Pharmacy Pearls

August 2022

Best Practice Guidance for Reduction of Outpatient Migraine in Adults- an update

Contact: AHPPharmacist@urmc.rochester.edu

Migraine ranks in the top 6th of the world's most disabling medical illnesses and the highest major cause of diaability 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  - Diagnosis supported when headache frequency increases with increased medication use or improves when medication is withdrawn.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.

First-Line Treatment Options- Uncomplicated Migraine*	
Acute (Abortive) Treatment	**Preventative Treatment**
Sumatriptan 100 mg tablets	Metoprolol ER
Zolmitriptan 5 mg tablets	Propranolol ER
Rizatriptan 10 mg tablets	Topiramate
Naratriptan 2.5 mg tablets	Amitriptyline
Ibuprofen 600-800 mg	

*Based on efficacy, tolerability, onset and duration (triptans), and cost

New Options for Migraine Management

Drug	Acute or Preventative tx	Mechanism of Action	Drug Interactions	Adverse Events	Notes
"Highly Selective" Serotonin Agonist ("ditan")					
Lasmiditan (Reyvow®)	Acute	↓ stimulation of trigeminal system w/out vasoconstriction	Many (CNS depression)	Dose-related CNS effects: dizziness, fatigue, drowsiness	No renal dose adjustment Not recommended in severe hepatic dysfunction
Oral CGRP Antagonists ("gepants")					
Ubrogepant (Ubrelvy™)	Acute	Small molecule CGRP receptor antagonist	Many (CYP)	Drowsiness, nausea, dry mouth	CrCl 15-29 and/or severe hepatic dysfunction: DNE 50 mg/dose and 100 mg/24 hrs CrCl <15: avoid
Rimegepant (Nurtec®)	Both	Small molecule CGRP receptor antagonist	Many (CYP and P-gp)	Nausea, abdominal pain	CrCl <15 and/or severe hepatic dysfunction: avoid
Atogepant (Qulipta™)	Preventative	Small molecule CGRP receptor antagonist	Many (CYP and P-gp)	↓ appetite, wt loss, constipation, nausea, drowsiness, fatigue, LFT elevations	CrCl <30: DNE 10 mg daily Not recommended in severe hepatic dysfunction
Injectable CGRP Antagonists (MOABs)					
Eptinezumab (Vyepti®)	Preventative	IV MOAB, binds to CGRP ligand	Minimal	Antibody development, hypersensitivity rxn, nausea, fatigue	No dose adjustments required
Erenumbab (Aimovig®)	Preventative	SQ MOAB, binds to and inhibits CGRP receptor	Minimal	Injection site rxn, constipation, antibody development	No dose adjustments required May cause clinically significant HTN
Fremanezumab (Ajovy®)	Preventative	SQ MOAB, binds to CGRP ligand	Minimal	Injection site rxn, antibody development	No dose adjustments required CVD excluded from trials
Galcanezumab (Emgality®)	Preventative	SQ MOAB, binds to CGRP ligand	Minimal	Injection site rxn, antibody development	No dose adjustments required CVD excluded from trials

Place in Therapy: There is no comparative data suggesting these new agents are more effective than current first-line options (acute or preventative treatment). These agents are often rejected by insurance and/or cost-prohibitive. Consider turning to these agents when patients have failed *at least 2 first-line* treatment options (this is often required documentation for insurance coverage/prior authorizations).