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| **Trascript** |
| **Redefining Care for Breast Cancer Patients:**  **Clinical Perspectives on the Impact of OlympiA and OlympiAD**  **An Interview with Dr Priyanka Sharma**  Priyanka Sharma | Breast Cancer Research Foundation  Priyanka Sharma, MD, Frank B. Tyler Professor in Cancer Research at the University of Kansas Medical Center and Co-Program Leader of the Drug Discovery, Delivery, and Experimental Therapeutics Program at the University of Kansas Cancer Center.  Dr Sharma has been compensated by AstraZeneca for her participation.  **Select Safety Information**  LYNPARZA is associated with serious and potentially fatal adverse events including myelodysplastic syndrome/acute myeloid leukemia (MDS/AML), pneumonitis, and venous thromboembolism (VTE). Monitor patients for signs and symptoms and discontinue LYNPARZA if MDS/AML or pneumonitis is confirmed. Monitor patients for signs and symptoms of VTE and treat as medically appropriate. LYNPARZA can cause fetal harm.  Please see full Important Safety Information at the end of the video. |

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| **Screen 1** |
| Hi, my name is Dr Priyanka Sharma.  The breast cancer treatment landscape is continuously evolving thanks to our broadening understanding of the value of precision medicine. And of course, when we think about precision medicine, one of the very effective treatments that we think about is LYNPARZA. It’s amazing that LYNPARZA has been available to patients with certain types of breast cancers for quite some time now.2  As the first approved PARP inhibitor for patients with germline *BRCA* mutation-associated metastatic breast cancer, and the only PARP inhibitor approved for g*BRCA* mutation-associated early-stage breast cancer, LYNPARZA represented a significant treatment advance for patients with germline *BRCA*1 or 2 mutation, giving them a targeted treatment option that was not previously available.1,2 |
| **Screen 2** |
| In 2017 the first phase 3 trial of LYNPARZA in breast cancer was published. OlympiAD, compared LYNPARZA with standard-of-care chemotherapy in patients with g*BRCA*m HER2-negative metastatic breast cancer. This study showed that LYNPARZA was superior to standard-of-care chemotherapy in terms of progression free survival.1,3 |
| **Screen 3** |
| The results from the OlympiAD trial led to the 2018 approval of LYNPARZA for patients with g*BRCA*m associated HER2-negative metastatic breast cancer, which allowed us to use this effective oral medication in clinic.1,2 |
| **Screen 4** |
| *BRCA*-associated breast cancers represent 5-10% of all breast cancers. However, breast cancer is a very common cancer. So, in sheer numbers, 5-10% of breast cancers represent modest number of patients that we see in clinic.4,5  Prior to the approval of targeted therapy, genetic testing was primarily limited to counseling for second cancers, cascade testing the family members, preventative strategies, etc. But once targeted therapies were approved, genetic testing information became important for making cancer treatment decisions. This meant that patients needed information and access to genetic testing in a time-sensitive fashion. Many models of point-of-care testing with support from physician extenders are now used in clinic. The goal is to provide rapid access to testing for all eligible patients, even if genetic counselor services are not readily available.6  With *BRCA* mutation-associated breast cancers, the approval of LYNPARZA led to a change in guidelines to recommend testing for germline *BRCA1/2* in all patients with metastatic breast cancer, as there was an available targeted treatment option. This led to shift in how we think of genetic testing in clinical practice, which was good for our patients.6,7 |
| **Screen 5** |
| As we started to gain experience with LYNPARZA in our patients with *BRCA*-mutated metastatic breast cancer, the high-risk early stage breast cancer trial, OlympiA began enrolling patients with germline *BRCA* mutated, triple negative or hormone receptor positive HER2-negative breast cancer.1,8  This was a monumental trial and a significant international effort to test the efficacy of LYNPARZA in curative setting.8 |

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| **Screen 6** |
| Results from the landmark OlympiA demonstrated clinically meaningful improvement in disease free survival and eventually also clinically significant improvement in overall survival with one year of adjuvant olaparib compared to placebo. The trial demonstrated the value of precision medicine in an early setting.1,10  In spite of all the advances in the treatment of breast cancer, there have been very few adjuvant treatments in breast cancer that have led to improvement in overall survival, so this was a major milestone for patients.11-14 |
| **Screen 7** |
| 4 years after OlympiAD, results from the OlympiA trial led to the 2022 approval of LYNPARZA for patients with *BRCA1/2* mutation-associated early-stage breast cancer. This represented a major treatment advance. We are able to use this targeted therapy to treat more patients. In the early-stage setting, drugs that improve overall survival, have such a tremendous impact on natural course of the disease.20,21 |
| **Screen 8** |
| Based on this subsequent approval, further refinements were made in recommendations for genetic testing, paving the way to where we are today. While there is some variability among guidelines, recommendations include testing for all patients with metastatic breast cancer. In early-stage setting, recommendations include testing for patients with triple negative breast cancer and for patients with hormone positive breast cancer if they meet the risk criteria for adjuvant LYNPARZA based on the OlympiaA eligibility. It's not just based on family history, but if patients with hormone positive breast cancer meet the criteria in terms of the number of positive nodes or amount of residual disease after preoperative chemotherapy, they are candidates for g*BRCA* testing. Regardless of family history, these individuals should be tested to ensure that we are not missing an opportunity to prescribe a targeted treatment that improves survival.8,22 |
| **Screen 9** |
| In my clinical practice, LYNPARZA is fairly well tolerated. It's got nausea, fatigue, impact on hemoglobin and blood counts.1 |
| **Screen 10** |
| The field continues to move forward, and we look for better treatments for our patients. There are some phase 2 trials that have looked at PARP inhibitors in the neoadjuvant setting as a chemotherapy free regimen and shown interesting results. It's not something we currently use in clinic, but it’s an area of expanding research.23,24 |
| **Screen 11** |
| In general, my experience with LYNPARZA in clinic has been very positive. It is a very tolerable oral drug for our patients. And it's quite efficacious in appropriately selected patients.  In other cancers, specifically ovarian and prostate, the indications are wider than just germline *BRCA* mutation. In breast cancer, the data from phase 2 trials in patients with somatic *BRCA* mutationslooks quite promising.1,25 |

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| **Screen 12** |
| I would like to share a case of a patient who was treated with LYNPARZA. A 56-year-old woman was diagnosed with pT2N2 HR+, HER2- breast cancer. She underwent a bilateral mastectomy with reconstruction and received adjuvant AC-T followed by 5 years of aromatase inhibitor therapy. Her family history was significant only for her mother who had ovarian cancer, but there was no family history of breast cancer.  Two years after stopping adjuvant AI therapy, she developed osseous metastasis and two small pulmonary nodules. She was treated with first line endocrine therapy with AI plus a CDK46 inhibitor, which resulted in disease control for 2.5 years. At that point, she began to show progression in osseous disease and developed malignant pleural effusion. Her care was transferred to a new institution, where they performed germline testing, which showed that she had a pathogenic germline *BRCA2* mutation.  The patient was started on then recently approved LYNPARZA for her metastatic breast cancer and had disease control for 2 years. She experienced mild nausea, which was managed with antiemetics. 4 months after starting LYNPARZA, her hemoglobin dropped to 6.6 but she showed no signs or symptoms of bleeding. LYNPARZA was paused for 3 weeks until her hemoglobin count rose to >10, and LYNPARZA was started at one dose level reduction, which the patient was able to tolerate for the rest of her therapy for another year when eventually there was progression of the cancer.  Cascade testing was performed for her family and showed one of her two daughters also had a germline *BRCA2* mutation. Clearly the genetic testing information was helpful not just for the patient for also very informative for her family |
| **Screen 13** |
| In terms of where I see LYNPARZA headed in the future, the first aspect is expanding the use of germline *BRCA* testing to all appropriate patients. While in academic clinics, we often do well with proactive testing for patients with triple negative breast cancer, there are many missed opportunities in patients with metastatic disease and HR+ early-stage patients who don't receive *BRCA* testing.  Additionally, oncologists are time strapped and may not have access to the required resources and infrastructure to offer/refer for genetic testing. Historically, genetic testing when only used for cancer risk counseling was done by genetic counselors, which limits access for many patients who may not be able to get an appointment with a genetic counselor in a timely fashion, don’t have access to counselors or have to wait weeks to get tested, or simply just fall through the cracks because they are too overwhelmed with cancer diagnosis and could not get to yet another appointment with a provider. In patients with breast cancer *BRCA* testing’s main purpose is to inform treatment of cancer and an easier process which is not burdensome for patients is desirable.  Many practices now have a point-of-care testing initiated by treating providers (eg by oncologist, surgeons, physician extenders) to expedite the testing and to make the process easy for the patients. Efforts are being made to integrate genetic testing into routine oncology workflow; however, a lot more work needs to be to be done to improve testing rates.26  Most patients with metastatic breast cancer are getting somatic tumor or ctDNA testing, which could pick up germline mutations but requires germline testing to confirm. It is to be noted that somatic tumor/ctDNA testing can also miss germline mutations so are not a good way to screen for germline mutations.27  As stated earlier, for early-stage disease, the oncology community is doing okay in terms of genetic testing for patients with triple negative breast cancer. However, in hormone receptor-positive disease, eligible patients might be missed if they're older and don't have family history of breast cancer or don’t have a record of family history.  The literature suggests that a quarter or more eligible patients are still not getting germline tested, and it varies based on type of practice and the healthcare setting. For example, in marginalized communities, access to resources is more challenging. Due to these disparities in healthcare access, minorities, individuals living in rural communities, and those from lower socioeconomic demographics are getting tested less. Through improved infrastructure and access to resources, oncologists and support teams could be better empowered to discuss genetic testing. Note that oncology providers are ordering somatic testing on a routine basis to aid in treatment decision making.28,29  While LYNPARZA may already be helping many patients with certain breast cancers, improving genetic testing rates in breast cancer patients will help to identify more patients who are eligible for targeted therapy with LYNPARZA. |

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| **Screen 14** |
| In the context of current approval, genetic *BRCA1/2* testing is recommended for all patients with metastatic breast cancer, among patients with early stage disease for all patients with TNBC regardless of age of diagnosis of cancer or family history, for patients with HER2 negative breast cancer who may be eligible of adjuvant LYNPARZA again regardless of family history, and for others who might meet criterion based on age of diagnosis or family history.22  In terms of where we should be headed outside of current approval, I think there's a lot of scientific questions that would fall under research.  I look forward to seeing how LYNPARZA can continue to expand across different treatment settings and across different tumor types. |
| **Important Safety Information**  **CONTRAINDICATIONS**  There are no contraindications for LYNPARZA.  **WARNINGS AND PRECAUTIONS**  **Myelodysplastic Syndrome/Acute Myeloid Leukemia (MDS/AML):** Occurred in approximately 1.2% of patients with various *BRCA*m, g*BRCA*m, HRR gene-mutated or HRD-positive cancers who received LYNPARZA as a single agent or as part of a combination regimen, consistent with the approved indications, and the majority of events had a fatal outcome. The median duration of therapy in patients who developed MDS/AML was approximately 2 years (range: <6 months to >4 years). All of these patients had previous chemotherapy with platinum agents and/or other DNA-damaging agents, including radiotherapy.  In SOLO-1, patients with newly diagnosed advanced *BRCA*m ovarian cancer, the incidence of MDS/AML was 1.9% (5/260) in patients who received LYNPARZA and 0.8% (1/130) in patients who received placebo based on an updated analysis. In PAOLA-1, in patients with newly diagnosed advanced ovarian cancer with HRD-positive status, the incidence of MDS/AML was 1.6% (4/255) in patients who received LYNPARZA and 2.3% (3/131) in the control arm.  In SOLO-2, patients with *BRCA*m platinum-sensitive relapsed ovarian cancer, the incidence of MDS/AML was 8% (15/195) in patients who received LYNPARZA and 4% (4/99) in patients who received placebo. The duration of LYNPARZA treatment prior to the diagnosis of MDS/AML ranged from 0.6 years to 4.5 years.  Do not start LYNPARZA until patients have recovered from hematological toxicity caused by previous chemotherapy (≤Grade 1). Monitor complete blood count for cytopenia at baseline and monthly thereafter for clinically significant changes during treatment. For prolonged hematological toxicities, interrupt LYNPARZA and monitor blood count weekly until recovery.  If the levels have not recovered to Grade 1 or less after 4 weeks, refer the patient to a hematologist for further investigations, including bone marrow analysis and blood sample for cytogenetics. Discontinue LYNPARZA if MDS/AML is confirmed.  **Pneumonitis:** Occurred in 0.8% of patients exposed to LYNPARZA monotherapy, and some cases were fatal. If patients present with new or worsening respiratory symptoms such as dyspnea, cough, and fever, or a radiological abnormality occurs, interrupt LYNPARZA treatment and initiate prompt investigation. Discontinue LYNPARZA if pneumonitis is confirmed and treat patient appropriately.  **Venous Thromboembolism (VTE):** Including severe or fatal pulmonary embolism (PE) occurred in patients treated with LYNPARZA. In the combined data of two randomized, placebo-controlled clinical studies (PROfound and PROpel) in patients with metastatic castration-resistant prostate cancer (N=1180), VTE occurred in 8% of patients who received LYNPARZA, including pulmonary embolism in 6%. In the control arms, VTE occurred in 2.5%, including pulmonary embolism in 1.5%. Monitor patients for signs and symptoms of venous thrombosis and pulmonary embolism, and treat as medically appropriate, which may include long-term anticoagulation as clinically indicated.  **Embryo-Fetal Toxicity:** Based on its mechanism of action and findings in animals, LYNPARZA can cause fetal harm. Verify pregnancy status in females of reproductive potential prior to initiating treatment.  *Females* Advise females of reproductive potential of the potential risk to a fetus and to use effective contraception during treatment and for 6 months following the last dose.  *Males*  Advise male patients with female partners of reproductive potential or who are pregnant to use effective contraception during treatment and for 3 months following the last dose of LYNPARZA and to not donate sperm during this time.  **ADVERSE REACTIONS** **—First-Line Maintenance *BRCA*m Advanced Ovarian Cancer**  Most common adverse reactions (Grades 1-4) in ≥10% of patients who received LYNPARZA in the **first-line maintenance setting** for **SOLO-1** were: nausea (77%), fatigue (67%), abdominal pain (45%), vomiting (40%), anemia (38%), diarrhea (37%), constipation (28%), upper respiratory tract infection/influenza/nasopharyngitis/bronchitis (28%), dysgeusia (26%), decreased appetite (20%), dizziness (20%), neutropenia (17%), dyspepsia (17%), dyspnea (15%), leukopenia (13%), urinary tract infection (13%), thrombocytopenia (11%), and stomatitis (11%).  Most common laboratory abnormalities (Grades 1-4) in ≥25% of patients who received LYNPARZA in the **first-line maintenance setting** for **SOLO-1** were: decrease in hemoglobin (87%), increase in mean corpuscular volume (87%), decrease in leukocytes (70%), decrease in lymphocytes (67%), decrease in absolute neutrophil count (51%), decrease in platelets (35%), and increase in serum creatinine (34%).  **ADVERSE REACTIONS—First-Line Maintenance Advanced Ovarian Cancer in Combination with Bevacizumab**  Most common adverse reactions (Grades 1-4) in ≥10% of patients treated with LYNPARZA/bevacizumab and at a ≥5% frequency compared to placebo/bevacizumab in the **first-line maintenance setting** for **PAOLA-1** were: nausea (53%), fatigue (including asthenia) (53%), anemia (41%), lymphopenia (24%), vomiting (22%), and leukopenia (18%). In addition, the most common adverse reactions (≥10%) for patients receiving LYNPARZA/bevacizumab irrespective of the frequency compared with the placebo/bevacizumab arm were: diarrhea (18%), neutropenia (18%), urinary tract infection (15%), and headache (14%).  In addition, venous thromboembolism occurred more commonly in patients receiving LYNPARZA/bevacizumab (5%) than in those receiving placebo/bevacizumab (1.9%).  Most common laboratory abnormalities (Grades 1-4) in ≥25% of patients for LYNPARZA in combination with bevacizumab in the **first-line maintenance setting** for **PAOLA-1** were: decrease in hemoglobin (79%), decrease in lymphocytes (63%), increase in serum creatinine (61%), decrease in leukocytes (59%), decrease in absolute neutrophil count (35%), and decrease in platelets (35%).  **ADVERSE REACTIONS—Maintenance g*BRCA*m Recurrent Ovarian Cancer**  Most common adverse reactions (Grades 1-4) in ≥20% of patients who received LYNPARZA in the **maintenance setting** for **SOLO-2** were: nausea (76%), fatigue (including asthenia) (66%), anemia (44%), vomiting (37%), nasopharyngitis/upper respiratory tract infection (URI)/influenza (36%), diarrhea (33%), arthralgia/myalgia (30%), dysgeusia (27%), headache (26%), decreased appetite (22%), and stomatitis (20%).  Most common laboratory abnormalities (Grades 1-4) in ≥25% of patients who received LYNPARZA in the **maintenance setting** for **SOLO-2** were: increase in mean corpuscular volume (89%), decrease in hemoglobin (83%), decrease in leukocytes (69%), decrease in lymphocytes (67%), decrease in absolute neutrophil count (51%), increase in serum creatinine (44%), and decrease in platelets (42%).  **ADVERSE REACTIONS—Adjuvant Treatment of g*BRCA*m, HER2-Negative, High-Risk Early Breast Cancer**  Most common adverse reactions (Grades 1-4) in ≥10% of patients who received LYNPARZA in the **adjuvant setting** for **OlympiA** were: nausea (57%), fatigue (including asthenia) (42%), anemia (24%), vomiting (23%), headache (20%), diarrhea (18%), leukopenia (17%), neutropenia (16%), decreased appetite (13%), dysgeusia (12%), dizziness (11%), and stomatitis (10%).  Most common laboratory abnormalities (Grades 1-4) in ≥25% of patients who received LYNPARZA in the **adjuvant setting** for **OlympiA** were: decrease in lymphocytes (77%), increase in mean corpuscular volume (67%), decrease in hemoglobin (65%), decrease in leukocytes (64%), and decrease in absolute neutrophil count (39%).  **ADVERSE REACTIONS—g*BRCA*m, HER2-Negative Metastatic Breast Cancer**  Most common adverse reactions (Grades 1-4) in ≥20% of patients who received LYNPARZA in the **metastatic setting** for **OlympiAD** were: nausea (58%), anemia (40%), fatigue (including asthenia) (37%), vomiting (30%), neutropenia (27%), respiratory tract infection (27%), leukopenia (25%), diarrhea (21%), and headache (20%).  Most common laboratory abnormalities (Grades 1-4) in ≥25% of patients who received LYNPARZA in the **metastatic setting** for **OlympiAD** were: decrease in hemoglobin (82%), decrease in lymphocytes (73%), decrease in leukocytes (71%), increase in mean corpuscular volume (71%), decrease in absolute neutrophil count (46%), and decrease in platelets (33%).  **ADVERSE REACTIONS—HRR Gene-mutated Metastatic Castration-Resistant Prostate Cancer**  Most common adverse reactions (Grades 1-4) in ≥10% of patients who received LYNPARZA for **PROfound** were: anemia (46%), fatigue (including asthenia) (41%), nausea (41%), decreased appetite (30%), diarrhea (21%), vomiting (18%), thrombocytopenia (12%), cough (11%), and dyspnea (10%).  Most common laboratory abnormalities (Grades 1-4) in ≥25% of patients who received LYNPARZA for **PROfound** were: decrease in hemoglobin (98%), decrease in lymphocytes (62%), decrease in leukocytes (53%), and decrease in absolute neutrophil count (34%).  **ADVERSE REACTIONS—Metastatic Castration-Resistant Prostate Cancer in Combination with Abiraterone and Prednisone or Prednisolone**  Most common adverse reactions (Grades 1-4) in ≥10% of patients who received LYNPARZA/abiraterone with a difference of ≥5% compared to placebo for **PROpel** were: anemia (48%), fatigue (including asthenia) (38%), nausea (30%), diarrhea (19%), decreased appetite (16%), lymphopenia (14%), dizziness (14%), and abdominal pain (13%).  Most common laboratory abnormalities (Grades 1-4) in ≥20% of patients who received LYNPARZA/abiraterone for **PROpel** were: decrease in hemoglobin (97%), decrease in lymphocytes (70%), decrease in platelets (23%), and decrease in absolute neutrophil count (23%).  **DRUG INTERACTIONS**  **Anticancer Agents:** Clinical studies of LYNPARZA with other myelosuppressive anticancer agents, including DNA-damaging agents, indicate a potentiation and prolongation of myelosuppressive toxicity.  **CYP3A Inhibitors:** Avoid coadministration of strong or moderate CYP3A inhibitors when using LYNPARZA. If a strong or moderate CYP3A inhibitor must be coadministered, reduce the dose of LYNPARZA. Advise patients to avoid grapefruit, grapefruit juice, Seville oranges, and Seville orange juice during LYNPARZA treatment.  **CYP3A Inducers:** Avoid coadministration of strong or moderate CYP3A inducers when using LYNPARZA.  **USE IN SPECIFIC POPULATIONS**  **Lactation:** No data are available regarding the presence of olaparib in human milk, its effects on the breastfed infant or on milk production. Because of the potential for serious adverse reactions in the breastfed infant, advise a lactating woman not to breastfeed during treatment with LYNPARZA and for 1 month after receiving the final dose.  **Pediatric Use:** The safety and efficacy of LYNPARZA have not been established in pediatric patients.  **Hepatic Impairment:** No adjustment to the starting dose is required in patients with mild or moderate hepatic impairment (Child-Pugh classification A and B). There are no data in patients with severe hepatic impairment (Child-Pugh classification C).  **Renal Impairment:** No dosage modification is recommended in patients with mild renal impairment (CLcr 51-80 mL/min estimated by Cockcroft-Gault). In patients with moderate renal impairment (CLcr 31-50 mL/min), reduce the dose of LYNPARZA to 200 mg twice daily. There are no data in patients with severe renal impairment or end-stage renal disease (CLcr ≤30 mL/min).  **INDICATIONS**  LYNPARZA is a poly (ADP-ribose) polymerase (PARP) inhibitor indicated:  **First-Line Maintenance *BRCA*m Advanced Ovarian Cancer** For the maintenance treatment of adult patients with deleterious or suspected deleterious germline or somatic *BRCA*-mutated (g*BRCA*m or s*BRCA*m) advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy. Select patients for therapy based on an FDA-approved companion diagnostic for LYNPARZA.  **First-Line Maintenance HRD-Positive**  **Advanced Ovarian Cancer in Combination with Bevacizumab**  In combination with bevacizumab for the maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either a deleterious or suspected deleterious *BRCA* mutation, and/or genomic instability. Select patients for therapy based on an FDA-approved companion diagnostic for LYNPARZA.  **Maintenance *BRCA*-mutated Recurrent Ovarian Cancer** For the maintenance treatment of adult patients with deleterious or suspected deleterious germline or somatic *BRCA*-mutated (g*BRCA*m or s*BRCA*m) recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, who are in complete or partial response to platinum-based chemotherapy. Select patients for therapy based on an FDA-approved companion diagnostic for LYNPARZA.  **Adjuvant Treatment for g*BRCA*m, HER2-Negative, High-Risk Early Breast Cancer**  For the adjuvant treatment of adult patients with deleterious or suspected deleterious g*BRCA*m, human epidermal growth factor receptor 2 (HER2)-negative, high-risk early breast cancer who have been treated with neoadjuvant or adjuvant chemotherapy. Select patients for therapy based on an FDA-approved companion diagnostic for LYNPARZA.  **g*BRCA*m, HER2-Negative Metastatic Breast Cancer**  For the treatment of adult patients with deleterious or suspected deleterious g*BRCA*m, human epidermal growth factor receptor 2 (HER2)-negative metastatic breast cancer who have been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine therapy or be considered inappropriate for endocrine therapy. Select patients for therapy based on an FDA-approved companion diagnostic for LYNPARZA.  **HRR Gene-mutated Metastatic Castration-Resistant Prostate Cancer** For the treatment of adult patients with deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC) who have progressed following prior treatment with enzalutamide or abiraterone. Select patients for therapy based on an FDA-approved companion diagnostic for LYNPARZA.  ***BRCA*m Metastatic Castration-Resistant Prostate Cancer in Combination with Abiraterone and Prednisone or Prednisolone** In combination with abiraterone and prednisone or prednisolone (abi/pred) for the treatment of adult patients with deleterious or suspected deleterious *BRCA*-mutated (*BRCA*m) metastatic castration-resistant prostate cancer (mCRPC). Select patients for therapy based on an FDA-approved companion diagnostic for LYNPARZA.  **Please see complete Prescribing Information, including Medication Guide, at** [**www.lynparzahcp.com**](http://www.lynparzahcp.com) **or at the link on this website.**  You are encouraged to report negative side effects of AstraZeneca prescription drugs by calling 1-800-236-9933. If you prefer to report these to the FDA, call 1-800-FDA-1088.  LYNPARZA is a registered trademark of the AstraZeneca group of companies.  ©2025 AstraZeneca. All rights reserved. US-94501 Last Updated 2/25 |

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