



Pharmacy Pearls

March 2019

Best Practice Guidance for Reduction of Outpatient Migraine in Adults

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Migraine ranks in the top 6th of the world's most disabling medical illnesses and the highest major cause of disability in age <50, but remains under-recognized and undertreated. Timely identification and treatment is associated with improved outcomes. In collaboration with providers from primary care and neurology, AHP has developed *Best Practice Guidance for Reduction of Outpatient Migraine in Adults*, an evidence- and value-based consensus document intended to help guide PCPs in the treatment of migraine in their adult population. You can find the full length guidance document on the AHP website [here](#).

Key Steps for Migraine Management:

1

Identify Migraine:

Use of ID Migraine™ Screener is recommended

(based on Lipton et al. Neurology 2003)

1. Over the last 3 months, have you limited your activity on at least 1 day because of your headaches?
 2. Do lights bother you when you have a headache?
 3. Do you get sick to your stomach or nauseated with your headache?
- ≥ 2 "yes" answers = **probable migraines**

2

Identify and Resolve Medication Overuse Headache:

- **Medication Overuse Headache (MOH) Definition:** Secondary disorder in which excessive use of acute medications causes chronic daily headache in a headache prone patient.
- **MOH Clinical Diagnosis:** > 15 headache days/month, history regular acute medication use more than 2-3 days/week.
 - Diagnosis supported when headache frequency increases with increased medication use or improves when medication is withdrawn.
- **Identify and resolve MOH prior to initiating other migraine therapies:** MOH can render headaches refractory to other treatments and reduce the efficacy of abortive therapy.
- **Medication associated risk:** Opioids, Butalbital-containing combinations or ASA/APAP/Caffeine combinations > Triptans > APAP, ASA, NSAIDs
- **Most effective treatment for MOH:** Discontinue overused medication.

3

Implement/Optimize Lifestyle Strategies: Table 1

Strategies	Goal(s)
Reduce caffeine intake	< 8 oz. of caffeinated beverages before noon
Maintain a regular sleep schedule	At least 7 hours of sleep per night Avoid screen time for ≥ 1 hour before bed
Improve diet and avoid triggers	Monitor and avoid foods identified as triggers Avoid fasting for more than 6 hrs while awake Eat a well-balanced, healthy, diet
Improve hydration	48 oz. of non-caffeinated beverages daily
Regular exercise	At least 20 min. of elevated heart rate per day, 4 days per week

4

Initiate Treatment:

- See **Table 2** for treatment recommendations.

Clinical Practice Pearls:

Preventative treatment trials

- Medications should be given an adequate trial before determining treatment failure (clinical efficacy can take 2-4 months).
- If a patient fails a preventative treatment option, consider an agent in an alternative medication class.

The Use of Opioids and Butalbital for Migraine

[Choosing Wisely](#) recommendations from the American Academy of Neurology encourage providers to avoid the use of medications containing opioids and/or butalbital for the treatment of migraine.

- These medications are more likely to cause MOH and are not as effective as other migraine medications.
- They carry addiction risk and are associated with serious adverse effects.

When to refer to neurology

- Patients with episodic migraine should trial and fail at least 1 abortive and 1 preventative treatment before being referred.
- Patients with chronic migraine should be referred to neurology for treatment options once diagnosed.

Treatment Recommendations: Table 2

<p>First-Line Options</p>	<p>Initiate Acute (Abortive) Treatment: <i>choice of medication should be based on comorbidities/side effects</i></p> <ul style="list-style-type: none"> • Triptans: Sumatriptan 100 mg (tablets only) or Zolmitriptan 5 mg (tablets only) • Ibuprofen 600 - 800 mg <p><i>*NOTE: Triptans are all equally safe and effective and are safe to use with aura. Selection is based on cost, onset, and duration of action. If a patient does not tolerate a triptan well (chest pain, dizziness, flushing, etc.) almotriptan can be better tolerated than other triptans, but is more expensive*</i></p>
	<p>AVOID</p> <ul style="list-style-type: none"> • Caffeine-containing medications: Limit use. Using these medications more than 2 days per week greatly increases the risk of medication overuse headache. • Opioids: Avoid. Opioids contribute to medication overuse headache, tolerance/dependency, and decrease responsiveness to acute and preventative meds • Butalbital: Avoid completely. Butalbital is less effective and very likely to contribute to medication overuse headache.
	<p>How to Optimize Treatment</p> <ul style="list-style-type: none"> • Initiate abortive agent as early as possible in acute attack • Restrict use of abortive medications to only 2-3 days per week • Co-prescribe antiemetics if concurrent nausea or vomiting <ul style="list-style-type: none"> ○ metoclopramide 5-10 mg tablets, or prochlorperazine 10 mg tablets/25 mg suppositories • Set patient-centered expectations and monitor ability to resume daily activities • Treat 2-3 attacks before judging effectiveness of an agent

<p>First-Line Options</p>	<p>Initiate Preventative Treatment for Episodic Migraine: <i>headache burden of < 15 days per month</i></p> <ul style="list-style-type: none"> • Candidates = Frequency of 4 migraines per month or > 6 headache days per month
	<ul style="list-style-type: none"> • Beta-Blockers: Metoprolol succinate ER or Propranolol ER, or • Topiramate, or • Amitriptyline <p><i>*NOTE: First-line recommendations are for uncomplicated migraine; treatment recommendations for various comorbidities can be found in full detail document.</i></p>
	<p>Optimizing Treatment</p> <ul style="list-style-type: none"> • Initiate preventative therapy as soon as clinically indicated. • Consider referral to neurology if patients have tried (and failed) at least 1 abortive and 1 preventative treatment.

Preventative Treatment of Chronic Migraine: *headache burden of > 15 days per month (≥ 8 being migraine-like or responding to migraine-specific medication)*

- Optimize lifestyle changes (Table 1), address MOH (Step 2 above) and refer to neurology for preventative treatment.

Newest Available Medication Class for Migraines: The Calcitonin Gene-Related Peptide (CGRP) antagonists are a novel class of medications (human monoclonal antibodies) approved for prevention of migraine headache. CGRP receptor stimulation is believed to be a key part of migraine pathophysiology and increased CGRP is associated with pain, phonophobia, photophobia, and nausea.

<p>Medication Names and Mechanisms:</p>	<p>Erenumab (Aimovig®)</p> <p><i>Binds to the CGRP receptor and antagonizes its function</i></p>	<p>Fremanezumab (Ajovy®)</p> <p><i>Binds to CGRP ligand and blocks its binding to the receptor</i></p>	<p>Galcanezumab (Emgality®)</p> <p><i>Binds to CGRP ligand and blocks its binding to the receptor</i></p>
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- Currently available trials of these agents show modest treatment benefits with few harms:
 - **Reduction in headache days per month = 1.0 – 2.8 and reduction in days of acute medication use = 0.6 – 2.6**
- Concerns with available evidence include uncertainty about durability of effects and adverse effects from prolonged use (trial outcomes concluded after 12-24 weeks), theoretical concerns about long-term use and cardiovascular disease, CGRP antagonists were compared to placebo (not standard of care) in clinical trials, and patient populations were restricted to those that failed only 2-3 other preventive therapies (generalizability of results is limited).
- Cost will vary based on patients' insurance (**average cost is ~ \$575 per month**). For patients with chronic or episodic migraine that have failed other preventive treatments, cost-effectiveness is below/near the upper limit of commonly accepted thresholds.