finding a priori criteria for deciding when to use one method versus another.

RESULTS:

The published literature is sparse and there are no specific criteria available for deciding when to use one method of development versus another. The proposed multi-step algorithm identifies similar steps in the production of all types of CPGs: the set-up phase; establishing the need for a new CPG in consultation with a guideline development group and local stakeholders; developing research question(s); conducting searches for suitable existing guidelines; and finalizing the guideline. HTA can help set the health question(s) and identify and screen existing CPGs. When CPGs are not available, HTA methods are implemented to update the evidence in a blend of de novo and adaptation processes by reviewing umbrella reviews, systematic reviews, and primary studies. Quality appraisal of existing guidelines and syntheses of evidence in a rapid review fashion help determine whether there are enough studies to support the guideline scope.

CONCLUSIONS:

Deciding which method of guideline development to employ requires ample methodological expertise, an intimate knowledge of the clinical practice environment, and access to detailed contextual information. The proposed multi-step algorithm shows how to successfully leverage HTA resources to support CPG production and move research evidence into practice.

PP146 Cost-Effectiveness Of Nivolumab Plus Ipilimumab In Advanced Melanoma

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INTRODUCTION:

This study was done to assess the cost effectiveness of nivolumab plus ipilimumab (NIV+IPI) versus nivolumab alone (NIV) for previously untreated patients with advanced melanoma (AM) from the Dutch health system perspective.

METHODS:

A Markov model was constructed with a lifetime horizon. Future effects and costs were discounted at 1.5 and four percent, respectively. Risks of progression and death were based on progression-free survival rates obtained from a phase III clinical trial (NIV+IPI and NIV versus ipilimumab). Conjectural overall survival rates were calculated indirectly by using progression-free survival and overall survival rates from another trial (NIV versus dacarbazine), and were extrapolated later using the Weibull distribution. Utility values of health states and disutility values of adverse events were derived from the literature. Unit costs were derived from the Dutch Diagnosis Treatment Combination Care Products Tariff, Erasmus University Medical Center prices, and Dutch pharmacy purchase prices. Chronic management costs of AM and treatment costs of adverse events were calculated based on the results of a survey of clinicians that determined the necessary healthcare services and their utilization rates.

RESULTS:

On average, over a lifetime an AM patient treated with NIV+IPI was estimated to live 4.2 years and 2.6 quality-adjusted life-years (QALYs) at a discounted net cost of EUR 262,824 per patient, while a patient treated with NIV was estimated to live 3.3 years and 2.0 QALYs at a discounted net cost of EUR 195,341 per patient. The incremental cost-effectiveness ratio was EUR 70,770 per life-year saved, and the incremental cost-utility ratio was EUR 115,533 per QALY gained.

CONCLUSIONS:

At a willingness-to-pay threshold of EUR 80,000 per QALY gained, NIV+IPI may not be a cost-effective tool, compared with NIV, for preventing the high mortality and morbidity associated with AM from the Dutch health system perspective.

PP147 Olaratumab With Doxorubicin For Advanced Soft Tissue Sarcoma

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