Supplemental Material

Table S1. Modeling Inputs – DELIVER Population Only.

	Value	Range	Source
Transition Probabilities*			
Worsening HF events	0.022	0.016-0.032	Trial
Cardiovascular Mortality	0.004	0.003-0.006	Trial
Effectiveness of Dapagliflozin vs. Placebo			
Worsening HF events	0.73	0.62-0.87	Trial
Cardiovascular Mortality	0.88	0.74-1.05	Trial
Proportions of Events (US Population)			
Proportion of Worsening HF Events attributable to HF Hospitalization	0.92	0.87-0.95	Trial
Proportion of All-Cause Mortality attributable to CV Mortality	0.47	0.36-0.57	Trial
Utilities			
Dapagliflozin	0.825	0.821-0.829	Isaza et. al. & prior modeling[6,29,30]; Trial
Placebo	0.811	0.806-0.815	Isaza et. al. & prior modeling[6,29,30]; Trial

*Transition probabilities derived from placebo event rates among US participants in DELIVER. Worsening HF events include hospitalization for HF and urgent HF visits.

"Trial" refers to participant-level data from the DELIVER trial. All other modeling parameters are consistent with those reported in Table 1.

Table S2. Cost Effectiveness at Various Monthly Costs of Dapagliflozin using Pooled Data from DAPA-HF and DELIVER.

	Mean # Worsening HF Events	Life-years	Costs ($)	Effectiveness (QALYs)	Incremental Cost ($)	Incremental Effectiveness (QALYs)	ICER ($/QALY)
Medicare Part-D ($514.95/mo)[23]							
Standard of Care	2.38	7.47	109,003	6.04	45,509	0.53	85,554
Dapagliflozin	1.87	7.98	154,512	6.57			
Medicare Part-D w/ 49% Rebate ($262.62/mo)^[8]							
Standard of Care	2.38	7.47	111,561	6.04	21,321	0.53	40,081
Dapagliflozin	1.87	7.98	130,324	6.57			
Wholesale Acquisition Cost ($548.83/mo)[24]							
	2.38	7.47	109,003	6.04	48,765	0.53	91,675
	1.87	7.98	157,768	6.57			
Federal Supply Schedule Big Four ($396.14/mo)[25]							
	2.38	7.47	109,003	6.04	34,120	0.53	64,143
	1.87	7.98	151,913	6.57			
Medicare Part-D w/ Reduced Rebate ($314.08/mo)*[8,21]							
	2.38	7.47	109,003	6.04	26,257	0.53	49,362
	1.87	7.98	135,260	6.57			
Canadian Estimate ($68.25/mo)[27]							
	2.38	7.47	109,003	6.04	2,688	0.53	5,053
	1.87	7.98	111,691	6.57			

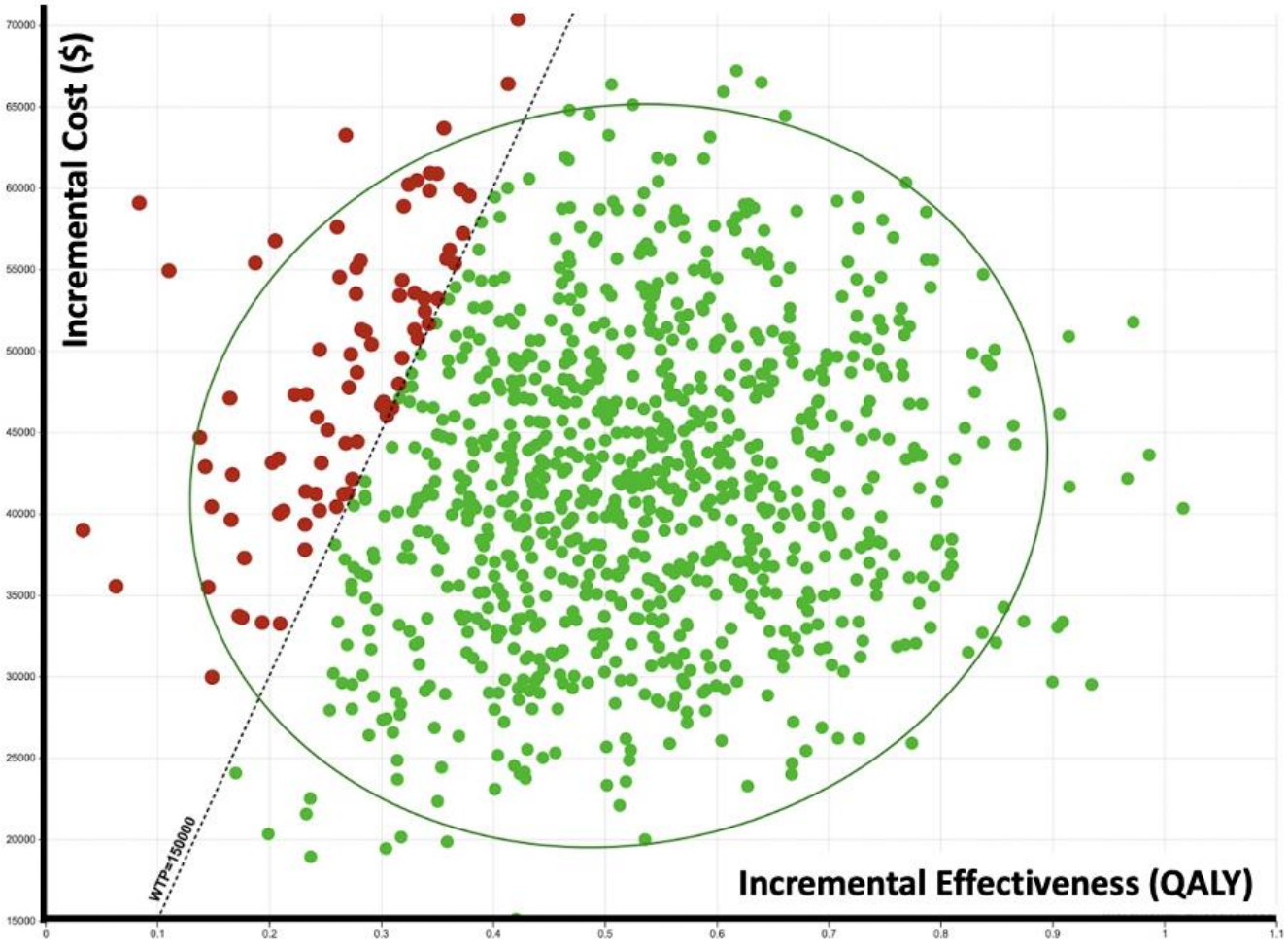
Worsening HF events = hospitalization for heart failure or urgent HF visit; QALYs = quality-adjusted life years; mo = month

^ Based on published estimate of 49% rebates.

*Based on published estimates of a reduced rebate in which 20% of the rebate is retained by entities.

Note: ICERs represent ratio of incremental costs and incremental QALY without rounding.

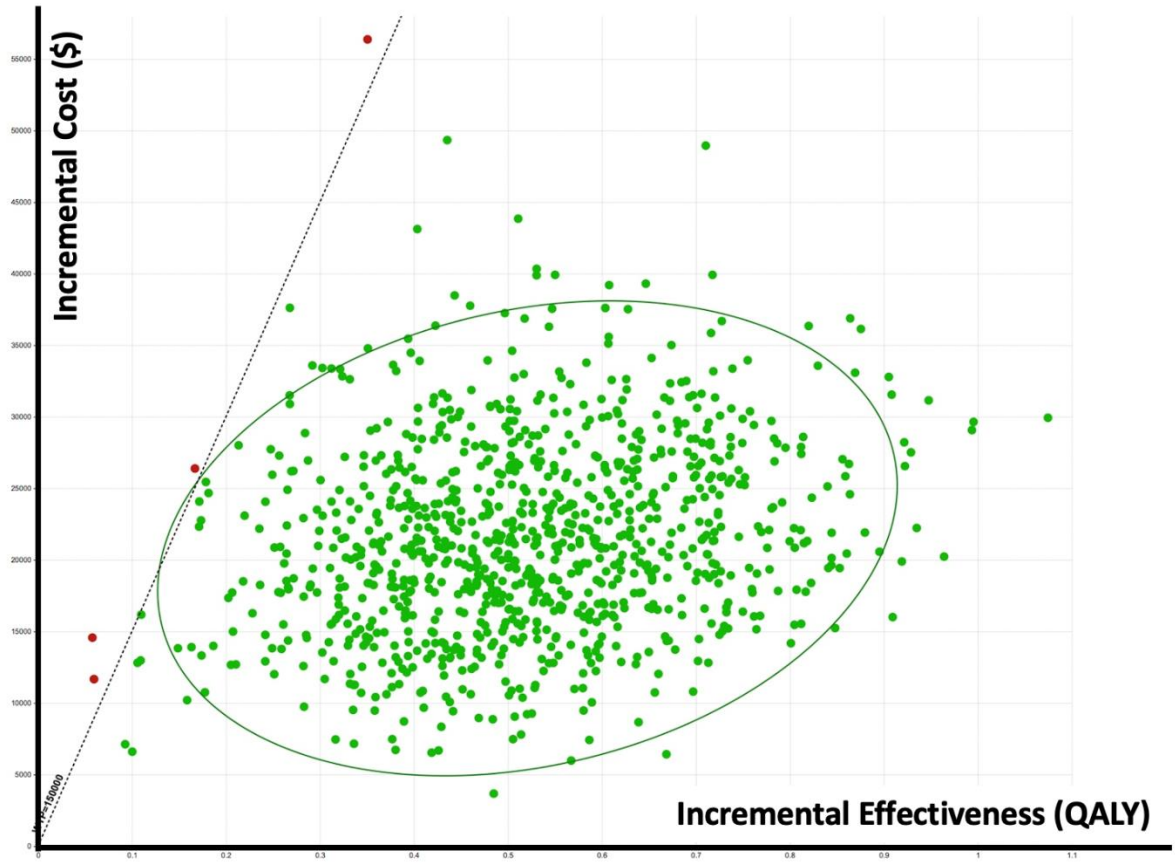
Figure S1. **Probabilistic Sensitivity Analysis of the Addition of Dapagliflozin to Standard of Care in Chronic HF.**



Model parameters were independently varied across their distributions in a probabilistic sensitivity analysis for 100,000 iterations using the full (undiscounted) Medicare cost, with each iteration displayed as a dot in this scatter plot. The dashed black line represents a willingness to pay threshold of $150,000 per QALY gained. The green oval represents points falling in the 95% credible interval. Green dots represent iterations at an ICER <$150,000 per QALY gained; red dots represent iterations at an ICER ≥$150,000 per QALY gained.

WTP = willingness-to-pay

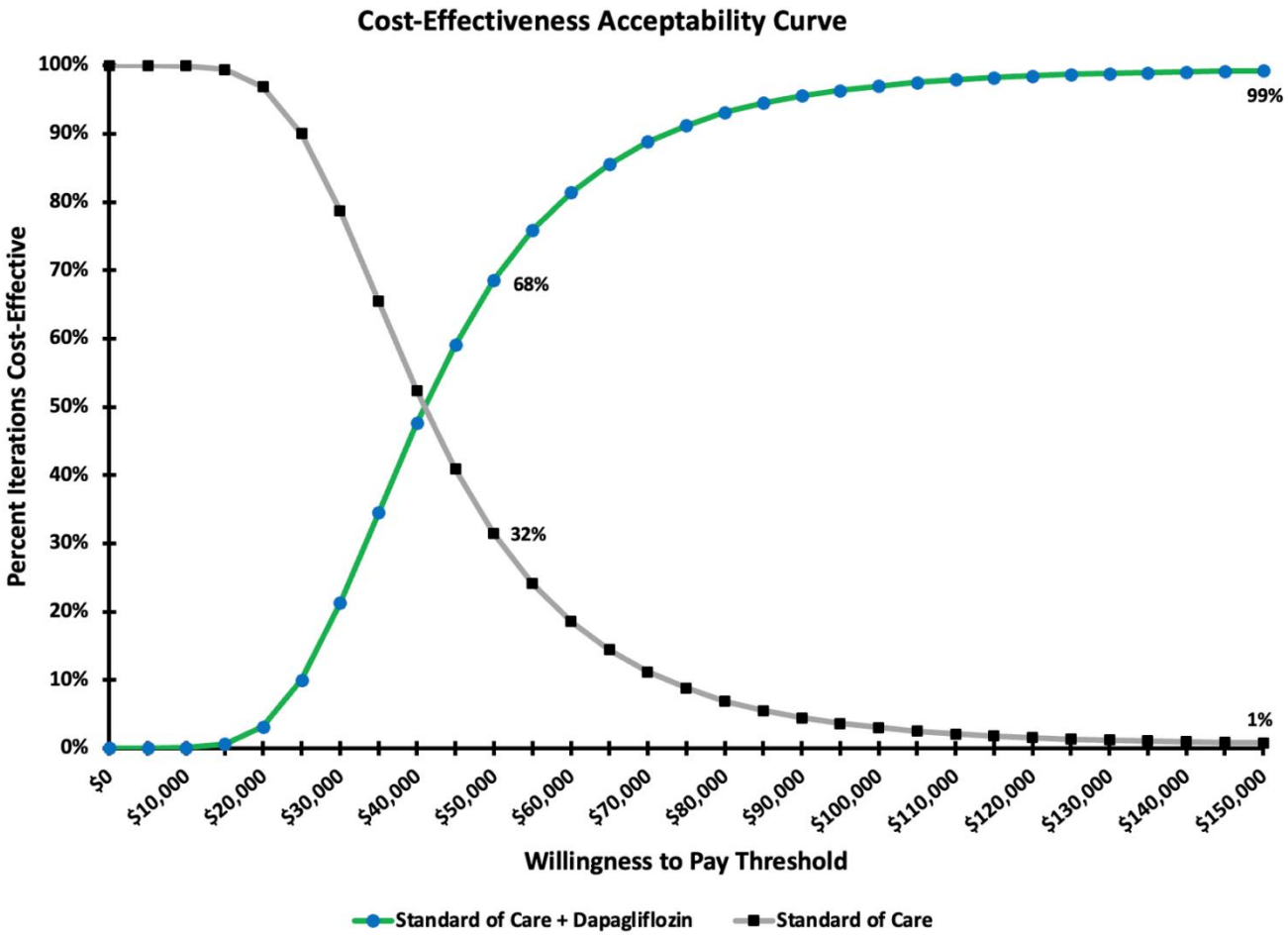
Figure S2. **Probabilistic Sensitivity Analysis of the Addition of Dapagliflozin to Standard of Care in Chronic HF.**



Model parameters were independently varied across their distributions in a probabilistic sensitivity analysis for 100,000 iterations using the discounted Medicare cost ($262/mo), with each iteration displayed as a dot in this scatter plot. The dashed black line represents a willingness to pay threshold of $150,000 per QALY gained. The green oval represents points falling in the 95% credible interval. Green dots represent iterations at an ICER <$150,000 per QALY gained; red dots represent iterations at an ICER ≥$150,000 per QALY gained.

WTP = willingness-to-pay

Figure S3. Cost-effectiveness Acceptability Curve based on Probabilistic Sensitivity Analysis.



All model parameters were independently varied across their distributions in a probabilistic sensitivity analysis for 100,000 iterations using the discounted Medicare cost ($262/mo). The percentage of iterations that were cost-effective is plotted across various willingness-to-pay thresholds.

CHEERS 2022 Checklist

Topic	No.	Item	Location where item is reported
Title			
	1	Identify the study as an economic evaluation and specify the interventions being compared.	Title, Page 1
Abstract			
	2	Provide a structured summary that highlights context, key methods, results, and alternative analyses.	Abstract, Page 5
Introduction			
Background and objectives	3	Give the context for the study, the study question, and its practical relevance for decision making in policy or practice.	Introduction, Paragraph 1-2
Methods			
Health economic analysis plan	4	Indicate whether a health economic analysis plan was developed and where available.	Methods, Paragraph 1
Study population	5	Describe characteristics of the study population (such as age range, demographics, socioeconomic, or clinical characteristics).	Methods, Paragraph 1
Setting and location	6	Provide relevant contextual information that may influence findings.	Methods, Paragraph 1
Comparators	7	Describe the interventions or strategies being compared and why chosen.	Methods, Paragraph 1
Perspective	8	State the perspective(s) adopted by the study and why chosen.	Methods, Paragraph 1
Time horizon	9	State the time horizon for the study and why appropriate.	Statistical Analysis, Paragraph 1
Discount rate	10	Report the discount rate(s) and reason chosen.	Statistical Analysis, Paragraph 1
Selection of outcomes	11	Describe what outcomes were used as the measure(s) of benefit(s) and harm(s).	Baseline assumptions and modeling inputs,

Topic	No.	Item	Location where item is reported
Measurement of outcomes	12	Describe how outcomes used to capture benefit(s) and harm(s) were measured.	Baseline assumptions and modeling inputs,
Valuation of outcomes	13	Describe the population and methods used to measure and value outcomes.	Baseline assumptions and modeling inputs,
Measurement and valuation of resources and costs	14	Describe how costs were valued.	Costs, Paragraph 1-2
Currency, price date, and conversion	15	Report the dates of the estimated resource quantities and unit costs, plus the currency and year of conversion.	Costs, Paragraph 3
Rationale and description of model	16	If modelling is used, describe in detail and why used. Report if the model is publicly available and where it can be accessed.	Statistical Analysis, Paragraph 1
Analytics and assumptions	17	Describe any methods for analysing or statistically transforming data, any extrapolation methods, and approaches for validating any model used.	Baseline assumptions and modeling inputs
Characterising heterogeneity	18	Describe any methods used for estimating how the results of the study vary for subgroups.	Statistical Analysis, Paragraph 2
Characterising distributional effects	19	Describe how impacts are distributed across different individuals or adjustments made to reflect priority populations.	Baseline assumptions and modeling inputs
Characterising uncertainty	20	Describe methods to characterise any sources of uncertainty in the analysis.	Not Statistical Analysis, Paragraph 2
Approach to engagement with patients and others affected by the study	21	Describe any approaches to engage patients or service recipients, the general public, communities, or stakeholders (such as clinicians or payers) in the design of the study.	N/A
Results			
Study parameters	22	Report all analytic inputs (such as values, ranges, references) including uncertainty or distributional assumptions.	Results, Paragraph 1

Topic	No.	Item	Location where item is reported
Summary of main results	23	Report the mean values for the main categories of costs and outcomes of interest and summarise them in the most appropriate overall measure.	Results, Paragraph 2
Effect of uncertainty	24	Describe how uncertainty about analytic judgments, inputs, or projections affect findings. Report the effect of choice of discount rate and time horizon, if applicable.	Paragraph 3
Effect of engagement with patients and others affected by the study	25	Report on any difference patient/service recipient, general public, community, or stakeholder involvement made to the approach or findings of the study	Not reported
Discussion			
Study findings, limitations, generalisability, and current knowledge	26	Report key findings, limitations, ethical or equity considerations not captured, and how these could affect patients, policy, or practice.	Discussion
Other relevant information			
Source of funding	27	Describe how the study was funded and any role of the funder in the identification, design, conduct, and reporting of the analysis	Disclosures, Page 3
Conflicts of interest	28	Report authors conflicts of interest according to journal or International Committee of Medical Journal Editors requirements.	Disclosures, Page 2-3

From: Husereau D, Drummond M, Augustovski F, et al. Consolidated Health Economic Evaluation Reporting Standards 2022 (CHEERS 2022) Explanation and Elaboration: A Report of the ISPOR CHEERS II Good Practices Task Force. Value Health 2022;25. doi:10.1016/j.jval.2021.10.008