COST-EFFECTIVENESS OF LAPTANIB IN METASTATIC BREAST CANCER: Significance role in the treatment of mCRPC. Is the first study which compares the cost-effectiveness of enzalutamide to 2 years have brought multiple new therapies for mCRPC. To our knowledge, this recent years. Where there previously had been few options for patients, the last found that out of the 16 sensitivity analyses conducted, 4 fell below the (1.39, 1.30 respectively) as well as QALYs gained (1.24, 1.05 respectively). The ICER of enzalutamide was also associated with greater life years gained than abiraterone for the treatment of docetaxel refractory metastatic castrate resistant prostate cancer (mCRPC) from a payer perspective. Costs and quality-adjusted life years (QALYs) were discounted at 3% annually. One-way sensitivity analyses were conducted. RESULTS: Using a $50,000/QALY threshold, baseline screening with $4 dominated 52 and 53 by reducing overall cost, annual cancer incidence, and improving QALYs; and was cost-effective compared to S1. In the 1-year follow-up scenario, S4 was cost-effective compared to all other strategies. Detection of HPV 16/18 with $4 resulted in earlier diagnosis of clinically relevant CIN 2/3 at the initial visit as well as more effective use of screening tests during follow-up. Sensitivity analyses showed that the model results were most influenced by the costs of tests used. CONCLUSIONS: Incorporating the cobas HPV test with HPV 16/18-effective screening strategy to various Ca screening strategies, and resulted in improved protection against CaC. COST-UTILITY ANALYSIS OF ENZALUTAMIDE VERSUS ABRIBERON FOR THE TREATMENT OF DOCETAXEL REFRACTORY METASTATIC CASTRASE RESISTANT PROSTATE CANCER Young J1, Liu J2, Chung C1, 1University of California, Los Angeles, CA, USA OBJECTIVES: To compare the costs and outcomes of enzalutamide versus abiraterone for the treatment of docetaxel refractory metastatic castrate resistant prostate cancer (mCRPC) from a limited societal perspective using a lifetime horizon. METHODS: We developed a Markov model with 3 health states: pre-prostatectomy, and death. Transition probabilities for all health states were derived from the pivotal phase 3 clinical trials: AFFIRM (enzalutamide) and COU-AA-301 (abiraterone). A 3% discount was applied to all costs and outcomes. Costs included drug acquisition costs, laboratory tests associated with treatment, as well as costs for 3/4 side effects management. Outcomes were assessed in quality-adjusted life-years (QALYs). We conducted 16 univariate sensitivity analyses varying model inputs (overall survival, progression-free survival, utility, drug acquisition cost) for each respective drug independently by 20%. RESULTS: In the base case analysis, we found that the costs for enzalutamide were higher than that of abiraterone, primarily due to drug acquisition costs. Enzalutamide was also associated with greater life years gained than abiraterone (1.39, 1.30 respectively) as well as QALYs gained (1.24, 1.05 respectively). The ICER was $55070/QALY. Sensitivity analyses indicated that the ICER varied widely, using commonly accepted thresholds of $50000/QALY and $100000/QALY, we found that out of the 16 sensitivity analyses conducted, 4 fell below the $50000/QALY threshold and 7 fell below the $100000/QALY threshold. CONCLUSION: Abiraterone is the more cost-effective treatment option. Integration of the cobas HPV test with HPV 16/18 dominates S2 and S3 by reducing overall cost, annual cancer incidence, and improving QALYs; and was cost-effective compared to S1. In the 1-year follow-up scenario, S4 was cost-effective compared to all other strategies. Detection of HPV 16/18 with S4 resulted in earlier diagnosis of clinically relevant CIN 2/3 at the initial visit as well as more effective use of screening tests during follow-up. Sensitivity analyses showed that the model results were most influenced by the costs of tests used. CONCLUSIONS: Incorporating the cobas HPV test with HPV 16/18-effective screening strategy to various Ca screening strategies, and resulted in improved protection against CaC. 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Cancer continues to be a significant economic burden to both payer and the cancer among the overall population was higher than the literature findings. The study identified 27 different types of cancer and the top three highly prevalent cancers were: breast cancer (0.91%), skin non-melanoma (0.88%) and prostate cancer (0.69%). The cancers that were more common in females than in males were bone, larynx, lymphoma, soft tissue, pancreatic, oral and thyroid. The mean total income reported was $29,583±20,696 and the median income was $20,512. The mean total family income reported was $56,254±52,729 and the median was $39,646. The highest mean total health care charges were for rectum ($92,022±146,560), pancreas ($82,022x46,560) and leukemia ($64,040±62,297). The mean total amount reimbursed by Medicare, Medicaid, and Private Health Insurance for all cancer ($64,040±62,297) and leukemia ($54,933±84,300). The mean total amount reimbursed by Medicare, Medicaid, and Private Health Insurance for all cancer types were $4,719±12,589, $1,209±7,106 and $3,415±1,043 respectively. CONCLUSIONS: The prevalence of cancer among the overall population was higher than the literature findings. Cancer continues to be significant economic burden to both payer and the patient.

A RETROSPECTIVE DATABASE ANALYSIS OF MEDICATION ADHERENCE AMONG PATIENTS RECEIVING SYSTEMIC FIRST LINE ORAL THERAPY FOR HEPATOCELLULAR CARCINOMA (HCC)
Mallik R, Cai J
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OBJECTIVES: To evaluate the magnitude and predictors of non-adherence among patients receiving oral therapy for HCC accounting for patient-level variation in total duration of treatment and differences in baseline characteristics. This retrospective study used an employer-based, commercially available, large claims database (2005-2011) to identify adult patients with ≥2 diagnoses of HCC (ICD-9 155), and ≥3 fills of sorafenib - the only approved oral therapy for HCC. Additional study inclusion criteria were not having other previous cancers, and a 3-month wash-out period of no systemic therapy prior to the incident sorafenib fill (index date). Adherence was assessed using a modified Proportion of Days Covered (PDC) metric. Additional sensitivity analyses were performed using the terms “patient compliance” or “patient adherence” or “patient non-compliance” or “non-adherence” or “non-compliance” or “non-adherence to the medication” or “non-adherence to oral therapy.”

RESULTS: Concluding citations (n=59) were searched for primary research articles with an objective of assessing adherence in adults taking oral oncolytics outside of a clinical trial (n=44). Bibliographies of these studies were reviewed and revealed 10 additional studies. Papers not reporting or with poorly described methods of assessing adherence were excluded as were those assessing adherence by proxy. Of the 54 papers, 43 were included. Over half (58%) included patients with breast cancer, 23% with CML, 16% studied multiple tumor types and 1 was in gastrointestinal stromal tumor. Data sources consisted mostly (51%) of secondary databases with patient self report either verified or unverified also common (28%). More than half (56%) were of retrospective cohort design. Most studies used retrospecive drug claims data and other drug claims data, with less than 10% using the terms “patient compliance” or “patient adherence” or “patient non-compliance” or “non-adherence” or “non-compliance” or “non-adherence to the medication” or “non-adherence to oral therapy.”

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