Lynparza®
olaparib
tablets 150 mg

Not an actual patient.

Survival matters to them

PRIMARY ENDPOINT

3.1 YEARS mPFS

Progression-free survival:
HR=0.33 (95% CI: 0.25–0.45)
3.1 years (37.2 months) median PFS with LYNPARZA + bevacizumab and ~1.5 years (17.7 months) with bevacizumab + placebo

KEY SECONDARY ENDPOINT

~6.3 YEARS mOS

Overall survival:
HR=0.62 (95% CI: 0.45–0.85)
~6.3 years (75.2 months) median OS with LYNPARZA + bevacizumab and ~4.8 years (57.3 months) with bevacizumab + placebo

See 5-YEAR follow up PFS results >

Choose a PARPi with both clinically meaningful PFS and OS in HRD-positive* aOC in combination with bevacizumab[1†]

after response to 1L platinum-based chemotherapy

*Select patients for this indication based on an FDA-approved companion diagnostic for LYNPARZA.[1]
†Results for PFS and OS may vary.
Data based upon a prespecified exploratory subgroup analysis. See PAOLA-1 study design and results section for additional information.

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.

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 (26/2219) with various *BRCA*m, g*BRCA*m, HRR gene-mutated or HRD-positive cancers who received LYNPARZA in clinical studies 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, of 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.

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

1L=first-line; aOC=advanced ovarian cancer; *BRCA*m=*BRCA*-mutated; CI=confidence interval; g*BRCA*m=germline *BRCA*-mutated; HR=hazard ratio; HRD=homologous recombination deficiency; HRR=homologous recombination repair; mOS=median overall survival; mPFS=median progression-free survival; OS=overall survival; PARPi=poly (ADP-ribose) polymerase inhibitor; PFS=progression-free survival.

PAOLA-1: A phase 3 trial evaluating LYNPARZA + bevacizumab vs an active comparator (bevacizumab + placebo) in advanced ovarian cancer[1-5]

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PAOLA-1 Study Design

PAOLA-1 studied the efficacy and safety of LYNPARZA + bevacizumab vs an active comparator (bevacizumab + placebo)

- Advanced ovarian cancer following response to first-line platinum-based chemotherapy with bevacizumab. Bevacizumab was prescribed for at least 3 cycles in combination with platinum-based chemotherapy
- Patients were stratified by tumor *BRCA* mutation status and first-line treatment outcome. HRD status was not a stratification factor
- The ITT population was randomized 2:1 (N=806) to receive LYNPARZA tablets 300 mg orally BID in combination with bevacizumab 15 mg/kg infusion every 3 weeks (n=537) or placebo orally BID in combination with bevacizumab 15 mg/kg infusion every 3 weeks (n=269)
- Treatment with LYNPARZA was continued for up to 2 years or until disease progression or unacceptable toxicity. Patients with a partial response could continue treatment beyond 2 years at the physician's discretion. Bevacizumab was administered every 3 weeks for a total duration of up to 15 months, including the period given with chemotherapy and given as maintenance*
- The primary endpoint was the investigator-assessed PFS, and a key secondary endpoint was overall survival
  - **FDA approval for LYNPARZA + bevacizumab was based on a prespecified exploratory subgroup of patients with HRD-positive tumors (n=387)**

*Patients continued bevacizumab in the maintenance setting and started treatment with LYNPARZA after ≥3 weeks and ≤9 weeks following completion of their last dose of chemotherapy.

Prespecified exploratory analysis in the HRD-positive subgroup:

Median PFS with LYNPARZA + bevacizumab[1,2]

	LYNPARZA + bevacizumab (n=255)	Bevacizumab + placebo (n=132)
PFS: HRD-positive subgroup (n=387)		
Median	**3.1 years** (37.2 months)	**~1.5 years** (17.7 months)
Events, % (n)	34% (87/255)	70% (92/132)
HR (95% CI)	**0.33** (0.25–0.45); **67% risk reduction of disease progression or death**	

HRD status was not a stratification factor in PAOLA-1, and analysis was not controlled for Type 1 error.

ITT population (n=806)
Statistically significant difference in PFS was observed for LYNPARZA + bevacizumab compared with bevacizumab + placebo.

HRD-negative subgroup (n=277)
Results from an exploratory analysis in this subgroup (HR=1.00 [95% CI: 0.75–1.34]) indicated that the clinical benefit was primarily attributed to the results seen in the HRD-positive subgroup.

PFS IN BRCAm *AND HRD-POSITIVE NON-*BRCAm

PFS BY CLINICAL RISK

IMPORTANT SAFETY INFORMATION (Cont'd)

WARNINGS AND PRECAUTIONS (Cont'd)

Myelodysplastic Syndrome/Acute Myeloid Leukemia (MDS/AML) (Cont'd):
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 counts 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: Including severe and fatal cases, has occurred in patients treated with LYNPARZA. In clinical studies, among patients who received LYNPARZA as a single agent or as part of a combination regimen, the incidence of pneumonitis, including fatal cases, was 1.0% (29/2851). If patients present with new or worsening respiratory symptoms such as dyspnea, cough, and fever, or a radiological abnormality occurs, interrupt LYNPARZA treatment and promptly assess the source of the symptoms. If pneumonitis is confirmed, discontinue LYNPARZA treatment and treat the patient appropriately.

Venous Thromboembolism (VTE): Including severe or fatal pulmonary embolism (PE), occurred in patients treated with LYNPARZA. 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.

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

BID=twice daily; ITT=intent-to-treat.

~6.3 years median OS with LYNPARZA + bevacizumab, ~1.5 years longer vs established maintenance bevacizumab + placebo[1,5]

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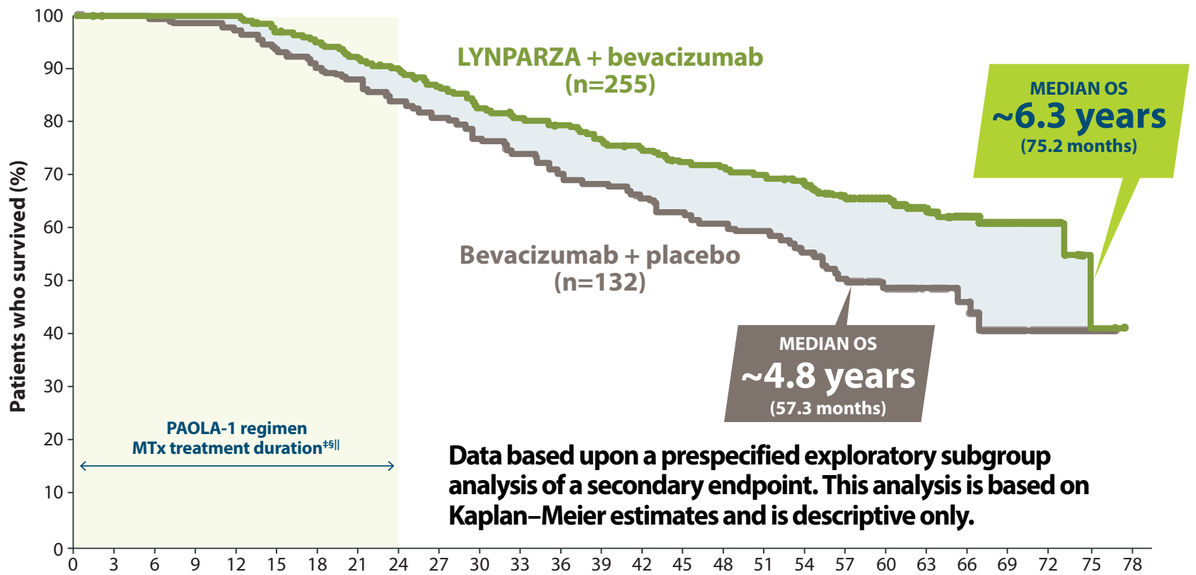
PAOLA-1

Maintenance treatment in HRD-positive*† aOC following CR or PR to 1L platinum-based chemotherapy + bevacizumab[1]



Data based upon a prespecified exploratory subgroup analysis of a secondary endpoint. This analysis is based on Kaplan–Meier estimates and is descriptive only.

Number of patients at risk

LYNPARZA + bevacizumab	255	253	253	252	252	244	238	231	225	215	205	200	195	189	183	176	174	170	164	142	116	83	62	32	17	4	0
Bevacizumab + placebo	132	130	129	128	126	121	117	114	109	105	100	96	91	89	86	82	79	77	70	59	44	29	21	9	2	1	0

38% REDUCTION IN RISK OF DEATH

HR=0.62 (95% CI: 0.45–0.85)

HRD status was not a stratification factor in PAOLA-1, and analysis was not controlled for Type 1 error.

HRD-positive subgroup (n=387)

Events, n (%): 93/255 (36) with LYNPARZA + bevacizumab and 69/132 (52) with bevacizumab + placebo.[5]

ITT population (n=806)

Statistical significance in OS was not reached for LYNPARZA + bevacizumab compared with bevacizumab + placebo.[5]

HRD-negative subgroup (n=277)

Results from an exploratory analysis in this subgroup (HR=1.18 [95% CI: 0.87–1.60]) indicated that the clinical benefit was primarily attributed to the results seen in the HRD-positive subgroup.[1]

Among patients with HRD-positive tumors, 19.6% of patients in the LYNPARZA + bevacizumab arm and 45.7% of patients in the bevacizumab + placebo arm received subsequent PARP inhibitor therapy following 1L maintenance. The effect of subsequent therapy on overall survival is unknown.[5]

OS IN* BRCA*m* *AND HRD-POSITIVE NON-*BRCA*m

OS BY CLINICAL RISK

*Select patients for this indication based on an FDA-approved companion diagnostic for LYNPARZA.[1]

†Including *BRCA* mutation (as determined by Myriad MyChoice® CDx) and other causes of HRD. HRD positive was defined as either a t*BRCA* mutation and/or an HRD score ≥42 by Myriad MyChoice® CDx.[4]

‡Bevacizumab was administered for a total of up to 15 months, including the period given with chemotherapy and given as maintenance.

§LYNPARZA was continued for up to 2 years or until progression of the underlying disease or unacceptable toxicity. Patients, who in the opinion of the treating physician could derive further benefit from continuous treatment, could be treated beyond 2 years.

||Patients with a complete response should stop treatment at 2 years. Patients with evidence of disease at 2 years can remain on therapy at physician discretion. In PAOLA-1, it was unknown how many HRD-positive patients remained on therapy longer than 2 years; therefore, results should be interpreted with caution.

IMPORTANT SAFETY INFORMATION (Cont'd)

WARNINGS AND PRECAUTIONS (Cont'd)

Hepatotoxicity, including Drug-Induced Liver Injury (DILI): Hepatotoxicity, including severe and potentially fatal cases of DILI has occurred in patients treated with LYNPARZA. Evaluate bilirubin and transaminases at baseline and throughout treatment with LYNPARZA. For patients who develop abnormal liver tests after LYNPARZA, monitor more frequently for liver test abnormalities and clinical signs and symptoms of hepatic toxicity. If DILI is suspected, withhold LYNPARZA. Upon confirmation of DILI, discontinue LYNPARZA.

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.

ADVERSE REACTIONS—First-Line Maintenance *BRCA*m Advanced Ovarian Cancer

Most common adverse reactions (all Grades) 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%).

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

CR=complete response; MTx=maintenance treatment; PR=partial response; t*BRCA*=tumor *BRCA*.

Post hoc 5-year follow-up: PFS at the time of OS analysis

~1 in 2 patients were living progression-free at 5 years: ~46% with LYNPARZA + bevacizumab and ~19% with bevacizumab + placebo[1,5]

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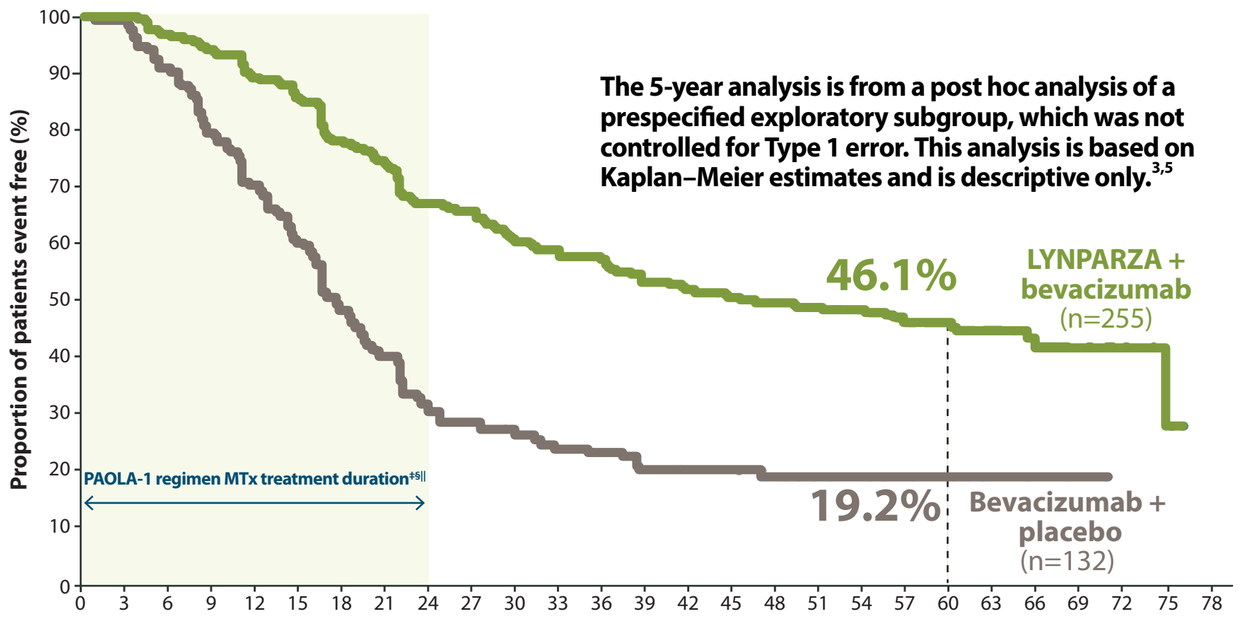
PAOLA-1

Maintenance treatment in HRD-positive*† aOC following CR or PR to 1L platinum-based chemotherapy + bevacizumab[1]



The 5-year analysis is from a post hoc analysis of a prespecified exploratory subgroup, which was not controlled for Type 1 error. This analysis is based on Kaplan–Meier estimates and is descriptive only.[3,5]

Number of patients at risk

LYNPARZA + bevacizumab	255	252	242	236	223	214	194	183	165	162	147	143	138	127	123	119	117	112	103	79	63	40	31	8	5	3	0
Bevacizumab + placebo	132	129	118	103	91	79	62	52	41	37	34	30	29	25	24	24	21	20	19	15	13	8	6	2	0		

	LYNPARZA + bevacizumab	Bevacizumab + placebo
Median PFS	46.8 months (3.9 years)	17.6 months (~1.5 years)
	HR=0.41 (95% CI: 0.32–0.54)	

Events, n (%): 136 (53) events in the LYNPARZA + bevacizumab and 104 (79) events in the bevacizumab + placebo arm.[5]

Median PFS follow-up time (post hoc follow-up analysis): Efficacy and safety were assessed with long-term follow-up of 5 years after the last patient was randomized (5.1 years for LYNPARZA + bevacizumab and 5.2 years for bevacizumab + placebo); DCO: March 22, 2022.[5]

*Select patients for this indication based on an FDA-approved companion diagnostic for LYNPARZA.[1]

†Including *BRCA* mutation (as determined by Myriad MyChoice® CDx) and other causes of HRD. HRD positive was defined as either a t*BRCA* mutation and/or an HRD score ≥42 by Myriad MyChoice® CDx.[4]

‡Bevacizumab was administered for a total of up to 15 months, including the period given with chemotherapy and given as maintenance.

§LYNPARZA was continued for up to 2 years or until progression of the underlying disease or unacceptable toxicity. Patients, who in the opinion of the treating physician could derive further benefit from continuous treatment, could be treated beyond 2 years.

‖Patients with a complete response should stop treatment at 2 years. Patients with evidence of disease at 2 years can remain on therapy at physician discretion. In PAOLA-1, it was unknown how many HRD-positive patients remained on therapy longer than 2 years; therefore, results should be interpreted with caution.

IMPORTANT SAFETY INFORMATION (Cont'd)

ADVERSE REACTIONS—First-Line Maintenance *BRCA*m Advanced Ovarian Cancer (Cont'd)

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%).

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

DCO=data cutoff.

Adverse reactions from the primary analysis in PAOLA-1 were mostly Grades 1 and 2[1]

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Primary analysis: ARs occurring in ≥10% of patients treated with LYNPARZA + bevacizumab and at ≥5% frequency compared with bevacizumab + placebo[1]

LYNPARZA + bevacizumab (n=535)
Bevacizumab + placebo (n=267)

Adverse reactions*	Grades 1–4 (%)	Grades 3–4 (%)
General disorders and administration site conditions		
Fatigue (including asthenia)†	53 32	5 1.5
Gastrointestinal disorders		
Nausea	53 22	2.4 0.7
Vomiting	22 11	1.7 1.9
Blood and lymphatic disorders		
Anemia‡	41 10	17 0.4
Lymphopenia§	24 9	7 1.1
Leukopenia‖	18 10	1.9 1.5

Primary analysis[1]:

Fatal adverse reactions occurred in 1 patient due to concurrent pneumonia and aplastic anemia. Serious adverse reactions occurred in 31% of patients who received LYNPARZA + bevacizumab. Serious adverse reactions in >5% of patients included hypertension (19%) and anemia (17%).

In addition, venous thromboembolism occurred more commonly in patients receiving LYNPARZA + bevacizumab (5%) than in those receiving bevacizumab + placebo (1.9%).

*Graded according to the National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE), version 4.0.
†Includes asthenia and fatigue.
‡Includes anemia, anemia macrocytic, erythropenia, hematocrit decreased, hemoglobin decreased, normochromic anemia, normochromic normocytic anemia, normocytic anemia, and red blood cell count decreased.
§Includes B-lymphocyte count decreased, lymphocyte count decreased, lymphopenia, and T-lymphocyte count decreased.
‖Includes leukopenia and white blood cell count decreased.

At 5-year follow-up analysis[5]:

No new safety signals were identified, and the safety profile remained generally consistent with the primary analysis

- **The incidence of MDS/AML/AA was 1.7% (9/535) in the LYNPARZA + bevacizumab group and 2.2% (6/267) in the bevacizumab + placebo group**
  - **In the HRD-positive subgroup, the incidence of MDS/AML was 1.6% (4/255) in patients who received LYNPARZA + bevacizumab and 2.3% (3/131) in patients who received bevacizumab + placebo[1];**
- **22 (4.1%) new primary malignancy events occurred in the LYNPARZA + bevacizumab group, and 8 (3.0%) events occurred in the bevacizumab + placebo group;**
- **7 (1.3%) pneumonitis events occurred in the LYNPARZA + bevacizumab group, and 2 (0.7%) events occurred in the bevacizumab + placebo group**

Please see Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

AA=aplastic anemia; AML=acute myeloid leukemia; AR=adverse reaction; MDS=myelodysplastic syndrome.

Laboratory abnormalities from the primary analysis in PAOLA-1 were mostly Grades 1 and 2[1]

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Primary analysis: Lab abnormalities reported in ≥25% of patients on LYNPARZA + bevacizumab vs bevacizumab + placebo[1]*

LYNPARZA + bevacizumab (n=535)†

Bevacizumab + placebo (n=267)†

Laboratory parameter‡	Grades 1–4 (%)	Grades 3–4 (%)
Decrease in hemoglobin	79 55	13 0.4
Decrease in lymphocytes	63 42	10 3
Increase in serum creatinine	61 36	0.4 0.4
Decrease in leukocytes	59 45	3.4 2.2
Decrease in absolute neutrophil count	35 30	7 3.7
Decrease in platelets	35 28	2.4 0.4

*Reported within 30 days of the last dose.
†This number represents the safety population. The derived values in the table are based on the total number of evaluable patients for each laboratory parameter.
‡Patients were allowed to enter clinical studies with laboratory values of CTCAE Grade 1.

Please see Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

8 out of 10 patients remained on LYNPARZA as prescribed, in combination with bevacizumab, without discontinuing due to ARs[1]

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Primary analysis: Dose modifications due to an AR[1,2]

	(LYNPARZA component)	(Placebo component)
	LYNPARZA + bevacizumab (n=535)	**Bevacizumab + placebo (n=267)**
Dose interruptions due to ARs (%)	54	24
Dose reductions due to ARs (%)	41	7
Discontinuations due to ARs (%)	20	6

- Anemia (4%) and nausea (3%) were reported to cause discontinuation rates ≥2%; all other ARs leading to discontinuation occurred with a frequency of 1% or below[3]
- Recorded ARs occurred during study treatment or up to 30 days after discontinuation of the intervention[3]

Please refer to the bevacizumab package insert for more information on the management of ARs related to bevacizumab and bevacizumab dose adjustments.

IMPORTANT SAFETY INFORMATION (Cont'd)

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).

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

SOLO-1 studied the efficacy and safety of LYNPARZA vs placebo in BRCAm advanced ovarian cancer[1,6]

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SOLO-1 Study Design

SOLO-1: A phase 3 trial evaluating PFS as a primary endpoint and OS as a key secondary endpoint

- *BRCA*-mutated advanced ovarian cancer following response to first-line platinum-based chemotherapy
- Patients were stratified by response to first-line platinum-based chemotherapy (complete or partial response)
- Randomized 2:1 (N=391) to receive LYNPARZA tablets 300 mg orally BID (n=260) or placebo orally BID (n=131)
- Treatment with LYNPARZA was continued for up to 2 years or until disease progression or unacceptable toxicity. Patients who remained in CR could receive LYNPARZA for a maximum of 2 years; patients with evidence of disease at 2 years could continue treatment beyond 2 years at the physician's discretion
- The primary endpoint was investigator-assessed PFS, and a key secondary endpoint was overall survival

Primary analysis: Median PFS was not reached with LYNPARZA vs ~1.2 years (13.8 months) with placebo

	LYNPARZA (n=260)	Placebo (n=131)
PFS: Primary endpoint		
Median	**Not reached**	**~1.2 years** (13.8 months)
Events, % (n)	39% (102/260)	73% (96/131)
HR (95% CI)	**0.30** (0.23–0.41); *P*<0.0001; **70% risk reduction of disease progression or death**	

Median duration of follow-up (primary analysis): 41 months for both LYNPARZA and placebo; DCO: May 17, 2018.

OVERALL SURVIVAL >

IMPORTANT SAFETY INFORMATION (Cont'd)

USE IN SPECIFIC POPULATIONS (Cont'd)

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).

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 (26/2219) with various *BRCA*m, g*BRCA*m, HRR gene-mutated or HRD-positive cancers who received LYNPARZA in clinical studies 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.

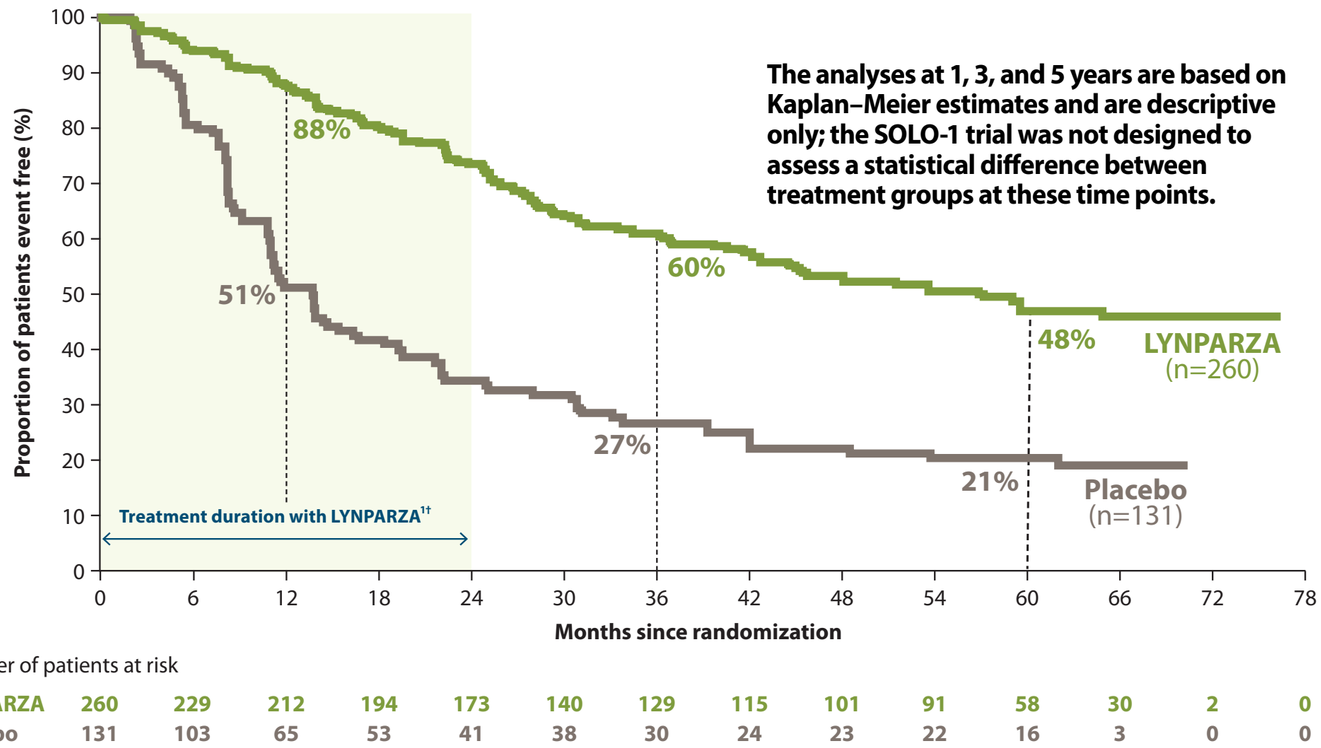
Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

PFS at the post hoc 5-year follow-up analysis

~4.7 years mPFS with LYNPARZA vs ~1.2 years with placebo[6,7]

SOLO-1

Maintenance treatment in *BRCA*m* aOC following CR or PR to 1L platinum-based chemotherapy[1]



The analyses at 1, 3, and 5 years are based on Kaplan–Meier estimates and are descriptive only; the SOLO-1 trial was not designed to assess a statistical difference between treatment groups at these time points.

	LYNPARZA	Placebo
Median PFS	56 months	13.8 months
	HR=0.33 (95% CI: 0.25–0.43)	

Events, n (%): 118/260 (45) with LYNPARZA and 100/131 (76) with placebo.[6,7]

Median PFS follow-up time (post hoc analysis not controlled for Type 1 error): 4.8 years for LYNPARZA and 5 years for placebo; DCO: March 5, 2020.[7,8]

*Select patients for this indication based on an FDA-approved companion diagnostic for LYNPARZA.[1]

†In SOLO-1, treatment with LYNPARZA was continued for up to 2 years or until disease progression or unacceptable toxicity. Patients who remained in CR received a maximum treatment duration of 2 years; patients with evidence of disease could continue to receive LYNPARZA beyond 2 years. 26 (10%) patients on LYNPARZA continued beyond 2 years. At the time of DCO May 17, 2018, 13 patients were still receiving LYNPARZA.[1,6]

IMPORTANT SAFETY INFORMATION (Cont'd)

WARNINGS AND PRECAUTIONS (Cont'd)

Myelodysplastic Syndrome/Acute Myeloid Leukemia (MDS/AML) (Cont'd):
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, of 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 counts 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.

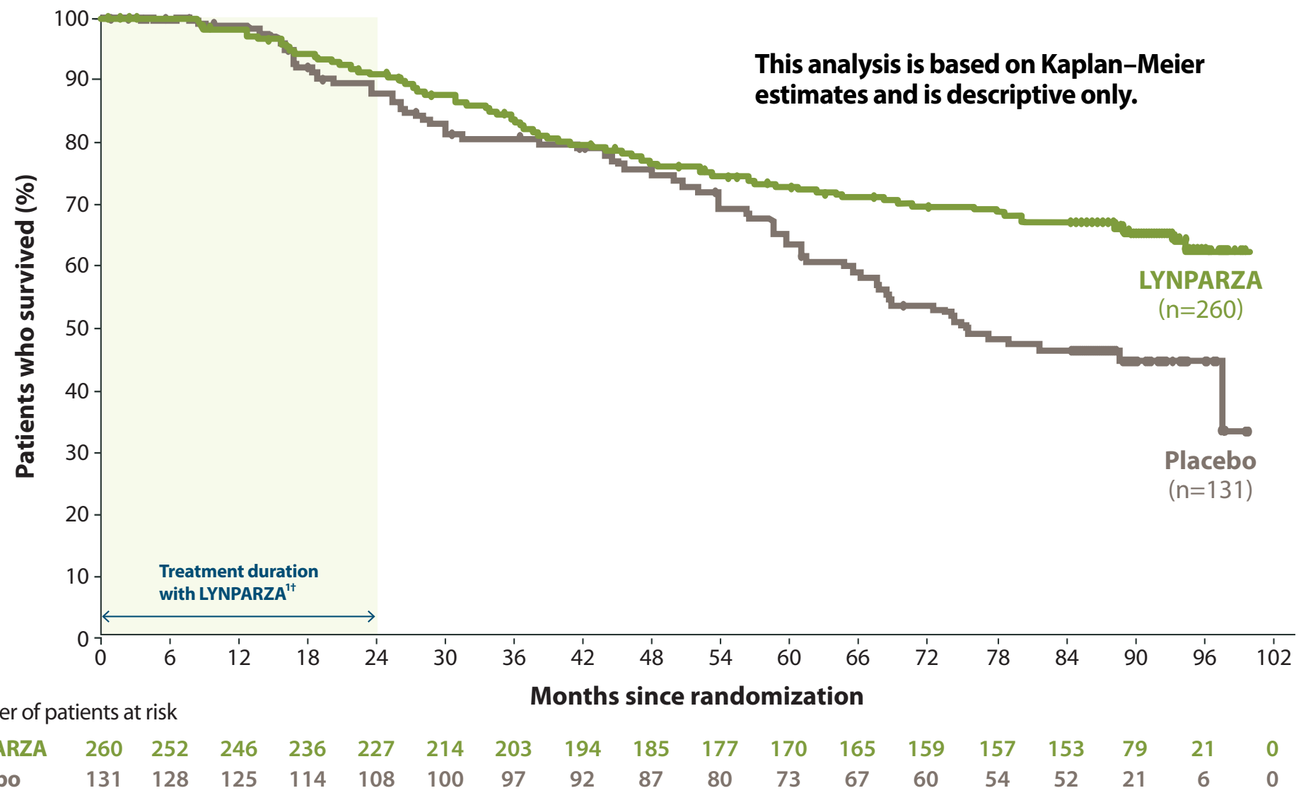
Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

Descriptive interim 7-year follow-up OS analysis

Median OS was not reached with LYNPARZA vs 75.2 months (~6.3 years) with placebo[9]

SOLO-1

Maintenance treatment in *BRCA*m* aOC following CR or PR to 1L platinum-based chemotherapy[1]



45% REDUCTION IN RISK OF DEATH

HR=0.55 (95% CI: 0.40–0.76)

Events, n (%): 84/260 (32.3) with LYNPARZA and 65/131 (49.6) with placebo.[9]

Interim median OS follow-up time: ~7.3 years (median duration of follow-up was 88.9 months for the olaparib arm and 87.4 months for placebo); DCO: March 7, 2022.[9]

*Select patients for this indication based on an FDA-approved companion diagnostic for LYNPARZA.[1]

†In SOLO-1, treatment with LYNPARZA was continued for up to 2 years or until disease progression or unacceptable toxicity. Patients who remained in CR received a maximum treatment duration of 2 years; patients with evidence of disease could continue to receive LYNPARZA beyond 2 years. 26 (10%) patients on LYNPARZA continued beyond 2 years. At the time of DCO May 17, 2018, 13 patients were still receiving LYNPARZA.[1,6]

14.6% of patients in the LYNPARZA arm and 44.3% of patients in the placebo arm received subsequent PARP inhibitor therapy following 1L maintenance. The effect of subsequent therapy on overall survival is unknown.[9]

IMPORTANT SAFETY INFORMATION (Cont'd)

WARNINGS AND PRECAUTIONS (Cont'd)

Pneumonitis: Including severe and fatal cases, has occurred in patients treated with LYNPARZA. In clinical studies, among patients who received LYNPARZA as a single agent or as part of a combination regimen, the incidence of pneumonitis, including fatal cases, was 1.0% (29/2851). If patients present with new or worsening respiratory symptoms such as dyspnea, cough, and fever, or a radiological abnormality occurs, interrupt LYNPARZA treatment and promptly assess the source of the symptoms. If pneumonitis is confirmed, discontinue LYNPARZA treatment and treat the patient appropriately.

Venous Thromboembolism (VTE): Including severe or fatal pulmonary embolism (PE), occurred in patients treated with LYNPARZA. 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.

Hepatotoxicity, including Drug-Induced Liver Injury (DILI): Hepatotoxicity, including severe and potentially fatal cases of DILI has occurred in patients treated with LYNPARZA. Evaluate bilirubin and transaminases at baseline and throughout treatment with LYNPARZA. For patients who develop abnormal liver tests after LYNPARZA, monitor more frequently for liver test abnormalities and clinical signs and symptoms of hepatic toxicity. If DILI is suspected, withhold LYNPARZA. Upon confirmation of DILI, discontinue LYNPARZA.

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.

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

Adverse reactions from the primary analysis in SOLO-1 were mostly Grades 1 and 2[1]

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Primary analysis: Adverse reactions in ≥10% of patients who received LYNPARZA[1]

LYNPARZA (n=260) Placebo (n=130)

Adverse reactions*	All Grades	Grades 3–4 (%)
Gastrointestinal disorders		
Nausea	77 38	1 0
Abdominal pain†	45 35	2 1
Vomiting	40 15	0 1
Diarrhea‡	37 26	3 0
Constipation	28 19	0 0
Dyspepsia	17 12	0 0
Stomatitis§	11 2	0 0
General disorders and administration site conditions		
Fatigue‖	67 42	4 2
Blood and lymphatic system disorders		
Anemia	38 9	21 2
Neutropenia¶	17 7	6 3
Leukopenia#	13 8	3 0
Thrombocytopenia**	11 4	1 2
Infections and infestations		
Upper respiratory tract infection/influenza/ nasopharyngitis/bronchitis	28 23	0 0
UTI††	13 7	1 0
Nervous system disorders		
Dysgeusia	26 4	0 0
Dizziness	20 15	0 1
Metabolism and nutrition disorders		
Decreased appetite	20 10	0 0
Respiratory, thoracic, and mediastinal disorders		
Dyspnea‡‡	15 6	0 0

*Graded according to the National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE), version 4.0.
†Includes abdominal pain, abdominal pain lower, abdominal pain upper, abdominal distension, abdominal discomfort, and abdominal tenderness.
‡Includes colitis, diarrhea, and gastroenteritis.
§Includes stomatitis, aphthous ulcer, and mouth ulceration.
‖Includes asthenia, fatigue, lethargy, and malaise.
¶Includes neutropenia and febrile neutropenia.
#Includes leukopenia and white blood cell count decreased.
**Includes platelet count decreased and thrombocytopenia.
††Includes urosepsis, UTI, urinary tract pain, and pyuria.
‡‡Includes dyspnea and dyspnea exertional.

At 7-year follow-up analysis[1,9,10]:

No new safety signals were identified, and the safety profile remained generally consistent with the primary analysis[§§]

- **4 (1.5%) cases of MDS/AML were reported in the LYNPARZA group and 1 (0.8%) case was reported in the placebo group**
  - **Another case of MDS/AML was reported based on an updated analysis (5/260: 1.9%)[1];**
- **14 (5.4%) cases of new primary malignancies were reported in the LYNPARZA group and 8 (6.2%) cases were reported in the placebo group;**
- **5 (1.9%) cases of pneumonitis were reported in the LYNPARZA group and none were reported in the placebo group**

§§ DCO: May 17, 2018; DCO2: March 5, 2020.

Please see Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

DCO2=data cutoff 2; UTI=urinary tract infection.

Laboratory abnormalities from the primary analysis in SOLO-1 were mostly Grades 1 and 2[1]

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Primary analysis: Laboratory abnormalities reported in ≥25% of patients who received LYNPARZA[1]

Laboratory parameter†	All Grades	Grades 3–4 (%)
Decrease in hemoglobin	LYNPARZA (n=260)*: 87 Placebo (n=130)*: 63	LYNPARZA (n=260)*: 19 Placebo (n=130)*: 2
Increase in mean corpuscular volume	LYNPARZA (n=260)*: 87 Placebo (n=130)*: 43	LYNPARZA (n=260)*: – Placebo (n=130)*: –
Decrease in leukocytes	LYNPARZA (n=260)*: 70 Placebo (n=130)*: 52	LYNPARZA (n=260)*: 7 Placebo (n=130)*: 1
Decrease in lymphocytes	LYNPARZA (n=260)*: 67 Placebo (n=130)*: 29	LYNPARZA (n=260)*: 14 Placebo (n=130)*: 5
Decrease in absolute neutrophil count	LYNPARZA (n=260)*: 51 Placebo (n=130)*: 38	LYNPARZA (n=260)*: 9 Placebo (n=130)*: 6
Decrease in platelets	LYNPARZA (n=260)*: 35 Placebo (n=130)*: 20	LYNPARZA (n=260)*: 1 Placebo (n=130)*: 2
Increase in serum creatinine	LYNPARZA (n=260)*: 34 Placebo (n=130)*: 18	LYNPARZA (n=260)*: 0 Placebo (n=130)*: 0

*This number represents the safety population. The derived values in the table are based on the total number of evaluable patients for each laboratory parameter.
†Patients were allowed to enter clinical studies with laboratory values of CTCAE Grade 1.

Monitor patients for hematological toxicity at baseline and monthly thereafter

Please see Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

~9 in 10 women remained on LYNPARZA without an AR-related discontinuation[1]

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Primary analysis: Dose modifications due to an AR[1,6]

	LYNPARZA (n=260)	Placebo (n=130)
Dose interruptions due to ARs (%)	52	17
Dose reductions due to ARs (%)	28	3
Discontinuations due to ARs (%)	12	2

~3 in 4 women did not require a dose reduction due to an AR[1]

IMPORTANT SAFETY INFORMATION (Cont'd)

ADVERSE REACTIONS—First-Line Maintenance *BRCA*m Advanced Ovarian Cancer

Most common adverse reactions (all Grades) 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%).

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

LYNPARZA is the ONLY PARPi approved as both monotherapy and combination therapy in advanced ovarian cancer[1,11-14]

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1L maintenance following response to 1L platinum-based chemotherapy in combination with bevacizumab

PAOLA-1: LYNPARZA + bevacizumab in HRD-positive aOC*

5-year follow-up data for **PFS** and **OS**†

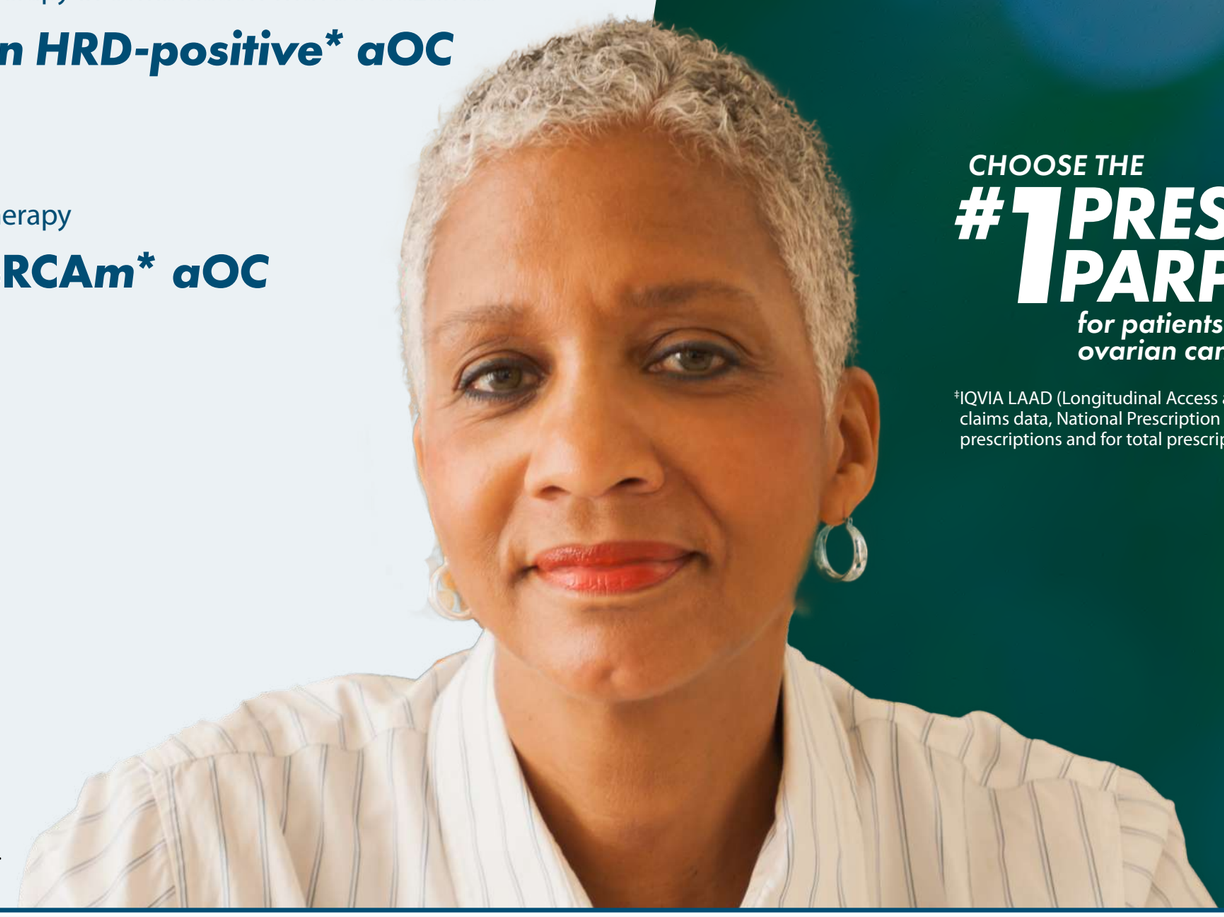
1L maintenance following response to 1L platinum-based chemotherapy

SOLO-1: LYNPARZA in sBRCAm or gBRCAm* aOC*

5-year follow-up data for **PFS**

7-year follow-up data for interim **OS**†

See what's possible with LYNPARZA



CHOOSE THE
#1 PRESCRIBED PARPi
for patients with certain types of ovarian cancer[15‡]

‡IQVIA LAAD (Longitudinal Access and Adjudication Dataset) prescription claims data, National Prescription Audit as of January 2024. #1 for new prescriptions and for total prescriptions.[15]

Not an actual patient.

*Select patients for therapy based on an FDA-approved companion diagnostic.
†PFS was the primary endpoint in both the PAOLA-1 and SOLO-1 clinical trials. OS was a secondary endpoint.

IMPORTANT SAFETY INFORMATION (Cont'd)

ADVERSE REACTIONS—First-Line Maintenance Advanced Ovarian Cancer in Combination with Bevacizumab (Cont'd)

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%).

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.

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

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.

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 (26/2219) with various *BRCA*m, g*BRCA*m, HRR gene-mutated or HRD-positive cancers who received LYNPARZA in clinical studies 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, of 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 counts 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: Including severe and fatal cases, has occurred in patients treated with LYNPARZA. In clinical studies, among patients who received LYNPARZA as a single agent or as part of a combination regimen, the incidence of pneumonitis, including fatal cases, was 1.0% (29/2851). If patients present with new or worsening respiratory symptoms such as dyspnea, cough, and fever, or a radiological abnormality occurs, interrupt LYNPARZA treatment and promptly assess the source of the symptoms. If pneumonitis is confirmed, discontinue LYNPARZA treatment and treat the patient appropriately.

Venous Thromboembolism (VTE): Including severe or fatal pulmonary embolism (PE), occurred in patients treated with LYNPARZA. 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.

Hepatotoxicity, including Drug-Induced Liver Injury (DILI): Hepatotoxicity, including severe and potentially fatal cases of DILI has occurred in patients treated with LYNPARZA. Evaluate bilirubin and transaminases at baseline and throughout treatment with LYNPARZA. For patients who develop abnormal liver tests after LYNPARZA, monitor more frequently for liver test abnormalities and clinical signs and symptoms of hepatic toxicity. If DILI is suspected, withhold LYNPARZA. Upon confirmation of DILI, discontinue LYNPARZA.

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.

Important Safety Information (Cont'd)

ADVERSE REACTIONS—First-Line Maintenance *BRCA*m Advanced Ovarian Cancer

Most common adverse reactions (all Grades) 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%).

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).

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

You may report side effects related to AstraZeneca products.

References

1. LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025. **2.** Ray-Coquard I, Pautier P, Pignata S, et al; PAOLA-1 investigators. Olaparib plus bevacizumab as first-line maintenance in ovarian cancer. *N Engl J Med*. 2019;381(25):2416-2428. **3.** Ray-Coquard I, Pautier P, Pignata S, et al; PAOLA-1 investigators. Olaparib plus bevacizumab as first-line maintenance in ovarian cancer. Supplementary Appendix. *N Engl J Med*. 2019;381(25):2416-2428. **4.** Ray-Coquard I, Pautier P, Pignata S, et al; PAOLA-1 investigators. Olaparib plus bevacizumab as first-line maintenance in ovarian cancer. PAOLA-1 Protocol. *N Engl J Med*. 2019;381(25):2416-2428. **5.** Ray-Coquard I, Leary A, Pignata S, et al; PAOLA-1/ENGOT-ov25 investigators. Olaparib plus bevacizumab first-line maintenance in ovarian cancer: final overall survival results from the PAOLA-1/ENGOT-ov25 trial. *Ann Oncol*. 2023;34(8):681-692. **6.** Moore K, Colombo N, Scambia G, et al. Maintenance olaparib in patients with newly diagnosed advanced ovarian cancer. *N Engl J Med*. 2018;379(26):2495-2505. **7.** Banerjee S, Moore KN, Colombo N, et al. Maintenance olaparib for patients with newly diagnosed advanced ovarian cancer and a *BRCA* mutation (SOLO1/GOG 3004): 5-year follow-up of a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet Oncol*. 2021;22(12):1721-1731. **8.** Moore K, Colombo N, Scambia G, et al. Maintenance olaparib in patients with newly diagnosed advanced ovarian cancer. SOLO1 Protocol. *N Engl J Med*. 2018;379(26):2495-2505. **9.** DiSilvestro P, Banerjee S, Colombo N, et al; SOLO-1 Investigators. Overall survival with maintenance olaparib at a 7-year follow-up in patients with newly diagnosed advanced ovarian cancer and a *BRCA* mutation: the SOLO1/GOG 3004 trial. *J Clin Oncol*. 2023;41(3):609-617. **10.** DiSilvestro P, Banerjee S, Colombo N, et al. Overall survival at 7-year follow-up in patients with newly diagnosed advanced ovarian cancer and a *BRCA* mutation who received maintenance olaparib in the SOLO1/GOG 3004 trial. Presented at: ESMO Congress 2022; September 9-13, 2022; Paris, France. **11.** Rubraca® (rucaparib) [prescribing information]. Vienna, Austria: zr pharma& GmbH; 2024. **12.** Talzenna® (talazoparib) [prescribing information]. New York, NY: Pfizer Inc.; 2025. **13.** Zejula® (niraparib) [prescribing information]. Durham, NC: GlaxoSmithKline; 2025. **14.** Akeega® (niraparib and abiraterone acetate) [prescribing information]. Horsham, PA: Janssen Biotech, Inc.; 2024. **15.** Data on File, US-87051. AstraZeneca Pharmaceuticals LP. **16.** Harter P, Mouret-Reynier MA, Pignata S, et al. Efficacy of maintenance olaparib plus bevacizumab according to clinical risk in patients with newly diagnosed, advanced ovarian cancer in the phase III PAOLA-1/ENGOT-ov25 trial. *Gynecol Oncol*. 2022;164(2):254-264. **17.** Lorusso D, Mouret-Reynier MA, Harter P, et al. Updated progression-free survival and final overall survival with maintenance olaparib plus bevacizumab according to clinical risk in patients with newly diagnosed advanced ovarian cancer in the phase III PAOLA-1/ENGOT-ov25 trial. *Int J Gynecol Cancer*. 2024;34(4):550-558.

Lower-risk patients: PFS with LYNPARZA + bevacizumab and bevacizumab + placebo[16]

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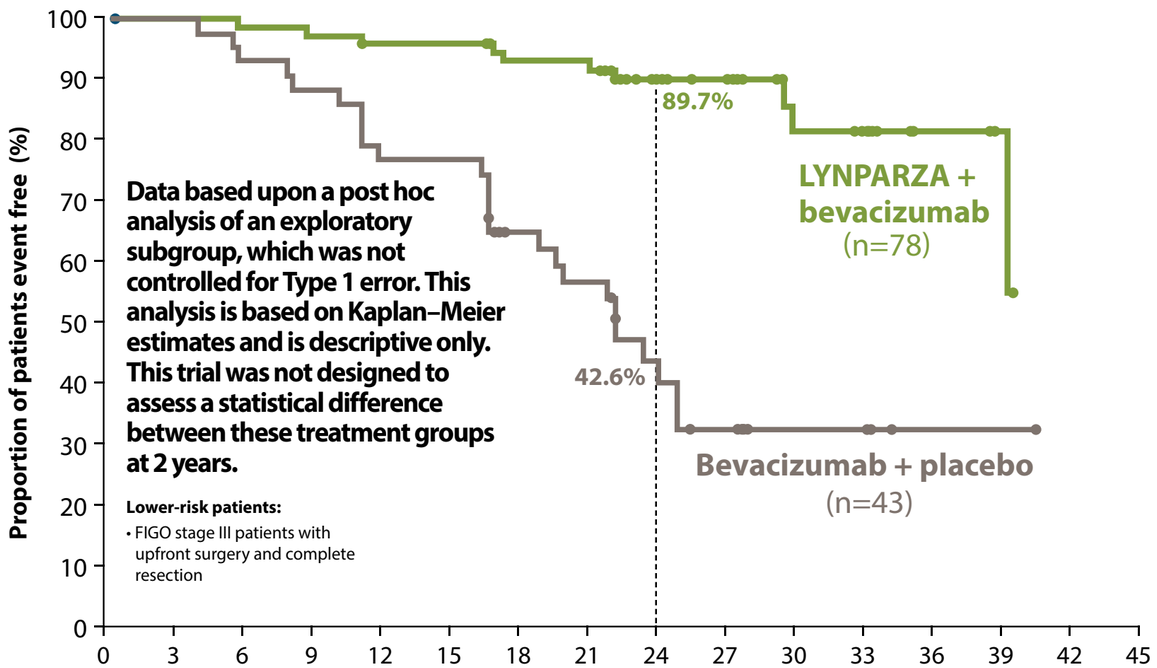


Months since randomization

Number of patients at risk															
LYNPARZA + bevacizumab	78	77	76	75	73	73	60	60	40	35	19	14	6	3	0
Bevacizumab + placebo	43	42	39	37	32	32	23	20	12	7	3	3	1	1	0

Return to PFS >

	LYNPARZA + bevacizumab	Bevacizumab + placebo	
mPFS in lower-risk HRD-positive patients			
	Not reached (n=78)	**~1.8 years** (22.1 months) (n=43)	**HR=0.15** (95% CI: 0.07–0.30)
mPFS in HRD-positive, non-*BRCA*m patients			
	39.3 months* (n=33)	**23.4 months** (n=18)	**HR=0.19** (95% CI: 0.06–0.55)
mPFS in *BRCA*m patients			
	Not reached (n=48)	**22.2 months** (n=25)	**HR=0.11** (95% CI: 0.03–0.31)

Post hoc exploratory analysis conducted using data from the primary analysis

*Unstable median due to lack of events.

There was insufficient evidence to suggest differential efficacy between the 2 groups.

There is no official clinical consensus on what is considered higher vs lower risk. Data are based on post hoc exploratory subgroup analyses in 2 clinical subgroups (higher risk and lower risk), including biomarker status. Neither HRD status nor risk factor was a stratification factor in PAOLA-1.[2,3]

DCO: March 22, 2019.

PFS: HIGHER-RISK PATIENTS >

IMPORTANT SAFETY INFORMATION (Cont'd)

WARNINGS AND PRECAUTIONS (Cont'd)

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.

ADVERSE REACTIONS—First-Line Maintenance *BRCA*m Advanced Ovarian Cancer

Most common adverse reactions (all Grades) 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%).

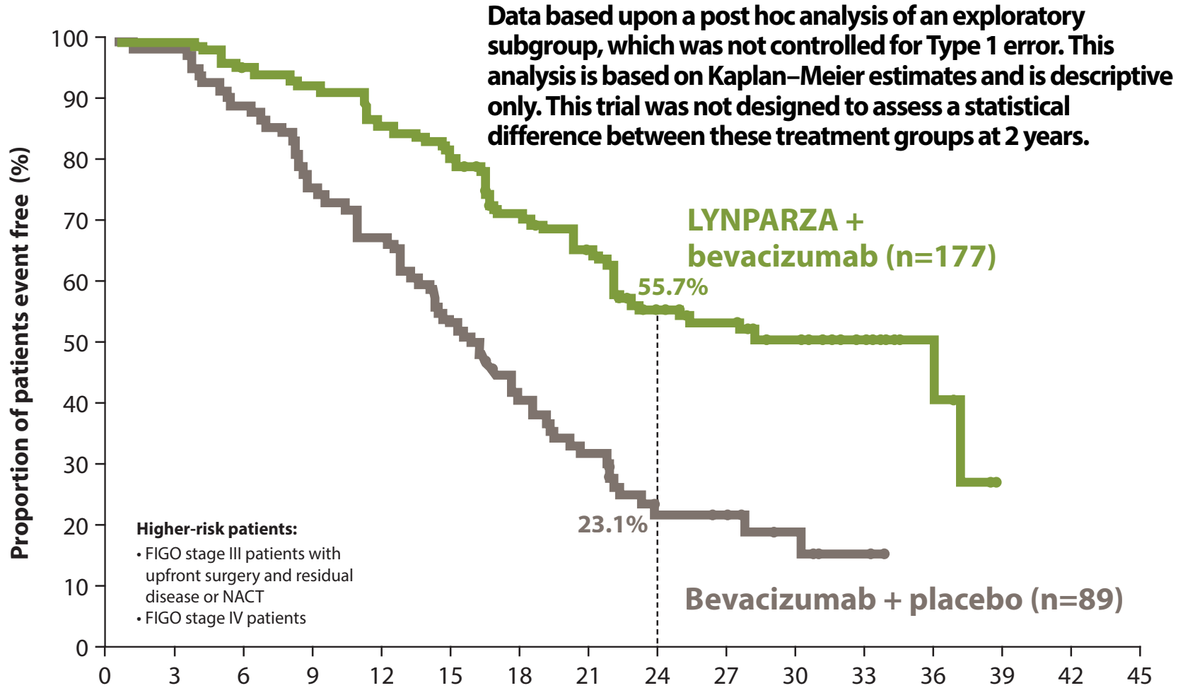
Most common laboratory abnormalities (Grades 1-4) in ≥25% of patients who received LYNPARZA in the **first-line maintenance setting** for **SOLO-1** were: decrease in hemoglobin (87%), increase in mean corpuscular volume (87%), decrease in leukocytes (70%), decrease in lymphocytes (67%), decrease in absolute neutrophil count (51%), decrease in platelets (35%), and increase in serum creatinine (34%).

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

FIGO=International Federation of Gynecology and Obstetrics.

Higher-risk patients: PFS with LYNPARZA + bevacizumab and bevacizumab + placebo[16]

Return to PFS >



Number of patients at risk

LYNPARZA + bevacizumab	177	175	166	161	150	140	109	95	63	50	27	15	5	0
Bevacizumab + placebo	89	86	78	66	59	47	31	24	16	11	5	2	0	

LYNPARZA + bevacizumab	Bevacizumab + placebo	
mPFS in higher-risk HRD-positive patients		
3 years (36.0 months*) (n=177)	**~1.3 years** (16.0 months) (n=89)	**HR=0.39** (95% CI: 0.28–0.54)
mPFS in HRD-positive, non-*BRCA*m patients		
20.3 months (n=64)	**15.4 months** (n=37)	**HR=0.51** (95% CI: 0.31–0.83)
mPFS in *BRCA*m patients		
36 months* (n=109)	**19.4 months** (n=55)	**HR=0.37** (95% CI: 0.23–0.59)

Post hoc exploratory analysis conducted using data from the primary analysis

*Unstable median due to lack of events.

There was insufficient evidence to suggest differential efficacy between the 2 groups.

There is no official clinical consensus on what is considered higher vs lower risk. Data are based on post hoc exploratory subgroup analyses in 2 clinical subgroups (higher risk and lower risk), including biomarker status. Neither HRD status nor risk factor was a stratification factor in PAOLA-1.[2,3]

DCO: March 22, 2019.

IMPORTANT SAFETY INFORMATION (Cont'd)

WARNINGS AND PRECAUTIONS (Cont'd)

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.

ADVERSE REACTIONS—First-Line Maintenance *BRCA*m Advanced Ovarian Cancer

Most common adverse reactions (all Grades) 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%).

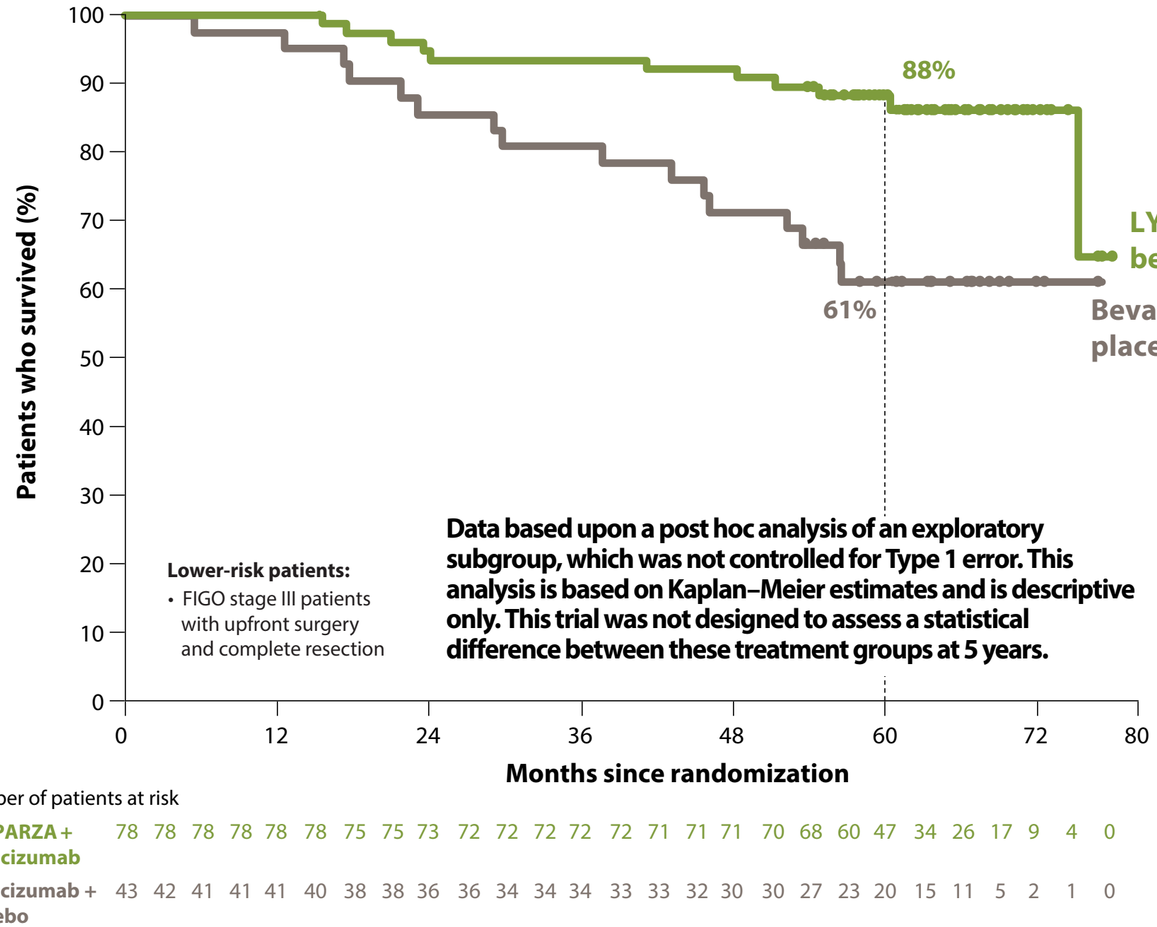
Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

NACT=neoadjuvant chemotherapy.

Lower-risk patients: OS with LYNPARZA + bevacizumab and bevacizumab + placebo[17]

Lynparza® olaparib tablets 150 mg

Return to OS >



Lower-risk patients:
- FIGO stage III patients with upfront surgery and complete resection

Data based upon a post hoc analysis of an exploratory subgroup, which was not controlled for Type 1 error. This analysis is based on Kaplan–Meier estimates and is descriptive only. This trial was not designed to assess a statistical difference between these treatment groups at 5 years.

	LYNPARZA + bevacizumab (n=78)	Bevacizumab + placebo (n=43)
Events, n (%)	11 (14)	16 (37)
Median OS, months	NR	NR
5-year OS rate, %	88	61
	HR=0.31 (95% CI: 0.14–0.66)	
Patients receiving a PARP inhibitor during any subsequent treatment, %	14	40

There was insufficient evidence to suggest differential overall survival between the 2 groups.

There is no official clinical consensus on what is considered higher vs lower risk. Data are based on post hoc exploratory subgroup analyses in 2 clinical subgroups (higher risk and lower risk), including biomarker status. Neither HRD status nor risk factor was a stratification factor in PAOLA-1.[2,3]

OS: HIGHER-RISK PATIENTS >

IMPORTANT SAFETY INFORMATION (Cont'd)

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%).

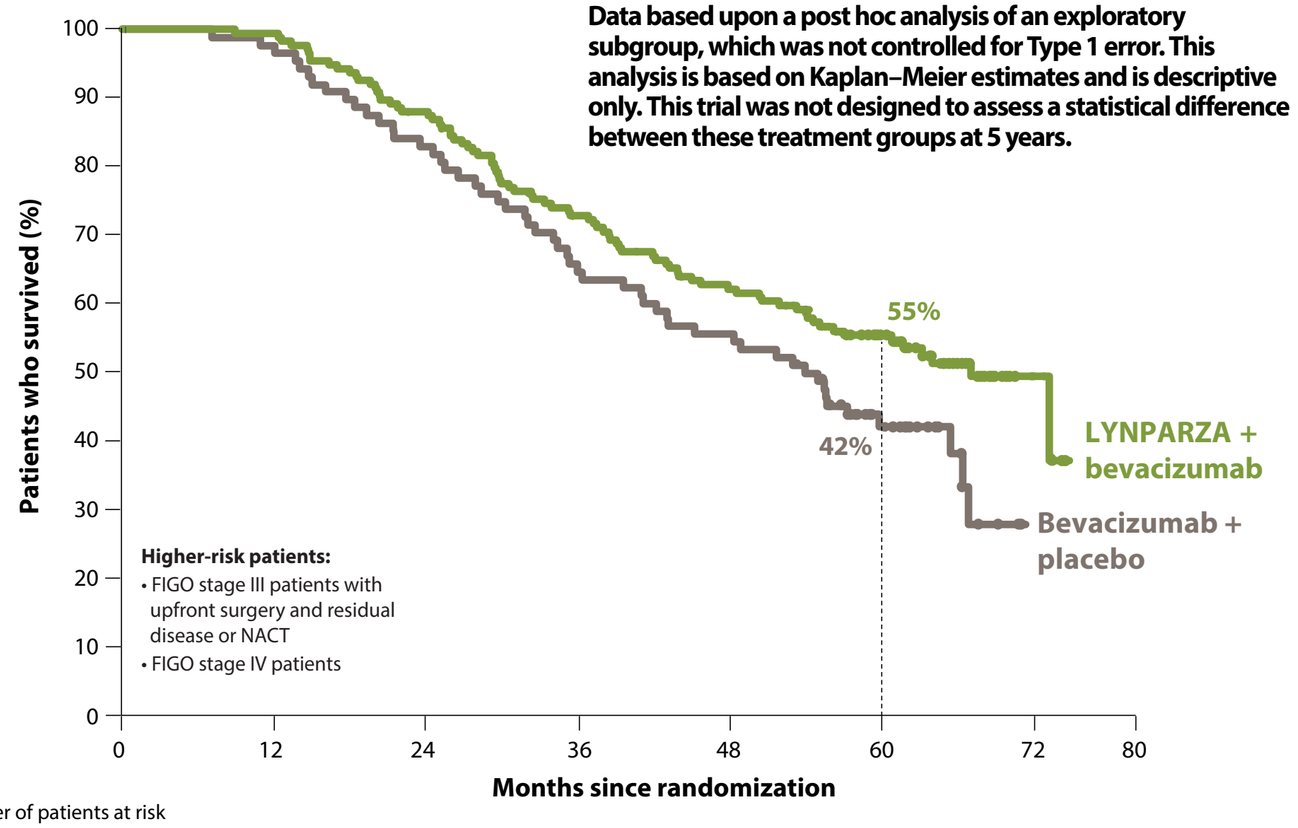
Most common laboratory abnormalities (Grades 1-4) in ≥25% of patients for LYNPARZA in combination with bevacizumab in the **first-line maintenance setting** for **PAOLA-1** were: decrease in hemoglobin (79%), decrease in lymphocytes (63%), increase in serum creatinine (61%), decrease in leukocytes (59%), decrease in absolute neutrophil count (35%), and decrease in platelets (35%).

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

NR=not reached.

Higher-risk patients: OS with LYNPARZA + bevacizumab and bevacizumab + placebo[17]

Return to OS >



	LYNPARZA + bevacizumab (n=177)	Bevacizumab + placebo (n=89)
Events, n (%)	82 (46)	53 (60)
Median OS, months	67.0*	54.0
5-year OS rate, %	55	42
	HR=0.70 (95% CI: 0.50–1.00)	
Patients receiving a PARP inhibitor during any subsequent treatment, %	19	56

There was insufficient evidence to suggest differential overall survival between the 2 groups.

There is no official clinical consensus on what is considered higher vs lower risk. Data are based on post hoc exploratory subgroup analyses in 2 clinical subgroups (higher risk and lower risk), including biomarker status. Neither HRD status nor risk factor was a stratification factor in PAOLA-1.[2,3]

*Unstable median due to lack of events.

IMPORTANT SAFETY INFORMATION (Cont'd)

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%).

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

PAOLA-1: A phase 3 trial evaluating LYNPARZA + bevacizumab vs an active comparator (bevacizumab + placebo) in advanced ovarian cancer[1-5]

Lynparza® olaparib tablets 150 mg

PAOLA-1

Study Design

PAOLA-1 studied the effi
comparator (bevacizuma

- Advanced ovarian cancer f bevacizumab. Bevacizuma based chemotherapy
- Patients were stratified by status was not a stratificati
- The ITT population was ra BID in combination with b orally BID in combination v
- Treatment with LYNPARZA unacceptable toxicity. Patie 2 years at the physician's d duration of up to 15 month maintenance*
- The primary endpoint was overall survival
  - **FDA approval for LY exploratory subgrou**

*Patients continued bevacizumab in the following completion of their last dose

Prespecified exploratory analysis in the HRD-positive subgroup:

Median PFS with LYNPARZA + bevacizumab[1,2]

	LYNPARZA + bevacizumab (n=255)	Bevacizumab + placebo (n=132)
		years (17.7 months)
		70% (92/132)
		e progression or death

s not controlled for Type

vacizumab compared with

5–1.34]) indicated that the itive subgroup.

OSITIVE NON-BRCAm

Additional prespecified subgroup analyses[1,2]

Median PFS in HRD-positive, non-*BRCA*m patients

LYNPARZA + bevacizumab (n=97)	Bevacizumab + placebo (n=55)
28.1 months	16.6 months
HR=0.43 (95% CI: 0.28–0.66 [prespecified exploratory analysis])	

Median PFS in *BRCA*m patients

LYNPARZA + bevacizumab (n=157)	Bevacizumab + placebo (n=80)
37.2 months	21.7 months
HR=0.31 (95% CI: 0.20–0.47 [stratified subgroup])	

There was insufficient evidence to suggest differential efficacy between the 2 groups.

IMPORTANT SAFETY IN

WARNINGS AND PRECAU

Myelodysplastic Syndrome/Acute Myeloid Leukemia (MDS/AML) (Cont'd): 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 counts 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: Including severe and fatal cases, has occurred in patients treated with LYNPARZA.

le agent or as part of a combination regimen, the incidence of pneumonitis, including fatal cases, was 1.0% (29/2851). If patients present with new or worsening respiratory symptoms such as dyspnea, cough, and fever, or a radiological abnormality occurs, interrupt LYNPARZA treatment and promptly assess the source of the symptoms. If pneumonitis is confirmed, discontinue LYNPARZA treatment and treat the patient appropriately.

Venous Thromboembolism (VTE): Including severe or fatal pulmonary embolism (PE), occurred in patients treated with LYNPARZA. 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.

Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

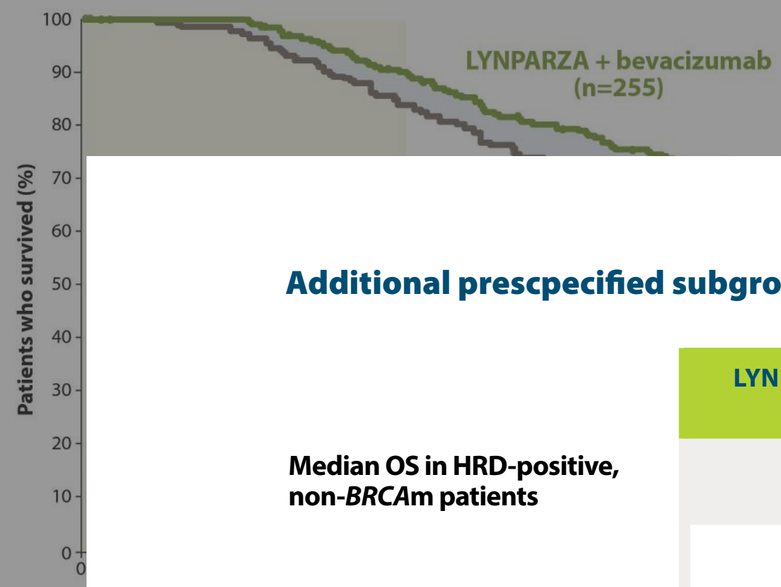
BID=twice daily; ITT=intent-to-treat.

~6.3 years median OS with LYNPARZA + bevacizumab, ~1.5 years longer vs established maintenance bevacizumab + placebo[1,5]

Lynparza® olaparib tablets 150 mg

PAOLA-1

Maintenance treatment in HRD-positive*† aOC following CR or PR to 1L platinum-based chemotherapy + bevacizumab[1]



MEDIAN OS ~6.3 years (75.2 months)

38% REDUCTION IN RISK OF DEATH

HR=0.62 (95% CI: 0.45–0.85)

Additional prescpecified subgroup analyses[3,5]

	LYNPARZA + bevacizumab (n=97)	Bevacizumab + placebo (n=55)
Median OS in HRD-positive, non-*BRCA*m patients	Not reached	52.0 months
	HR=0.71 (95% CI: 0.45–1.13 [prespecified exploratory analysis])	

	LYNPARZA + bevacizumab (n=157)	Bevacizumab + placebo (n=80)
Median OS in *BRCA*m patients	75.2 months (unstable; data maturity 30.6%)	66.9 months
	HR=0.60 (95% CI: 0.39–0.93 [stratified subgroup])	

There was insufficient evidence to suggest differential efficacy between the 2 groups.

*BRCA*m status was determine by central labs; HRD status was determined by Myriad MyChoice® HRD Plus.

*Select patients for this inc
†Including *BRCA* mutation (as ≥42 by Myriad MyChoice® CD
‡Bevacizumab was administer
§LYNPARZA was continue of the treating physician
‖Patients with a complete physician discretion. In F should be interpreted w

…on factor in PAOLA-1, …for Type 1 error.

…ARZA + bevacizumab …+ placebo.[5]

…t reached for LYNPARZA + …cizumab + placebo.[5]

…s in this subgroup …ed that the clinical …the results seen in

…19.6% of patients in the LYNPARZA …the bevacizumab + placebo arm …following 1L maintenance. The …ival is unknown.[5]

…OSITIVE NON-BRCAm

IMPORTANT SAFETY I…

WARNINGS AND PRECAU…

Hepatotoxicity, including Drug-Induced Liver Injury (DILI): Hepatotoxicity, including severe and potentially fatal cases of DILI has occurred in patients treated with LYNPARZA. Evaluate bilirubin and transaminases at baseline and throughout treatment with LYNPARZA. For patients who develop abnormal liver tests after LYNPARZA, monitor more frequently for liver test abnormalities and clinical signs and symptoms of hepatic toxicity. If DILI is suspected, withhold LYNPARZA. Upon confirmation of DILI, discontinue LYNPARZA.

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.

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.

ADVERSE REACTIONS—First-Line Maintenance *BRCA*m Advanced Ovarian Cancer

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Please see additional Important Safety Information throughout and complete Prescribing Information, including Medication Guide.

CR=complete response; MTx=maintenance treatment; PR=partial response; t*BRCA*=tumor *BRCA*.