the case of expensive drugs with individualised dosing if we treated only a few patients on different days. This is the case of infliximab.

**Purpose** The aim of this study was to retrospectively examine the pattern of utilisation in clinical practise (clustering patients at the same day of the week or not) and the saving costs associated with the optimization of infliximab use in the treatment of rheumatoid arthritis or Crohn's disease.

**Materials and Methods** We collected data of patients treated with infliximab during the first two months of 2012. We clustered patients by weeks, so we calculated the total weekly dose by adding the dose of each patient and total number of vials required of infliximab (clustering patients or not). Infliximab was given at dose of 3–5 mg/kg every 6–8 weeks. We calculated treatment costs between two alternatives.

**Results** Eighteen patients received at least one infliximab infusion during a selected observation period were studied. The mean infliximab dose administered to all the patients was 342 ± 80 mg per patient. The number of vials used was 67, if we cluster patients, and 71 without cluster patients Infliximab vial optimization allows us, for the whole year, to reduce the amount of vials from 486 to 458, with a significant saving of 15612 €/year.

**Conclusions** Clustering patients in a agreed day of week allows significant cost savings in the context of a regional hospital. The cost of treatment could be reduced by using infliximab vial optimization. These results could be applied for the vial optimization of some monoclonal antibodies and cytostatic agents.

No conflict of interest.

**DSL-027** RISK ANALYSIS OF MEDICINES PRODUCED IN HOSPITAL PHARMACY – A TOOL FOR ENSURING OPTIMAL SUPPLY

**Background** The hospital pharmacy unit for the preparation of licensed sterile medicines manufactures 110 different extemporaneous preparations and licenced medicines for injection or infusion. This unit needs a tool for production planning i.e. an assessment of which medicines are critical and hence must always be in stock.

**Purpose** To create a tool for risk assessments for all medicines manufactured in the unit, enabling appropriate prioritising of resources from a treatment perspective.

**Materials and Methods** All risk assessments are executed and stored in SAID (National question and answer database). The advantages of this method are that each risk assessment is quality assured and acts as a dynamic document that can be updated regularly. Risk assessments are based on relevant literature (e.g. Summary of Product Characteristics and Micromedex).

For each risk assessment the following is examined as a minimum:

- Which patient group will benefit from the medicine?
- Therapeutic indications and administration
- Are there any alternative treatments?
- Does a synonymous/analogous medicine exist? Any safety concerns regarding method of administration? Can the manufacturers maintain the flow of supply?

Based on the above the risk assessments are allocated a score 1 to 5, which indicates the severity of a back order.

**Results** The risk assessments were distributed as follows:

- 18% scored 5 (no alternative medicine exists)
- 38% scored 4 (analogous medicine exists)
- 24% scored 3 (synonymous extemporaneous or non-licenced medicine exists)
- 9% scored 2 (synonymous medicine exists)
- 11% scored 1 (more than one analogue/synonym exists)

The risk assessments showed that none of the medicines could be dispensed from a treatment perspective. Shorter periods of back order of some medicines can be tolerated with no effect of patient care and safety, if alternative synonyms/analogous medicines are supplied from other manufacturers.

**Conclusions** Risk assessments have given the unit a tool for production planning and prioritising the manufacturing of medicines.

No conflict of interest.