immunotherapeutic cycles were administered: 705 (38.1%) nivolumab and 1144 (61.9%) pembrolizumab.

The annual economic impact of FD and DB was calculated at € 573 235 and € 529 556 for nivolumab and € 110 3387 and € 820 262 for pembrolizumab, respectively; estimating a potential annual economical saving for DB of nivolumab at € 43 679 and pembrolizumab at € 283 125. The application of DB in nivolumab would lead to an increase of 58 annual cycles administered, with no change in the case of pembrolizumab. In terms of drug exposure, immunotherapy with DB dosage would suppose a median dose deviation from FD of −4.17% (−16.67–0.0) for nivolumab and −20.0% (−35.0 to −20.0) for pembrolizumab.

Conclusion and relevance The implantation of a DB programme in immunotherapy with nivolumab and pembrolizumab would lead to an efficiency increase and a dosing reduction in comparison with FD regimens, especially in pembrolizumab, which would achieve higher annual savings without detriment of clinical assistance.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. DOI:10.1093/annonc/mdx235
2. DOI:10.1186/s40425-017-0242-5

Conflict of interest No conflict of interest

1ISG-013 USERS' EXPECTATIONS AND OPINIONS ON A COMPUTERISED PHYSICIAN ORDER ENTRY (CPOE) SYSTEM BEFORE AND AFTER ITS IMPLEMENTATION

[1,2]V Jungreithmayr*, [1,2]EK Rein, [3]H Implementation Team, [1,2]WE Haefeli, [1,2]HM Seidling. *[1]Heidelberg University Hospital, Department of Clinical Pharmacology and Pharmacoepidemiology, Heidelberg, Germany; [2]Heidelberg University Hospital, Cooperation Unit Clinical Pharmacy, Heidelberg, Germany; [3]Heidelberg University Hospital, Center of Information and Medical Technology, Heidelberg, Germany*

10.1136/ejhpharm-2022-eahp.8

Background and importance Computerised physician order entry (CPOE) systems can enhance medication safety, but their implementation often faces hurdles, frequently due to user resistance. Implementation success depends on users' acceptance of the system. Therefore, it is important to know the users' views to tailor the implementation process and future optimisation of the system.

Aim and objectives Our aim was to examine physicians' and nurses' expectations before and opinions after the implementation of a CPOE system.

Material and methods We set up a survey combining validated tools and implementation-oriented questions to compare expectations before with opinions after CPOE implementation. The latter questions addressed quality of care, traceability of clinical decisions, readability, availability of patient information, quality of documentation, and time spent on documentation. Responses were rated on a five-point Likert scale. Additionally, respondents were asked to rate the implementation on a scale from 0 (negative) to 100 (positive). The survey was distributed to seven orthopaedic wards 4 weeks before and 3 months after implementation and anonymously collected. For the analysis of Likert responses, the number of responses of the upper and lower two Likert points was added up. Surveys with a non-response rate of >25% (excluding demographic questions) were not analysed.

Results The return rate was 36% (N=72) before and 26% (N=53) after implementation. Of the total of 125 surveys (25 returned by physicians and 100 by nurses), 121 were included in the analyses. The majority of respondents (60%–87%) expected CPOE implementation to improve the questioned criteria, except for quality of patient care (40% expected an improvement) and time spent on documentation (76% predicted an increase). After implementation, respondents reported improvements in readability (84%) and availability of patient information (57%); 78% of respondents indicated that the amount of time spent on documentation had increased. All other criteria were reported as improved, unchanged or worsened in approximately equal proportions. When asked to rate the implementation, the mean score was 56.5 ±30.0 before and 56.9 ±33.2 after implementation (p=0.809).

Conclusion and relevance The fact that positive and negative attitudes remained unchanged suggests that the opinions of doubters and enthusiasts were not significantly affected by the implementation. It might be worthwhile to choose different implementation strategies for these two groups.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

1ISG-014 ABSTRACT WITHDRAWN

Section 2: Selection, procurement and distribution

2SPD-001 HOW CAN WE BEST MANAGE SUPPLY SHORTAGES OF EXCLUSIVELY HUMAN MOLECULES FOR SUBSTITUTION? THE EXAMPLE OF IMMUNOGLOBULINS

[1]V Ratsimbazafy*, [1]S Bonnet, [1]C Lestang, [1]J Jost, [1]C Reygner, [1]S Oses, [1]N Gosse-Boeuf, [1]F Renon-Carron, [1]A Marie-Daragon, [1]A Cournede, [2]AL Fauchais. *[1]University Hospital, Pharmacy, Limoges, France; [2]University Hospital, Internal Medicine and Polyclinic, Limoges, France*

10.1136/ejhpharm-2022-eahp.10

Background and importance Drug supply shortages that have increased over the past decade were worsened by the SARS-CoV-2 health crisis. Among the products affected are immunoglobulins (IG), essential for substitution in primary immune deficiencies in particular. In contrast with some plasmatic proteins, IG are only produced from blood donations that have decreased. Recently, IG supply was reduced, 42% in our case, mostly affecting intravenous IG (IVIG).

Aim and objectives To identify, among the existing clinical situations, those that should benefit from IG (subcutaneous IG (SCIG) preferentially in primary substitutions; IVIG treatment to as many patients as possible for whom there is no alternative).

Material and methods Meet physicians representing the most important prescribing departments. Take stock of consumption and supply. Identify ways to optimise the use of available IG.

Results The neurology, clinical haematology, internal medicine and paediatrics representatives were brought together at a Medicinal Products and Medical Devices Commission (MPMDC) session.

First 6 months of 2021, data on IVIG:

Patient number: 168. IVIG mass: 27.8 kg (70.4% of total IG). Treatment number: 510. On average: 27.6 g/patient/month; 3 cures/patient over 6 months.

IVIG use: off-label, 27.4%; immune deficiencies, 41.6% (secondary 9 times; primary 1 time); immunomodulation, 31% (of which: idiopathic thrombocytopenic purpura (ITP), 42.3%; Guillain-Barré syndrome, 9.6%; Kawasaki disease, 3.8%; chronic inflammatory demyelinating polyradiculopathy (CIDP), 38.5%; multifocal motor neuropathies, 5.8%).

Discussions at MPMDC led to the development of the following ways to cope:

1. 'Switch' as many patients as possible to SCIG.
2. As the dosage of 2 g/kg/cure is indicative, lower the doses gradually and/or space out the courses.
3. Use corticosteroids whenever possible.
4. Use IVIG for life–threatening authorised situations (eg, acute ITP).
5. Reactivate the plasma exchange pathway for immunomodulations.
6. Reduce off–label use.
7. For off–label indications, include patients in therapeutic trials of IVIG.
8. If life–threatening emergency immunomodulation off–label, treat with molecules such as rituximab and use IVIG only during the latency period.

Conclusion and relevance The implementation of these suggestions, while awaiting the publication of the IG indications' hierarchy by the relevant authorities, should optimise management of the shortage. European, or even international, recommendations would be welcome because of the globalisation of supply.

REFERENCES AND/OR ACKNOWLEDGEMENTS

We acknowledge *(in alphabetical order)*: Mélodie Billac, Carole Nivet and Martine Raymondeau.

Conflict of interest No conflict of interest

2SPD-005 SIGNIFICANT DISCONTINUATION RATES IN PATIENTS INITIATING OR SWITCHING FROM CT-P13: A RETROSPECTIVE COHORT STUDY IN A UNIVERSITY HOSPITAL

[1,2,3,4]M Krstic, [2,3]JC Devaud, [5,6]J Marti, [1,2,3,4]F Sadeghipour*. *[1]Institute of Pharmaceutical Sciences of Western Switzerland, University of Geneva and University of Lausanne, Pharmaceutical Sciences, Geneva and Lausanne, Switzerland; [2]Service of Pharmacy, Lausanne University Hospital and University of Lausanne, Pharmacy, Lausanne, Switzerland; [3]Centre for Research and Innovation in Clinical Pharmaceutical Sciences, Lausanne University Hospital and University of Lausanne, Pharmacy, Lausanne, Switzerland; [4]School of Pharmaceutical Sciences, University of Geneva, Pharmaceutical Sciences, Geneva, Switzerland; [5]University of Lausanne, Faculty of Biology and Medicine, Lausanne, Switzerland; [6]University of Lausanne, Centre for Primary Care and Public Health Unisanté, Lausanne, Switzerland*

10.1136/ejhpharm-2022-eahp.11

Background and importance CT-P13 is an infliximab biosimilar that received market authorisation in the European Union in 2013. CT-P13 has undeniable cost-saving opportunities and extensive literature supporting its equivalence to originator infliximab (OI) in terms of efficacy, safety and immunogenicity. Despite these elements, CT-P13 remains largely underused in our country, either underprescribed or discontinued after its introduction.

Aim and objectives The aim of this study was to explore the reasons behind the high discontinuation rate observed among the patients on CT-P13 in a large tertiary hospital.

Material and methods A retrospective cohort study using routinely collected data was carried out. Patients were eligible if they received OI or CT-P13 between September 2017 and December 2020. They were included if they had received at least two CT-P13 infusions during the same period. Patients were excluded if their medical history was incomplete prior to or 6 months after their first CT-P13 infusion and if they had an oncological main diagnosis.