adoption from the budget holders. However, if discounts approach 30%, physicians are likely to have less influence. **CONCLUSIONS:** Generally, budget holders and clinicians have differing views on the utility and placement of biosimilars in the clinical pathway. The uptake of which will ultimately depend on geographies, discounts offered and clinician experience. Biosimilars are not going away, however, there are strategies that the originator company can utilize and leverage to delay uptake and maintain strong market share.

PCN65

THE CLINICAL AND ECONOMIC BURDEN OF POST-THORACOTOMY PAIN SYNDROME (PTPS) AFTER LUNG RESECTION SURGERY: A RETROSPECTIVE ANALYSIS OF REAL-WORLD DATA

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OBJECTIVES: Post-thoracotomy pain syndrome (PTPS) is widely reported as one of the primary comorbidities following lung resection surgery. The objective of this retrospective study was to quantify the clinical and economic burden of post-thoracotomy pain syndrome (PTPS) following lung resection surgery in the United States using a large real-world database. **METHODS:** This study utilized claims data from the Truven MarketScan databases. Adult patients undergoing a lobectomy or a segmentectomy as the primary surgical procedure were categorized by the surgical approach (video-assisted thoracoscopic surgery (VATS) versus open) and primary diagnosis (lung cancer vs. non-lung cancer). The PTPS cohort was identified based on a diagnosis of non-neurogenic and neurogenic pain lasting more than two months post-operatively. Data were collected for: patient demographics, index hospital costs and post-discharge costs. Mean, standard deviation, median values are reported for observed differences between the groups. **RESULTS:** A total of 5,502 patients (4,898 lung cancer and 604 non-lung cancer) met the study criteria. The incidence of PTPS was 5% (n=261) in the cancer group and 7% (n=42) in the non-cancer group. PTPS was more common following open procedures vs VATS (6.1% vs. 4.6%). The one year observed post-discharge costs were consistently higher in the PTPS cohort vs. the non-PTPS cohort for both cancer and non-cancer patients with a greater difference of mean values in the cancer group (cancer: $36,872±$23,035 vs. $31,728±$15,176; non-cancer: $16,497±$9,822 vs. $16,040±$5,988). PTPS patients diagnosed in the first two months post-operatively cost more to manage than the corresponding non-PTPS cohort (cancer: $39,159±$40,030 vs. $32,302±$50,336; non-cancer: $16,584±$14,233 vs. $11,005±$19,371). **CONCLUSIONS:** Real world data shows a lower rate of PTPS in the US when compared to data published in the peer-reviewed literature, suggesting an under-reporting of PTPS in claims databases. PTPS is more common following open procedures and the post-discharge cost of managing PTPS patients is higher than non-PTPS patients.

PCN66

THE CLINICAL AND ECONOMIC BURDEN OF SIGNIFICANT BLEEDING DURING LUNG RESECTION SURGERY: A RETROSPECTIVE MATCHED COHORT ANALYSIS OF REAL-WORLD DATA

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OBJECTIVES: There is increasing clinical evidence to support the adoption of video assisted thoracoscopic surgery (VATS) for lung resection procedures. While the frequency of significant intraoperative bleeding requiring follow-up interventions is generally low, there is a lack of real-world data quantifying its incidence and cost of management. The objective of this retrospective study was to quantify the clinical and economic burden of significant bleeding in lung resection surgery in the United States. **METHODS:** This study utilized 2009-2012 data from the Premier Perspective DatabaseTM. Adult patients with primary pulmonary lobectomy or segmentectomy procedures were categorized by the surgical approach (VATS versus open) and primary diagnosis (lung cancer (primary or metastatic) vs. non-lung cancer). Data were collected for patient demographics, length of stay, cost and amount of blood product utilized. Patients requiring ≥3 units of blood products were categorized as the "significant bleeding" cohort. Those requiring <3 units were the "non-significant bleeding" cohort and those not requiring any blood products were the "no bleeding" cohort. A matched cohort analysis was performed between the "significant bleeding" and the "non-bleeding cohort" using the following matching variables: hospital identifier, lung cancer diagnosis, procedure type and gender. **RESULTS:** A total of 29,737 patients (20,370 in the lung cancer group and 9,367 in the non-lung cancer group) met the selection criteria. The matched cohort analysis showed a higher cost for the "significant bleeding" cohort vs. the "non-bleeding" cohort ($32,140 vs. $19,037). The matched analysis for each APR-DRG Severity score showed that the significant bleeding cohort cost more for the hospital than the non-bleeding cohort. **CONCLUSIONS:** Significant chest bleeding during lung resection surgery is a rare complication in the US, occurring with a frequency of 0.63%. However, patients with significant intraoperative bleeding could cost an average of $13,103 more for the hospital to manage and have a longer length of stay.

PCN67

EVALUATING THE COST OF TREATING BLADDER CANCER WITH AND WITHOUT METASTASES

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OBJECTIVES: Recent systematic literature reviews of bladder cancer (BC) indicated that more economic research on management strategies, particularly in the metastatic setting, is needed. This study evaluated the cost of care among patients diagnosed and treated for BC with and without metastases. **METHODS:** Retrospective data from 2 large integrated claims databases spanning July 2008 to December 2010 were used to identify adult patients with a diagnosis of malignant neoplasm of the bladder (ICD-9 188.0–188.9; ICD-10 C67.0–67.9). Patients were included if they (1) had continuous eligibility for 6 months prior to at least 6 months following their index diagnosis, (2) had no diagnosis of any other cancer in the pre-period, and (3) received no chemotherapy in the pre-period. Patients were stratified into 2 cohorts based on the presence of metastatic disease within 180 days of diagnosis: non-metastatic (NM) and metastatic (M). Resource use and all-cause costs (2013 USD) were evaluated after cancer diagnosis. **RESULTS:** There were 10,250 (9,268 NM, 982 M) and 22,965 (20,786 NM, 2,179 M) patients in each of the databases meeting all inclusion criteria, respectively. Mean follow-up was 35.1 months and 38.6 months in the 2 datasets. Total costs 6 months prior to index ranged from $6,497–$6,852 (NM) and $6,766–$7,831 (M) and increased to $13,127–$13,559 (NM) and $40,695–$45,817 (M) in the 6-month post-index period. The majority of costs in the 6-month post-index period were attributable to medical services: NM, 88.7%–91.8%; M, 94.8%–96.5%. Inpatient and emergency department costs accounted for 38.2%–40.8% (NM) and 50.4%–52.5% (M) of total medical costs. **CONCLUSIONS:** Healthcare costs are highest among BC patients with metastatic disease, totaling as much as $45,817 in the 6-month period after diagnosis. Approximately 50% of costs are related to inpatient and emergency department services.

PCN68

COST OF CARE FOR GASTRIC CANCER IN PATIENTS WITH AND WITHOUT METASTASES

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OBJECTIVES: Due to the paucity of data with respect to real-world costs of care among individuals with gastric cancer (GaCa), the objective of this analysis is to evaluate the cost of care among individuals diagnosed with GaCa in 2 large retrospective databases. **METHODS:** Two large integrated claims databases spanning July 2008 to September 2012 were used to identify patients ≥18 years old diagnosed and treated for GaCa. Patients were required to be chemotherapy-naïve, continuously enrolled for ≥6 months pre- and post-diagnosis, and have no other cancer diagnosis at baseline. Eligible patients were stratified into cohorts based on the presence and timing of metastasis (M) diagnosis: no metastasis (NM), ≤120 days (M1), and ≥121 days (M2). All costs were adjusted to 2013 dollars. **RESULTS:** There were 5,609 (3,486 NM, 1,469 M1, 654 M2) and 3,203 (2,004 NM, 875 M1, 324 M2) patients in each of the databases, with 189 and 23, respectively, without cost data. Mean follow-up was 24 months in one dataset and 25 months in the other. Total average monthly costs at baseline were: NM $770–$847; M1 $662–$773; and M2 $634–$1,020. Total average monthly costs during follow-up were: NM $1,631–$2,004; M1 $9,813–$9,945; and M2 $6,598–$8,465. Medical costs represented 86%, 94%, and 93% of monthly costs for NM, M1, and M2 patients, respectively. Overall, 33% of patients received chemotherapy during follow-up and mean monthly chemotherapy-related costs were $966–$1,109, $2,502–$3,079, and $1,480–$1,521 for NM, M1, and M2, respectively. **CONCLUSIONS:** The results demonstrate the high burden to treat this population, with the highest costs in the group with metastases at diagnosis (M1) and medical-related costs as a major driver of overall treatment costs.

PCN69

COST OF TREATMENT OF RADIOPHARMACEUTICAL AND CHEMOTHERAPY FOR THE TREATMENT OF CASTRATION-RESISTANT PROSTATE CANCER WITH BONE METASTASES IN HOSPITAL SETTING

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OBJECTIVES: A substantial proportion of prostate cancer care is expected to be completed in the outpatient hospital setting; however, there is limited information on the actual cost of care in this setting. The objective of this analysis was to evaluate the total annual costs of treatments for castration-resistant prostate cancer (CRPC) with bone metastases for the following agents: cabazitaxel, docetaxel, radium 223, and sipuleucel-T. **METHODS:** An economic model was developed from the hospital outpatient perspective with a 1-year time horizon. The expected cost of each treatment from the outpatient practice perspective was based on reported per-visit treatment costs, professional/administration costs, laboratory/monitoring costs, and allocated overhead costs. The total treatment cost per visit was multiplied by the annual number of expected treatment cycles to calculate annual treatment costs. Hospital-specific adverse event (AE) costs were applied to published grade 3 and 4 AE rates for each comparator and added to the total cost per treatment. **RESULTS:** The total annual cost of therapy was lowest for docetaxel ($72,051), followed by radium 223 ($92,489), cabazitaxel ($93,742), and sipuleucel-T ($101,499). The treatment cost per visit was highest for sipuleucel-T ($30,936), followed by radium 223 ($12,362), cabazitaxel ($11,564), and docetaxel ($3,396). AE cost were $765 for sipuleucel-T, $5,123 for radium 223, $8,074 for cabazitaxel, and $11,223 for docetaxel. **CONCLUSIONS:** Total annual costs for CRPC treatments ranged from $72,000 to $101,500 per patient. Docetaxel had the lowest total annual costs, followed by radium 223, cabazitaxel, then sipuleucel-T, while sipuleucel-T had the lowest AE costs followed by radium 223, cabazitaxel, and docetaxel.

PCN70

COST – EFFICACY STUDY FOR IPILIMUMAB IN THE CHILEAN MARKET

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OBJECTIVES: To establish the cost per month of mean overall survival improvement, in Chilean patients treated with ipilimumab, from a third payer perspec-

tive. **METHODS:** We compared ipilimumab treatment for advance melanoma with other drugs for advanced cancer that met inclusion criteria including: (1) positive phase three study with overall survival as primary or secondary aim, (2) authorized by Chilean government agency, and (3) verifiable price in the private market. We performed a cost – efficacy analysis, using local prices obtained from published local sources to calculate an average cost to progression. Time to progression was obtained from published clinical trials. Mean overall survival improvement was used as the efficacy metric. Cost – efficacy outputs were plotted and compared. All costs are presented in 2014 USD. Additionally, a survey to Chilean oncology specialist was designed to obtain qualitative information about their experience(s) with ipilimumab for the treatment of metastatic melanoma patients in Chile. **RESULTS:** Nineteen drugs met inclusion criteria with 28 advance cancer indications. The average cost per month of mean survival improvement was estimated at $24,802 (range 1,737 – $91,256). We estimated the cost per additional month of mean survival improvement at $13,122 and $14.843 for first and second line treatment with ipilimumab respectively. Based on the survey, local expert opinion unanimously stated that ipilimumab is the best treatment alternative for patients with advanced melanoma. **CONCLUSIONS:** Compared with other innovative drugs for the treatment of advanced cancers, the cost per mean survival improvement with ipilimumab was below the average market value and may provide good value for money from a third payer perspective in Chile. Based on the survey, specialists noted ipilimumab as the best treatment option for Chilean patient with advanced melanoma.

PCN71

BEVACIZUMAB FOR FRONT-LINE TREATMENT OF EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER PATIENTS WITH HIGH RISK OF RELAPSE: A COST EFFECTIVE OPTION FOR CANADIAN PATIENTS

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OBJECTIVES: In the ICON7 randomized controlled trial, Oza et al. reported that the 502 front line ovarian cancer patients who were at a high-risk of relapse, that is patients with stage III suboptimal debulking, stage III unresectable or stage IV disease, could benefit most effectively from the addition of bevacizumab (7.5mg/kg) to chemotherapy (carboplatin, paclitaxel), compared to chemotherapy alone in the front line setting. The objective of this study is to investigate the cost effectiveness (CE) of this proposed change in treatment practices. **METHODS:** Long-term PFS and OS were predicted using log-logistic time-to-event parametric functions over a time horizon of 10 years. Canadian PFS health state utility values were obtained from the mapping of EQ5D scores from ICON7's high risk patient population. Post progression utility values were derived from Naik et al (2014) Canadian study. The cost inputs, including standard resource use practices, for this CE model were informed from public sources, gynecological oncology experts and ICON7. An annual 5% discount rate was applied to both efficacy and costs. A probabilistic sensitivity analysis (PSA) as well as one-way sensitivity analyses were conducted. **RESULTS:** The ICON7 high-risk patients receiving bevacizumab plus chemotherapy had a mean LY gain of 5.8 months compared to patients on chemotherapy alone, and a mean QALY gain of 4.5 months. This resulted in an ICER of $74,084CAD per LY gained and $96,261CAD per QALY gained. 55% PSA simulation of the QALY ICERs were at $100,000CAD or less. **CONCLUSIONS:** Although no formal willingness-to-pay threshold exists for health technology assessments in Canada, $100,000CAD has been estimated for oncology drugs. At a $100,000CAD threshold, bevacizumab in addition to chemotherapy provides a cost-effectiveness alternative for high-risk patients (i.e. stage III suboptimal debulking, stage III unresectable or stage IV) with ovarian cancer in the front line setting.

PCN72

INDIRECT COSTS AMONG METASTATIC BREAST CANCER PATIENTS RECEIVING ERIBULIN

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OBJECTIVES: This study examined indirect costs in terms of productivity loss among patients who received eribulin vs. other commonly used chemotherapies in the treatment of metastatic breast cancer (MBC). **METHODS:** The MarketScan Health and Productivity Management Database (2008-2012) was used. Patients who initiated eribulin, or received single-agent gemcitabine/capecitabine/vinorelbine as the last chemotherapy during the index period (July 2008-Nov 2012) were defined as each corresponding study cohort. Adult MBC patients eligible for ≥1 month employee benefits of short-term disability (STDI) were identified. Difference in STDI days was compared between study cohorts using Wilcoxon-rank-sum-test. STDI-related costs were estimated by multiplying leave days by median weekly wages. Two-step generalized linear models were used to estimate adjusted indirect costs by controlling for age, payer, region, comorbidities, prior chemotherapy, and hormone therapy. **RESULTS:** A total of 43 patients receiving eribulin, 99 gemcitabine, 54 vinorelbine, and 303 capecitabine were eligible for STDI (mutually exclusive). Eribulin patients had either similar (vs. gemcitabine or vinorelbine) or more (vs. capecitabine) chemotherapy agents prior to initiating index treatment. Eribulin patients had either numerically lower or similar STDI days per-patient-per-month compared to those receiving other therapies (6.2±10.8 vs. 8.8±11.0 [gemcitabine], P=.055; 7.1±10.3 [vinorelbine], P=.201; 6.1±9.2 [capecitabine], P=.295). In addition, eribulin (vs. gemcitabine) patients were less likely to have any STDI leave (30% vs. 53%, P=.014). The adjusted mean indirect costs associated with STDI per-patient-per-month were $720 (95% CI: $470-$1,102), $944 (95% CI: $595-$1,175), $837 (95% CI: $744-$1,198) and $635 (95% CI: $536-$753) for eribulin, gemcitabine, vinorelbine and capecitabine patients, respectively. **CONCLUSIONS:** Productivity loss, as measured by utilization of STDI and associated costs, tended to be lower in MBC patients treated with eribulin vs. gemcitabine and similar to vinorelbine or capecitabine.

PCN73

COST-EFFECTIVENESS ANALYSIS OF ARSENIC TRIOXIDE FOR THE TREATMENT OF IN PATIENTS WITH ACUTE PROMYELOCYTIC LEUKEMIA

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OBJECTIVES: Acute promyelocytic leukemia (APL) is a distinct subtype of acute myeloid leukemia (AML) with approximately 1,000 to 1,500 new cases diagnosed each year in the United States (US). Trisenox (arsenic trioxide, ATO) is currently licensed for the treatment of patients with APL who are refractory to, or have relapsed from previous treatment with all-trans retinoic acid (ATRA) and anthracycline-based chemotherapy. This analysis evaluated the cost-effectiveness of ATO+ATRA in the treatment of newly diagnosed low-to-intermediate risk APL in adult patients, compared to two other widely used regimens: ATRA+Ara-C+chemotherapy, and ATRA+Idarubicin (AIDA). Cost-effectiveness was measured as incremental cost per quality-adjusted life year (QALY) gained and per incremental cost per life year (LY) saved from a third-party payer perspective in the US. **METHODS:** A Markov cohort model with monthly cycles and four health states (1st-line stable disease, 2nd-line stable disease, 2nd-line disease event, and dead) was developed. Patients in the model begin treatment at age 45 and were followed until death. Eight months duration of ATO+ATRA was compared to either 15 months of ATRA+Ara-C+chemotherapy or 33 months of AIDA. Efficacy data (event-free survival.overall survival) were obtained from key clinical trials. Quality of life/health utility data were obtained from the literature. Costs were obtained from standard US data sources. Transition probabilities were estimated by calibrating the model to event-free and overall survival Kaplan-Meier curves for each treatment. Deterministic and probabilistic sensitivity analyses were conducted. **RESULTS:** Compared to ATRA+Ara-C+chemotherapy, ATO+ATRA had incremental cost effectiveness ratios of $5,900/QALY gained and $4,800/LY saved. ATO+ATRA weakly dominated AIDA (had a lower incremental cost-effectiveness ratio and more QALYs and LYs) in newly diagnosed patients. The results were robust to sensitivity analysis. **CONCLUSIONS:** The shorter and better-tolerated regimen of ATO+ATRA is a highly cost-effective strategy compared to ATRA+Ara-C+chemotherapy or AIDA in the treatment of newly diagnosed low-to-intermediate risk APL patients.

PCN74

COST-EFFECTIVENESS OF RADIUM-223 DICHLORIDE (RADIUM-223) IN ALSYMPCA: A COST-EFFECTIVENESS ANALYSIS OF RADIUM-223+BEST STANDARD OF CARE (BSOC) COMPARED WITH PLACEBO+BSOC IN TREATMENT OF CASTRATION-RESISTANT PROSTATE CANCER (CRPC) AND SYMPTOMATIC BONE METASTASES IN CANADA

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OBJECTIVES: In ALSYMPCA, radium-223+BSoC significantly prolonged overall survival by 3.6 months (HR=0.70; 95% CI, 0.58-0.83; P<0.001). Analysis of prospectively collected medical resource utilization (MRU) data from ALSYMPCA demonstrated that radium-223+BSoC vs BSoC reduced overall MRU, including number of hospitalization days/patient/year (8.1 vs 14.6; P<0.001). An existing cost-effectiveness analysis (CEA) model was modified by incorporating the prospective MRU data from ALSYMPCA to evaluate their effect on estimated cost-effectiveness of radium-223+BSoC vs placebo+BSoC in Canada. **METHODS:** A Markov model was developed with 5 health states, reflecting disease progression and SSEs. The Canadian payer perspective was used. Quality of life data were from ALSYMPCA; cost inputs were from recognized Canadian sources. Costs and outcomes were discounted at a 5% annual rate. Model time horizon was 5 years. **RESULTS:** Incorporating MRU data reduced the incremental cost estimate by $11,065 relative to CEA without MRU data and improved the incremental cost-effectiveness ratio for radium-223+BSoC vs placebo+BSoC by ~35% to $73,408 ($20,098 incremental cost, 0.274 quality-adjusted life years [QALYs] gained), substantially lower than the frequently referenced, although not explicitly stated, Canadian cancer drug threshold ($100,000/QALY). Sensitivity analyses demonstrated robustness of cost-effectiveness results. Patient management costs were affected primarily by differential hospital utilization between treatment groups. **CONCLUSIONS:** Including directly observed MRU data in this model markedly improved the impact of radium-223 vs modeled benefits alone, confirming its cost-effectiveness as a treatment for CRPC with symptomatic bone metastases and no visceral metastases. Reduced hospital utilization with radium-223 may be driven by delays in time to symptomatic skeletal event (SSE) and reduced hospitalization days/patient/year after SSE (Cislo et al. ASCOQCS 2014).

PCN75

COST-EFFECTIVENESS ANALYSIS OF FEMALE HUMAN PAPILLOMAVIRUS VACCINATION IN MAINLAND CHINA

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OBJECTIVES: To evaluate cost-effectiveness of different HPV vaccination as alternatives or additions to the current screening program to prevent and control cervical cancer in Mainland China. **METHODS:** A Markov model was developed for a cohort of 100,000 12-year-old girls to simulate the natural history of low risk and high risk to HPV infection and its progress to cervical cancer or genital warts. Three recommended screening (protocol 1. Liquid-based cytology test + HPV DNA test; protocol 2. Pap smear cytology test + HPV DNA test; protocol 3. Visual inspection with acetic acid) and two types of HPV vaccination programs (bivalent and quadrivalent vaccines) were incorporated to the two kinds of HPV vaccines. Input data were obtained from literature review, national databases, and a field study. Sensitivity analyses