Lynparza®
olaparib
tablets 150 mg

Rationale for Combination Maintenance Therapy

AstraZeneca

US-101108 Last Updated 7/25

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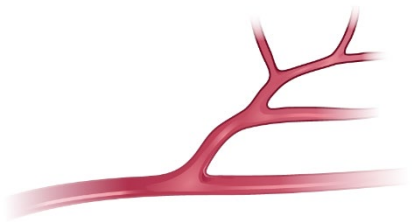
Why Consider Maintenance Therapy Combinations in Advanced Ovarian Cancer?

The PARP inhibitor **LYNPARZA® (olaparib)** is indicated both as monotherapy and in combination with the angiogenesis inhibitor **bevacizumab** (a VEGF inhibitor) as maintenance therapy in biomarker-selected patients with advanced ovarian cancer, see below for full indications[1,2]

Cancer cells may rely on **distinct and complementary mechanisms** for survival. Combination therapy with LYNPARZA plus bevacizumab was designed to target 2 mechanisms commonly seen in ovarian tumors[1-5*]

Angiogenesis



Genomic instability and mutation

Poly (ADP-ribose) polymerase (PARP) inhibitors and antiangiogenic agents are known to have limited overlapping **toxicity profiles**[6]

*The exact mechanism of disease in the context of combination treatment strategies is yet to be elucidated, and the exact mechanism of action of LYNPARZA is unknown.

Combination therapy with LYNPARZA plus bevacizumab targets 2 distinct survival mechanisms commonly seen in ovarian tumors[1-5]

ADP, adenosine diphosphate; VEGF, vascular endothelial growth factor

1. LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025.
2. Avastin® (bevacizumab) [prescribing information]. South San Francisco, CA: Genentech Inc; September 2022.
3. Hanahan D, et al. *Cell*. 2011;144:646-674.
4. Moghaddam SM, et al. *Cancer Metastasis Rev.* 2012;31:143-162.
5. Konstantinopoulos PA, et al. *Cancer Discov.* 2015;5:1137-1154.
6. Secord AA, et al. *Gynecol Oncol*. 2021;162:482-495.

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LYNPARZA Indications as First-Line Maintenance Therapy

	gBRCAm	sBRCAm	HRD+	HRD-
SOLO-1	**Monotherapy indication:** LYNPARZA is indicated for the maintenance treatment of adult patients with deleterious or suspected deleterious germline or somatic *BRCA*-mutated 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[1]	✓	✓	—	—
PAOLA-1	**Combination therapy indication:** LYNPARZA is indicated 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 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[1]	✓	✓	✓	—

Only first-line maintenance indications in ovarian cancer are described. See Prescribing Information for full indications.

LYNPARZA is approved both **as monotherapy and in combination with bevacizumab** as first-line maintenance therapy in selected patients with advanced ovarian cancer and both indications **require an approved companion diagnostic test**[1]

BRCA, BReast CAncer gene; FDA, US Food and Drug Administration; g*BRCA*m, germline *BRCA*-mutated; HRD, homologous recombination deficiency; HRD+, homologous recombination deficiency-positive; HRD-, homologous recombination deficiency-negative; s*BRCA*m, somatic *BRCA*-mutated.

LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025.

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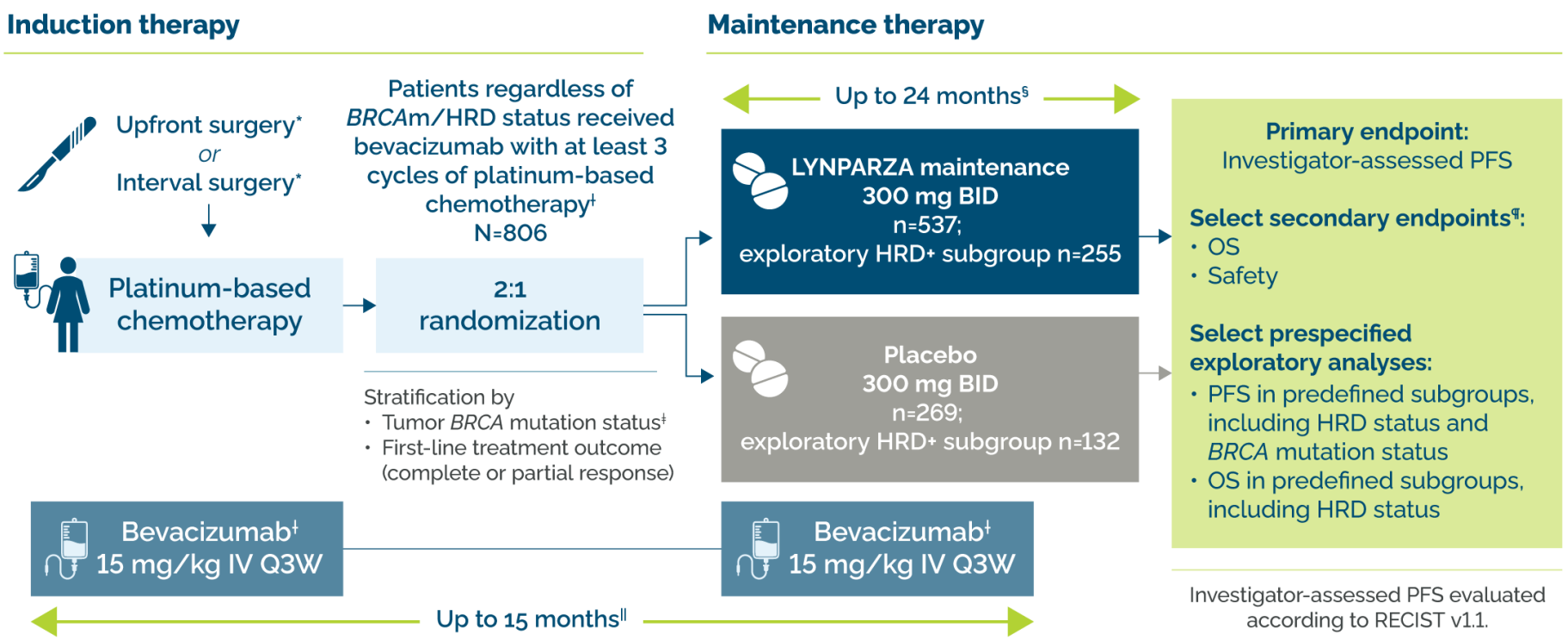
Design of the PAOLA-1 Trial

PAOLA-1

The **combination of LYNPARZA and bevacizumab** as **first-line maintenance therapy** in advanced ovarian cancer was examined in the **PAOLA-1 clinical trial**.[1]

Design of the PAOLA-1 trial[1-4]



Investigator-assessed PFS evaluated according to RECIST v1.1.

*Not all patients received surgery. †Patients continued bevacizumab in the maintenance setting and started treatment with LYNPARZA after a minimum of 3 weeks and up to a maximum of 9 weeks following completion of their last dose of chemotherapy. ‡*BRCA* mutation status was determined by local laboratories. §LYNPARZA or placebo 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. ‖Bevacizumab was administered for a total of up to 15 months, including the period given with chemotherapy and given as maintenance. ¶More endpoints than those noted here were studied in PAOLA-1. Not all results from these endpoints are detailed on this site. This study did not implement a prespecified crossover study design.

BRCA, BReast CAncer gene; *BRCA*m, *BRCA* mutation; BID, twice daily; IV, intravenous; HRD, homologous recombination deficiency; HRD+, homologous recombination deficiency–positive; OS, overall survival; PFS, progression-free survival; Q3W, every 3 weeks; RECIST, Response Evaluation Criteria in Solid Tumors.

1. LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025.
2. Ray-Coquard I, et al. *N Engl J Med*. 2019;381:2416-2428.
3. Ray-Coquard I, et al. Supplementary Information. *N Engl J Med*. 2019;381:2416-2428.
4. Ray-Coquard I, et al. *Ann Oncol*. 2023;34:681-692.

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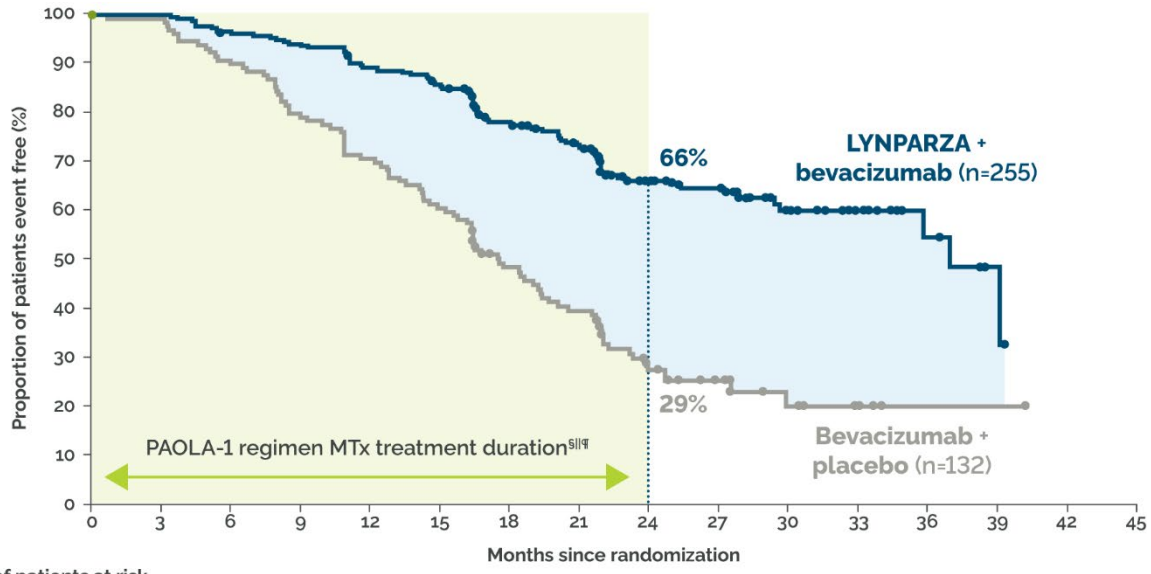
PAOLA-1 PFS Results in the HRD-Positive Subgroup

US Food and Drug Administration (FDA) approval of LYNPARZA plus bevacizumab was based on a **prespecified exploratory HRD-positive**[*‡] **subgroup** in the PAOLA-1 trial[1,2]

- A prespecified exploratory subgroup analysis showed clinically meaningful PFS benefit in HRD-positive (including tumor *BRCA*-mutated) patients after response to first-line platinum-based chemotherapy[1-3‡]
- Median PFS was 3.1 years (37.2 months) with LYNPARZA plus bevacizumab vs ~1.5 years (17.7 months) with bevacizumab plus placebo[2§‖¶]
- 67% risk reduction of disease progression or death; HR=0.33 (95% CI 0.25–0.45)[2]
- Data was based upon a prespecified exploratory subgroup analysis, which was not controlled for Type 1 error. HRD status was not a stratification factor in PAOLA-1[4]

PFS in the HRD subgroup[1,2]



Number of patients at risk

LYNPARZA + bevacizumab	255	252	242	236	223	213	169	155	103	85	46	29	11	3	0
Bevacizumab + placebo	132	128	117	103	91	79	54	44	28	18	8	5	1	1	0

*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 is defined as either a tumor *BRCA* mutation and/or an HRD score ≥42 by Myriad MyChoice® CDx.[2,5] ‡Prespecified exploratory analysis of PFS in the HRD-positive subgroup. Data based upon a prespecified exploratory subgroup analysis, which was not controlled for Type 1 error. HRD status was not a stratification factor in PAOLA-1. The analysis is based on Kaplan–Meier estimates and is descriptive only. This trial was not designed to assess a statistical difference between treatment groups at 2 years.[4] §Bevacizumab was administered for a total of up to 15 months, including the period given with chemotherapy and given as maintenance.[1] ‖LYNPARZA was continued for up to 2 years or until progression of the underlying disease or unacceptable toxicity.[1] 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.[1] 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.
BRCA, BReast CAncer gene; CI, confidence interval; FDA, US Food and Drug Administration; HR, hazard ratio; HRD, homologous recombination deficiency; PFS, progression-free survival.

1. LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025.
2. Ray-Coquard I, et al. *N Engl J Med*. 2019;381:2416-2428.
3. Ellis LM, et al. *J Clin Oncol*. 2014;32:1277-1280.
4. Ray-Coquard I, et al. *Ann Oncol*. 2023;34:681-692.
5. Myriad Genetic Laboratories, Inc. Myriad MyChoice® CDx Technical Information. Accessed June 30, 2025. https://s3.amazonaws.com/myriad-web/myChoiceCDx/downloads/myChoiceCDxTech.pdf.

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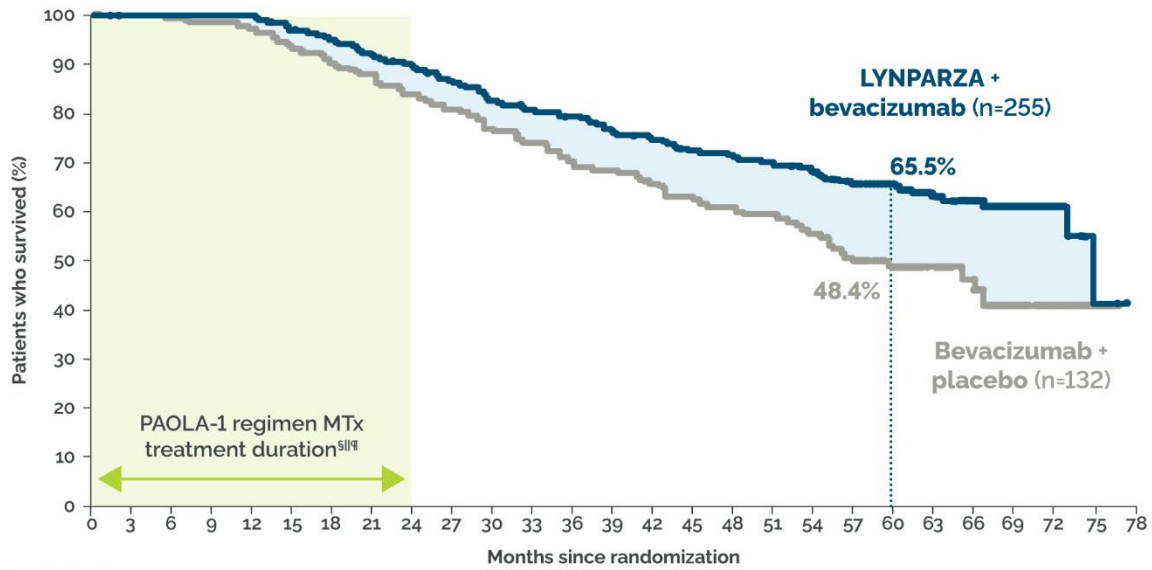
PAOLA-1 OS Results in the HRD-Positive Subgroup

Prespecified exploratory analysis of the secondary endpoint **overall survival (OS) in the HRD-positive*† subgroup** showed a clinically meaningful survival benefit after response to first-line platinum-based chemotherapy[1-3‡]

- Median OS was ~6.3 years (75.2 months) with LYNPARZA plus bevacizumab vs ~4.8 years (57.3 months) with bevacizumab plus placebo[1§‖¶]
- 38% reduction in the risk of death; HR=0.62 (95% CI 0.45–0.85)[1]
- Data based upon a prespecified exploratory subgroup analysis, which was not controlled for Type 1 error. HRD status was not a stratification factor in PAOLA-1[2]

PAOLA-1 reported clinically meaningful PFS and OS results in HRD-positive*† advanced ovarian cancer after response to first-line platinum-based chemotherapy[1-4‡]

OS in the HRD subgroup[1,2]



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	174	77	70	59	44	29	21	9	2	1	0

*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 is defined as either a tumor *BRCA* mutation and/or an HRD score ≥42 by Myriad MyChoice® CDx.[4,5] ‡Secondary endpoint: Prespecified exploratory analysis of OS in the HRD-positive subgroup. Data based upon a prespecified exploratory subgroup analysis, which was not controlled for Type 1 error. HRD status was not a stratification factor in PAOLA-1. The analysis is based on Kaplan–Meier estimates and is descriptive only. This trial was not designed to assess a statistical difference between treatment groups at 5 years.[4] §Bevacizumab was administered for a total of up to 15 months, including the period given with chemotherapy and given as maintenance.[1] ‖LYNPARZA was continued for up to 2 years or until progression of the underlying disease or unacceptable toxicity.[1] 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.[1] 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.
BRCA, BReast CAncer gene; CI, confidence interval; FDA, US Food and Drug Administration; HR, hazard ratio; HRD, homologous recombination deficiency; OS, overall survival.

1. LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025.
2. Ray-Coquard I, et al. *Ann Oncol*. 2023;34:681-692.
3. Ellis LM, et al. *J Clin Oncol*. 2014;32:1277-1280.
4. Ray-Coquard I, et al. *N Engl J Med*. 2019;381:2416-2428.
5. Myriad Genetic Laboratories, Inc. Myriad MyChoice® CDx Technical Information. Accessed June 30, 2025. https://s3.amazonaws.com/myriad-web/myChoiceCDx/downloads/myChoiceCDxTech.pdf.

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PAOLA-1 Safety Results

ARs occurring in ≥10% of patients treated with LYNPARZA plus bevacizumab and ≥5% frequency compared with placebo plus bevacizumab[1]

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

*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.

AA, aplastic anemia; AML, acute myeloid leukemia; MDS, myelodysplastic syndrome.

Adverse reactions (ARs) and laboratory abnormalities from the primary analysis in PAOLA-1 were **mostly Grades 1 and 2**[1]

Primary analysis:

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 plus bevacizumab. Serious adverse reactions in >5% of patients included hypertension (19%) and anemia (17%)[1]

In addition, venous thromboembolism occurred more commonly in patients receiving LYNPARZA plus bevacizumab (5%) than in those receiving placebo plus bevacizumab (1.9%)[1]

At 5-year follow-up analysis:

- No new safety signals were identified[2]
- The incidence of MDS/AML/AA was 1.7% (9/535) in the LYNPARZA plus bevacizumab group and 2.2% (6/267) in the bevacizumab plus placebo group[2]
  - In the HRD-positive subgroup, the incidence of MDS/AML was 1.6% (4/255) in patients who received LYNPARZA plus bevacizumab and 2.3% (3/131) in patients who received bevacizumab plus placebo[1]
- 22 (4.1%) new primary malignancy events occurred in the LYNPARZA plus bevacizumab group and 8 (3.0%) events occurred in the bevacizumab plus placebo group[2]
- 7 (1.3%) pneumonitis events occurred in the LYNPARZA plus bevacizumab group and 2 (0.7%) events occurred in the bevacizumab plus placebo group[2]

1. LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025.
2. Ray-Coquard I, et al. *Ann Oncol*. 2023;34:681-692.

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PAOLA-1 Dose Modifications Due to an AR

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

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

	LYNPARZA + bevacizumab (n=535)	Placebo + bevacizumab (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]

Adverse reactions (ARs) and laboratory abnormalities from the primary analysis in PAOLA-1 were mostly Grades 1 and 2; most patients remained on LYNPARZA as prescribed.[1]

AR, adverse reaction.

1. LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025.
2. Ray-Coquard I, et al. *N Engl J Med*. 2019;381:2416-2428.
3. Ray-Coquard I, et al. Supplementary Information. *N Engl J Med*. 2019;381:2416-2428.

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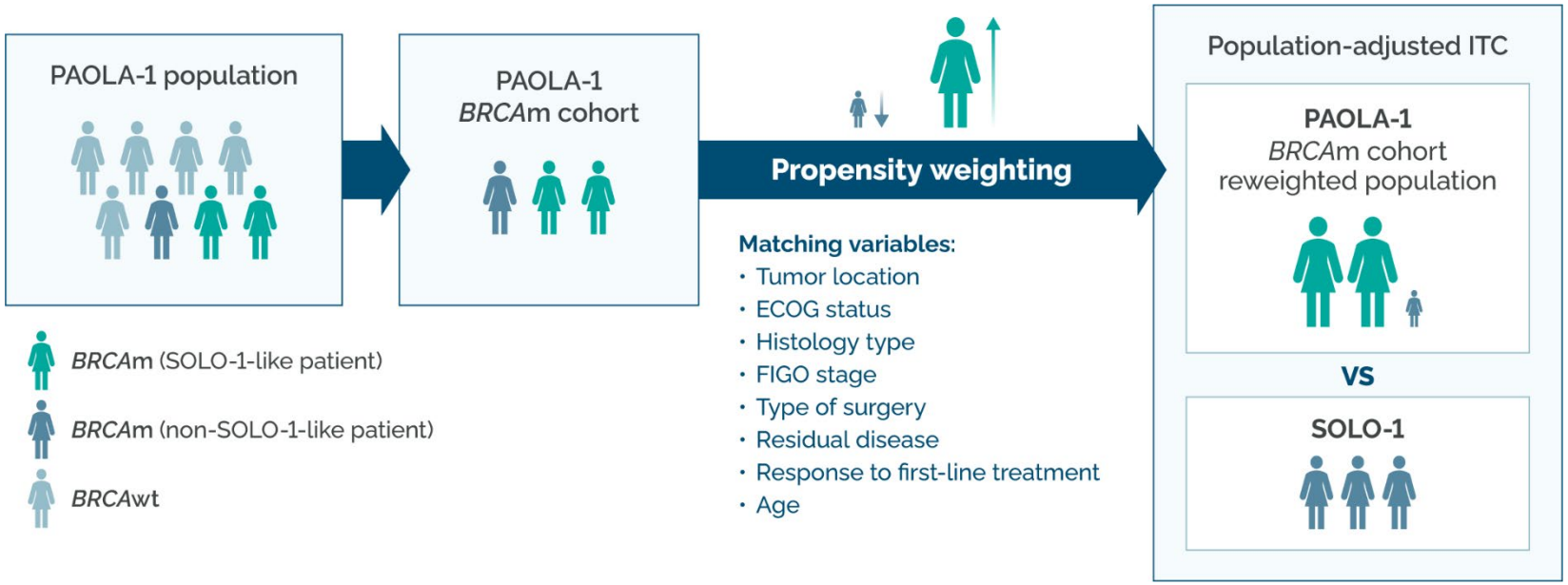
Has LYNPARZA plus Bevacizumab Combination Maintenance Therapy Been Compared to LYNPARZA Maintenance Monotherapy?

There was **no olaparib-only** arm in the PAOLA-1 trial, so **LYNPARZA plus bevacizumab could not be compared to LYNPARZA monotherapy** directly

A hypothesis-generating population-adjusted ITC of SOLO-1 and PAOLA-1 was performed to assess the comparative efficacy of maintenance

The PAOLA-1 *BRCA*m cohort was adjusted to match the SOLO-1 patient population using a propensity score weighting method, weighting each individual by their odds of being in the olaparib arm of SOLO-1



Icon size to denote weights. The olaparib arm of SOLO-1 was selected as the target population as it represents the current standard of care for patients with newly diagnosed advanced ovarian cancer and a *BRCA*m.

All analyses were performed in patients with complete baseline data. Although this ITC analysis is based on accepted methodology, it was not possible to address all differences in baseline characteristics as the analysis was non-randomized.

*BRCA*m, *BRCA* mutation; *BRCAwt*, *BRCA* wildtype; ECOG, Eastern Cooperative Oncology Group; FIGO, International Federation of Gynecology and Obstetrics; ITC, indirect treatment comparison.

Vergote I, et al. *Eur J Cancer.* 2021;157:415-423.

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Limitations of the ITC Model

- This ITC is for descriptive purposes only. The outcomes of this ITC are the results of statistical modeling and should therefore be interpreted with caution
- This analysis uses patient-level data to provide additional context to the role of olaparib and bevacizumab in the treatment of newly diagnosed advanced ovarian cancer. The results of this cross-trial comparison rely on matching of observed prognostic and effect modifier factors across the studies to minimize differences in patient characteristics and are therefore subject to assumptions around the absence of unobserved confounding variables
- Although this ITC analysis is based on an accepted methodology, it is not possible to address all differences in baseline characteristics as the analysis was non-randomized
- This analysis is not meant to replace a randomized control trial. It was completed because currently there is no randomized control trial that investigates maintenance PARPi monotherapy, bevacizumab monotherapy, PARP inhibitor plus bevacizumab combination therapy, and watch/wait placebo

ITC, indirect treatment comparison; PARP, poly (ADP-ribose) polymerase; PARPi, poly (ADP-ribose) polymerase inhibitor.

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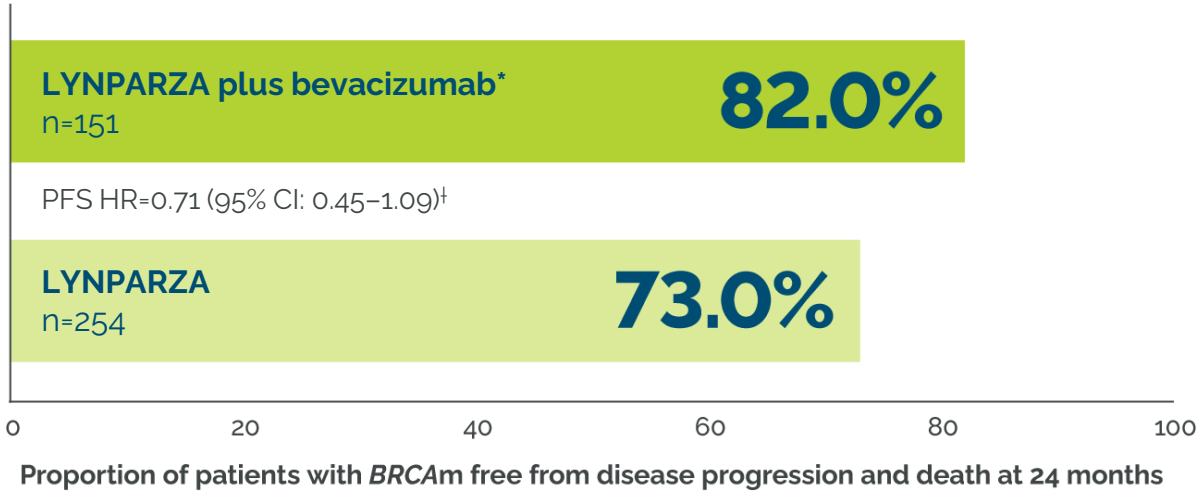
Results of Population-Adjusted ITC

The **population-adjusted ITC** reported **PFS** for olaparib plus bevacizumab vs olaparib alone in patients with *BRCA* mutations



Proportion of patients with *BRCA*m free from disease progression and death at 24 months

These results should be interpreted with caution as this analysis was not a randomized, controlled trial and the outcomes of the ITC were the result of statistical modeling

*These results are based on weighted outcomes after matching tumor location status, ECOG status, FIGO stage, type of surgery (interval vs upfront), residual disease status after surgery, response to first-line treatment and age to SOLO-1.
†Confidence intervals generated via bootstrapping.
At the time of primary PFS analyses, median follow-up in SOLO-1 was 40.7 months (IQR, 34.9-42.9) in the olaparib arm and 41.2 months (IQR, 32.2-41.6) in the placebo arm (DCO: May 17, 2018). In PAOLA-1, median follow up was 22.7 months (range, 18.0-27.7) in the olaparib + bevacizumab arm and 24.0 months (range, 18.7-27.7 in the placebo + bevacizumab arm (DCO: March 22, 2019).
The PAOLA-1 *BRCA*m cohort was adjusted to match the SOLO-1 patient population using a propensity score weighting method.
All analyses were performed in patients with complete baseline data.

*BRCA*m, *BRCA* mutation; CI, confidence interval; DCO, data cutoff; ECOG, Eastern Cooperative Oncology Group; FIGO, International Federation of Gynecology and Obstetrics; HR, hazard ratio; IQR, interquartile range; ITC, indirect treatment comparison; PARP, poly (ADP-ribose) polymerase; PFS, progression-free survival.

ITC analysis reported **PFS for olaparib plus bevacizumab vs olaparib alone** in patients with *BRCA* mutations

Vergote I, et al. *Eur J Cancer*. 2021;157:415-423.

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Treatment Guidelines on Combination Maintenance Therapy

Treatment guidelines recommend the combination of olaparib with or without bevacizumab as **first-line maintenance therapy** as a treatment option in selected patients with advanced ovarian cancer in complete or partial response to first-line therapy, depending on biomarker status[1-3]

	BRCAm	HRD+/*BRCAwt*	Notes
National Comprehensive Cancer Network® (NCCN®)[1]	✓	✓	**NCCN Category 1* recommendation,** only in patients that received bevacizumab as part of primary therapy.
ASCO[2,3]	✓	✓	

*NCCN Category 1: Based upon high-level evidence (≥1 randomized phase 3 trial or high-quality, robust meta-analyses), there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.
ASCO, American Society of Clinical Oncology; *BRCA*m, *BRCA*-mutated; *BRCAwt*, *BRCA*-wildtype; HRD+, homologous recombination deficiency-positive; NCCN, National Comprehensive Cancer Network® (NCCN®).

Treatment guidelines **recommend olaparib in combination with bevacizumab** as first-line maintenance therapy in selected patients with advanced ovarian cancer[1-3]

1. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer. V3.2025. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed July 16, 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.
2. Tew WP, et al. *J Clin Oncol.* 2022;40:3878-3881.
3. Gaillard S, et al. *J Clin Oncol.* 2025;43:868-891.

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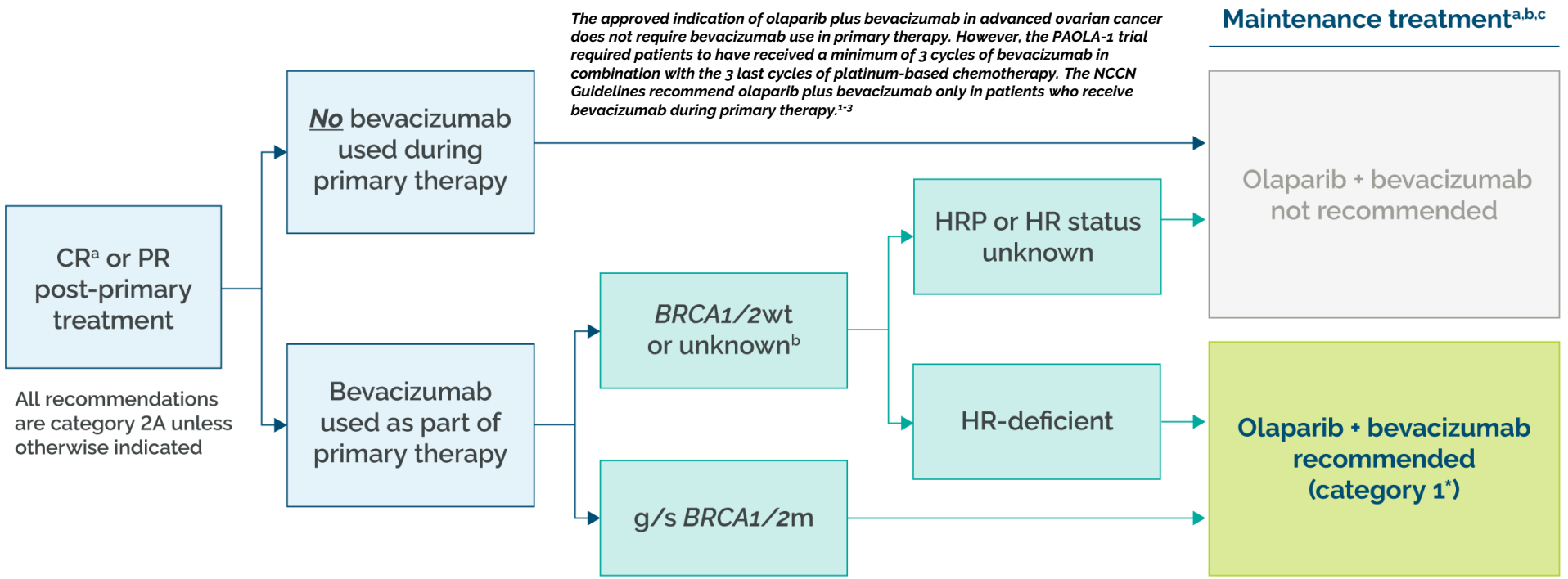
NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Regarding Olaparib Plus Bevacizumab in Advanced Ovarian Cancer

Olaparib plus bevacizumab is recommended as a maintenance therapy option in selected patients with advanced ovarian cancer following surgery and first-line platinum-based chemotherapy with bevacizumab.[1]



Olaparib plus bevacizumab is a **category 1* recommendation** in selected patients with *BRCA1/2*m/HR-deficient disease who received bevacizumab as part of primary therapy[1]

[a]No definitive evidence of disease. [b]In the absence of a *BRCA1/2* mutation, HRD status may provide information on the magnitude of benefit of PARP inhibitor therapy. [c]See Principles of Systemic Therapy (OV-C) and Management of Drug Reactions (OV-D), NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Ovarian Cancer (including Fallopian Tube Cancer and Primary Peritoneal Cancer) V.2.2025. *Category 1: Based upon high-level evidence (≥1 randomized phase 3 trial or high-quality, robust meta-analyses), there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.
*BRCA*1/2m, *BRCA*1/2 mutation; *BRCA*1/2wt, *BRCA*1/2 wild-type; CR, complete response; g/s, germline or somatic; HR, homologous recombination; HRP, homologous recombination proficient; PARP, poly (ADP-ribose) polymerase; PR, partial response.

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2. LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025.
3. Ray-Coquard I, et al. Supplementary Information. *N Engl J Med*. 2019;381:2416-2428.

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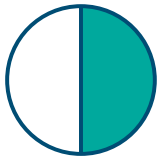
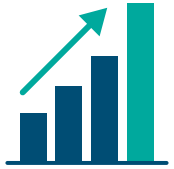
Implications of HRD on Selecting Maintenance Therapy



About half of newly diagnosed, high-grade serous ovarian cancers **exhibit HRD**.[1]

Treatment guidelines **recommend olaparib in combination with bevacizumab** as first-line maintenance therapy in selected patients with advanced ovarian cancer.[3-5]

- Bevacizumab plus olaparib is a category 1 recommendation in selected patients with BRCAm/HR-deficient disease who received bevacizumab as part of primary therapy.[5]



HRD is associated with **increased sensitivity to PARP inhibitor maintenance therapy**.[2]

The FDA-approved indication of LYNPARZA plus bevacizumab **requires a positive HRD test*** with a companion diagnostic.[6-8]

*HRD-positive is defined as either a tumor *BRCA* mutation and/or an HRD score ≥42 by Myriad MyChoice® CDx.[6-8]
HRD, homologous recombination deficiency.

Testing for HRD is required to identify HRD-positive* patients eligible for LYNPARZA plus bevacizumab.[6]

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5. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer. V3.2025. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed July 16, 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.
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Take-Home Message

- Combination therapy with LYNPARZA plus bevacizumab is designed to target 2 distinct survival mechanisms commonly seen in ovarian tumors.[1-5]
- LYNPARZA is approved both as monotherapy and in combination with bevacizumab as first-line maintenance therapy in selected patients with advanced ovarian cancer and both indications require an approved companion diagnostic test.[1]
- PAOLA-1 reported clinically meaningful PFS and OS results in HRD-positive*‡ advanced ovarian cancer after response to first-line platinum-based chemotherapy.[1,6-8‡]
- ARs and laboratory abnormalities from the primary analysis in PAOLA-1 were mostly Grades 1 and 2; most patients remained on LYNPARZA as prescribed.[1]
- ITC analysis reported PFS for olaparib plus bevacizumab vs olaparib alone in patients with *BRCA* mutations.[9]
- Treatment guidelines recommend olaparib in combination with bevacizumab as first-line maintenance therapy in selected patients with advanced ovarian cancer.[10-12]
- Olaparib plus bevacizumab is a category 1§ recommendation in selected patients with *BRCA1/2*m/HR-deficient disease who received bevacizumab as part of primary therapy.[10]
- Testing for HRD is required to identify HRD-positive* patients eligible for LYNPARZA plus bevacizumab.[1]
- All patients with advanced ovarian cancer should be tested for HRD, so that bevacizumab plus olaparib first-line maintenance therapy can be offered to all eligible patients.[1,12]

*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 is defined as either a tumor *BRCA* mutation and/or an HRD score ≥42 by Myriad MyChoice® CDx.[6,13] ‡Secondary endpoint: Prespecified exploratory analysis of OS in the HRD-positive subgroup. Data based upon a prespecified exploratory subgroup analysis, which was not controlled for Type 1 error. HRD status was not a stratification factor in PAOLA-1. The analysis is based on Kaplan–Meier estimates and is descriptive only.[6] §Category 1: Based upon high-level evidence (≥1 randomized phase 3 trials or high-quality, robust meta-analyses), there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.[10] NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

AR, adverse reaction; *BRCA1/2*m, *BRCA1/2* mutated; CDx, companion diagnostic; HR, homologous recombination; HRD, homologous recombination deficiency; ITC, indirect treatment comparison; OS, overall survival; PFS, progression-free survival.

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