Indication	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 unless the patient was entered into the company's early access scheme for maintenance olaparib after 1st line chemotherapy and all the other treatment criteria on this form are fulfilled.
Treatment Intent	Disease modification
Frequency and number of cycles	Repeat every 28 days. **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. A formal medical review as to whether maintenance treatment with olaparib should continue or not will be scheduled to occur at least by the start of the third cycle of treatment.

Monitoring Parameters pre-treatment	• **NB: Olaparib tablets should not be substituted for olaparib capsules due to differences in the dosing and bioavailability of each formulation.**
	• Monitor FBC, LFT's and U&E's prior to each cycle for 12 months and then every 3 months.
	• Commence treatment if neuts $\geq$1.5 x10^9 /l and PLT $\geq$75x 10^9 /l
	• **Renal impairment:** The recommended dose for patients with moderate impairment (CrCl 31-50 ml/min) is 200mg twice a day. Not recommended to be used in patients with severe or end stage renal disease, clinician's decision.
	• **Hepatic Impairment:** Olaparib can be administered to patients with mild or moderate hepatic impairment (Child-Pugh classification A or B) with no dose adjustment. Not recommended for use in patients with severe hepatic impairment (Child-Pugh classification C).
	• **Dose Modifications to manage adverse reactions:**
	• 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.*
	• 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.
	• **Haematological toxicity:**
	  • If neuts >/=1.5, WBC >/= 3, PLT >/=75 and Hb >100, proceed with treatment.
	  • If neuts 1.0-1.4 and/or WBC 2-2.9 and/ or PLT 50-74 and /or Hb 80-100 d/w consultant.
	  • If neuts <1 and/or WBC <2 and/or PLT <50 and/or Hb <80 delay until neuts >/=1.5 , WBC >/=3, 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. • **Drug interactions** • 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. • Olaparib should be stopped 3 days prior to surgery and restarted when the wound has healed. Treatment should be discontinued for a minimum of 3 days prior any radiation treatment. • Olaparib may cause drowsiness and dizziness, patients should be made aware and advised if affected to not drive or operate machinery. • Live vaccines should not be administered whilst the patient is receiving olaparib and for 30 days after treatment stops. • For oral self-administration: refer to local Trust policy on oral anti-cancer medicines and supply Patient Information Leaflet.
References	SPC accessed online 05/12/2019, SOLO1 Lynparza instructions for investigational product use (EAP physicians pack) v1, National CDF list v 1.157

NB For funding information, refer to the CDF and NICE drug funding list

Repeat every 28 days

TTO	Drug	Dose	Route	Directions
Day 1	**Olaparib tablets**	**300mg**	PO	BD, 12 hours apart, to be taken as continuous treatment. Do not take with grapefruit juice. If a dose is missed then the patient should take their normal dose at the appropriate time. **Swallow whole** do not crush/chew or dissolve. Available as 150mg and 100mg tablets
	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	2-4mg	PO	Take 4mg initially then 2mg after each loose stool when required (max 16mg a day) (dispense 1x op on cycle 1, then when required)