Indication	**Breast:** Olaparib **in combination** with hormone therapy for the adjuvant treatment of high-risk hormone receptor positive, HER 2 negative, high risk early breast cancer previously treated with neoadjuvant or adjuvant chemotherapy and definitive local therapy in patients with a deleterious or suspected deleterious germline BRCA mutation. N.B adjuvant olaparib, adjuvant abemaciclib and adjuvant ribociclib are not to be prescribed concurrently OR sequentially. If a patient meets the criteria for more than one of these options, the patient and clinician must decide which ONE of the THREE options are to be used. Olaparib **monotherapy** as adjuvant treatment of high-risk triple negative **early breast cancer** treated with neoadjuvant or adjuvant chemotherapy and definitive local therapy in patients with a deleterious or suspected deleterious germline BRCA mutation. N.B Breast cancer patients should start treatment no more than 12 weeks, ideally 8 weeks, from the date of the last treatment (surgery, chemotherapy, radiotherapy). Patients must be a minimum of 2 weeks after completion of radiotherapy and a minimum of 3 weeks since the last chemotherapy. Olaparib **monotherapy** for the treatment of HER-2 negative **locally advanced or metastatic breast cancer** with deleterious or suspected deleterious germline BRCA1 or 2 mutations previously treated with an anthracycline and a taxane (unless these chemotherapy agents were contraindicated) in the adjuvant/neoadjuvant/advanced disease settings and also treated with prior endocrine-based therapy if hormone-receptor positive disease. NB Patients must have not received prior treatment with a PARP inhibitor unless talazoparib for this indication has had to be stopped within 3 months of its start solely as a consequence of dose-limiting toxicity and in the clear absence of disease progression or the patient has received adjuvant olaparib and this was completed without disease progression during therapy or within 12 months of its completion or the patient has received olaparib via a company compassionate access scheme. **Urology:** Monotherapy for metastatic castration-resistant prostate cancer bearing germline and/or somatic BRCA 1 or 2 mutations in patients who have progressed following previous treatment with an androgen receptor targeted agent. NB prior treatment with docetaxel is permitted (select appropriate Blueteq form). **Gynae:** For maintenance treatment in patients with high grade epithelial (serous or endometrioid) stage III or IV ovarian, fallopian tube or primary peritoneal carcinoma who are in response following a minimum of 4 cycles of platinum-based first, second or subsequent line chemotherapy AND who have a deleterious or suspected deleterious germline and/or somatic BRCA mutation. Patients should start treatment with olaparib no later than 8 weeks after completion of their final dose of the platinum-containing regimen.
Treatment Intent	Adjuvant / Palliative / Disease modification
Frequency and number of cycles	Repeat every 28 days.

	Early Breast cancer: continue until disease progression, unacceptable toxicity or patient choice to stop treatment or for a **total treatment duration of 1 calendar year**. **Locally advanced or metastatic Breast cancer:** continue until disease progression, unacceptable toxicity or patient choice to stop treatment. **Urology:** continue until disease progression, unacceptable toxicity or patient choice to stop. **Gynae:** **Maintenance treatment following first line:** Continue until disease progression or unacceptable toxicity or patient choice to stop and • Stop at 2 years if the patient is in complete remission • For patients with stable residual disease after 2 years treatment, continue if deemed appropriate. **Maintenance treatment following second or subsequent line:** Continue until disease progression or unacceptable toxicity or patient choice to stop.
Monitoring Parameters pre-treatment	• **Virology screening:** All new patients referred for systemic anti-cancer treatment should be screened for hepatitis B and C and the result reviewed prior to the start of treatment. Patients not previously tested who are starting a new line of treatment, should also be screened for hepatitis B and C. Further virology screening will be performed following individual risk assessment and clinician discretion. • Monitor FBC, LFT's and U&E's prior to each cycle for 12 months and then every 2 months if clinically appropriate. • If neuts >/=1.5, PLT >/=75 and Hb >100, proceed with treatment. Otherwise see below. • **Hepatic impairment:** No dose adjustment required in mild or moderate hepatic impairment (Child-Pugh classification A or B). Not recommended for use in patients with severe hepatic impairment (Child-Pugh classification C). • **Renal impairment:** No dose reduction required in mild impairment (CrCL 51-80ml/min), in moderate impairment (CrCl 31-50 ml/min) a dose reduction of 200mg twice a day is recommended. Not recommended to be used in patients with severe or end stage renal disease (CrCl</=30ml/min), clinician's decision. • **Management of adverse reactions and dose adjustments:** o Treatment may be interrupted to manage adverse reactions such as nausea, vomiting, diarrhoea, and anaemia and dose reduction can be considered. o The recommended dose reduction is to 250mg twice daily (equivalent to a total daily dose of 500 mg). If a further final dose reduction is required, then reduction to 200mg twice daily (equivalent to a total daily dose of 400 mg) is advised. NB see below for dose adjustment when co-administered with CYP3A inhibitors. o **Pneumonitis:** If patients present with new or worsening respiratory symptoms such as dyspnoea, cough and fever, or a radiological abnormality occurs, treatment with olaparib should be interrupted and prompt investigation initiated. If pneumonitis is confirmed, treatment with olaparib should be discontinued and the patient treated appropriately. o Monitor patients for clinical signs and symptoms of venous thrombosis and pulmonary embolism and treat as medically appropriate. Patients with a prior history of VTE may be more at risk of a further occurrence and should be monitored appropriately. o If severe haematological toxicity or blood transfusion dependence occurs, treatment should be interrupted and appropriate haematological testing should be initiated. o **Hepatotoxicity:** Cases of hepatotoxicity have been reported in patients treated with olaparib. If drug-induced liver injury is suspected, treatment should be interrupted, or if severe, consider discontinuing treatment.

	○ **Haematological toxicity:** ○ If neuts 1.0-1.4 and/ or PLT 50-74 and /or Hb 80-100 d/w consultant. ○ If neuts <1 and/or PLT <50 and/or Hb <80 delay until neuts >/=1.5, PLT >/=75 and Hb >/= 90 and consider dose reduction. ○ If reoccurrence interrupt and dose reduce. ○ Treatment must be interrupted if any grade 3 or 4 non-haematological toxicity. • **<u>Common drug interactions (for comprehensive list refer to BNF/SPC)</u>:** ○ Avoid concomitant treatment with strong or moderate CYP3A inhibitors (e.g. ketoconazole, itraconazole, clarithromycin, and erythromycin). If a strong CYP3A inhibitor must be given, the recommended dose reduction is to 100 mg taken twice daily. If a moderate CYP3A inhibitor must be given, the recommended dose reduction is to 150 mg taken twice daily. ○ Avoid grapefruit and grapefruit juice throughout the course of treatment. ○ Co-administration with strong or moderate CYP3A inducers is not recommended. In the event that a patient requires treatment with a strong (e.g. phenytoin, rifampicin, carbamazepine) or moderate (e.g. rifabutin, efavirenz) CYP3A inducer, the prescriber should be aware that the efficacy of olaparib may be substantially reduced. ○ Caution and appropriate monitoring when administered with sensitive CYP3A substrates or substrates with a narrow therapeutic margin (e.g. simvastatin, cisapride, and cyclosporine). ○ Co-administration may reduce the exposure to substrates of the CYP2C9, CYP2C19 and P-gp; the efficacy of some hormonal contraceptives may be reduced. ○ Olaparib may increase exposure to substrates of BCRP, OATP1B1, OCT1, OCT2, OAT3, MATE1 and MATE2K. Caution should be exercised if olaparib is administered in combination with any statin. • **Missed doses:** If a patient misses a dose of olaparib, they should take their next normal dose at its scheduled time. • Combination of olaparib with vaccines or immunosuppressant agents has not been studied. Therefore, caution should be taken if these medicinal products are co-administered. • **Driving:** Olaparib may cause drowsiness and dizziness, patients should be made aware and advised if affected to not drive or operate machinery. • For oral self-administration: refer to local Trust policy on oral anti-cancer medicines and supply Patient Information Leaflet.
References	SPC accessed online 07.10.2025 KMCC protocol MULTI-029 V4 CDF list V1.381 accessed online 31.12.2025

NB For funding information, refer to CDF and NICE Drugs Funding List

Repeat every 28 days

TTO	Drug	Dose	Route	Directions
Day 1	**OLAPARIB**	**300mg**	PO	BD, 12 hours apart, to be taken as continuous treatment. Do not take with grapefruit juice. Swallow whole do not crush/chew or dissolve. Available as 150mg and 100mg tablets
	Hormone therapy must be prescribed. **BREAST PATIENTS:** Add hormone therapy for hormone receptor positive breast patients. **PROSTATE PATIENTS:** Add LHRH agonists/antagonists where appropriate			
	Metoclopramide	10mg	PO	TDS PRN Do not take for more than 5 days continuously. Dispense 28 tablets on cycle 1, then only if specified.
	Loperamide	2mg-4mg	PO	Take 4mg initially then 2mg after each loose stool when required max 16mg a day. Dispense 1 x op on cycle 1, then when required.