longer in women living in the Pacific region (p=10.64 days, CI 95%: 0.51-20.77, p>0.04), compared to Bogotá, the capital of Colombia. Women with state insurance had a significantly longer TTI than those insured by the third payer (p=18.35 days, CI 95%: 11.00-25.50, p=0.01).

Conclusions: Demographic variables (region of residence and health insurance) which are proxies of social disparities and poor access to quality health care services, were associated with delays in TTI in Colombian women with CC.

Cancer - Health Technology Assessment

PCN230
A SYSTEMATIC LITERATURE REVIEW ON COST-EFFECTIVENESS OF NEXT-GENERATION SEQUENCING (NGS): NGS COMPARED TO OTHER HIGH-THROUGHPUT SEQUENCING METHODS IN THE CONTEXT OF PERSONALIZED CANCER THERAPY
Filipov A,1 Mitova R,2 Slavchev G,3 Sjambazov S,4 Vekov T5
1HTA Ltd., Sofia, 2, Bulgaria, 2Medical University Pleven, Pleven, Bulgaria

Objectives: The objective of this review was to investigate and collate the cost-effectiveness data of Next-Generation Sequencing (NGS) in comparison to other high-throughput sequencing (HTS) methods in the field of cancer research. NGS was analyzed in terms of subsequent treatment strategy.

Methods: Articles relevant to the objectives were chosen through key terms such as cancer/malignancy, next generation sequencing versus high-throughput sequencing, and cost/benefit/cost-effectiveness analysis. Costs included direct and indirect costs of the sequencing methods, and downstream costs such as treatment price. The review was based on the incremental cost-effectiveness ratio (ICER). Databases were screened for research articles with European data evaluating the cost-effectiveness of NGS and other HTS. Due to the rapid development of sequencing technology, our search was limited to articles that were published in the last five years (since 2015). Results: The data regarding NGS and subsequent treatment cost-effectiveness is limited and conflicting with some studies showing that NGS is cost-effective, while others reveal the opposite. Reported ICER in terms of NGS followed by targeted therapy is not affected much by sequencing costs and is affected by treatment choice and benefit instead.

Conclusions: The high-throughput nature of NGS produces better clinical results due to the improved targeting of therapies compared to HTS. However, the costs of NGS vary in different countries, and there is a growing need for economic analysis that facilitates decision-making processes regarding the use of diagnostic tools. Moreover, the varying costs of treatments across countries warrant local economic analyses of NGS in conjunction with targeted treatment.

PCN231
ASSESSING RECENT EU HTA TRENDS IN THE PD-(L)1 CLASS
Yewo L,1 Simmons G,2 Zhang M,3 Hunt M2
1CBPartners, London, LON, UK, 2CBPartners, New York, NY, USA

Objectives: The PD-(L)1 landscape has expanded rapidly since their first launch and well beyond into many pipeline trials. This poster aims to identify HTA trends and the drivers behind them for PD-(L)1s in France, Germany, and the UK over the last 5 years, in order to reveal key insights to support upcoming submissions for new PD-(L)1 products / indications. Methods: This study analyzed the HTA outcomes (i.e., HTA, CBA, and NICE) since 2015 for the EU-approved PD-(L)1s available. Key trends were identified and the drivers behind those trends were evaluated through reviewing product specific HTA commentary. Results: The influx of PD-(L)1 products and indications in recent years has led to an increase in payer scrutiny, with emerging HTA challenges for the PD-(L)1 class, particularly in France, Germany, and the UK. In France, a growing number of PD-(L)1 assessments are receiving SMR insufficient (i.e., no reimbursement) or ASMR V (i.e., no added value) from the TC. Furthermore, the TC is more often requesting additional longer-term follow-up data (e.g., 2-year OS) to validate product efficacy and confirm conditional ratings. In Germany, a rise in the number of PD-(L)1s receiving “non-quantifiable” added benefit ratings is observed, likely catalyzed by more frequent orphan indication submissions, as well as a greater perception of data uncertainty from the G-BA.

Conclusions: The proof of concept for CDF-approved drugs and to investigate whether there is differential access to CDF-approves drugs and to investigate whether there is differential access to oncology medicines in Scotland due to the absence of a CDF type fund. The secondary objective was to assess the reasons for entry into the CDF and reasons for negative or restricted use recommendations by the SMC. Methods: 34 drugs were identified via the NICE website as being in the CDF and eligible for analysis. The Managed Entry Access agreements were identified for each drug in the CDF and data collection requirements were completed. The reasons for uncertainty were categorized into 7 different categories. As a next step, the 34 drugs were identified on the SMC website and their assessment outcome recorded. For the drugs which were restricted or rejected, the submission paperwork was reviewed and categorised using the same 7 categories as the CDF drugs for comparison. Results: Out of 34 drugs that are currently in the CDF, 52% (19/