publication. ***Results:*** The study included 1109 patients (median age 72, 50% female). Real-world duration of therapy was median 5.0 months (95% Confidence Interval [CI]: 4.2-5.7). Median overall survival was 13.8 months (95% CI: 11.8-16.2) over the full study period. The sensitivity analysis excluding patients with missing PDL1 status found median overall survival of 14.9 months (95% CI: 12.5-17.6). The shorter time horizon (October 2016 to June 2018) estimated median overall survival of 13.1 months (95% CI: 10.8-NR). ***Conclusions:*** In this case, EHR-derived data offered longer follow-up time (max 49 months) than the trial follow-up (max 22 months) used for extrapolation. This cohort had a median overall survival of 13.8 months while the trial (n=154) estimated 30.0 months and a similar Medicare claims analysis (n=3079) estimated 11.4 months. Real-world median age was 7-9 years older than the trial. Our study demonstrates that EHRs can be a source of mature data on specific cohorts of interest with potential to contextualize trial evidence and inform HTA-decision making.

P15
TRANSCATHETER VERSUS SURGICAL AORTIC VALVE REPLACEMENT: A REAL-WORLD COMPARISON OF CLINICAL OUTCOMES BASED ON A GERMAN CLAIMS DATASET

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Objectives: This study aimed to describe clinical outcomes after transcatheter aortic valve implantation (TAVI) and surgical aortic valve implantation (SAVR). ***Methods:*** This study consisted of a retrospective analysis of German health insurance claims data from 01/01/2013-30/06/2019. Continuously insured adults with either TAVI (OPS 5-35a.0) or SAVR (OPS 5-351.0) between 01/01/2014 and 30/06/2018, who had aortic valve stenosis (ICD-10 I35.0, I35.2) were included. Patients with previous TAVI or SAVR were excluded. Both cohorts were described with regards to their baseline characteristics (one-year baseline) and the incidence rate (IR) of events during the follow-up period for death, transient ischemic attack (TIA), stroke, major bleeding event, periprocedural complications, and myocardial infarction (MI). ***Results:*** Overall, 2,932 TAVI and 826 SAVR patients were identified. Compared to SAVR patients, TAVI patients were on average older (81.75 years vs. 69.18 years), more often female (56.92% vs. 42.37%), more comorbid (CCI 5.86 vs. 3.82; CHA2DS2-VASc-Score 3.17 vs. 2.47), and they had a higher probability of previous TIAs (3.07% vs. 1.33%), strokes (8.29% vs. 4.00%), and MIs (10.57% vs. 3.87%). 3.07%/1.21% of TAVI/SAVR patients died during the index hospitalization. Outcomes were observed during a follow-up period of 2.43 years (TAVI) / 3.02 years (SAVR). The following IR have been observed for TAVI/SAVR: death (0.17 vs. 0.04; $p<0.001$), TIA (0.00 vs. 0.01, $p=0.046$), stroke (0.03 vs. 0.01, $p<0.001$), major bleeding event (0.08 vs. 0.04, $p<0.001$), periprocedural complications during index hospital stay (1.87 vs. 1.13, $p<0.001$), and MIs (0.02 vs. 0.00; $p<0.01$). ***Conclusions:*** TAVI has become the new standard of care in recent years and has replaced the classic aortic valve replacement, specifically in more fragile patients. The above results confirm that TAVI procedures are widely used in clinical practice, and that in line with current guidelines, physicians assess which patients should receive a TAVI or a SAVR procedure.

P16
RECENT ESTIMATES OF SURVIVAL IN PATIENTS WITH ADVANCED NON-SMALL CELL LUNG CANCER (NSCLC) IN THE US (2010-2020)

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Objectives: Despite availability of new treatments, the prognosis of lung cancer remains poor. This study aims to provide recent estimates of survival in patients with advanced non-small cell lung cancer (NSCLC) in the US. ***Methods:*** The survival of patients with advanced NSCLC was estimated using two US databases together covering 2010–2020. The study included patients with stage III or IV NSCLC diagnosed between 2010–2016 in the Surveillance, Epidemiology, and End Results Program (SEER) database, and patients with stage IIIB, IIIC or IV NSCLC, diagnosed between 2017–2020, without known oncogenic driver mutations who had completed ≥4 cycles of 1L treatment (restricted to platinum-based combinations, immuno-oncology monotherapy, or ipilimumab/nivolumab) in the Flatiron Health database, a US Oncology Electronic Medical Record database. Overall survival (OS) was defined as time from diagnosis of stage III or IV NSCLC to death or to date of last confirmed activity. ***Results:*** A total of 49,298 and 133,395 patients with stage III and IV diagnosis respectively were identified in SEER. The 1-, 3- and 5-year OS for patients with Stage III disease were 55.1%, 26.3% and 17.5%, and for stage IV disease were 25.8%, 7.4% and 4.0%, respectively. The Flatiron database had 1,045 patients with stage IIIB, 130 patients with stage IIIC and 3,210 patients with stage IV disease at diagnosis. The 1- and 3-year OS for stage IIIB/IIIC disease were 72.5% and 36.4%, and for patients with stage IV disease were 65.9% and 24.6%, respectively. ***Conclusions:*** Despite differences in study population characteristics between the two databases, the study shows that mortality in patients with advanced NSCLC remains high, underscoring the need for continued efforts to identify novel treatments and synergetic treatment combinations to improve patient outcomes.

Evaluating Individuals and Patients Preferences: Discrete Choice Experiments and Beyond

P17
PREFERENCE OF RHEUMATOID ARTHRITIS PATIENTS FOR TAPERING BIOLOGICS: A DISCRETE CHOICE EXPERIMENT

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Objectives: Tapering of biologics is a safe and feasible approach in the long-term management of rheumatoid arthritis (RA) patients who are in remission. However, the appeal of tapering strategies needs to be balanced against the risks of disrupting patients' disease control. The aim of this study was to measure the preferences of RA patients and their risk-benefit trade-offs in relation to biologic tapering. ***Methods:*** A web-based discrete choice experiment (DCE) was employed. Seven attributes (identified via focus groups and a systematic review) of varying levels describing three hypothetical choice were presented: frequency of treatment, chances of known adverse effects, chances of regaining disease control and healthcare service-related features. DCE data were analysed using mixed logit model to estimate the preference weights for key treatment features and to quantify trade-offs between the attributes. ***Results:*** A total of 142 complete responses were analysed. Mean age was 60.3 years with an average disease duration of 20.8 years Frequency of biologic treatment was the most important attribute, followed by the chance of flare upon tapering. Time to see the rheumatology team after a flare was ranked the least important among the seven attributes. On average, participants were willing to accept between 25.3% to 50.2% increase in chance of disease flare in exchange for reducing the frequency of biologic treatment, chance of serious infection and chance of skin cancer. ***Conclusions:*** This study provides evidence that RA patients' preference for tapering biologics are most influenced by the frequency of treatment and chance of flare. For these attributes, they are willing to accept a greater chance of flare in exchange for treatment benefits in the form of a reduction in biologic dosing and potential risk of serious infection and skin cancer associated with long-term biologic use. These findings have implications for clinical practice and policy making about tapering.

P18
PATIENT PREFERENCES FOR ATTRIBUTES OF A MULTI-CANCER EARLY DETECTION TEST: A DISCRETE CHOICE EXPERIMENT (DCE) QUANTITATIVE PILOT STUDY

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Objectives: Early cancer detection and intervention can significantly improve patient outcomes and reduce mortality rates. Evidence shows that emerging blood-based multi-cancer early detection (MCED) tests can detect a variety of cancer types across stages and provide a predicted cancer signal origin with high specificity. However, little is known about patients' preferences for MCED tests. This study aimed to quantify preferences for attributes of blood-based MCED tests among the US general population aged 50-80 years. ***Methods:*** A DCE consisting of five attributes (true positives, false negatives, false positives, likelihood of the cancer type unknown [e.g., inaccurate cancer signal origin], and number of cancers tested for) was administered online to US general population members to elicit preferences to quantitatively pilot test the DCE. Data were analyzed using an error-component multinomial logit model and relative attribute importance (RAI) was obtained. ***Results:*** Participants (N=303) were 62.0% male (n=188), mean age 68.2 years (SD=6.4). RAI indicated that the rank order of attribute importance was false negatives (35.7%), true positives (27.6%), false positives (17.3%), number of cancers tested for (16.8%), and cancer type unknown (2.7%). Attributes related to improved test accuracy were important and participants strongly preferred screenings that tested for more cancer types (all $p < 0.05$). Preferences were non-significant for the likelihood of cancer type unknown attribute levels. Overall, 71.9% of participants reported that they would prefer to receive the MCED test in addition to their currently recommended cancer screenings. ***Conclusions:*** Participants' preferences were strongly driven by the desire for a screening test with fewer false negatives and more true positives, with these 2 attributes comprising 63.3% of the RAI. False positive results and number of types of cancer tested for also impacted preferences but were of lower importance. The majority of participants preferred adding a MCED test to supplement current cancer screenings.

P19
ASSESSING HETEROGENEITY IN MAR: METHODS AND MODELS BEYOND DCE

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