OBJECTIVES: In many European jurisdictions relative effectiveness assessments (REAs) of breast cancer drugs are performed as part of the reimbursement decision making process. Collaboration in the production of these assessments across jurisdictions prevent duplication of information in various jurisdictions and save resources accordingly. A first pilot of a joint REA of pharmaceutical (paclitaxel) for the treatment of metastatic breast cancer was performed in 2011. The aim of this study is to verify how informative the joint REA is for national assessments by comparing the joint REA of paclitaxel with nationally produced assessments on the same topic. These REAs are performed in the limited number of programmes identified through a literature search and an email request to health technology assessment (HTA) organisations. Data were abstracted from the assessments using a structured data abstraction form including questions about the criteria assessed, the sources, the evidence included, the assessment of the evidence and the outcome of the assessment. The abstracted data were validated by representatives from the various organisations.

RESULTS: In total five jurisdiction specific HTA reports, available in English, were included in the review. Two of the NMB were published, the others were supplementary reports with included literature, extracted data, and assessed the quality of reviews. PRISMA checklist was used by the author to undertake the meta-analysis. RESULTS: 146 publications were retrieved. Final number of publications included went down to 14 [The PRISMA scoring for 71% of them (10 publications) were 21-24/27]. From which 25 cost effectiveness studies were extracted. Not every oncology drug showed high ICER (above £30 000), only 30 studies (45% of the publications), which contradicts the heterogeneity among studies, a random effects model is presented. Treatment decision was changed in 30.8% (95% CI 26.7% to 35.0%) of all patients. From all patients, net change of CT use was 16% (95%CI 12-20) in the low risk group (CT+HT to HT); 0% (4 to 9) in the intermediate risk; and -2% (3 to -1) in the high risk group, in this latter group CT use (vs CT+HT) was reduced. The joint REA showed a significant impact on treatment decisions (from 100 women, 31 will have their treatment optimized, and 14 less net CT overall). Its main effects consist of sparing chemotherapy in low risk patients, and increasing it in the high risk category.

PCN275
TOWARDS A FRAMEWORK FOR ANALYSING SUSTAINABILITY OF ECONOMIC VALUE: THE CASE OF A SHORT STAY PROGRAMME FOR BREAST CANCER SURGERY CARE AFTER FIVE YEARS AFTER IMPLEMENTATION
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OBJECTIVES: Critical analysis of sustainability of health care innovations is a relatively new concept. The aim of this study was to provide an analytical framework for the evaluation of sustainability of economic value in health care. The application of the framework was demonstrated by using an exemplary case on a short stay programme for breast cancer surgery care (SSP) in the Netherlands. METHODS: Sustainability of economic value was determined in terms of the incremental net monetary benefit (INMB), in this case, five years after the implementation of this programme was presented an analytical framework for the analysis of sustainability of economic value. The proposed framework provides guidance to analyse the sustainability of the economic value achieved in the post-implementation phase. Application of the framework raised issues as when to perform the analysis, the appropriate perspec-
tive and level of analysis (macro or meso level), and whether regression correction should be performed. A limitation of the illustrative case study was that costs of sustainability activities were not collected.

PCN276

CRITICAL ASSESSMENT OF COST-SHARING SCHEMES USING SIMPLE MODELING APPROACH

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OBJECTIVES: To critically assess cost-sharing schemes between payers and marketing authorization holders (MAHs) that are in some jurisdictions used as a means to control public spending on prescription drugs.

METHODS: Cost-sharing scheme can be theoretically expressed as the two-step process where the discount rate equals p when x > n, and 0 when x < n, where n is the number of weeks/months with reduced price of a drug and x is the length of treatment in weeks/months. Within such a scheme, the discount rate has no impact as it is not involved to x, i.e., n/p. Payers and MAHs may estimate and agree upon the expected length of treatment x–m, based on, e.g., randomized clinical trials (RCTs); however, these estimates may be unreliable due to, inter alia, market power of MAHs that could displace for stratified medicine in oncology. We wanted to identify p BRSPs to measure and estimate a decreased price of a drug and patient's years of a drug. The findings of this study may have practical applications in guiding resource allocation and planning in the oncology setting.

RESULTS: Two-step cost-sharing scheme results in the effective discount that is lower than expected by discount (k – m)/k, once x surpasses m. The lower limit of the discount can be achieved if the two-step cost-sharing scheme is modified by an additional step: the discount then equals (i) p when x > n, (ii) 0 when m < n < x, and (iii) n/pm when x > m. Cost-sharing scheme in this format guarantees that the effective discount remains at the expected level of n/pm, and gives no incentive to MAHs to exert their market power and prolong treatment duration. We applied our simple model to a real-life case of innovative oncological drug (p = 100%; n = 6 weeks; m = 30 weeks).

CONCLUSIONS: We have shown that cost-sharing schemes should be considered as a step function in order to ensure the effective control of expenditures for drugs. This finding may be of value to those jurisdictions that resort to cost-sharing as a tool in curtail prescription drug costs.

PCN277

NEW REIMBURSEMENT SCHEMES FOR STRATIFIED MEDICINE IN ONCOLOGY – A SYSTEMATIC REVIEW

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OBJECTIVES: Limited data regarding effectiveness, efficacy or cost-effectiveness are available. Many reimbursement schemes reflect uncertainties that payers try to counteract with performance-based risk-sharing arrangements (FBRAS). FBRAS link medicines’ reimbursement to health outcomes and seem to reduce these uncertainties – especially if implemented in a stratified medicine setting. We wanted to identify p BRSPs to describe stratified medicine in oncology. We wanted to identify p BRSPs to describe stratified medicine in oncology. We wanted to identify p BRSPs to describe stratified medicine in oncology. We wanted to identify p BRSPs to describe stratified medicine in oncology.

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CONCLUSIONS: We have shown that cost-sharing schemes should be considered as a step function in order to ensure the effective control of expenditures for drugs. This finding may be of value to those jurisdictions that resort to cost-sharing as a tool in curtail prescription drug costs.

PCN278

ANTI-CANCER TREATMENTS IN ELDERLY (≥ 75 YEARS OLD) PATIENTS: A RETROSPECTIVE ANALYSIS

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OBJECTIVES: To describe current guidance on BRCA testing practices in patients with familial history of breast cancer (OC). To describe current guidance on BRCA testing practices in patients with familial history of breast cancer (OC). To describe current guidance on BRCA testing practices in patients with familial history of breast cancer (OC).

METHODS: To describe current guidance on BRCA testing practices in patients with familial history of breast cancer (OC). To describe current guidance on BRCA testing practices in patients with familial history of breast cancer (OC).

RESULTS: We identified 43 publications resulting in 40 FBRAS (Canada: 12, Italy: 9, UK: 7, Australia: 8, The Netherlands: 2, USA: 1, Slovenia: 1). Most schemes are related to leukemia (mainly dasatinib, imatinib and nilotinib). These FBRAS were categorized in six different classes – risk-sharing arrangements (n = 29), outcomes (n = 5), cost-effectiveness (n = 4), quality assessment (n = 2), ambigous FBRAS (n = 1), and conditional treatment continuation schemes (n = 2). Money back guarantees (n = 3) and coverage with evidence development schemes (CED) such as ‘only in research’ schemes (n = 8). Quality assessment was limited by lack of reporting on FBRAS’ details. Therefore, ambiguity remains about FBRAS’ cost-effectiveness and their reduction of uncertainties. CONCLUSIONS: RRS provide faster access to therapies, guarantee reimbursement for manufacturers and possibly cost containment for payers, but do not necessarily collect additional evidence. The administrative burden and related costs appear to be huge. Existing value of information analysis approaches were not applied to CED schemes. Evaluation of FBRAS is necessary to assess their value.

PCN279

SYSTEMATIC TREATMENT OF METACHRONOUS METASTASIS AFTER CURATIVE TREATMENT OF BREAST CANCER

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OBJECTIVE: To describe systemic treatment of metachronous metastases and the reasons of not receiving systemic treatment in patients with breast cancer.

METHODS: Patients diagnosed with breast cancer without metastasis at initial diagnosis (M0) between 2006-2008 were selected from the Eindhoven Cancer Registry. By means of active follow-up by the Cancer Registry staff until January 2012, data on median age of metastasis, treatment, and reasons for not receiving systemic treatment were collected directly from the patients.

RESULTS: Of 1,382 patients diagnosed with M0 breast cancer, 116 (8%) developed metachronous metastases during follow-up of 4.4 years. Of the patients developing metachronous metastases, 86 (74%) patients received systemic treatment with a median (± SD) age of 59.7 (± 13.4) years. Of these, 46 patients (53%) received chemotherapy, 19 patients (24%) received hormonal therapy and 21 patients (25%) received a combination of chemotherapy and hormonal therapy. Median (± SD) age of the patients who did not receive systemic treatment (n = 30) was 70.0 (± 15.9) years. Of the 67 patients receiving chemotherapy, 17 patients (25%) were treated with taxane containing chemotherapy as first-line treatment. Of the 30 patients without any systemic treatment, 10 patients received radiotherapy, 3 patients underwent surgery and 6 patients refrained from systemic treatment. Other reasons for not receiving systemic treatment included poor performance status, diagnosis by means of clinical examination, advanced age, and refusal of systemic treatment, primarily due to other treatment policies, refraining from treatment or poor condition. This study provides more insight into the treatment of metachronous metastases in breast cancer.

PCN280

CURRENT GUIDANCE FOR BRCA MUTATION TESTING IN OVARIAN CANCER PATIENTS

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OBJECTIVES: To describe current guidance on BRCA testing practices in patients in whom there is a strong suspicion of ovarian cancer (OC).

METHODS: To describe current guidance on BRCA testing practices in patients in whom there is a strong suspicion of ovarian cancer (OC).

RESULTS: We identified 43 publications resulting in 40 FBRAS (Canada: 12, Italy: 9, UK: 7, Australia: 8, The Netherlands: 2, USA: 1, Slovenia: 1). Most schemes are related to leukemia (mainly dasatinib, imatinib and nilotinib). These FBRAS were categorized in six different classes – risk-sharing arrangements (n = 29), outcomes (n = 5), cost-effectiveness (n = 4), quality assessment (n = 2), ambigous FBRAS (n = 1), and conditional treatment continuation schemes (n = 2). Money back guarantees (n = 3) and coverage with evidence development schemes (CED) such as ‘only in research’ schemes (n = 8). Quality assessment was limited by lack of reporting on FBRAS’ details. Therefore, ambiguity remains about FBRAS’ cost-effectiveness and their reduction of uncertainties. CONCLUSIONS: RRS provide faster access to therapies, guarantee reimbursement for manufacturers and possibly cost containment for payers, but do not necessarily collect additional evidence. The administrative burden and related costs appear to be huge. Existing value of information analysis approaches were not applied to CED schemes. Evaluation of FBRAS is necessary to assess their value.

PCN281

PREVENTING PATTERN OF ANTI-EMETICS FOR PREVENTION OF CHEMOTHERAPY INDUCED NAUSEA & VOMITING—AN OBSERVATION OF CLINICAL PRACTICE VERSUS STANDARD GUIDELINES

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