data to calculate direct, indirect and intangible costs in patients receiving ART. **METHODS:** Multicenter prospective observational study in eight German specialized centres for infectious diseases: four private practices/outpatient centres and four hospitals offering inpatient- and outpatient facilities. CORSAR started recruitment during 2009 and ends in July 2012, when the last patient reaches week 96. After signing informed consent, patients were included and stratified by treatment line. Treatment history and concomitant therapy were taken from the patients' records. Direct costs for hospitalization, outpatient care, other medical care and treatment as well as out of pocket payments and quality of life data were calculated from the data collected by quarterly questionnaires. **RESULTS:** A total of 1154 patients with a mean age 47.5y receiving ART were included. Time since HIV-diagnosis was10.6 years, 10.2% had viral load >50 cp/ml; 10.6% female; employment ratio 60.8%. Direct costs of treatment were mainly driven by antiretroviral drugs, accounting for 83.3%. Due to use of less complex ART-regimens and more frequent use of NNRTI-based ART in earlier treatment lines total costs were highest in advanced treatment-lines (>3rd) with 26,243 €/year compared to 22,718 €/year for initial therapy. The labour market participation rate also decreases with advancement in treatment lines (65% in first treatment line vs. 46% in >3rdtreatment lines). Indirect cost due to productivity losses account for 7% of total costs. **CONCLUSIONS:** Total costs were higher in later lines of therapy due to more complex, less NNRTI-based regimens. In comparison to earlier studies the impact of Non-ART-costs decreased. Expenses to be borne by the patient increased but are still less than 1%, indicating an increasing financial burden of people living with HIV by their disease within the German health system.

PIN34

DEVELOPMENT OF TREATMENT COSTS OF PATIENTS UNDERGOING REMISSION INDUCTION CHEMOTHERAPY: A HISTORICAL COMPARISON BEFORE AND AFTER INTRODUCTION OF POSACONAZOLE PROPHYLAXIS

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OBJECTIVES: Prior trials have demonstrated efficacy and effectiveness of posaconazole in the prophylaxis of invasive fungal diseases (IFDs) in high-risk patients. Controversy exists about the cost effectiveness of posaconazole prophylaxis in neutropenic patients with a high risk of IFDs. We performed an analysis comparing the direct costs of posaconazole prophylaxis against topical polyene (thrush) prophylaxis in patients with acute myelogenous leukemia (AML) and myelodysplastic syndrome (MDS). **METHODS:** Data of AML/MDS patients receiving remission-induction chemotherapy were analysed to compare hospital costs of patients before (2003-05) and after (2006-08) introduction of posaconazole prophylaxis. All cases were part of an earlier analysis demonstrating effectiveness of posaconazole over topical prophylaxis. Duration on general ward, intensive care unit, mechanical ventilation, diagnostic procedures and all anti-infective drugs were included into the cost analysis. **RESULTS:** Patient groups were well matched according to age, gender, underlying disease, and duration of neutropenia. The average costs per patient in the posaconazole group (n=76) and the topical polyene group (n=81) were 21,040 € (95% CI: 18,204-23,876 €) and 23,169 € (95% CI: 19,402-26,937 €) per patient, respectively. Antifungal treatment costs were nominally higher in the posaconazole group (4,580 € [95% CI: 3,678-5,482 €] vs. 4,019 € [95% CI: 2,825-5,214 €]). Costs for antibacterials (1,316 € [95% CI: 1,039-1,593 €] vs. 1,533 € [95% CI: 1,238-1,827 €]) were numerically decreased in the posaconazole group. Average duration of ICU stays were 1.79 (95% CI: 0.68-2.90) days per patient compared to 3.83 (95% CI: 1.53-6.13) days per patient. Costs for diagnostic procedures were 611 € (95% CI: 478-744 €) and 653 € (95% CI: 552-754 €) per patient, respectively. **CONCLUSIONS:** In our hospital, there was a trend towards cost-saving by posaconazole prophylaxis in patients receiving remission-induction chemotherapy. These cost savings were primarily caused by a shorter overall length of stay and the less frequent ICU treatment of patients receiving posaconazole.

PIN35

COST OF ANTIMICROBIAL PRESCRIBING USING A LARGE PHARMACY DATABASE IN SOUTH AFRICA

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OBJECTIVES: To provide a general overview of antimicrobial prescribing cost in a South African primary care patient population whose prescriptions were dispensed by community pharmacies. **METHODS:** A retrospective, cross-sectional pharmacoepidemiological study was conducted on prescription data of a national community pharmacy group in South Africa for 2010. All records for antimicrobials were analysed. The MIMS classification system was used. **RESULTS:** A total of 660 500 patients received 1 576 593 antimicrobial products during 2010 (average of 2.39 products per year) at a total cost of R191 875 007. The average age of patients was 34.23 years. Most patients were females (58.32%), and they were prescribed 60.12% of antimicrobial products. The average cost per antimicrobial product was R121.70 (SD=R158.21). Antiviral agents were the most expensive (R195.67), followed by aminoglycosides (R188.42). The least expensive products were chloramphenicols (R17.25) and sulphonamides and combinations (R22.68). Beta-lactams were the most often prescribed class accounting for 36.02% of all antimicrobial prescriptions. The average cost for a beta-lactam prescription was R99.53. The average cost per over-the-counter product was R32.75, compared to R158.21 for prescription-only antimicrobials. Most products were tablets (61.80%), followed by capsules (16.25%) and suspensions (14.39%). Per prescription, the injections were the most expensive (average of R343.85 per prescription), followed by ampoules (R324.56) and solutions (R267.33). Creams were on average the least expensive (R31.24). There was a clear peak in prescribing during the winter months (May to August). The single most often prescribed trade name product was a generic combination product of amoxicillin and clavulanic acid. On average, the most expensive trade name product was Valcyte 450R tablets (valganciclovir) at R12 217.76. **CONCLUSIONS:** This study provided a general overview of antimicrobial prescribing cost in a South African primary care patient population. Costs varied hugely with generic prescribing influencing costs.

PIN36

SIX YEARS OBSERVATIONAL STUDY OF THE COST OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY AND HIV/AIDS CONTROL

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OBJECTIVES: To analyze the changes in the highly active antiretroviral pharmacotherapy during the period 2006-2011 and its impact on cost and disease control of HIV/AIDS patients in Bulgaria. **METHODS:** It is a combined retrospective and prospective observational real life study on cost and therapeutic results of AIDS patient's therapy. Information was gathered for 2/3 of the treated patients for the antiretroviral combinations therapy and its cost, CD4 count and viral load. The changes in the dosage regimes, cost of therapy and its influence on CD4 count and viral load were evaluated. Descriptive statistic, Willcoxon tests, and Spearman correlation analysis were applied. **RESULTS:** On total 162 patients were included and out of them 48 identified with the changes in their therapy. Nearly 40 different dosage regimes were found prescribed as combinations of 3 or 4 medicines. During the period were introduces 3 new antiretroviral medicines (tenofovir, emtricitabine, darunavir). The average yearly cost of pharmacotherapy is increasing from 155 837.64 euro to 319 571.76 euro during 2006 - 2011. To all treatment naive patients were prescribed the newly authorized medicines that lead to sustained suppression of viral load to <20 in 45.46%. Introduction of the new medicines led to the increase in total pharmacotherapy cost with 291 89.64 euro, but also to better disease control. Statistically significant were the changes in the mean cost of therapy in 2007 vs 2006 (p=0,0002) and in 2010 vs 2009 (p< 0,0001). We found the statistically significant changes among the mean cost of therapy and viral load (p=0,0221), as well as among the mean cost of therapy and CD4 count (p=0,05). The correlation among the therapeutic results and the therapeutic combinations were found in 2011 (p=0,0064). **CONCLUSIONS:** AIDS remain costly disease for the health insurance budget but new medicines led to better control on its progression.

PIN37

THE ECONOMIC BURDEN OF INITIAL EMPIRIC ANTIBIOTIC FAILURE ON HEALTH CARE RESOURCE UTILIZATION FOR HOSPITALIZED PATIENTS WITH COMPLICATED INTRA-ABDOMINAL INFECTIONS (CIAIS) IN GREECE

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OBJECTIVES: To estimate the impact of initial empiric antibiotic treatment failure on pharmacological and total health care costs in hospitalized patients with cIAIs. **METHODS:** The economic impact associated with initial empiric antibiotic treatment failure was based on the results of an observational epidemiological study involving 201 adults with cIAI in Greece (NCT00929643). An average per patient-per day DRG value was estimated based on diagnosis at discharge and DRG mapping. Daily cost was then extrapolated to the additional length of stay (LOS), associated with initial antibiotic failure. Costs included expenditure for additional ICU and surgical interventions. DRG matching was validated by a specialist medical advisor. Mean per patient DRGs were weighed against subject percentage in each diagnosis group. Mean per patient costs for unsuccessful initial therapies were calculated using the latest formulary prices and the mean number of days on each antibiotic agent, as recorded in the observational study. **RESULTS:** The most frequently reported diagnoses (201 subjects) were perforation of the intestine (15.9%), acute appendicitis with peritoneal abscess (13.4%) and post–operative peritonitis (13.4%). Patients most commonly received metronidazole (59.2%), followed by b–lactamase inhibitors (38.3%) and second generation cephalosporines (30.3%) as empiric antibiotic treatment (as part of monotherapy, double therapy or triple therapy schemes). 78 patients exhibited failure of the initial treatment, whereas initial treatment was successful in 111 subjects with respective hospitalization of 21.9±16.4 and 8.9 ± 4.5 days. Total additional per patient resource cost was estimated to be €3,761.56 inclusive of unsuccessful mean empiric antibiotic expenditure, which was estimated to be €220.06 per patient. **CONCLUSIONS:** Retrospective data collected for a 2-year period showed that a significant percentage (42.9%) of patients exhibited failure of their initial antibiotic treatment. These patients had a greater chance of requiring prolongation of hospitalization and more extensive use of health care expenditure during times where resources are scarce.

PIN38

REAL LIFE STUDY OF ANTIFUNGAL TREATMENT IN GREEK ICUS: THERAPEUTIC STRATEGY AND HOSPITAL RESOURCE UTILIZATION – ESTIMATOR STUDY

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OBJECTIVES: The ESTIMATOR study aims to provide information on clinical and economic outcomes associated with the management of fungal infections across intensive care units (ICUs) in Greece. **METHODS:** ESTIMATOR was a non-interventional prospective cohort study conducted in 14 ICUs in Greece. Adult patients initiating therapy with a systemic antifungal agent between July 2011 and February 2012 were included. Information on predisposing factors, management and therapeutic strategies, clinical outcomes and length of ICU stay (LOICUS) were recorded until end of therapy or death. **RESULTS:** A total of 155 eligible patients were recruited. 68% of patients presented at least 5 predisposing factors for fungal infection at antifungal treatment (AT) onset, while the mean APACHE score was 22.4 (s.d. 5.9). Median time until AT initiation was 6 days after ICU admission, while the median LOICUS was 31 days. 49.7% of patients received treatment with an empiric strategy while prophylaxis, pre-emptive and definitive strategies where used at 6.4%, 20.0% and 23.9% of the study population respectively. Echinocandins (57.3%), Fluconazole (20.0%) and Itraconazole (12.9%) were the most utilized therapies in the study. The overall treatment success and mortality rates were 43.9% and 49.7% respectively. Variations in death and response rates were observed when adjusted to the treatment strategy and the class of drug used. The mean total cost per patient treated was estimated at 22,012 Euros. Average LOICUS accounts for the 80.8% of total direct costs, while antifungal treatment, tests and investigations account for the remaining 19.2%. Limited efficacy of first line antifungal agent is associated with an increase in economic costs of 74%. **CONCLUSIONS:** Treating patients for fungal infections imposes a high economic burden to hospitals. Significant cost drivers are prolonged LOICUS and treatment failure. Treatment options that result in LOICUS reduction and increased first line efficacy have the potential to reduce hospital cost.

PIN39

A COST CONSEQUENCE ANALYSIS OF A QUADRIVALENT MENINGOCOCCAL VACCINE (MENACWY-TT) IN CANADA

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OBJECTIVES: Neisseria meningitidis is a leading cause of life-threatening invasive meningococcal diseases (IMD). In most populated Canadian provinces, vaccination with the monovalent vaccine (MenC; against serogroup C) is recommended at one year of age. This study aimed to assess various quadrivalent vaccination strategies (MenACWY-TT covering serogroups A, C, W135 and Y) schedule (12 months with and without booster at 12 or 15 years) in Canada compared to the current strategy. **METHODS:** IMD incidence under the different scenarios was estimated using a dynamic model. The cost associated with IMD treatment, IMD sequelae and IMD mortality were estimated. Input data (mortality, rates of sequelae and costs) were retrieved from Canadian statistics and published studies. The time horizon was 50 years. A discount rate of 5% was applied on costs. Costs were estimated from the third-party payer (TPP) and the societal perspective (accounting for the productivity lost from IMD and its sequelae). Deterministic and probabilistic sensitivity analyses were conducted. **RESULTS:** Compared with MenC at 12 months, MenACWY-TT at 12 months was estimated to prevent an additional 862 IMD cases and 76 deaths, 3,362 IMD cases and 296 deaths with a booster at 12 years and 4,007 IMD cases and 353 deaths with a booster at 15 years. The treatment costs averted while switching to the MenACWY-TT vaccine were estimated at C$8.4 (no booster), C$31.9 (+ booster at 12 years) and C$39.6 millions (+ booster at 15 years) from the TPP perspective and respectively C$24.0, C$89.8 and C$112.2 millions from the societal perspective. Results were most sensitive to the incidence of IMD and serogroup-specific incidence of post-IMD sequelae. **CONCLUSIONS:** The model predicted that vaccinating with MenACWY-TT at 12 months with an adolescent booster would result in additional IMD and cost reduction compared to the current MenC at 12 months.

PIN40

COST-EFFECTIVENESS OF BOCEPREVIR-BASED TREATMENT OF CHRONIC GENOTYPE 1 HEPATITIS C VIRUS (HCV) INFECTION FROM THE PERSPECTIVE OF THE GERMAN STATUTORY HEALTH INSURANCE (SHI)

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OBJECTIVES: SPRINT-2 and RESPOND-2 randomized clinical trials have demonstrated substantially higher sustained virologic response rates (SVR) for boceprevir-based treatment compared to peginterferon and ribavirin (PR) alone in patients with chronic genotype 1 HCV infection. Our objective was to evaluate the cost-effectiveness of using boceprevir in Germany from the perspective of German Statutory Health Insurance (SHI). **METHODS:** A Markov model was created to project the effect of antiviral therapy options on Hepatitis C disease progression using German life tables and baseline patient demographics from the trials - mean age, gender, and fibrosis stage distribution. The first part of the model simulated two strategies - treatment with boceprevir/peginterferon/ribavirin (as defined by the European Medicines Agency) and treatment with peginterferon/ribavirin. The second part of the model projected lifetime incidences of decompensated cirrhosis, hepatocellular carcinoma, liver-transplant, and liver-related death. All hepatitis C-related state transition probabilities were obtained from previously published studies. Pharmacy retail prices minus rebates (Social code book V, § 130 (1) and § 130a (1a)) were used. The model was validated with previously published studies and probabilistic sensitivity analysis was performed. **RESULTS:** Liver-related morbidity and mortality were projected to be reduced by 43% to 53%. for a quality adjusted life year (QALY) gain of 0.8 in treatment naïve patients, and 1.4 in treatment experienced patients in comparison with SOC. The cost per QALY gained on boceprevir-based regimes compared to PR alone was 17,511€ for treatment naïve patients and 16,645€ for treatment experienced patients in comparison with SOC. **CONCLUSIONS:** In German SHI, the addition of boceprevir to PR in patients with chronic genotype 1 HCV infection reduces liver-related morbidity and mortality in a quantifiable and cost-effective fashion, irrespective of whether patients have been previously treated.

PIN41

COST-EFFECTIVENESS OF PERTUSSIS ADOLESCENT BOOSTER IN ENGLAND AND WALES: A DYNAMIC MODEL BASED ANALYSIS

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OBJECTIVES: Epidemiology of pertussis shows that despite effective vaccination in childhood, naturally acquired and vaccine induced immunity is waning over time leading to higher incidence in adolescents and adults. Literature estimates the annual incidence of pertussis in the UK reaches 330/100,000 compared with an incidence of 4/100,000 based on statutory notifications, highlighting the degree of under-reporting. This analysis examines the cost-effectiveness of the addition of an adolescent routine booster vaccination against pertussis to the schedule in England and Wales from a payer perspective. **METHODS:** An age stratified, compartmental dynamic model was developed and calibrated on HPA data corrected for symptomatic and asymptomatic cases and empirical contact rates. Two scenarios were compared: current pertussis vaccination schedule (2, 3, and 4 months of age) and a similar schedule with additional booster vaccination at 15 years with coverage of 59%. Total costs and quality adjusted life years (QALYs) were estimated. **RESULTS:** At equilibrium pertussis booster vaccination at 15 years is projected to reduce the combined reported and unreported incidence of pertussis in the following age categories: 10-19 years (55.0%), 20-59 years (31.3%) and 60-75 years (27.9%). There are 7155 QALYs gained annually in the UK population. Unreported symptomatic cases were assumed to incur no cost and 50% of the QALY benefit of reported cases but provided 98% of the total quality of life gained through total symptomatic cases. Annual implementation costs (£9.4M) would be partially offset by savings associated with reported cases (£1.5M). The incremental cost per QALY would be £1,103 from a payer perspective. **CONCLUSIONS:** Model projection indicates that adolescent routine booster vaccination against pertussis would reduce pertussis burden, and is likely to be cost-effective from a payer perspective.

PIN42

COST-EFFECTIVENESS-ANALYSIS OF THE COMBINATION- THERAPY TELAPREVIR, PEG-IFNA2A AND RIBAVIRIN IN PATIENTS WITH CHRONIC HEPATITIS-C IN AUSTRIA

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OBJECTIVES: Due to the fact that an infection with the Hepatitis-C-Virus usually runs chronic, this disease represents a major public-health challenge. Hence, the aim of this study is to evaluate the treatment of the Hepatitis-C-Infection with the standard-therapy Peg-IFNα2a in combination with Ribavirin vs. the combination-therapy Peg-IFNα2a, Ribavirin and Telaprevir. **METHODS:** For the decision tree analysis model, an extended cost-per-cure-analysis was performed. The used data derived from two large-scale double-blind, randomized, placebo-controlled Phase-III-Studies by Jacobson et al. (2011) and Zeuzem et al. (2011). The modeling was performed for the time horizons of 24 weeks, 48 weeks, respectively, which correspond to the duration of therapy. Examined patients were adults who were either treatment-experienced or treatment-naïve patients. **RESULTS:** The costs per responder in the group of previous relapser with the Telaprevir-combination-therapy amount to €47,097.89. In the control-group, the standard-care of treatment caused costs per responder of €80,563.05. For the combination-therapy with Telaprevir this results in a cost-advantage of €33,465.16 (42%) per responder. Costs per responder in the previous partial responders amount to €78,541.24 for the Telaprevir-containing regimen. In the control-group, the standard-therapy caused €128,900.89 (cost advantage of €50,359.65 (39%) for the combination-therapy). The costs-per-responder in the group of previous non-responders amount to €159,790.80 for the triple-therapy, compared to the standard-therapy with €386,702.66, resulting in a cost-advantage per responder of €226,911.86 (59%) for the combination-therapy. Total costs of the Telaprevir-containing therapy with naïve-patients amount to €54,410.53 per responder, compared to the control-group with €43,943.48, causing a cost disadvantage of €10,467.05 per responders (24%) for the combination-therapy with Telaprevir. Across all patient groups, a cost advantage per responder of €50,298.68 (42%) incurred (standard therapy Peg-IFNα2a and Ribavirin: €118,559.52, combination-therapy with Telaprevir: €68,260.84). **CONCLUSIONS:** The results of the analysis show that the combination-therapy with Telaprevir is the dominant strategy in the treatment of chronic Hepatitis-C Genotype-1 in Austria.

PIN43

THE USE OF FUTILITY RULES IN ECONOMIC EVALUATIONS WITH DIRECT ACTING AGENTS (DAA) IN THE TREATMENT OF GENOTYPE 1 HEPATITIS C VIRUS (HCV) FROM A SPANISH HEALTH CARE PERSPECTIVE

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Data on TB treatment cost and disease burden in South Africa. Appendix B. Costs of TB Drug Development [36,37]. Discover the world's research. 17+ million members.Â PIN35 Cost of Antimicrobial Prescribing Using a Large Pharmacy Database in South Africa. November 2012 Â· Value in Health. Ilse Truter. Read more. Article. Appendix: South Africa. June 1970 Â· The Journal of Commonwealth Literature. Tim Couzens. PIN35 COST OF ANTIMICROBIAL PRESCRIBING USING A LARGE PHARMACY DATABASE IN SOUTH AFRICA Truter I Nelson Mandela Metropolitan University, Port Elizabeth, Eastern Cape, South Africa OBJECTIVES: To provide a general overview of antimicrobial prescribing cost in a South African primary care patient population whose prescriptions were dispensed by community pharmacies. METHODS: A retrospective, cross-sectional pharmacoepidemiological study was conducted on prescription data of a national community pharmacy group in South Africa for 2010. All records for antimicrobials were analysed. The MIMS class Introduction: South Africa has an appreciable burden of both communicable and non-communicable diseases as well as high maternal, neonatal, and child morbidity. In recent years there have been significant strides with improving the public health system, and addressing current inequalities, with the right to health a constitutional provision in South Africa.Â Furthermore, there are increasing concerns with the global growth of antimicrobial resistance (AMR) similarly in South Africa, including multidrug resistant bacteria, fungi, HIV, and TB (Paruk et al., 2012). South Africa has responded through the development of a national AMR strategy (NDoH, 2015a), which is being put into action through the national implementation plan (NDoH, 2015b).