OBJECTIVES: Equine recurrent uveitis (ERU) is the most common cause of blindness in horses world-wide. Several organisms have been associated with ERU, with leptospires being the most commonly reported agent. Irrespective of substantial treatment costs, the value of affected horses is progressively reduced as ocular involvements (unilateral or bilateral visual impairment or blindness) increase. This study aimed to estimate the number of horses affected by ERU in the U.S, and approximate the associated depreciation due to vision impairment. **METHODS:** The U.S. horse population size was estimated by market research. Published sources allowed the estimation of (1) the risk of ERU, (2) the associated visual impairments, accounting for breed differences, and (3) the loss of value in function of different ocular involvements and variable uses of a horse. Considering U.S. horse breeds and use distributions, the number of horses allocated to different levels of vision impairment and associated relative depreciations were calculated. Average value of horses was derived from official sources, conservatively excluding very high-priced competition/race horses. **RESULTS:** It was estimated that 576,000 horses are currently affected by ERU in the U.S. Based on retrospective studies, 198,513 and 104,269 of these horses are or are expected to become blind in one or both eyes during the next 11 years, respectively. From those horses being impaired but maintaining vision, 151,046 horses are unilaterally and 122,172 bilaterally affected. Depreciation in horses currently affected by ERU was conservatively calculated to $802,482,773. It was estimated that 70% of those losses are caused by leptospires. **CONCLUSIONS:** Approximately 576,000 horses are currently affected by ERU in the U.S., from which more than 300,000 horses will become blind in one or both eyes. ERU represents a substantial economic burden which conservatively calculates to more than $800 MM due to the loss of horse value, not considering treatment costs.

PSS14

COST OF ILLNESS, DIAGNOSIS AND TREATMENT PATTERNS FOR DIABETIC MACULAR EDEMA ACROSS 13 COUNTRIES

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OBJECTIVES: To estimate the cost of illness associated with diabetic macular edema (DME) in 13 countries, with a focus on diagnosis, treatment and cost of advanced disease. **METHODS:** A structured literature review to assess prevalence and cost of DME was conducted including Embase, Medline, government and professional association websites. Structured face-to-face or online interviews were conducted with 378 ophthalmologists experienced in managing DME to determine rates of diagnosis, use of drug and laser treatments and frequency of follow-up and monitoring visits. Countries were Belgium, Czech Republic, Finland, France, Germany, Ireland, the Netherlands, Poland, Portugal, Spain, Sweden, Switzerland and China. An excel model synthesizing data and estimated overall cost of illness was built; costs were converted to Euros at 2014 market rates. **RESULTS:** Across the 13 countries an estimated 5.3 million people have DME; physicians estimated 32-68% (range between countries) of DME patients are undiagnosed, a total of 3.1m people. Annual medical cost of DME was estimated to be €1.2bn, median medical cost per patient was €918, range from €46 (China) to €4,858 (Switzerland). Productivity loss due to poor vision in DME patients costs €4.7bn, 71% of the total cost of illness. Other cost components were laser and drug treatments (mean across countries 17.9%, range 1.4-38.9%), follow-up visits (5.8%, 2.6-33.9%) and monitoring visits (2.9%, 0.3-15.9%). Diagnosis accounted for 0.3% of the total cost (range 0.1-0.9%). Some cost components could not be reliably estimated for all countries. **CONCLUSIONS:** Considerable variation was identified in screening, diagnosis and treatment between countries. Despite the availability of effective therapies, physicians reported that current practice fails to identify a substantial proportion of patients with DME. Poor vision due to DME results in economic loss that is much larger than current spending on therapy. Limitations include use of expert opinion and incomplete data; results may not be generalizable outside the countries studied.

PSS15

COMPARING TOTAL AND DISEASE SPECIFIC HEALTHCARE COSTS FOR GLAUCOMA PATIENTS BEFORE AND AFTER THEIR INDEX DIAGNOSIS: A RETROSPECTIVE CLAIMS DATABASE ANALYSIS

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OBJECTIVES: Describing the cost of care for glaucoma patients will lead to a better understanding of the disease impact on the healthcare system. Few studies have determined healthcare costs associated with glaucoma patients, and even fewer examined a commercially insured population. This study sought to characterize and compare the glaucoma specific costs and overall healthcare costs before and after diagnosis. **METHODS:** We analyzed a large US commercial claims database to identify patients 18 years and older with an initial diagnosis of open-angle glaucoma occurring in 2011. Patients with two separate occurrences of open-angle glaucoma codes (ICD-9 365.10 or 365.11) were included. Patients were excluded for presence of a glaucoma code in the 12 months before their initial diagnosis, other types of glaucoma (i.e. angle-closure glaucoma), or other possible causes of vision loss (i.e.: cataracts). Outcomes of interest were glaucoma specific and overall healthcare costs for the 12-months before (baseline) and 12-months after (follow-up) initial diagnosis. Costs consisted of inpatient stays, emergency department visits, general and vision related office visits, glaucoma diagnostic tests, glaucoma surgeries, and medications. Paired t-tests were used to compare baseline and follow-up costs. **RESULTS:** 8,575 patients were identified as having newly diagnosed glaucoma in 2011. Mean glaucoma specific baseline costs were $107 (95% CI: $102, $112) and follow-up costs were $487 (95% CI: $475, $498); resulting in a 4.6-fold increase from baseline ($p \leq 0.001$). 41% of follow-up glaucoma costs were due to glaucoma medications. Mean overall healthcare costs at baseline were $5,405 (95% CI: $5,122, $5,688) and at follow-up were $7,106 (95% CI: $6,677, $7,534); resulting in a 1.3-fold increase from baseline ($p \leq 0.001$). 23.2% of follow-up total healthcare costs were due to medications. **CONCLUSIONS:** Glaucoma specific and overall healthcare costs significantly increase after glaucoma diagnosis for patients who are commercially insured.

PSS16

ESTIMATING THE TREATMENT COSTS FOR PATIENTS WITH CHRONIC SPONTANEOUS/IDIOPATHIC URTICARIA IN TAIWAN

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OBJECTIVES: Chronic spontaneous (or idiopathic) urticaria (CSU/CIU) affects approximately 0.6% of Taiwanese population. However, little is known about its economic impacts in the healthcare system. This study aims to examine the costs of CSU/CIU-related treatment in National Health Insurance (NHI) program of Taiwan. **METHODS:** Patients who had at least two outpatient visits (primary/secondary ICD-9-CM diagnosis code of 708.1, 708.8 or 708.9) with antihistamine prescription and occurred at least 42 days apart during 2011 were considered as the CSU/CIU cases from the NHI Research database(NHIRD). The cases were matched with controls in a 1:4 ratio by age, gender and residential areas from the 2011 NHI claims data files for 1-million beneficiaries who were representative of the population of Taiwan in 2005. Differences in costs associated with outpatient care, inpatient care, emergency care, medical tests and drugs between CSU/CIU cases and their comparison groups were predicted by the two-part models and the generalized linear models. All analysis was stratified by the severity level of CSU/CIU and all costs were reported in 2012 New Taiwan dollars (US$1 = NT$30). **RESULTS:** There were 145,700 CSU/CIU patients identified as the study cases based on above algorithm, of which 83.96% were mild CSU/CIU (dCSU), 15.79% were moderate CSU/CIU (mCSU) and 0.25% were severe CSU/CIU (sCSU). The case-comparison analysis showed that the NHI costs for patients with dCSU, mCSU and sCSU was 1.23 times, 1.43 times, and 1.93 times the costs of the matched controls, respectively. The annual total costs attributed to dCSU, mCSU and sCSU were NT$5,730, NT$9,168 and NT$20,522, respectively. Costs associated with outpatient care comprised the largest proportion of total costs for dCSU patients (60.0%) and for mCSU patients (57.5%). As for sCSU patients, the largest components of costs were medical tests (35.0%) and drugs (39.4%). **CONCLUSIONS:** CSU/CIU has substantially impact on direct medical costs in Taiwan. The costs increase remarkably with the severity of disease.

PSS17

COST OF CANALICULAR LACERATION REPAIR IN DIFFERENT HOSPITAL SETTINGS: A DECISION ANALYSIS

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OBJECTIVES: To calculate the costs of canalicular laceration (CL) repair at a tertiary academic eye care center based on setting and surgeon type. **METHODS:** A retrospective review of hospital records over a 10-year span of all primary CL repairs performed at a tertiary eye institution. Input variables included repair setting (minor procedure room; MPR vs. operating room; OR), surgeon type (oculoplastic surgeon, ophthalmologist, fellow, or resident), stent type (mini-Monoka vs. Crawford), and success rate (no epiphora/tearing down face, even with environmental stressors, at >3 months after stent removal). Procedure-level data were used to inform probabilities in a decision analytic model (TreeAge Pro). Costs inputs included supplies (institution acquisition prices for drugs and disposable equipment) and personnel (institution wages + 30% fringe benefits for surgeon, nurse, nurse anesthetist, anesthesiologist, and scheduler). Output of the model was cost per successful repair. Univariate sensitivity analyses were performed to test the impact of modifying base case inputs ± SD. **RESULTS:** The estimated cost per procedure was $US323 in the MPR and $US589 in the OR. The overall success rate in the MPR was 37%, vs. 88% in the OR ($p<0.0001$). The ICER revealed the incremental cost of performing CL repair in the OR per success to be $521.56. Within each setting, cost effectiveness of oculoplastic surgeons dominated vs. the other surgeon types. Sensitivity analyses revealed OR costs to be most sensitive to nurse anesthetist and nurse time, whereas MPR costs were most sensitive to ophthalmologist and nurse time. **CONCLUSIONS:** While it was more costly to perform CL repair in the OR, success rates were much higher. In addition, success rates were optimal when performed by oculoplastic surgeons, suggesting that sub-specialty training maximizes patient outcome. Findings are limited to a single institution but call to question whether this procedure should be performed in a MPR.

PSS18

COST-EFFECTIVENESS OF AFLIBERCEPT IN THE TREATMENT OF CENTRAL RETINAL VEIN OCCLUSION IN TURKEY

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OBJECTIVES: The objective of this study is to evaluate the cost-effectiveness of aflibercept compared to ranibizumab and dexamethasone in the treatment of central retinal vein occlusion (CRVO) in Turkey. **METHODS:** A Markov model consisting of health states based on the number of letters read in 15 letter increments from legal blindness (<35 letters) to 80+ letters with 30-year timeframe, was adapted to the Turkish local setting. Clinical inputs as transitions probabilities and incidences of adverse effects were mainly derived from the results of Phase III COPERNICUS and GALILEO trials. Economic inputs were based on the expert opinion addressing local treatment, monitoring and adverse event management algorithms. The primary endpoint was QALYs. Analyses were conducted from the Turkish Payer Social Security Institution perspective. All costs were calculated in Turkish Liras (TL) and converted to USD using TL/USD currency rate as 2,1 (mid-2014). **RESULTS:** The total number of QALYs associated with aflibercept, ranibizumab and dexamethasone were 17.926, 17.194 and 16.928 QALYs respectively; resulting in total of 0,101 and 0,368 more QALYs for the treatment with aflibercept

relative to ranibizumab and dexamethasone. Total costs associated with aflibercept, ranibizumab and dexamethasone were 4.260 USD, 5.219 USD and 1.631 USD respectively, resulting for the cost of aflibercept treatment being 959 USD lower compared to ranibizumab and 2.629 USD higher compared to dexamethasone. Aflibercept was dominant over ranibizumab. The ICER for aflibercept as compared to dexamethasone was calculated as 7.144 USD/QALY. **CONCLUSIONS:** For the treatment of CRVO in Turkish setting, aflibercept was found to be the dominant treatment option when compared with ranibizumab while being more effective and less costly. Compared with dexamethasone aflibercept was found as cost-effective with an ICER of 7.144 USD, well below the willingness-to-pay threshold (GDP per capita „Ÿ 10.782 USD) for Turkey.

PSS19

COST-EFFECTIVENESS OF SECUKINUMAB COMPARED TO CURRENT TREATMENTS FOR THE TREATMENT OF MODERATE TO SEVERE PLAQUE PSORIASIS IN CANADA

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OBJECTIVES: To assess the cost-effectiveness of secukinumab versus current therapies for plaque psoriasis in adults from the Canadian healthcare perspective. **METHODS:** A Markov model was designed to determine the cost-effectiveness of secukinumab 300mg for moderate to severe plaque psoriasis over a 10-year horizon versus secukinumab 150mg, adalimumab, etanercept, infliximab, ustekinumab (45mg or 90mg), and standard of care (oral systemics, topicals, and phototherapy, SoC). Year 1 of the model consisted of 4-week cycles with 4 Psoriasis Area and Severity Index (PASI) response level-based health-states (PASI ≥ 90, 75-89, 50-74, and < 50). Years 2-10 used annual cycles, with 3 health-states (PASI ≥ 75, PASI <75, and death). Decisions to switch to SoC were made at week 12 and 52, then annually. Efficacy data from a network meta-analysis informed first-year model transitions. Resource use, costs, and utilities were collected from clinical trials, published literature, expert opinion, and standard Canadian sources. **RESULTS:** The order of treatments by increasing quality-adjusted life years (QALYs) were: SoC, etanercept, adalimumab, ustekinumab 45mg, secukinumab 150mg, ustekinumab 90mg, secukinumab 300mg, and infliximab. The cost-effectiveness frontier showed etanercept was strongly dominated, while adalimumab, ustekinumab 45mg, secukinumab 150mg and ustekinumab 90mg were weakly dominated by secukinumab 300mg. The ICER for secukinumab 300mg versus SoC was $87,368/QALY gained. The ICER for infliximab versus secukinumab 300mg was $1,039,403/QALY gained. Deterministic sensitivity analyses indicated the results are most sensitive to time horizon, cost of biologics, and utility values. The probabilistic sensitivity analysis demonstrated that at a willingness-to-pay threshold of ~$90,000/QALY, secukinumab 300mg has the highest probability of being the cost-effective option. **CONCLUSIONS:** For adults with moderate to severe plaque psoriasis, secukinumab 300mg was associated with increased QALYs at a lower incremental cost compared to etanercept, adalimumab, ustekinumab and secukinumab 150mg. For each QALY gained versus SoC, treatment with secukinumab costed an additional $87,368.

PSS20

COST ANALYSIS OF THE PHILADELPHIA GLAUCOMA COMMUNITY DETECTION AND TREATMENT PROJECT

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OBJECTIVES: To report the cost per outcome of a robust model to deliver glaucoma examinations to older Philadelphians at community centers. **METHODS:** The cost-outcome analysis was performed taking a health system perspective, with outcome defined as diagnostic yield (cases of glaucoma detected and cases of any ocular disease detected). Costs included supplies (slit lamp, visual field machine, handheld fundus camera, laptops, medical and office supplies), travel (van rental, fuel, maintenance, personnel mileage reimbursements), and personnel time (for examination, travel to sites, training, and supervision). Personnel time was captured by time and motion data collected during site visits. Costs of community health workers and medical assistants were based on regional 2013 US Bureau of Labor and Statistics (BLS) wage rates, and ophthalmologist wages were based on 2013 NIH salary cap. Wage rates for project supervisors were assumed to be 25% more than a medical assistant. Fringe benefits were added to all wage costs at 31% (BLS). **RESULTS:** 1649 participants were examined from 2012-2013, of whom 68% were females, 70% were African-Americans, and the mean age was 69 (SD 11). The mean total examination time was 56 minutes (SD 4). Visual field and physician consult were the most time-consuming steps (11-13 minutes each). Glaucoma and angle closure represented 17% of the 2197 diagnoses made. Other diagnoses made included glaucoma suspect (16%), cataracts (52%), diabetic retinopathy (2%), and macular degeneration (1%). Examination and staff travel were the largest components of total costs at $67,018 and $24,340, respectively. The total program cost was $229,082 ($139/participant). The cost/case of glaucoma diagnosis (confirmed, suspected or angle-closure) was $550. The cost/case to detect any ocular disease was $104. **CONCLUSIONS:** The cost to deliver glaucoma examinations through this program is relatively low in relation to its diagnostic yield, however opportunities exist to improve efficiency of examination and travel.

PSS21

COST-EFFECTIVENESS OF AFLIBERCEPT IN THE TREATMENT OF WET AGE-RELATED MACULAR DEGENERATION IN TURKEY

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OBJECTIVES: The objective of this study is to evaluate the cost-effectiveness of aflibercept compared to ranibizumab for the treatment of wet age-related macular degeneration (wAMD) in Turkey. **METHODS:** A Markov model consisting of six health states on vision impairment as "no vision impairment; mild vision impairment; moderate vision impairment; severe vision impairment; total blindness; death" with a 20-year timeframe was adapted to the Turkish setting through an expert panel. Clinical transition inputs between visual acuity states and safety data were mainly derived from the results of Phase III VIEW-1 and VIEW-2 trials. Economic inputs were based on the expert opinion addressing local treatment, monitoring and adverse event management algorithms. The primary and secondary endpoints for the study were blind years and QALYs, respectively. Analyses were conducted from the Turkish Payer Social Security Institution perspective. All costs were calculated in Turkish Liras (TL) and then converted to USD using TL/USD currency rate as 2,1 (mid-2014). **RESULTS:** Aflibercept was associated with 6,614 blind years and 4,805 QALYs, while ranibizumab was associated with 6,599 blind years and 4,810 QALYs; resulting in total of 0,015 more blind years and 0,005 less QALYs for aflibercept compared with ranibizumab in the treatment of wAMD. Total costs associated with aflibercept and ranibizumab were 25.954 USD and 30.311 USD respectively; resulting with a total of 4.357 USD less costs for aflibercept compared with ranibizumab, driven by savings in medication, administration and monitoring costs. **CONCLUSIONS:** Aflibercept was found as the cost-effective treatment option when compared with ranibizumab in the treatment of wAMD in Turkish setting. Aflibercept was associated with significant less cost leading to savings in medication, administration and monitoring costs; while being clinically equivalent with negligible benefits as blind years averted and QALYs gained in comparison with ranibizumab.

PSS22

COST-EFFECTIVENESS OF IKERVIS® IN SEVERE DRY EYE DISEASE IN THE UK

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OBJECTIVES: Routine clinical practice in UK patients with severe dry eye disease is a combination of artificial tears (AT) and ocular lubricant ointments. This study aims to assess the cost-effectiveness to the UK NHS of the addition of Ikervis® (Ciclosporin A; CsA) to routine practice for patients who have not adequately responded to therapy. **METHODS:** Using a Markov framework, future health effects and costs were modeled. Eligible patients receive six months therapy with Ikervis® plus AT and ocular lubricants or AT and ocular lubricants without CsA. Upon completion, those who respond sufficiently remain on CsA treatment for the duration of the response, achieving a higher quality of life (HRQoL) and lower AT use. Incremental cost effectiveness ratios (ICER) were expressed in GBP (£) per QALY gained with costs and health effects discounted at 3.5% over a lifetime time horizon. Deterministic and probabilistic sensitivity analyses were employed to assess the effect of uncertainty on the model. Scenario analyses including less stringent improvement criteria, alternative approaches to deriving response stratified utility values and a shorter initial trial period were performed. **RESULTS:** Compared with AT alone, Ikervis® results in a lifetime cost to the UK NHS of £713 per patient, but offers an additional 0.04 QALYs. The ICER is £19,156/QALY gained. At a commonly accepted cost-effectiveness threshold of £30,000 per QALY, Ikervis® is cost-effective in 70.8% of simulations. Tornado analysis showed the model is most sensitive to the incremental benefit on patient's long-term HRQoL associated with responding to therapy compared with non-response. **CONCLUSIONS:** The modelling study showed that from an NHS perspective, health gains can be achieved at a low cost. The Ikervis® ICERs are well below the NICE's commonly accepted cost-effectiveness threshold of £30,000/QALY gained, indicating that Ikervis® in the target patient population would represent a cost-effective intervention in the UK.

PSS23

COST EFFECTIVENESS OF ANTIGLAUCOMA MEDICATIONS

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OBJECTIVES: To check prescribing pattern for glaucoma and to design a treatment guideline for POAG that is more cost effective from the perspective of a third party payer than the current practice based on real world evidence **METHODS:** A retrospective descriptive study of glaucoma patients was carried out with the aid of data collection form. The prices (95% CL) of antiglaucoma drugs were estimated from hospital price list and the 5 nearby community pharmacies. Eighty randomly selected case notes of glaucoma patients on therapy for at least 3 months were studied. Data collected were the demographics and diagnosis, IOP per month and the drugs prescribed. A Stochastic Monte model based on the outcome and cost was constructed with the aid of vanguard studio 5.0 (Cary, North Carolina, USA). The outcome of the therapy which was entered as the proportion of patients whose IOPs were normal, reduced or either increased or unchanged per month of treatment. Sensitivity analysis was conducted by varying the input data by ±50%. **RESULTS:** The proportion of patients that IOP was checked regularly was low 26.76% .The commonly prescribed drugs were the beta blockers and carbonic anhydrase inhibitors. The current practice will cost USD430.86 (NGN 77,783.76) per patient per annum whereas the proposed guideline that result in improved outcome will cost USD 44.10 (NGN7, 953.12). Treatment guideline is absent in Standard treatment guideline of Nigeria **CONCLUSIONS:** The patients that IOP was checked regularly were low and multi therapy was prescribed at onset with the Beta blockers plus Carbonic anhydrase inhibitors. A cost savings of NGN69, 830.64 will be obtained by the proposed guideline for POAG per patient per annum thus it could be adopted after evaluation at several sites

PSS24

ECONOMICS IN CLINICAL GUIDELINES: A COST-EFFECTIVENESS ANALYSIS OF REPOSITIONING STRATEGIES FOR THE PREVENTION OF PRESSURE ULCERS

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