non-steroidal anti-inflammatory drugs (NSAIDs) increase vascular and gastrointestinal risks. These risks have not been described with chondroitin sulphate (CS). This study aims to evaluate the economic impact of osteoarthritis (OA) treatment with CS versus NSAIDs for the Public Healthcare System in Catalonia (Spain). METHODS: An economic model was developed to estimate the health care costs of ethical CS (due to the absence of comparative trials) and traditional adverse events (GIAE and coronary ischemic events (CIE)) associated with NSAIDs. The estimated population with knee and hands OA was calculated from epidemiological official data (age ≥20 years) and a population-based study on osteoarthritis. The utility drug utilization study in patients with OA. The annual probabilities of suffering GIAE and CIE with CS versus NSAIDs were obtained from a systematic review of published meta-analyses. The direct medical costs (drug acquisition, hospital, ambulatory, and adalimumab was considered as the most cost-saving option, with increased significance in the current economic environment of restricted healthcare resources and significant budget constraints.

PMS35 ECONOMIC EVALUATION OF CHONDROITIN SULFATE AND NON-STERoidal ANTI-INFLAMMATORY DRUGS FOR THE TREATMENT OF OSTEoARTHRITIS
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OBJECTIVES: Non-steroidal anti-inflammatory drugs (NSAIDs) increase vascular and gastrointestinal risks. These risks have not been described with chondroitin sulphate (CS). This study aims to evaluate the economic impact of osteoarthritis (OA) treatment with CS versus NSAIDs for the Public Health System in Catalonia (Spain). METHODS: An economic model was developed to estimate the health care costs of ethical CS (due to the absence of comparative trials) and traditional adverse events (GIAE and coronary ischemic events (CIE)) associated with NSAIDs. The estimated population with knee and hands OA was calculated from epidemiological official data (age ≥20 years) and a population-based study on osteoarthritis. The utility drug utilization study in patients with OA. The annual probabilities of suffering GIAE and CIE with CS versus NSAIDs were obtained from a systematic review of published meta-analyses. The direct medical costs (drug acquisition, hospital, ambulatory, and adalimumab was considered as the most cost-saving option, with increased significance in the current economic environment of restricted healthcare resources and significant budget constraints.

PMS36 EXTENDED-RELEASE OXOCODONE HYDROCHLORIDE (OXCONTIN®) FOR PAIN MANAGEMENT IN PATIENTS UNDERGOING ARTHROPLASTY: A COST ANALYSIS FROM THE BRAZILIAN PUBLIC AND PRIVATE HEALTHCARE SYSTEMS PERSPECTIVES
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OBJECTIVES: Arthroplasty is a complex condition which can result in loss of quality of life and significant financial burden. This study aims to evaluate extended-release oxycodone versus morphine in an ‘if necessary’ regime in the management of pain post-arthroplasty, from the Brazilian public and private healthcare systems perspectives. METHODS: A decision model was developed to analyze two scenarios. In both, patients in group 1 received extended-release oxycodone and immediate-release opioid, and in scenario 2, immediate-release opioid and placebo. Efficacy data were obtained from Bee et al., 2005 (scenario 1) and Cheville et al., 2001 (scenario 2). Direct costs were obtained from official prices lists. In scenario 1, time horizon was related to a 3-week treatment period and, in scenario 2, determined by the hospitalization period. Discount rates were not applied. Univariate sensitivity analysis was performed to evaluate different hospital categories. RESULTS: Total costs from the public perspective were $1,486 BRL and $1,520 BRL per patient treated in scenario 1, and $3,294 BRL and $3,591 BRL per patient treated in scenario 2, in groups 1 and 2, respectively. From the private perspective, total costs in scenario 1 were $3,132 BRL and $3,457 BRL per patient treated and $7,197 BRL and $8,181 BRL per patient treated in scenario 2, in groups 1 and 2, respectively. In the univariate sensitivity analysis, all evaluated scenarios remained consistent and favorable to the use of extended-release oxycodone. CONCLUSIONS: The inclusion of extended-release oxycodone can result in reduction of hospitalization costs, which would lead to resource savings for the payer.

PMS37 THE COST BURDEN OF MONOClonAL ANTibody THERAPY IN AN ATHENS GREECE TERTIARY HOSPITAL. A SEVEN YEAR COST COMPARISON ANALYSIS
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OBJECTIVES: To estimate the cost burden of monoclonal antibodies in an Athens/Greece tertiary hospital in a seven year cost comparison analysis and to compare results to other in-patient drug categories. METHODS: In this study (2008-2014) monoclonal antibodies (MABs) consumption in Evagelismos hospital (Piraeus area) was analysed. MABs consumption/cost in hematology, oncology, rheumatology, gastroenterology, ophthalmology and neurology departments was especially studied. The pharmacological cost per response (ADACTA trial, in terms of cost per response and the cost per disease remission of TCZ vs ADA for treating RA patients intolerant to MTX or for whom MTX is inappropriately prescribed (DAS28 ≤28) was calculated, reducing signs and symptoms of rheumatoid arthritis (RA) in patients by way of treatment or for whom MTX is inappropriately prescribed in terms of clinical benefits, economic and clinical benefits, and drug cost analysis. CONCLUSIONS: From 2008 to 2012, though a substantial reduce of hospital pharmaceutical expenditure was obtained, due to memorandum obligations, an increase in MABs consumption was observed. The cost saving for all drugs were reduced for the same period. The total cost saving is mainly due both to generics and off-patent drugs use and drugs’ price negotiations supported with an obligation of the Ministry of Health 5% and 6.5% rebate for in-patent drugs.

PMS38 ECONOMIC EVALUATION OF TOCILIZUMAB MONOTHERAPY VS ADALIMUMAB MONOTHERAPY IN PATIENTS WITH RHEUMATOID ARTHRITIS IN ITALY
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OBJECTIVES: In a randomized, double blind, controlled phase IV trial (ADACTA*), Tocilizumab (TCZ) demonstrated superiority versus Adalimumab (ADA) in monotherapy, reducing signs and symptoms of rheumatoid arthritis (RA) in patients by way of treatment or for whom MTX is inappropriately prescribed (DAS28 ≤28). The aim of this analysis was to evaluate the cost per response and the cost per disease remission of TCZ vs ADA in an RA monotherapy setting from the Italian health care systems perspectives. METHODS: Tocilizumab (8 mg/kg subcutaneous every 4 weeks) and adalimumab (40 mg/QW) monotherapy were compared, using efficacy results from ADACTA trial, in terms of cost per response (American College of Rheumatology-ACR20-50-70) and cost per remission for both Disease-Activity-Score (DAS28<2.6) and Health Assessment Questionnaire (HAQ=0.5). The considered costs for drug acquisition, administration and monitoring, obtained from published sources. Drug acquisition cost was derived from the ex-factory price. Drug administration cost for TCZ-IV (only) was base on the cost for nursing and medical staff required for each infusion; monitoring visits and tests were considered as one per month for TCZ-IV and one every three months for ADA-SC. The analysis was conducted from the Hospital perspective and the time horizon was 24 weeks. RESULTS: Compared with ADA, TCZ-IV showed a substantial economic and clinical benefits, and cost per response was lower with TCZ than with ADA: ACR20: -10,494.5 ± 12,533.4; ACR50: €14,652.2 vs €22,711.3; ACR70: -20,989.1 ± 34,589.3 respectively. The cost per remission was €17,096.4 ± €58,966.6 for DAS28<2.6 and €39,658.6 ± €66,575.2 for CDAI≤2.8 for TCZ vs ADA respectively. CONCLUSIONS: According to this analysis, in Italy TCZ monotherapy can be considered as an efficient strategy compared to ADA for treating RA patients intolerant to MTX or for whom MTX is inappropriately prescribed (DAS28 ≤28) and adalimumab. CONCLUSIONS: Tocilizumab monotherapy versus adalimumab monotherapy for treatment of rheumatoid arthritis (ADACTA) randomised, double-blind, controlled phase 4 trial. Lancet 2013,381(9877):1541-50

PMS39 ECONOMIC BURDEN OF CONTROLLED GOUT, UNCONTROLLED GOUT, AND GOUT EXACERBATION BY COMMON COMORBIDITIES: RESULTS FROM THE 2012-2013 NATIONAL HEALTH AND WELLNESS SURVEY
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OBJECTIVES: Gout is a urate crystal deposition disease caused by chronic high serum uric acid (sUA) levels (i.e., hyperuricemia), resulting in painful flares and tophi. Treatment guidelines recommend maintenance of sUA levels <6 mg/dL, however, sUA often remains elevated because lack of, or inadequate response to therapy. Our goal was to understand the relationship between gout control and economic burden and to explore the impact of comorbidities. METHODS: Data were collected from 2012 and 2013 US National Health and Wellness Survey (NHWS), a representative, cross-sectional national health survey (2012, n=71,157, 2013, n=75,000) of which 3729 individuals self-reported a gout diagnosis (n=344 controlled [sUA ≤6 mg/dL, and no flares in past year], n=2215 uncontrolled [sUA >6 or ≥1 flare], and n=1170 unknown). Estimated total cost was calculated by adding direct cost (e.g. resource use) and indirect cost (e.g., work productivity loss). Those with gout + comorbidities (e.g., cardiovascular disease [CVD]) and their relationship with total cost were also examined. Multivariable generalized linear models were used to control for demographic and clinical characteristics to assess unique burden of uncontrolled gout. CONCLUSIONS: Adjusted models indicate that those with controlled gout do not statistically differ from non-gout subjects. Those with uncontrolled gout reported significantly higher total annual costs and costs than those with controlled gout, the difference was not significant. Similar patterns were observed for gout control and comorbidities. Those with uncontrolled gout + comorbidity (diabetes or CVD) reported higher total costs than those without gout or their respective comorbidity. There were no statistical differences in total cost controlled gout + comorbidity versus those without gout or comorbidity. CONCLUSIONS: Uncontrolled gout results in higher total costs than for non-gout patients. Controlled gout patients have lesser burden—closest to non-gout subjects. Total cost for uncontrolled gout may be further exacerbated by comorbidities.