identified from the 100% national Medicare data population from 01JAN2009-31DEC2013. The first diagnosis date was designated as the index date. Patients were required to have continuous medical and pharmacy benefits 12 months pre- and post-index date. Study outcomes included demographic and clinical characteristics as well as health care costs and utilization for patients diagnosed with MDS. **RESULTS:** A total of 166,545 MDS patients were identified. The mean age was 80 years. The majority of patients were female (53.42%), white (88.06%), and resided in the South (38.99%) or Midwest (24.18%) US region. The mean Charlson Comorbidity Index scores were 4.99 (standard deviation = 3.49). The most commonly diagnosed comorbid conditions included hypertension (78.36%), and diabetes mellitus (33.07%). Health care utilization was assessed, including the proportion of patients with inpatient (26.89%), emergency room (ER; 28.00%), physician office (94.00%), outpatient hospital (80.81%), skilled nursing facility (SNF; 8.07%), hospice (2.04%), home health agency (HHA; 16.27%), and durable medical equipment (DME; 39.91%) claims. Patients with MDS incurred higher mean health care costs, including inpatient ($6,482), ER ($285), physician office ($4,805), outpatient hospital ($9,237), SNF ($1,720), hospice ($429), HHA ($1,004), DME ($511), Part D pharmacy ($2,496), and total costs ($26,968). **CONCLUSIONS:** During a 12-month period, Medicare patients diagnosed with MDS incurred substantial health care utilization and costs.

PCN240

OPPORTUNITIES FOR HIGH-COST DRUGS IN INDIA

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OBJECTIVES: Healthcare in India is a rapidly expanding sector. Increased urbanisation, better standards of living, a growing middle class, improvements in health standards cumulatively have led to increased longevity and a shift in burden of disease dominated by infectious diseases to non-communicable diseases (NCDs). NCDs like cancer are now one of the leading cause of morbidity and mortality in India. Oncology therapeutics are generally highly priced and recognised as defining the 'high-cost drugs' space in the Indian market. Emerging markets such as India represent untapped revenue potential for the major pharmaceutical companies. We sought to assess market access opportunity for such drugs in India including current disease treatment landscape and reimbursement channels. **METHODS:** Research involved targeted review of literature published on the topic, followed by primary research with senior oncologists involved in formulary decision-making and nationally influential on the field of practice. **RESULTS:** Various public and private health insurance schemes were identified, particularly those that reimburse high cost drugs. Extrapolating from the cover provided under various schemes and affordability across income groups, a threshold of ₹2 lakh (~$3000) per treatment course was set beyond which any drug was considered high cost. Overall, ~6% of the population receive very comprehensive health cover that reimburse high cost drugs through schemes provided by central government, state government, railway, armed forces. **CONCLUSIONS:** At first glance, opportunities for high cost drugs in India can be considered low considering limited reimbursement options and lack of affordability for majority of the population. However, 6% of the population engaged in the public sector have good health cover which include reimbursement for high cost drugs. Together, this is a substantial market and the opportunity should be considered as 'high'.

PCN241

THE IMPACT OF DIFFERENT TYPES OF PAYER ON HEALTHCARE RESOURCE UTILIZATION AND COSTS AMONG CANCER PATIENTS IN INDIA

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OBJECTIVES: To review the patient characteristics and treatment methods of breast, oral and ovarian cancer patients at a tertiary care hospital in India. **METHODS:** This study was a retrospective review of electronic medical records from a tertiary care hospital in Mumbai, India. Patients $\geq$18 years of age hospitalized for breast (BC), oral (OC) and ovarian cancer (OVC) treatment between Jan 2014 and May 2015 were included in the study. Descriptive and inferential statistics were used to analyze and compare differences between patients. Regression models were also used to determine predictors of total costs for all patients. **RESULTS:** A total of 323 cancer patients met the study criteria (BC=146 patients, OC=132 patients, OVC=45 patients). The mean length of stay was highest for OVC patients (OVC=9.4+4.55 days, OC=9.1+5.13 days, BC=5.3+2.5 days). Patients with BC went into surgery early and were discharged the early (Pre-surgery: BC=3.6+1.8 days, OVC=4.2+2.32 days, OC=4.6+1.9 days; Post-surgery: BC=3.2+1.2 days, OVC=7.2+2.57 days, OC=6.3+3.3 days) from the hospital. Among BC patients, patients with private insurance (PI) received the highest number of per patient clinician visits (PI=16.3 visits/patient, no insurance (NI)= 11.8, CGHS=2.7, RGJAY scheme=2.2; $p<0.001$). Among OC and OVC patients, patients with NI received the highest number of per patient clinician visits (OC: PI=36.5 visits/patient, NI=24.6, CGHS=8, RGJAY scheme=1.2; $p<0.001$; OVC: NI-35.9 visits/patient, CGHS-19.5, RGJAY-1.1, PI-30.3; $p<0.001$). Among BC and OC patients, mean hospital costs were highest for patients with PI (BC: PI= $2381.03+1739.31, NI=$1558.70+1342.56, CGHS=$723.19+731.57, RGJAY= $637.41+118.20; OC: PI=$5132.61+6158.41, NI=$1998.52+2057.81, CGHS= $1178.21+309.23, RGJAY=$795.77+$314.92). While NI patients incurred the highest mean hospital costs among OVC patients (OVC: NI=$3843.77+$2735.89, PI= $2735.89+2454.62, CGHS=$1849.73+1023.56, RGJAY=$653.01+$257.18). Clinician visits was found to be the significant predictor of costs in all regression models across cancer type. **CONCLUSIONS:** Patients with PI and NI incurred higher costs but received more resources, which could lead to better care, compared to patients covered under other insurance schemes.

PCN242

REAL-WORLD TREATMENT PATTERNS AND COSTS AMONG ADVANCED HEPATOCELLULAR CARCINOMA (AHCC) PATIENTS TREATED WITH SYSTEMIC CANCER THERAPIES

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OBJECTIVES: To describe the patient characteristics, pharmacologic treatment patterns and costs among commercially insured patients diagnosed with aHCC. **METHODS:** Newly diagnosed aHCC adults were identified using the Truven MarketScan Research Databasesbetween 1/1/2008-9/30/2015 (ICD-9-CM 155.0.x, 155.2x; on $\geq$1 inpatient or $\geq$2 outpatient claims). Continuous enrollment was required 6 months prior- and 1 month post- first diagnosis (index date). A claim for systemic therapy after the index date was required. Patients with prior diagnosis of other primary/secondary cancers were excluded. Outcomes included a descriptive assessment of patient characteristics, patterns of systemic therapy use and monthly/total healthcare costs. **RESULTS:** 4,902 patients met study criteria, mean (±SD) age 60.9 (±11.0) years, 32.6% female, and mean follow-up of 467 days (±466). 25.1% had a pre-index diagnosis of cirrhosis, 16.3% had HCV only, 3.0% had HBV only, 0.7% had both HCV and HBV. 43.6% of patients received sorafenib (SOR) as a first exposure. SOR users were more likely to have cirrhosis (39.5% versus 13.2%), HBV (6.3% versus 1.5%), and HCV (27.6% versus 8.3%) than non-SOR patients (all $p>0.01$). Among SOR users (n=2,217), 42.5% used target therapies, 5.1% used chemotherapies, and only 1 patient used immunotherapy within 60 days after first SOR use. Overall, mean total per patient per month (PPPM) healthcare costs were $16,148 (±$14,502). PPPM costs for SOR users (vs non-SOR) were significantly lower ($14,033 (±$12,488) vs $17,894 (±$15,766), $p<0.01$). Among sub-sets of patients with 6-months (n=3,309) or 12-months (n=2,103) of continuous enrollment, mean total costs were $101,119 (±$95,807) and $164,897 (±$143,357), respectively. **CONCLUSIONS:** The majority of aHCC patients received SOR (in first-line); however a variety of agents are used post-SOR despite no approved standard of care in second line. Given the limited number of approved treatment options overall and substantial PPPM costs, there is a clear need for more effective aHCC treatments.

PCN243

ASSOCIATION BETWEEN CANCER INFORMATION SEEKING VIA INTERNET AND CANCER FATALISTIC BELIEFS AMONG AMERICANS USING HEALTH INFORMATION NATIONAL TRENDS SURVEY

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OBJECTIVES: To determine association between internet cancer information seeking behavior and cancer fatalistic beliefs across people with and without cancer history. We hypothesized that the behavior would mitigate cancer fatalistic thoughts on cancer prevention and treatment. **METHODS:** A pooled cross-sectional study was conducted among US adults ($\geq$ 18 years) using Health Information National Trends Survey 2012 and 2014 data. Participants were categorized into two groups: with and without cancer history. The behavior of interest was whether they sought cancer information for themselves via internet (the eSeekers) in past 12 months (yes/no). Fatalistic beliefs were operationalized by participants' agreement or disagreement with three statements along the lines of everything causes cancer, cancer prevention is not possible, and too many recommendations are available for preventing cancer. Each fatalistic belief was analyzed separately across both groups. Weighted descriptive bivariate analyses were used to explore associations between socio-demographic factors and each fatalistic belief. Adjusted multivariable logistic regression was then employed to examine association between internet cancer information seeking behavior and each fatalistic belief. **RESULTS:** Of the total 5,454 participants, 1,022 (18.7%) reported using internet for seeking cancer information. Greater proportions of the eSeekers were aged 35-64 years, college graduates, urban dwellers, and with either personal or family cancer history. The eSeekers also reported higher agreement on behaviors (such as diet, smoking, exercise) cause cancer ($p<0.001$). The eSeekers without cancer history were 38% less likely to believe that they were overwhelmed with many recommendations for preventing cancer (Adj.OR: 0.62, 95% CI: 0.44-0.86). However, internet cancer information seeking behavior was insignificantly associated with the other fatalistic beliefs across both groups. **CONCLUSIONS:** Information seeking is a desired behavior for cancer prevention. However, we did not observe significant associations between the behavior and two out of the three cancer fatalistic beliefs across participants with and without cancer history.

PCN244

FDAMA114 LANDSCAPE ASSESSMENT: ARE US PAYER AND PROVIDER ACCESS DECISION MAKERS RECEPTIVE TO HEALTHCARE ECONOMIC INFORMATION CONSIDERING THE RECENT CHANGES TO FDAMA114

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OBJECTIVES: Section 114 of the FDA Modernization Act of 1997 (FDAMA114) provides companies with guidelines to share healthcare economic information (HCEI) with formulary decision makers. However, ambiguity in the phrasing of FDAMA114 has caused companies to exercise caution when distributing HCEI. The enactment of the 21stCentury Cures Act in December 2016 aimed to remove this ambiguity in an effort to increase HCEI utilization and standardization, and encourage collaboration in addressing rising healthcare costs. This research