

to two drugs, one patented (RPV) and one generic drug (FTC/TDF). Both were administered once-daily, providing the same therapeutic efficacy and treatment compliance but in a more cost-effective way.

Purpose To describe the procedure to implement this strategy and patient's acceptance of it.

Material and methods After several meetings between the Pharmacy (PD) and the Infectious Diseases Department (IDD) it was decided to make the change at the following patient's visit to the HS, either in the PD when the patient attended to pick up the medication or in the IDD in the patient's scheduled consultations.

Inclusion criteria: HIV patients treated with FTC/TDF/RPV up to June 2018 using e-prescribing records. Patients that did not contact our HS were excluded.

A retrospective review from July to October 2018 was conducted. Patients that would not accept the PD's change were referred to the IDD.

Collected data were: age, gender, treatment after the change and acceptance.

Results Out of 133 patients, seven were excluded. Mean age 47.6 years, 20% women. PD was responsible for 86% of the changes.

Out of 126 patients included, 16 (13%) did not accept the change.

Of these 16 patients, five ended up accepting it (three after visiting the IDD and two on their second visit to the PD) and 11 declined to switch therapy for the following reasons: swallowing problems (one) (actual treatment: elvitegravir/cobicistat/emtricitabine/tenofovir-alafenamide); adverse events (actual treatment: dolutegravir ±TDF/FTC (one); abacavir/lamivudine (two) or lamivudine (one); and six patients continued with FTC/TDF/RPV (four waiting for IDD next consultation and two due to medical decisions).

Conclusion By the time this abstract was written, the change was made in 115/126 patients (91%).

It is very important to highlight the efficient teamwork between the PD and the IDD in order to implement the new strategy in a short period of time.

Although initially 13% disagreed, finally only 9% of patients did not accept the proposed change.

On the other hand, this strategy has reduced the economic impact of HIV treatment in 51% of patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Infectious Diseases Department.

No conflict of interest.

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HEPATITIS C TREATMENT: COST AND EFFECTIVENESS

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Background The hepatitis C virus (HCV) infection is one of the major causes of chronic liver disease. Due to the HCV infection prevalence in European regions (1.5%), increasing health expenditure has been made in order to eradicate HCV.

Purpose Assess the cost, effectiveness and safety of treated HCV patients with pegylated interferon-ribavirin (IFN-RIB) compared to new direct acting antivirals (DAA).

Material and methods Retrospective observational comparative study of two cohorts of patients including HCV patients who started and finished treatments with IFN-RIB in 2011 (except the above 12 months) and with DAAs in 2017. Exclusion criteria: deaths, no therapeutic adherence and transfer to another hospital. Data were extracted from electronic records.

Results In 2011, 49 patients (87.8% male) with a mean age 44.4 ± 7.1 years were included: 12.2% were previously treated, 40.8% co-infected and genotypes 1 was predominant (51.0%), and 73.5% were treated with IFN α 2a-RIB and the remaining with IFN α 2b-RIB.

In 2017, 185 patients (75.0% male) were included, with a mean age 52.2 ± 9.9 years, 28.1% co-infected. Genotype 1 (64.9%) was the most common: 79.3% patients had severe or moderate fibrosis (FD ≥ 2). Only 11.4% were previously treated (four with DAA). Treatments were: 71.9% Ledipasvir/Sofosbuvir; 7.6% Sofosbuvir/Velpatasvir; 7.0% Sofosbuvir; 7.0% Elbasvir/Grazoprevir; 3.2% Ombitasvir/Paritaprevir/Ritonavir+Dasabuvir; 2.2% Daclatasvir +Sofosbuvir; 0.5% Sofosbuvir +Ombitasvir/Paritaprevir/Ritonavir+Dasabuvir; and 0.5% Ombitasvir/Paritaprevir/Ritonavir.

Comparing treatments of two cohort patients (IFN-RIB/DAA): in 2011 average treatment length was 8.1 months/patient much longer than 2017 (3.5 months/patient) and 12 weeks' length in 70.4%. In 2011, drug discontinuation occurred in 36.7% treatments because the patients had serious adverse reactions (AR) or were non-responders. In 2017, DAA had fewer and lower severity AR (100% compliance). According to guidelines' alterations, eight patients had shortened their initial duration of treatment. Treatments with IFN-RIB (€4287.7/patient) were less expensive than DAA (€14867.1/patient), representing an increase of €1309.2% annually. Although the success rate was significantly higher with DAA (96.8%) than with IFN-RIB (53.1%), 23/49 patients, in 2011, were posteriorly treated with DAA. The incremental cost-effectiveness ratio (DAA/IFN-RBV) was €238.1/patient successfully treated. Costs are higher, but, in 2018, the costs of treatment/patient are half that of 2017.

Conclusion DAA treatments have higher effectiveness against HCV infection (>95%) and treatments are shorter, more effective and safer than older therapies, despite higher costs.

REFERENCE AND/OR ACKNOWLEDGEMENTS

WHO Guidelines for the screening, care and treatment of persons with chronic HCV infection 2016.

No conflict of interest.

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PEMETREXED'S LESSON

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Background In May 2008, the European Medicines Agency (EMA) granted authorisation to Pemetrexed as a first-line treatment for locally advanced or metastatic non-small cell lung cancer (NSCLC), other than predominantly squamous cell (non-SC) histology patients. A phase III trial compared Pemetrexed with Gemcitabine, both in association with cisplatin, and found a similar overall survival between both groups (10.3 months). The EMA authorisation was only based in a