pharmacoeconomics, economic burden and quality of life (QoL) was conducted. Further, a Delphi panel was organized to discuss the disease and management of NM-CRPC and mCRPC. More, one-to-one web-meeting among 35 clinical experts specialized in urological oncology were performed. Finally, Delphi panel meetings were organized to discuss the disease burden of NM-CRPC and mCRPC. The rejection of drugs with a proved efficacy was based on individual national data from the National Registry of Reimbursed Health Services and the National Cancer Registry. The cost of treatment was estimated by comparing all healthcare provided in the period 2010–2018 for cases and controls (persons with/without CRC). Costs were calculated by age, stage and clinical phase of the disease. Subsequently, the lifetime costs of individuals were estimated and included in the cost-effectiveness analysis (together with the specification of the natural history of the disease and the screening process) of three strategies (without screening, with early screening, or screening using the Markov model).

**Results:** Through screening program, with a baseline participation of 45%, it is possible to reduce the incidence of CRC by 44% (FIT/colonoscopy) and 34% (FIT), respectively. Similar results can be observed for CRC mortality, where screening has the potential to reduce mortality by 47% and 35%, respectively. The increase in costs associated with the screening and follow-up diagnostics in screening scenarios is offset by an increase in the cost of treatment of patients with CRC. In the cohort, which was offered FIT, the average costs per individual decreased by 3,010 CZK and in the cohort, which also offered colonoscopy, by 3,653 CZK compared to the cohort without screening. **Conclusions:** The presented study clearly demonstrated the cost-effectiveness and even cost savings for both screening strategies offered in the Czechia in comparison with the absence of screening.

**PCN167**

**ESTIMATION OF THE FINANCIAL IMPACT OF CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL THERAPY FOR FRENCH HOSPITALS**

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**Objectives:** The purpose of this study was to estimate incremental cost-effectiveness ratio (ICER) values of the antitumor drugs approved and rejected for the vital and essential drugs list (VEDL) in Russia in 2018. **Methods:** We estimated ICER values of the antitumor drugs proposed for the inclusion into VEDL in 2018 in Russia to compare the values of the approved and rejected drugs using a simplified method—cost-effectiveness acceptability curve (CEAC) and the Markov model, the difference between the cost-effectiveness acceptability curves (CEACs) of approved and rejected drugs, and the denominator was the difference in years of life saved. **Results:** We compared ICER values of all approved and rejected drugs in 2018. The ICER values for approved drugs were significantly lower than those for rejected drugs. The ICER values of drugs approved in 2018 were significantly lower than those for rejected drugs. All rejected drugs with a proved benefit in progression-free survival have ICER from 9,690 USD to 238,783 USD per year life without tumor progression. **Conclusions:** The ICERS of drugs approved for the inclusion into VEDL 2018 vary significantly and often surpasses the same value for the rejected drugs.

**PCN166**

**COST-EFFECTIVENESS OF COLORECTAL CANCER SCREENING PROGRAM IN THE CZECH REPUBLIC**

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**Objectives:** Colorectal cancer is the most diagnosed cancer and one of the most common causes of death in the Czechia. A properly implemented screening program leads to a reduction in the burden of colorectal cancer (CRC) and thus to money savings. The objective of our study was to estimate cost of illness and evaluate cost-effectiveness of the screening program in the Czechia. **Methods:** The study was based on individual national data from the National Registry of Reimbursed Health Services and the National Cancer Registry. The cost of CRC treatment was estimated by comparing all healthcare provided in the period 2010–2018 for cases and controls (persons with/without CRC). Costs were calculated by age, stage and clinical phase of the disease. Subsequently, the lifetime costs of individuals were estimated and included in the cost-effectiveness analysis (together with the specification of the natural history of the disease and the screening process) of three strategies (without screening, with early screening, or screening using the Markov model).

**Results:** Through screening program, with a baseline participation of 45%, it is possible to reduce the incidence of CRC by 44% (FIT/colonoscopy) and 34% (FIT), respectively. Similar results can be observed for CRC mortality, where screening has the potential to reduce mortality by 47% and 35%, respectively. The increase in costs associated with the screening and follow-up diagnostics in screening scenarios is offset by an increase in the cost of treatment of patients with CRC. In the cohort, which was offered FIT, the average costs per individual decreased by 3,010 CZK and in the cohort, which also offered colonoscopy, by 3,653 CZK compared to the cohort without screening. **Conclusions:** The presented study clearly demonstrated the cost-effectiveness and even cost savings for both screening strategies offered in the Czechia in comparison with the absence of screening.
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PCN172
METASTATIC RENAL CELL CARCINOMA: INCIDENCE AND COSTS FROM A LARGE ITALIAN CLAIMS DATABASE
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Objectives: To evaluate the healthcare resources' consumption and integrated costs in the perspective of the Italian National Health System (NHS) of patients with renal cell carcinoma and incident metastasis (mRCC). Methods: Starting from the ReS database, through the NHS administrative data record linkage, patients aged ≥18 and hospitalized with IC9-CM code) with primary/secondary diagnosis of renal cancer and lymph node and/or distant metastases in the same discharge form (index date) were identified. The incidence of metastases was ascertained with their absence in two years before the index date. The cohort was characterized in the accrual by gender, age and comorbidities, other than the neoplastic care. Results: Out of >7 million inhabitants of the ReS database in 2015, 133 adults (2.1x100,000) were hospitalized with a diagnosis of mRCC. The 63.2% of them (1.4x100,000) received a new diagnosis of metastasis in 2015 (73.8% males, mean age (±SD): 68.13). The most common comorbidity was arterial hypertension (70.2% of the incident cohort). During the one-year follow-up, >50% of patients were hospitalized, mostly ascribed to kidney cancer, metastasis and antineoplastic therapy. On average, hospitalizations cost €8,897/patient; 61% of the expenditure in daily and 11.4% in ordinary regimen were ascribed to antineoplastic therapy. The 82.1% entrusted the outpatient specialist care accounting for €1,075/patient (26.9% for antineoplastic therapy). The mean total healthcare expenditure for the NHS was €22,067/patient. Conclusions: This study shows the current burden of mRCC in Italy. Real-world findings can reveal the real impact of mRCC, estimate the target population of incoming first line therapies and help responding to unmet clinical needs.

PCN173
INSURANCE STATUS AND HEALTH CARE RESOURCE UTILIZATION AMONG NON-INSTITUTIONALIZED ADULT CANCER SURVIVORS IN THE UNITED STATES
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Objective: To examine the association between insurance status and healthcare resource utilization among cancer survivors in the United States. Methods: A retrospective cross-sectional analysis of 2017 Medical Expenditure Panel Survey for cancer survivors aged ≥18 years, identified using International Classification of Diseases, Tenth Revision codes specific for cancer. Key independent variable was health insurance coverage categorized as private, Medicare, Medicaid and uninsured. Dependent variables consisted of health care visits (office-based, hospital outpatient, emergency room and inpatient hospital stays). Separate multivariable negative binomial regression were then used to adjust the adjusted differences in number of healthcare visits by insurance status after controlling for confounding factors. Results: A total of 1140 adult cancer survivors (weighted:138,785,30) were identified. In the unadjusted analysis, adults with Medicaid coverage had highest mean office-based visits followed by those with private insurance 15.6 (Standard deviation:15.30 vs 14.6 (SD:20.39); p<0.05) while emergency room visits were greater for adults with Medicaid and least for uninsured (0.58;SD:3.71 vs 0.30;SD:2.02; p<0.0001). When stratified by the type of cancer, patients with lung cancer had higher approvals. As of office-based (16.60;SD:7.09), outpatient (14.43;SD:15.5) and inpatient visits (0.42;SD:3.7) when compared to breast, colon, malignant neoplasms of skin and other types of cancers. In the adjusted analyses, the unexpected office-based visits for uninsured adults decreased by 47% (95% Confidence Interval CI): 0.05, 0.05). However, hospital outpatient and inpatient stays did not differ significantly between the insurance groups. Conclusion: Our findings suggest that office-based and emergency room visits can vary significantly by insurance status among adult cancer survivors. This data can be used for appropriate health care planning, especially for the cancer survivors.

PCN174
ACHIEVABILITY OF THE 2030 UNITED NATIONS SUSTAINABLE DEVELOPMENT GOALS IN BREAST CANCER CONTROL
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Objectives: Sustainable Development Goals (SDGs) target a one-third reduction in non-communicable disease (NCD) mortality between 2015-2030. In 2015, 22% of NCD deaths, and breast cancer is the leading cause of female cancer mortality. Therefore, reducing female breast cancer mortality is critical. We projected health outcomes for women with breast cancer in 195 countries to quantify progress towards the 2030 target of the SDGs. Methods: We used data on incidence and mortality rates for female breast cancer reported by The Global Burden of Disease (GBD) Study 2017 between 2000–2017. We projected mortality rate and MIR by national income level, as defined by the World Bank, for 2018–2030 using generalized linear mixed-effects models. Results: Overall, breast cancer mortality is projected to increase by 12.4% from 19.02 (95% confidence interval CI): 17.36–20.64) to 21.38 (95% prediction interval PI): 19.03–23.93), while MIR is projected to decrease by 10.3% from 0.404 (95% CI: 0.358–0.452) to 0.362 (95% CI: 0.342–0.383). In 2017, MIR was 2.22 times higher in low-income countries (LICs) and 1.71 times higher in lower middle-income countries (LMICs) than in high-income countries (HICs). Although MIR is projected to decrease by 2030 across all income groups (15.9% in HICs, 10.6% in upper middle-income countries, 3.66% in LMICs, 10.2% in LICs), 2030 MIR is projected to be 2.37 and 1.96 times higher in LICs and LMICs, respectively, than MIR in HICs. Conclusions: MIR is a better indicator than mortality to measure progress towards SDGs for breast cancer control. The decreasing global breast cancer MIR from 2015 to 2030, despite increasing mortality, indicates that global progress is being made in breast cancer. However, disparities across income levels will remain notable in the absence of significant resource-stratified policy reform.