ment levels of these drugs in both countries. **RESULTS:** Eight OD were identified. In Germany, G-BA decisions related to additional benefit were non-quantifiable for 1 drug and 100% for 2 drugs. In Germany, OD prices were about 20% higher for one drug and 65% for 2 drugs. In Germany, OD prices were about 20% higher than in France before rebates, and about 20% lower after rebates. **CONCLUSIONS:** Substantial improvement for OD were less frequently acknowledged by German HTA than by French HTA and prices appeared to be lower in Germany than in France. However, price volume agreements in France might have contributed to hidden discounts. Access level of OD appeared higher in Germany.

**PSY76**

**HEALTH ECONOMICS AND OUTCOMES DATA REQUIREMENTS IN INDOLENT NON HODGKIN Lymphoma (INHL) AND CHRONIC LYMPHOCYTIC Leukemia (CCL) FROM UNITED STATES PAYER PERSPECTIVE**

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**OBJECTIVES:** To understand current considerations and management of INHL and CLL disease states and the extent to which health economic outcomes data informs payer decision making process. **METHODS:** A national level in-depth telephone survey of 45 payers was done in the month of November, 2013. The payers included large commercial insurers (n=26), and Medicare (n=20) and other medical or pharmacy directors to determine clinical, economic and humanistic outcomes data critical for formulary and medical policy decisions for INHL and CLL. **RESULTS:** Most important measures are: clinical outcomes (n=26), resource utilization (n=29), and economic outcomes (n=21). Access to trial data is highly variable from payer to payer. **CONCLUSIONS:** While clinical data is the most important consideration for payers, there is a lack of quality data that directly ties to payer’s major cost drivers: hospitalization, re-hospitalization and emergency services in both the disease state. Payers were split on preferring the comparative data or additional benefit analysis as a standardized assessment of a burden impact model. There was no difference in payer types when it came to preference for any particular health economics model. Amongst the various adverse events related to treating INHL and CLL, neutropenia is the most concerning adverse event from both clinical and payer perspective, given the associated high cost of related treatments and hospitalizations. Payers consistently reported that the greatest unmet need in the INHL and CLL today is more treatment options for relapsed and refractory patients, with greater response rates, increased durability of response and less toxicity leading to increased overall survival and progression. **CONCLUSIONS:** While INHL/CLL space payers admit decisions are based more on clinical evaluations rather than cost drivers, payers appreciate the value of demonstrating a reduced cost in resource costs as they can directly evaluate the impact of this data on their health plan.

**PSY77**

**PATIENTS WITH RELAPSED OR REFRACtORY CHRONIC LYMPHOCYTIC Leukemia (R/R CCL) INELIGIBLE FOR CYTOTOxic THERAPY WHO ARE THEY AND WHAT IS THEIR UNMET NEED?**

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**OBJECTIVES:** To identify criteria used to categorize patients with R/R CCL who are ineligible for cytotoxic therapy and the unmet need in these patients. **METHODS:** Structured searches related to R/R CCL, performance status, comorbidities; organ function patterns were performed on PubMed, Google Scholar, and the Cochrane databases and supplemented with hand searches of published clinical, clinical guidelines, and online sources. **RESULTS:** 440 publications were identified. 123 were considered relevant to the study. Patients ineligible for cytotoxic therapy were identified by a combination of assessments for performance status (using ECOG), comorbidities (CIRS), and organ function (treatment clearance (CrCl)). Unfit patients are >65 years with a comorbidity (ECOG 3-4 or CIRS >-6 or CrCl <70 mL/min). NCCN clinical guidelines do not refer to assessment scores or define unfit: the NCCN categorizes R/R CCL patients as *“70 years, or younger with comorbidities” or “frail with significant comorbidity*.* These criteria are not aligned with others such as slow-go (ECOG 2-4 or CIRS 6 or CrCl <70 mL/ min) and no-go (fatal comorbilidades with very short life expectancy). Treatment regimens recommended by the NCCN contain drugs contraindicated for common comorbidities. The NCCN does not recommend regimens that do not contain drugs contraindicated for common comorbidities. There is an unmet need in these patients for appropriate treatment. **CONCLUSIONS:** There are unmet need in patients identified as unfit using current criteria: they can be restricted from recommended drugs due to contraindications for common comorbidities. Most of these patients also have not been included in RCTs. Criteria used to identify patients with R/R CCL ineligible for cytotoxic therapy are not yet standardized; standardized assessments are needed for uniform identification and RCT enrolment.

**PSY78**

**EMERGENCY PHYSICIANS’ INTENTION TO USE THE TEXAS PRESCRIPTION MONITOR PROGRAM (PMP) FOR Opioid Overutilization: A PILOT STUDY**

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**OBJECTIVES:** Inappropriate use of prescription opioids costs insurers over $72 billion annually in direct health care expenses. Prescription monitoring programs (PMP) are state-operated databases which allow authorized clinicians (e.g., prescribers, pharmacists) to query a patient's opioid dispensing history via a secured online connection, during patient care. Since the emergency department (ED) is a primary target for drug-seeking patients, this pilot study was conducted to validate returns and improve emergency medicine cooperation on how to use the recently available Texas PMP. **METHODS:** A cross-sectional survey of ED was conducted at a statewide emergency medicine conference. A 34-item questionaire, based on the Technology Acceptance Model (TAM), was developed to assess EDs intention to use the Texas PMP. Items related to technology acceptance (perceived ease of use, perceived usefulness, attitude, and intention) were assessed using 5-point Likert scale responses (1=strongly disagree to 5=strongly agree). The survey was expanded on a group of EDs in an exploratory survey of PMPs. Correlation analyses were used to validate the survey instrument scales. **RESULTS:** Of the 45 respondants, most were male (68.9%), attending EDs (57.8%), with 10.8±11.1 years in emergency medicine, from a community hospital setting (55.6%), and were users of the Texas PMP (51.1%). Among EDs who were not registered, 39.2% reported lack of awareness as the primary reason for not being registered. Standardized Cronbach’s alphas for the constructs of perceived ease of use, perceived usefulness, attitude, and intention for PMP users were 0.88, 0.90, 0.74, and 0.84, respectively. **CONCLUSIONS:** Considering the ED as a source of diversion, it is important to understand EDs utilization of PMPs. PMP use of PMPs may help to mitigate the economic burden associated with the non-medical use of prescription opioids, while improving patient outcomes. Future studies using this survey instrument are needed to further assess the predictive utility.

**PSY79**

**AN EVALUATION OF OPIOD OVERUTILIZATION QUALITY METRICS USING RECEIVER OPERATING CHARACTERISTIC CURVES AND PROXIES FOR POTENTIAL OVERUTILIZATION**

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**OBJECTIVES:** To evaluate the sensitivity and specificity of opioid overutilization quality measures based on the Centers for Medicare and Medicaid Services (CMS) Continuous and Monitoring System (CAMS) and the CMS criteria for potential overutilization. **METHODS:** Based on the CMS measure (proportion of patients with opioid prescriptions from ≥4 prescriptions and ≥4 pharmacies among patients with ≥2 opioid prescriptions), claims from the 2012 IMS LRs database were used to identify the different providers and pharmacy thresholds. Cash payment of ≥1 opioid prescription was used as a proxy for potential overutilization and set as the dependent variable in logistic regression models to generate separate receiver operating characteristic (ROC) curves for thresholds of 2-8 prescribers and 2-8 pharmacies. Optimal cutoffs for number of physicians and pharmacies were selected as the value on the curve with the shortest distance to perfect prediction. Sensitivity, specificity and positive predictive value (PPV) were calculated. As a sensitivity analysis, the process was repeated using ≥1 opioid-abuse related diagnosis as a proxy for potential overutilization. **RESULTS:** Of the 1,213,909 qualified patients, 5.9% met the CMS criteria for overutilization, while 13.8% met the alternative ROC optimal criteria (≥2 prescriptions and ≥3 pharmacies). Defining cash payment patients (12.3% of total) as overutilizers, the CMS definition had sensitivity (15.0%), specificity (95.3%) and PPV (31.0%). The ROC alternative had sensitivity (28.0%), specificity (88.2%) and PPV (41.5%). For patients with overutilization diagnosis, the CMS criteria (2.6% of total), the CMS criteria had sensitivity (16.1%), specificity (94.3%) and PPV (7.0%). The ROC alternative had sensitivity (28.5%), specificity (86.6%) and PPV (8.0%). **CONCLUSIONS:** The ROC curves suggested optimal criteria similar to the CMS criteria. Quality organizations can use the range of results and their preferences for sensitivity and specificity tradeoffs to develop needed quality measures.

**PSY80**

**THE IMPORTANCE OF FACT OVER OPINION IN CHOICE OF CONDITIONS TO BE RECOMMENDED FOR NEWBORN SCREENING (NBS)**

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**OBJECTIVES:** In 2006, the American College of Medical Genetics (ACMG) recommended expanding NBS. Recommendations relied largely on a stakeholder survey on 19 attributes of different rare conditions under consideration. The percentage of respondents agreeing to an attribute’s presence determined its score. This research examines one particular attribute and asks how the recommendation of included conditions changes with the substitution of scoring based on the actual facts for that based on surveyed opinion. **METHODS:** The original report indicated each condition’s scores for survey questions. Unlike some questions, that of whether multiplex technologies (allowing multiple conditions to be screened with a single test) were available, had a correct answer. Original scores for the question totaled between 0-200, depending on the respondents’ percentage indicating yes. Answers were re-scored 200 or 0 as factually appropriate - existence/non-existence of multiplex screening for each condition. **RESULTS:** After eliminating conditions with missing data, 78 out of the original 84 conditions remained. 42 conditions (54%) increased their score, 21 conditions (25%) decreased their score, 8 conditions (10%) remained. **CONCLUSIONS:** As the only conditions capable of having recommendations without a structured process, continuing to recommend conditions when adding those with uncertain prevalence is reasonable. Nonetheless the changes were significant (of those that could change, 50% did). As other questions in the survey were also questions of fact, doing a similar analysis for all such questions could further significantly alter the conditions recommended for the panel.