBV.
Treatment 3 (SOF+RBV associated with $1,993.3 and QALY gains of 0.31)
experience. dCV+SOF expected to be associated with cost savings of $13,701 and QALY gains of 0.24. Interferon-ineligible/intolerant
patients. RESULTS: 12 weeks of dCV+SOF appears a cost-effective treatment option
for patients with HCV genotypes 2 and 3. When compared to 24 weeks of SOF+RBV, dCV+SOF was predicted to be dominant.

PN74 COST IMPLICATIONS OF TIDALZIDINE USE IN ACUTE BACTERIAL SKIN
AND SULFURIC SITE INFECTION (ABSSSI) FOR HOSPITALS AND MANAGED CARE
ORGANIZATIONS (MCOS)
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OBJECTIVES: A 6-day, once-daily course of tidalzidine, a novel oxicodizole antibac-
terial, demonstrated non-inferior efficacy and comparable safety to a 10-day course
of twice-daily linezolid in ABSSSI. We examined the economic impact of tidalzidine as an
alternative to linezolid on hospitals and MCOS. METHODS: Cost implications of tidi-
zidine, compared to linezolid via cost-minimization analysis, were considered. Cost per
duration for tidalzidine and linezolid were modeled at 6 and 10 days, respectively,
consistent with approved drug labels. ABSSSIs were assumed to be initiated par-
terntly and modeled to oral therapy to complete any remaining days of therapy (DOT). Inpatient linezolid DOT were derived
from 2008-2012 the Truven MarketScan® claims and linked Hospital Drug Database
(HDD). Adult patients with a primary or secondary diagnosis consistent with ABSSSI and
an age of ≥18 years undergoing inpatient admission. Patients with ≤6 inpatient linezolid DOT were modeled as receiving the same inpa-
tient DOT with tidalzidine; patients with 7-10 inpatient linezolid DOT were modeled as
considering a 6-day course of tidalzidine in hospital. Daily drug costs were based on
lowest, published wholesale average cost and included preparation/administration
costs. RESULTS: Of 3,329 ABSSSI hospitalizations identified in the HDD, 261 (7.8%)
were treated with linezolid an average of 4.2 days; outpatient linezolid DOT were estimated at 3.8
and 2.2 days, respectively. Average total drug costs for a 10-day course of linezolid
calculated as $2,816 per patient ($1,050 inpatient, $1,766 outpatient), compared to
$1,562 ($910 inpatient, $652 outpatient) for a 6-day course of tidalzidine. Inpatient and
outpatient cost savings were maintained at linezolid daily costs at or above $213
and $111, respectively. CONCLUSIONS: Tidalzidine is expected to reduce antibiotic
treatment costs, with the greatest impact occurring in the outpatient setting.

PN75 HIGH-DOSE INACTIVATED INFLUENZA VACCINE IS ASSOCIATED
WITH COST-SAVINGS AND IS MORE COMPETITIVE TO STANDARD-DOSE
INACTIVATED INFLUENZA VACCINE IN SENIORS
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1A2D Pharma, Pluit, Switzerland, USA, 2Amgen, Thousand Oaks, CA, USA, 3Research, LLC, Hoboken, NJ, USA
OBJECTIVES: Adults ≥65 years account for most seasonal influenza-related hos-
thitals and deaths. A recent 32,000-participant, head-to-head RCT (FM12, NCT01427309) demonstrated that a high-dose influenza vaccine (HDV) was 24% more
efficacious than a standard-dose influenza vaccine (SD) in adults ≥65 years. A cost-
utility analysis (CUA) of HD vs. SD in FM12 participants was performed. METHODS:
Health-care resource utilization data collected in the FM12 study included: medica-
tions, non-routine medical and emergency room visits, and hospitalizations. Utilized
resources were summarized across vaccine arms and unit costs were applied, using
standard US cost sources, to each resource item (including vaccines; HD $131.82, SD
$12.00) to estimate the mean total direct medical and societal costs associated
with each vaccine. Adverse event data from the trial were mapped to quality of life data
from the literature to estimate the effectiveness of both vaccines. The time horizon
was one year's influenza season for costs and a lifetime for quality-adjusted life
years (QALYs). RESULTS: The average per-patient direct medical costs (including
influenza vaccine cost) and societal costs were $116 and $128 lower in the HD arm.
Inpatient admissions represented over 95% of the total cost and were less frequent in
the HD arm (7.7% of HD participants reported ≥1 hospitalization versus 8.4% in SD arm)
and average length of stay (LOS) across all participants was shorter in the HD arm (0.49
days vs 0.56 days). HD was associated with 0.004 more QALY’s per participant and,
due to cost savings, dominated SD in the CUA. CONCLUSIONS: Despite the higher
price of HD vs. SD, the total direct medical and societal costs were over $100 lower per
vaccine in those who received HD. This was driven by a reduction in the number of
hospitalizations and in the LOS for those hospitalized. HD dominated SD in the CUA.

PN76 COST/UTILITY ANALYSIS OF PNEUMOCOCCAL VACCINES PCV13 VERSUS
PPSV23 IN ADULTS OVER 18 YEARS OLD IN CHILE
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OBJECTIVES: Pneumococcal infections are a public health problem in older adults.
In Chile there are two vaccines at this time, PPSV23 and PCV13. The objective of