exact more stringent price controls. The purpose of this study is to provide empirical evidence on how price regulations in the OECD affected the adoption of new patent-protected pharmaceutical technologies during 1999–2008. METHODS: We use discrete time duration modelling with parametric and semi-parametric duration dependence to examine how price expectations shape the probability of launch, controlling for competition, market size expectations, firm and molecule heterogeneity across the major OECD markets during 1999–2008. A sub-sample analysis including only EU countries also investigates the impact of price interdependencies and potential firm strategies in launch and pricing decisions. RESULTS: The empirical analysis suggests there is a statistically significant and robust price and market size effect in the adoption of new pharmaceutical technologies. A unit increase in the log expected launch price and the log of expected market size increases the probability of launch by 0.003 and 0.002 respectively. Concentrated therapeutic subgroups, reflecting market crowding constitutes a significant barrier to entry. Among the European Union’s 50 largest strategic firms, 17 of them failed to launch any orphan medicines in the period 1999–2008. Large discounts, and, to a lesser extent, rebates and cost adjustments attributable to rebates.

CONCLUSIONS: The majority of the comments made by the CED about the strength of evidence indicated that the quality of the data was low. CONCLUSIONS: This review identified trends in the influence of different criteria involved in the CED’s drug assessment process. CONCLUSIONS: The development and application of a more comprehensive, consistent, and transparent framework for reimbursement decision-making.

PHP2 DESIGNING FEASIBLE MODELS FOR AN OPTIMAL PHARMACUTICAL CONSULTATION PROGRAM USING A SYSTEMATIC REVIEW

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OBJECTIVES: To evaluate whether the implementation of pharmaceutical consultation (PC) programs in healthcare settings is effective and feasible. METHODS: We conducted a systematic review of literature. We searched Scopus, Medline, and EMBASE databases to identify studies published from 2000–2010. We analyzed the programs by their organizational characteristics and the success score to identify the characteristics that maximize the program’s success. RESULTS: The analysis revealed three core patterns: consultation to patient and physician, patient alone, and physician alone. For each pattern, three feasible models for optimal PC were found. The organizational characteristics of each model included the subject and location of the consultation, target population, consultant’s profession, communication method, incentives, duration, financing, and the PC process steps. CONCLUSIONS: This method for optimizing a model for PC program could be implemented in a variety of HCS to maximize successful drug treatment reflected in the prevention and control of illnesses, improved clinical outcomes, enhanced well-being of the population and maximizing economic benefits. Interviews with a sample of key players in HCS could reveal preferences and benefits, which then will be combined with the results of the previous analysis to optimize a PC program for primary care in Israel and for other HCS.

PHP26 HEALTH OUTCOMES AND ECONOMICS RESEARCH FOR REGenerative MEDICINE AND CELLULAR THERAPIES: LESSONS FROM A MULTI-MARKET CONSULTATION TO patient {quote}a health care setting with health care budget constraints will pressure managed care plans to consider restricting market access. Coverage and reimbursement of ten FDA-designated orphan drugs (ceramide, alglucerase, imiglucerase, lamivudine, latanoprost, nafamostat mesilate, natalizumab, pegfilgrastim, palifermin, and rasburicase) was analyzed for ten popular Medicare Part D plans (AARP, Cigna, CVS Caremark, Humana, Medco, RxAmerica, EmbleemHealth, UniCare, WellCare, FirstHealth. METHODS: Formulary tier structure, out-of-pocket costs (OPC), monthly retail costs and utilization restrictions (UR)—pre-authorizations (PA), step therapy (ST)—were obtained from CMS (www.medicare.gov). Ur were assigned point values reflecting most to least restrictive—PA: 3, ST: 2, QL: 1, 6, 1; possible points per drug per plan unless excluded from formulary. OPC is the percentage of the drug’s cost paid by patients—average, budgeted, and largest. Maximum economic benefits. Interviews with a sample of key players in HCS could reveal preferences and benefits, which then will be combined with the results of the previous analysis to optimize a PC program for primary care in Israel and for other HCS.

PHP26 HEALTH OUTCOMES AND ECONOMICS RESEARCH FOR REGenerative MEDICINE AND CELLULAR THERAPIES: LESSONS FROM A MULTI-MARKET

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OBJECTIVES: Pharmaceutical drug costs represent a large portion of government health care spending. A national standard to regulate the process of public financial reimbursement for drugs does not exist in Canada and variations in practices are evident across the country. The purpose of this study was to provide a comprehensive overview of how drug-funding decisions are made in Ontario. METHODS: Access to Ontario’s Committee to Evaluate Drugs (CED) meeting minutes (July 2009–

July 2010) was granted. A database was developed and applications were analyzed. RESULTS: Forty-four submissions were included. Five main observations: 1) the CED considered certain criteria more frequently than others (e.g., clinical benefit was considered for all decisions, while societal values were discussed less frequently); 2) the relative impact of each criterion on the CED’s recommendation varied (e.g., overall clinical benefit, efficacy, value for money, and need had the largest influence); 3) the CED was more likely to discuss the strength of evidence when its recommendation did not support public funding (e.g., the strength of cost evidence was discussed 3 times more often for those drugs not recommended for funding); 4) the frequency with which the CED considered criteria varied according to whether or not the CED believed it was an established need; and 5) the majority of the comments made by the CED about the strength of evidence indicated that the quality of the data was low. CONCLUSIONS: This review identified trends in the influence of different criteria involved in the CED’s drug assessment process. CONCLUSIONS: The development and application of a more comprehensive, consistent, and transparent framework for reimbursement decision-making.