examination and those with drug exposure >5 yrs were prioritised. An MDT path-
way was established to manage anyone with signs of HCl toxicity.

Results: 2,132 patients are prescribed HCl in our county with population of
during therapy. 257 patients fell under our unit’s remit. 136 patients (62%) have
been screened with mean age of 58 yrs (24-84y), 65 (48%) have RA and remain-

6.4/100,000. This could potentially have a cost impact however the introduction
of a generic version would hopefully improve access to a wider patient cohort and perhaps allow
easier use in the treatment paradigm.

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Background: Systemic Lupus Erythematosus (SLE) is a chronic multorgan disease with an unpredictable disease course, which requires monitoring for disease activity, treatment efficacy and comorbidity. Data on the healthcare utilization and cost of SLE, especially from Australia are scarce.

Objectives: To determine the healthcare utilization and estimated costs of inpa-
tient admissions (IP), emergency (ED) and outpatient (OPD) hospital visits and
investigations for SLE patients in Western Australia (WA).

Methods: This is a longitudinal cohort study of SLE patients seen at a metropoli-
tan public hospital, with ≥6 months of follow-up (n=179, 95% female; baseline
age 36.2 ± 15.2 years). Electronic medical records provided data on OPD, ED
and IP visits, and investigations conducted at public hospitals from January 2000 -
December 2019. Direct healthcare costs were estimated from public hospital expenditure aggregates in FY2018/19.

Results: During a median observation period of 11.0 years (IQR 7.4, 13.5), SLE
patients required 13,320 OPD visits for a median of 5.3 (IQR 3.0, 9.3) appoint-
ments per annum. The majority of OPD visits were with Rheumatology (n=1,986,
14.9%), Immunology (n=1,527, 11.5%), and allied health services (n=1,952,
14.7%), followed by Ophthalmology (n=1,385,10.4%), maternal & fetal health
(n=873,6.8%) and Renal medicine (n=844,6.3%). In total 143 patients (79.3%),
attended ED on average of 3 times (IQR 2, 7; ED visit rate 4.0 (95%CI 4.0, 4.7))
per 100 person years. Overall, 125 patients (69.8%) were hospitalised at
average 3 times (IQR 2, 6), with a mean LOS of 5 days (IQR 3, 12) for an IP rate
of 376 per 100 person years (95%CI 34.8, 40.5). Only 12.8% of patients did not
attend ED or IP in the public health care system. A total of 367,087 labora-
atory investigations were performed (median nr. of tests per patient 205 (±290)
per year) across fields of haematology/biochemistry (89%), immunology (5%),
microbiology (4.5%) and histopathology (<1%). Minimum estimates for direct
health care cost during the study period were 25.4 million AUD (IP 11m, OPD
6.3m, ED 0.9m and investigations 9.1m) for a crude annual cost of 14,088 AUD
per patient.

Conclusion: SLE patients have extensive healthcare utilization across a range
of outpatient and inpatient services. The main direct costs for this multidisci-
plinary health care provision are for disease monitoring and in-hospital treatment.

Based on these conservative cost estimates to which median cost need to be
added, total costs for SLE care in WA are projected to be significantly higher
than reported from Europe.
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BUDGET IMPACT ANALYSIS OF INTRODUCING SUBCUTANEOUS INFLIXIMAB CT-P13 SC FROM THE UK PAYER PERSPECTIVE

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Background: CT-P13 subcutaneous (SC) is the first and only SC version of infliximab developed by Celtion Healthcare and currently approved by the European Medicines Agency (EMA) for the treatment of rheumatoid arthritis (RA). Infliximab has been only available in intravenous (IV) formulation and thus this new mode of administration will allow patients to self-inject at home. Self-injection will reduce number of outpatient visits and expected to decrease IV administration cost significantly. This research describes the economic impact of introducing infliximab SC from the UK payer perspective.

Objectives: The budget impact analysis (BIA) was conducted to assess the financial impact of the adoption of infliximab SC. The BIA calculates the costs of treatment (drug acquisition cost and administration) for patients with RA as first-line treatments, and compares the cost in a scenario without infliximab SC. The BIA was assumed to be the same as that of comparator treatments. Administration measures to assess service success and sustainability.

Methods: A prevalence-based BIA was developed incorporating epidemiological data, administration cost data from the literature and market share data from IQVIA. The analysis compared a market scenario where a proportion of patients were treated with infliximab SC ("World With" infliximab SC) to an alternative market scenario where infliximab SC was not available and all patients were treated with IV ("World Without" infliximab SC). The model assumed that the clinical outcomes are same between infliximab SC and infliximab IV, and patients entering the model were all naive and remained in the treatment for 5 years. In the "World With" scenario, patients receiving infliximab IV switched to SC administration at 30% in Year 1, 45% in Year 2, and remained 60% from Year 3 to 5. The drug cost of infliximab SC is assumed to be the same as that of comparator treatments. Administration cost per infliximab IV infusion was estimated to be £382 and £3.32 per SC administration.

Results: Compared to the "World Without" infliximab SC, the introduction of subcutaneous infliximab resulted in cost savings of £39.6 million in UK over a 5-year period, equating to 4,466 additional patients to be treated with infliximab SC in base case scenario.

Conclusion: Utilization of subcutaneous infliximab may lead to substantial cost savings for UK payers. Self-injection will significantly reduce the burden on healthcare delivery allowing resource to be spent elsewhere. Sensitivity analysis concluded that treatment with increased IV dose will result in higher savings from switching patients to subcutaneous infliximab.