this patient population, with a focus on related hospitalizations and costs. 

**Methods:** Men receiving ADT with ≥2 claims for a diagnosis of PC were identified in the International Commercial Medical Data registry (1/1/2009-12/31/2018). Index date was the first ADT claim. Patients were required to be continuously enrolled 6-months pre- and ≥2 months post-index. Patients with a major adverse cardiovascular event (MACE: myocardial infarction, cerebrovascular-accident, unstable angina, percutaneous coronary intervention, and/or coronary bypass graft) post index and insurance eligibility for ≥30 days after MACE were identified. Thirty-day (30) post-MACE hospitalizations and MACE-related costs (2018 USD) were assessed. **Results:** The study included 49,153 men with PC on ADT. 8,102 patients (16.5%) experienced a MACE during the entire study period. A total of 6,754 (13.7%) qualified for the post-MACE analysis; most had Medicare (86.6%) coverage. In the 30-days post-event, a high proportion of patients incurred a MACE-related hospitalizations (Medicare: 46.6%; Commercial: 45.3%); inpatient costs among patients with a MACE admission were $26,624 and $55,322 (SD: $569,539) in Medicare and commercial patients, respectively. **Conclusions:** PC patients treated with GnRH agonists are at increased risk of CV events. When MACE occurs, patients likely require a hospitalization, with a focus on related hospitalizations and costs. Early detection of bone metastases and SREs, and the use of vertebral fractures, non-vertebral fractures, radiation to bone, spinal cord compression, and surgery to bone were obtained from country-specific sources. Productivity losses were also calculated. Costs were expressed in 2020 USD for the costs. **Objectives:** To estimate the current and future economic burden of SREs in adult patients with cancer in Latin American countries: Argentina, Brazil, Colombia, and Mexico. Based on expert input and market research, 35%-70% of patients with PC on ADT; 8,102 patients (16.5%) experienced a MACE during the whole study period. A total of 6,754 (13.7%) qualified for the post-MACE analysis; most had Medicare (86.6%) coverage. In the 30-days post-event, a high proportion of patients incurred a MACE-related hospitalizations (Medicare: 46.6%; Commercial: 45.3%); inpatient costs among patients with a MACE admission were $26,624 and $55,322 (SD: $569,539) in Medicare and commercial patients, respectively. **Conclusions:** PC patients treated with GnRH agonists are at increased risk of CV events. When MACE occurs, patients likely require a hospitalization, with a focus on related hospitalizations and costs. Early detection of bone metastases and SREs, and the use of the most effective therapies are associated with additional costs which may be considered as reasonable and bearable from the Greek payer perspective. **Methods:** To estimate the budgetary impact from the introduction of liposomal Irinotecan as a treatment option for patients with metastatic pancreatic cancer (mPDAC) who have previously received gemcitabine-based regimens in Greek health system. **Objectives:** To estimate health care resource utilization (HCRU) and costs in different disease stages of acute myeloid leukemia (AML) in Finland. **Methods:** Real world data of adult patients (≥18 years) diagnosed with AML (ICD-10 C92.0) 2004-2016 was collected from Auria Biobank. Data on HCRU (secondary healthcare visits, medical procedures, laboratory tests, AML-related hospital drugs) were collected from the medical records of Turku university hospital. The unit costs were extracted from the 2020 hospital price list. Drug costs are not included in the cost calculation. Costs are reported as average costs per patient. Economic assessment of a new healthcare intervention, including the BIM comparing CPX-351 to conventional cytoreductive chemotherapies (7+3 regimen). The BIM followed a dynamic cohort entering the model every 6 months using the disease progression data provided by (French registry, NCT02050137) and (Ghanem et al, JCO 2018). This analysis was driven by the acceptance of CPX-351 and the projected uptake of liposomal Irinotecan was provided by Servier. Drug acquisition costs were considered in the analysis and were retrieved from the Greek Ministry of Health. The model measured outcome was incremental budget impact from the introduction of liposomal Irinotecan as a treatment option in the patients with mPDAC. **Results:** The regimen of liposomal Irinotecan plus 5-FU/LV (target population and patient pathway) are editable to enable adaptation at the hospital level. Model base case parameters/inputs are based on Study 301 (Lancet J. Clin Oncol 2018;36:2684-2692) and French real-world data. **Results:** At a national level, the introduction of CPX-351 increases total costs (+36%) and total revenues (+105%). The incremental budget impact is driven by the acceptance of CPX-351 and the projected uptake of liposomal Irinotecan. **Conclusions:** The analysis suggests that, those clinical benefits are associated with additional costs which may be considered as reasonable and bearable from the Greek payer perspective.