therapy are well established and the combination regimens including a fluoropyrimi- dine + oxaliplatin are the current standard of care. OBJECTIVES: To compare costs of XELOX with FOLFOX-4 as adjuvant treatment for stage III colon cancer under Brazilian private payer perspective. METHODS: Both regimens demonstrated to sig- nificantly improve disease-free survival when compared to S-FU/FOLFOX adjuvant treatment of stage III colon cancer (MOSAIc and XELOXA trials). In the absence of head-to-head trials comparing both regimens, an indirect comparison using Butcher approach (Butcher 1997) was conducted. No difference was found regarding efficacy of each regimen (XELOX vs. FOLFOX-4 in disease-free survival; HR 1.03, 95% CI 0.81-1.29); therefore, a cost-minimization analysis was used. A modified Delphi panel identified local practices to manage severe adverse events (SAEs) of each scheme. Only direct costs were considered for a patient with 1.7 m². Drug prices were obtained from official public sources (Kaiso Magazine, April 2009) and administration costs for the Swiss medical society physicians fee list (CBHPM2008, v.5). Time horizon was 6 months according to clinical recommendations: eight cycles for XELOX and 12 for FOLFOX-4. Discounting was not applied. RESULTS: XELOX is less costly than FOLFOX-4 ($Brz9,662 vs. $Brz57,846). XELOX has higher acquisition costs which is offset by savings in medical resource utilization. Mean acquisition costs for XELOX were $Brz4185 higher than with FOLFOX-4, but costs to treat SAEs and administration costs were $Brz22,169 higher for FOLFOX-4. One-way sensitivity analysis confirmed the robustness of results. CONCLUSIONS: Findings suggest XELOX as a cost-saving therapy. Setting under the private payer perspective in Brazil when compared to FOLFOX-4.

PCN94
CAPETITABINE + OXALIPLATIN (XELOX) VS S-FU/LY + OXALIPLATIN (FOLFOX) IN THE ADJUVANT TREATMENT OF PATIENTS WITH COLON CANCER (ACC): COMPARISON OF DIRECT MEDICAL AND SOCIETAL (INDIRECT) COSTS Winterhalder K1, Delmore G2, van Lier M3, Urspruch A4, Hieke K5
1Luzerner Kreiskrankenhaus, Luzern, Switzerland; 2Kantonsspital Thurgau, Frauenfeld, Switzerland; 3Roche Pharma (Schweiz), Renach, Switzerland; 4T. Hoffmann-La Roche Ltd, Basel, Switzerland; 5NÖS Health AG, Brinzing, Switzerland
OBJECTIVES: FOLFOX4 has been the chemotherapy of choice for patients with stage III colon cancer. Recently, the international NO16968 study reported results confirm- ing the efficacy of XELOX in this setting, and evidence suggests that both regimens have at least equivalent efficacy. Therefore, medical and societal resource utilization are important factors for providers, patients, and payers. The objective of this analysis was to compare total costs required to treat an average ACC patient with either XELOX or FOLFOX4 in Switzerland. METHODS: In the absence of a direct com- parison, detailed medical resource utilization (MRU) data collected for XELOX from study NO16,968 (ACC) and for FOLFOX4 from study NO16,966 (metastatic colorec- tal cancer) were analyzed. The FOLFOX4 regimens are identical in both indications; therefore, MRU data from NO16,966 were considered valid proxies. In addition to direct MRU (chemotherapy, hospitalizations due to adverse events [AEs], ambulatory encounters, AE medication, and central venous access [CVA] placements), patient time and travel costs for hospitalizations, ambulatory encounters, and drug administration were estimated. Unit costs were derived from official tariffs (Spezialitätenliste, Tarmed, CHF 1730). Savings in patient time and travel costs amounted to CHF 1912. RESULTS: XELOX appears to be cost-saving versus FOLFOX4 in a C from both a Swiss health-care system and the societal perspective, assuming a 61% likelihood of P-A satisfying a willingness-to-pay threshold of CHF 2588.

PCN95
A MARKOV MODEL TO ESTIMATE THE COST-EFFECTIVENESS OF OMACETAXINE IN CHRONIC MYELOID LEUKEMIA Breton NJ1, Baty AJ1, Foy CF2, McCormick AL1
1Taizethem, Sheffiled UK; 2Googles; Market Access, Pricelitified, UK
OBJECTIVES: In patients with chronic myeloid leukemia (CML), first-line treatment with imatinib therapy is beneficial. In cases of imatinib failure, second-generation tyrosine kinase inhibitors (TKIs) are recommended. Omacetaxine has a novel mode of action and acts independently of TKIs; thus, it may have therapeutic advantages for patients who have developed resistance to TKI therapy and have no available treatment options. The objective was to develop a health economic model to estimate the cost-effectiveness of omacetaxine in the treatment of CML. METHODS: A cost-utility Markov model was developed to capture the progression of CML and treatment effects. The model was developed from the perspective of the French health-care system. Patients entered the model treated either with omacetaxine or standard care, in one of three phases: chronic, accelerated, or blast phase, having failed on imatinib therapy (additional intolerance or intolerance). Patients moved to states no response, no death. Survival estimates for nonresponding and responding patients were taken from studies 202 and 203. These were extrapolated using parametric curve fits to estimate survival beyond the end of the trial. Resource use was based on the trial and from the expert opinion of a panel of French clinicians. Unit costs and utilities were elicited from the literature. One-way and probabilistic sensitivity analyses (PSA) were performed. RESULTS: The deterministic results demonstrated that treatment with omacetaxine is cost-effective at a threshold of €30,000. Sensitivity analysis showed that results were most sensitive to cost of omacetaxine, utility score, and survival that the model was sufficiently robust to param- eter uncertainty. CONCLUSIONS: The analysis demonstrated that omacetaxine is cost-effective in the treatment of CML patients who are resistant to TKI therapy and have no available treatment options.