of the Italian health care system. The following direct medical care costs were considered: drug costs (cost to the hospital at the dosage range reported in the SPC), administration costs (medical devices for deferoxamine, hospital cost), laboratory assessments (cost of laboratory exams from SPC, using hospital reimbursement tariff). All costs are expressed as Euros (year 2007 values). We considered the patients with beta thalassaemia major that live in the Veneto region. **RESULTS:** According to the Regional Rare Diseases Register, in Veneto 170 patients are affected by thalassaemia. 153 are eligible for deferasirox treatment. Switching all patients from deferoxamine (estimated annual costs: €734,808–1,327,797), to deferasirox (estimated annual costs: €3,615,382–5,575,618), would cause an expenditure increase of €2,881,074–4,247,823/year. From drug utilization data, it is estimated that about 15 patients with beta-talassemia are treated with deferiprone. In this scenario, the budget impact of switching all patients to deferasirox would be €2,858,547–4,283,481. **CONCLUSIONS:** Besides the advantage of the oral administration instead of continous subcutaneous infusion by pump, the impact of deferasirox on the regional budget is relevant. Alternative scenarios may take into account switching to the new drug only patients subgroups (e.g., patients who do not respond to deferoxamine) or patients for whom quality of life is strongly affected by the infusion pump.

PSY9

BUDGET IMPACT OF THE USE OF OROS® HYDROMORPHONE ONCE DAILY IN SEVERE CHRONIC PAIN PATIENTS IN THE GERMAN HEALTH CARE SYSTEM

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OBJECTIVES: The budget impact of introducing OROS® hydromorphone once-daily, a novel therapy for treating patients with severe chronic cancer and non-cancer pain, was determined in the German health care system. **METHODS:** The perspective of the social health insurance over a one-year time horizon was adopted. An Excel® based hypothetical budget impact model calculating the cost consequences of using strong opioids (WHO step III) was developed. The model accounts for the costs of opioids, breakthrough pain and adverse events. Patient numbers are calculated using epidemiological data from the literature; adverse event rates are based on literature. Comparators included sustained-release (SR) morphine (twice-daily), controlled-release (CR) oxycodone (twice-daily), hydromorphone (twice-daily), transdermal fentanyl and transdermal buprenorphine. Initial prescription share of OROS® hydromorphone was 2.4% (October 2007 MAT). This share was hypothetically extended to 8%. It was assumed that this increase in prescription of OROS® hydromorphone is gained by switching patients from their previous medication to OROS® hydromorphone (proportionally to the prescription share of the comparator at start). Titration and maintenance dosing schemes taken from previous analyses are used to model the switch. Morphine equivalence of hydromorphone was chosen according to SmPC. **RESULTS:** The number of patients treated was estimated to be 882,347 per year. The model predicted that the introduction of OROS® HM would lower the per patient drug cost from €684.28 to €679.52 (2008 public prices). The model also predicts that as the use of OROS® HM increases, the total budget for strong opioids decreases. If the prescription share of OROS® HM increased to 8% the total budget for strong opioids would decrease by €4,199,327. **CONCLUSIONS:** Our analysis suggests that under current circumstances the use of OROS® hydromorphone to treat patients with severe chronic pain will reduce the overall budget spent on strong opioids.

PSY10

ESTIMATION OF THE COSTS FOR A HEREDITARY HEMOCHROMATOSIS GENETIC SCREENING PROGRAMME PER 100.000 INDIVIDUALS UNDER 30 YEARS OF AGE IN SPAIN

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OBJECTIVES: Study costs of carrying out a genetic screening programme per 100.000 individuals from the Spanish population under 30 years of age for Hereditary Hemochromatosis (HH), based on the calculated penetrance of HH in the South-West Healthcare Area 11 of Madrid, and the published prevalence of the HH genotype in Spain. **METHODS:** Retrospective cross-sectional study of HFE genotyping requests from a subpopulation in South West Madrid pre-screened for high ferritin values, between January 2000 and June 2006. Based on our population's genotype and phenotype, clinical penetrance was calculated in a previous study. Costs, extracted from a Spanish Medical Cost database (SOYKOS), involved in treatment of HH-associated diseases, biochemical testing, genetic testing, treatment of phenotypical HH patients and follow up were analysed to compare the costs for genetic screening versus no screening. **RESULTS:** From our data, for the main HH-associated diseases, we have previously calculated a clinical penetrance, for HH genotype, in the population studied, of 1.11%, compared to 0.08% for those with wild-type HFE genotype. The main HH-associated pathologies considered are hepatopathy, diabetes and arthropathy. Cost for genetic testing of 100,000 Spanish individuals under 30 years of, biochemical follow up of those with HH genotype, and treatment of those with HH genotype and phenotype amounts to €1,808,353.29, equivalent to €1433.49/case with HH genotype detected and €129,168.09 per phenotypical case with HH genotype detected. Treatment of HH-associated pathologies, if no other preventive intervention is undertaken (biochemical monitoring, preventive phlebotomy treatment), would cost €407,043.70. **CONCLUSIONS:** The extremely low penetrance of HH-associated pathologies related to the HH genotype, suggests that a genetic screening programme for the population proposed is not economically justified for the Spanish National Healthcare System. However, this does not exclude genetic screening of first degree relatives of HH patients and their subsequent biochemical follow-up which could prove to be appropriate.

PSY11

EONOMIC EVALUATION OF ETANERCEPT COMPARED TO NO SYSTEMIC THERAPY IN THE MANAGEMENT OF LESS SEVERE CHRONIC PLAQUE PSORIASIS IN THE UK

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OBJECTIVES: NICE has recommended etanercept for use in patients with severe chronic plaque psoriasis, defined as a Psoriasis Area and Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10. This study assessed the cost-effectiveness of intermittent therapy with etanercept 25 mg twice weekly (biw) or 50 mg biw compared with no systemic therapy (NST) in patients with less severe disease. **METHODS:** An economic model was constructed to estimate the incremental cost per quality adjusted life year

(QALY) for etanercept compared with NST. Patients considered had chronic plaque psoriasis, PASI of 10–12 and any DLQI value at baseline. Response rates were taken from a pooled analysis of three studies of etanercept. Utility gain associated with response was assessed using patient level DLQI change mapped to EQ5D. Clinical and quality of life outcomes were extrapolated to a time horizon of ten years. Costs were estimated from a UK payer perspective including drug cost, administration visits and hospital stay for treatment failures. Probabilistic sensitivity analysis was undertaken. **RESULTS:** The model estimated incremental cost per QALY gained compared with NST to be: £2,850 (95% CI: Dominant to £6,084) for etanercept 25 mg biw and £10,351 (£7,056, £15,911) for etanercept 50 mg biw. Cost-effectiveness was sensitive to the duration of treatment holiday and response rate after therapy interruption. Cost per QALY gained in patients with baseline PASI in the range 10–72 and poor quality of life at baseline has previously been reported to be £3,299 for etanercept 25 mg biw and £10,923 for etanercept 50 mg biw. **CONCLUSIONS:** The model found treatment of a less severe psoriasis population to be cost-effective. Cost-effectiveness was comparable to findings in patients with more severe disease and poor quality of life at baseline.

PSY12

COST-EFFECTIVENESS OF FOOD FOR SPECIAL MEDICAL PURPOSES RELATIVE TO STANDARD CARE IN PATIENTS UNDERGOING ABDOMINAL SURGERY

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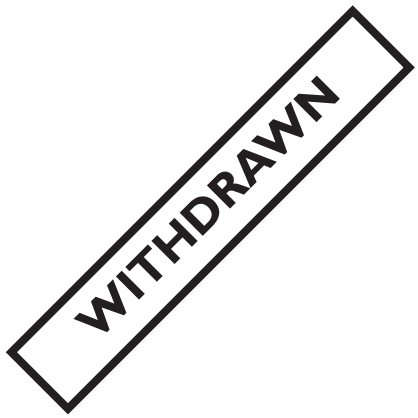
OBJECTIVES: To assess the cost-effectiveness of Food for Special Medical Purposes (FSMP) for the prevention of malnutrition in patients undergoing abdominal surgery from the perspective of the society in The Netherlands. **METHODS:** The costs and benefits of the two treatment strategies were assessed using a linear decision analytic model reflecting treatment patterns and outcomes in abdominal surgery. The model structure allowed for differences in costs and length of stay. The incremental cost difference was based on costs associated with cost of FSMP and hospitalization. Clinical probabilities and resource utilization were based on clinical trials and published literature; cost data were from official price tariffs. **RESULTS:** The use of FSMP reduces the costs from €3318 to €3066, which corresponds with a €252 (7.6%) cost savings per patient. The additional costs of FSMP are more than balanced by a reduction on hospitalization costs. The hospitalization costs reduce from €3318 to €3044 per patient, which is a 8.3% cost saving and corresponds with 0.72 days reduction in LOS. The use of FSMP would lead to an annual cost saving of €40.4 million based on the number of 160,283 abdominal procedures per year in The Netherlands. Sensitivity analyses were performed on all parameters, including length of stay and per diem costs. The results showed that the use of FSMP in all sensitivity analyses remain cost saving compared to "no use" of FSMP. A threshold analysis on the length of stay shows that at length of stay of 0.64 days, the use of FSMP is still cost-effective. **CONCLUSIONS:** The use of FSMP is a very cost-effective treatment in The Netherlands and is dominant over standard care without FSMP: cost savings and higher effectiveness.

PSY13



PSY14

COST-EFFECTIVENESS (CE) EVALUATION OF THE USE OF RITUXIMAB-CHOP VS. CHOP SCHEMES FOR THE TREATMENT OF AGGRESSIVE NON-HODGKIN LYMPHOMA (NHL) STAGES III AND IV: TREATMENT IMPACT OVER RELAPSE AND SURVIVAL, AT THE MEXICAN-NATIONAL CANCER INSTITUTE (MEX-INCAN)

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OBJECTIVES: To perform a CE evaluation of the use of CHOP vs R-CHOP for the treatment of aggressive NHL stages III and IV. **METHODS:** After a review of the medical literature about the economic impact of NHL treatment, we performed an analysis of the resources consumed by 116 patients with the diagnostic of NHL during 2004 in the Mex-INCan. The economic evaluation was done using an hypothetical cohort simulation through a five years by means of Markov Model with monthly transitions, using a five percent discount rate. The model included 11 health status: Diagnostic; 1st-line treatment, 1st-remission, 1st-relapse, 1st-progression, 2nd-line treatment