Introduction: Developed in 2014, the Systematic Review (SR) Toolbox has played a critical role in helping researchers to identify appropriate tools to support systematic reviews. Since the resource was launched, the systematic review and wider evidence synthesis process has evolved considerably. The way in which the SR Toolbox originally classified tools at launch had become dated. We updated and rebuilt the SR Toolbox in 2022 underpinned by a novel taxonomy to reflect the latest review and evidence synthesis landscape.
Methods: All guidance and software tools contained within the SR Toolbox were manually extracted in February 2022. Information contained from tool records were extracted by a single reviewer into an Excel spreadsheet, with a second reviewer checking a sample. The spreadsheet was translated to a Microsoft Access database underpinned with a new taxonomy to reflect the expansion of evidence synthesis methods and new review types (or 'families'). A brief analysis of the remapped tools was conducted to identify current gaps in software and guidance support for evidence synthesis. A new user interface was also developed.
Results: The updated version of the SR Toolbox was launched 13 May 2022. At that time, the resource included records on 235 software tools and 112 guidance tools. Regarding 'review families', most software tools (n = 223) and guidance documents (n = 78) were applicable to supporting systematic reviews. Fewer software (n = 66) and guidance (n = 22) tools were applicable to reviews of reviews, while qualitative reviews were less served by guidance documents (n = 19). In terms of 'review stages', most guidance documents were associated with quality assessment (n = 70), while most software was related to searching (n = 84) and synthesis (n = 82). To-date, there is a lack of software (n = 2) and guidance (n = 3) tools to support stakeholder engagement.
Conclusions: The SR Toolbox has received a significant update to ensure that tools are classified and shared based on the latest systematic review and evidence synthesis methods. As part of the update, analysis of the contents of the toolbox highlighted potential gaps in tool support for certain review types/stages.

PP87 Glecaprevir/pibrentasvir (Maviret®) Remains A Cost-effective Treatment For Chronic Hepatitis C Virus Infection After Changes To The Treated Population

Belinda Castles (Belinda.castles@abbvie.com), Emma Warren, Gillian Sharratt and Aitor Arteaga

Introduction: The first direct-acting antiviral (DAA) therapies for chronic Hepatitis C virus (HCV) infection were reimbursed via Australia's Pharmaceutical Benefits Scheme (PBS) in March 2016. This was based on the recommendation from the Pharmaceutical Benefits Advisory Committee (PBAC) that the regimens would be acceptably cost-effective at an incremental cost-effectiveness ratio (ICER) of AUD15,000/quality-adjusted life-year (QALY). Broad access to DAA therapies has been a key strategy in driving a national health goal to eliminate viral hepatitis as a major health threat by 2030. Since the initial PBS listings for DAA therapies and subsequent listings of newer DAA treatments such as Maviret, the demographics and disease characteristics of currently treated patients have markedly changed. The aim of our analysis was to reassess the cost-effectiveness of Maviret, accounting for the changes of the treated population characteristics and retreatment in first-line failures and reinfected individuals.
Methods: To assess the cost-effectiveness six years after initial listing of Maviret, an update was made to the Markov model used to achieve PBS reimbursement for Viekira-Pak® in May 2016. Amendments to the Viekira-Pak model include: changes to baseline age and fibrosis distribution of treated patients, and incorporation of retreatment of first-line failures (those not achieving a sustained virologic response (SVR)) and reinfected individuals. Treatment-related inputs including SVR response rates, adverse events, treatment-related disutility and discontinuations were sourced from pivotal glecaprevir/pibrentasvir clinical trials.
Results: Using the published price of Maviret, the ICER is above AUD15,000/QALY but well below the commonly used ICER threshold in other chronic diseases (AUD45,000/QALY). When the confidential effective price is used, the ICER is under the AUD15,000/QALY cost-effectiveness threshold set by the PBAC for DAA therapies.
Conclusions: Despite substantial changes to the population seeking treatment in Australia since reimbursement in 2016, Maviret remains a cost-effective treatment for chronic HCV infection.

PP88 An Exploratory Analysis Of The Potential Cost-Benefit Of Delaying Kidney Disease Progression In Australia

John Kim (john.kim@viforpharma.com), Francis Dehle, Alex Teal, Scott Brydon, Vanessa Stevens and Anthony Anselmo

Introduction: Chronic Kidney Disease (CKD) is a condition that leads to end-stage renal disease (ESRD), characterized by a gradual loss of kidney function. In 2021, the healthcare system expenditure of CKD in Australia was estimated to be over AUD2.3 billion (USD1.5 billion), largely attributed to Kidney Replacement Therapy (KRT, dialysis or kidney transplantation). This exploratory analysis aims to calculate the cost-benefit to the Australian healthcare system should KRT be delayed.
Methods: The prevalence of ESRD with and without KRT between 2016 and 2021 was estimated, and a simple linear regression model was created to estimate the prevalence of ESRD with KRT between 2022 and 2026. The projected cost of KRT management in 2022 was

https://doi.org/10.1017/S0266462323002167 Published online by Cambridge University Press