at-risk was set to 0.72, and it was assumed that new dialysis modality distribution would reach by year 3. The model allowed various sensitivity analyses. **RESULTS:** If PD utilization increased to 25% without any reimbursement increase for PD, 5-year savings was estimated to be €13 million. If APD was reimbursed by an additional €1300 per patient, 5-year savings increased to €18 million, assuming overall PD utilization increased to 30% and APD share of PD increased from 4.5% to 30%. If APD reimbursement increased an additional €2300 per patient and APD share of PD increased to 50%, it would require 35% of all PD patients undergoing dialysis treatment to achieve €18 million savings. Finally, at this level of additional APD reimbursement, 5-year savings increase to €25 million as PD utilization increases to 40%. With €25 million in savings, an additional 1478 patient-years of treatment could be provided in Romania. **CONCLUSION:** With additional reimbursement for PD and the resulting increase in PD utilization, there is an opportunity for government to lower the total dialysis budget. Government can apply the savings to treat additional ESRD patients.

PUK4

IN THE UNITED KINGDOM, AN INCREASED UTILISATION OF PERITONEAL DIALYSIS THERAPY COULD LEAD TO AN INCREASE IN THE NUMBER OF PATIENTS BEING TREATED FOR RENAL REPLACEMENT THERAPY (RRT)

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OBJECTIVES: There is expected to be an increase in the number of patients needing dialysis in the UK over the next 5 years. Outcomes for the different modalities available, haemodialysis (HD) and peritoneal dialysis (PD), have been shown to be similar yet the majority of dialysis patients are treated with HD. Any changes in dialysis delivery that could lead to a more efficient use of resources could increase the number of RRT patients that could be treated. The objective of this evaluation is to project a five-year impact on total dialysis costs when there is a hypothesised shift in modality from HD to PD. **METHODS:** An Excel-based budget impact model was used to estimate the impact of a shift in modality utilisation. The model takes into account dialysis modality shares, annual average cost of treating patients per modality, annual RRT growth rate and years to reach new modality distribution. Cost data from a recent UK study were used. At baseline (June 2007) there were 23,133 RRT patients undergoing dialysis therapy, 79% using HD and 21% using PD. Annual direct cost per patient was £39,412 for HD, £20,764 for home HD (HHD), £22,350 for automated PD (APD), and £16,355 for continuous ambulatory PD (CAPD). Total costs included drug treatment and transport costs. At baseline, 2% of the HD population was on HHD and 48% of the PD population was on CAPD. **RESULTS:** If PD utilisation increases to 30% (of which 60% is APD) by 2011, the cumulative 5-year budget is reduced by a total of £166 million. This cumulative 5-year savings can provide an additional 5,036 patient-years of treatment. **CONCLUSIONS:** In the UK, an increased use of PD provides an opportunity to treat additional patients within a fixed budget, which is a potential solution to the increased demand for RRT in the coming years.

PUK5

RETROSPECTIVE PHARMACOECONOMIC STUDY OF THE USE OF CYCLOSPORINE A MICROEMULSION (SANDIMMUN® NEORAL®) IN COMPARISON WITH CYCLOSPORINE A GENERICS FOR IMMUNOSUPPRESSION FOLLOWING KIDNEY TRANSPLANTATION

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OBJECTIVES: Identification of the better drug for immunosuppression following renal transplantation. **METHODS:** Efficacy data sources included completed comparative randomized clinical trials of Sandimmun Neoral and cyclosporine A generics (Stolyarevich E. S. 2006, Taber D. J. et al. 2005, CTS 2001); costs were derived from the wholesale prices of the study drugs (Protek, Cia International, Shreya Corporation, as of 11 October 2006). The study evaluated the costs of initial and maintenance immunosuppression, treatment of rejection episodes, and hemodialysis necessitated by transplant death in the compared groups. **RESULTS:** Analysis of randomized clinical trials has revealed that Sandimmun Neoral is superior to cyclosporine A generics as regards one-year renal graft survival rates (88% vs. 78%) (CTS 2001). Furthermore, application of cyclosporine A generics entails more frequent episodes of acute rejection (25% vs. 39%), recurrent rejection (4% vs. 13%), and rejection requiring administration of antibodies (8% vs. 19%, Taber D. J. et al. 2005). The total cost of 2-year therapy was over 58.8 million roubles and 72 million roubles per 100 patients in the Sandimmun Neoral and cyclosporine A generics groups, respectively. **CONCLUSION:** Sandimmun Neoral is the leading alternative for immunosuppression following renal transplantation, i.e. it is preferable from a clinicoeconomic perspective.

PUK6

RETROSPECTIVE PHARMACOECONOMIC STUDY OF THE USE OF CYCLOSPORINE A MICROEMULSION (SANDIMMUN® NEORAL®) IN COMPARISON WITH TACROLIMUS (PROGRAF®) FOR IMMUNOSUPPRESSION FOLLOWING KIDNEY TRANSPLANTATION

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OBJECTIVES: Identification of the better drug for immunosuppression following renal transplantation. **METHODS:** Efficacy data sources included completed comparative randomized clinical trials of cyclosporine microemulsion (Sandimmun Neoral, CsA) and tacrolimus (Prograf, Tac). Costs were derived from the wholesale prices of the study drugs (international drug distributor Shreya, as of 25 September 2006). Costs of other medicines with the exception of calcineurin inhibitors (Mycophenolate Mofetil, corticosteroids, Azathioprine), transplantation surgery, diagnostic laboratory procedures, and pharmacokinetic monitoring of blood concentrations of drugs were considered constant and left out of calculations in this comparative study. **RESULTS:** Analysis of randomized clinical trials has revealed similar efficacies for both analyzed treatment options, whereas the safety profile of tacrolimus is more of a problem: the frequency rates of the new onset post-transplant diabetes mellitus for CsA and Tac are 26.5% and 33.6%, respectively, according to Vincenti F. (2005), or 9.8% and 15.4%, respectively, as reported by Keown P. (2004). The rates of diarrhea in the study of Levy G. (2005) were 14% in the CsA group and 29% in those treated with Tac. This study evaluated the costs of initial and maintenance immunosuppression with Sandimmun Neoral and Prograf, which were approximately 22,600 roubles vs. 58,700 roubles for initial therapy and 176,300 roubles vs. 952,300 roubles for one-year maintenance immunosuppression, respectively. The amount of