PRIMARY CARE GUIDE TO MIGRAINE THERAPIES

Canadian Headache Society

Migraine patients need acute therapy as suboptimal therapy leads to increased disability.

Goals of Acute Therapy:

- Rapid and consistent relief from migraine (including headache and associated symptoms) without recurrence
- Return to normal function
- Reduced need for repeat dosing, rescue medications and emergency room visits
- Minimal or no adverse events (AEs)

Migraine Severity & Disability	Medication and Adult Dosing (screen for contraindications)	Therapy Principles
"I can GO." 	If therapy is needed: Diclofenac K+ (Cambia®) 1 sachet (use very small amount of water) Diclofenac Na+ (Voltaren) 50mg Indomethacin 25-50mg Mefenamic acid 250-500mg Nabumetone 500mg Naproxen 220-500mg Ubrogepant‡ (Ubrelvy®) 50, 100mg tab (take at prodrome)	Treat EARLY at the first sign of a migraine attack for best results. If therapy is ineffective or suboptimal switch to a different medication.
"I have to SLOW DOWN." 	Almotriptan*† 12.5mg tab Eletriptan (Relpax®) 40mg tab Frovatriptan (Frova®) 2.5mg tab Naratriptan* (Amerge) 2.5mg tab Rizatriptan* (Maxalt®) 10mg tab or RPD Sumatriptan* (Imitrex) 100mg tab, 6mg SC, 20mg nasal spray Sumatriptan 85mg + naproxen 500mg combined in 1 tab (Suvexx®) Zolmitriptan (Zomig®) 5mg nasal spray Rimegepant‡ (Nurtec®) ODT 75mg Ubrogepant‡ (Ubrelvy®) 50, 100mg tab	Both triptans and gepants can be effective. Choose a non-oral route if severe nausea or vomiting (eg zolmitriptan nasal spray or sumatriptan SC) and consider the addition of an oral antiemetic.
"I have to STOP." ***OR migraine upon awakening*** 	Triptan or gepant + NSAID combination *(early morning migraine, consider non-oral triptan)* OR Sumatriptan 85mg + naproxen 500mg combined in 1 tab (Suvexx®)	Limit triptan use to an average of 2 days per week to avoid medication overuse / induced headache

* EAP (Exceptional Access Program) may cover
† HC approved for ≥ 12 years old
‡ Ubrogepant (Ubrelvy®) and Rimegepant (Nurtec®) migraine specific oral CGRP receptor antagonist (gepant)

If acute medications are needed 1 day per week or more, a preventive medication should be offered. If prevention is already in place the dose can be increased, or a different agent can be layered in. Acute medication could also be changed.

Opioids are never recommended because they contribute to worsening headache and ineffectiveness of migraine therapy.

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Preventive therapy is a critical, underutilized part of migraine management.

Goals of Preventive Therapy: (several agents may have to be trialed)

- Reduce attack frequency, severity, duration and disability
- Improve responsiveness to acute therapy
- Improve ability to function
- Reduce interictal burden, reduce headache related distress and psychological symptoms

When to Consider Preventive Therapy:

- Attacks significantly interfere with patients' daily routines despite acute therapy
- Frequent attacks ≥ 4 per month
- Acute therapy overuse, contraindication, failure or adverse events (AEs)

Medication	Dose range	Co-morbidity Considerations
Candesartan	4-16mg	Hypertension
Topiramate	25-100mg	Obesity; avoid in depression and kidney stones
Gabapentin	300-1800mg	Insomnia, hot flashes, and other chronic pain conditions
Propranolol Metoprolol Nadolol	20-40mg bid 50mg bid 20-80mg AM	Anxiety, hypertension; avoid in asthma and depression
Amitriptyline Nortriptyline	10-40mg 10-30mg	Insomnia, low mood, anxiety **caution 2019 study suggests link to cognitive decline*
Venlafaxine Duloxetine	37.5-150mg 30-90mg	Low mood, anxiety
Flunarizine	5-10mg HS	Dizziness, vertigo
Magnesium citrate Riboflavin (B-2) CoQ10 Vitamin D Melatonin B complex	150-600mg 200mg bid 300mg 1000-2000 IU 3-9mg 1hr HS 50-100mg	Avoid evening doses of CoQ10, B complex and Riboflavin (B-2) to reduce insomnia

Best Practices

Ensure adequate acute therapy, coupled with education and lifestyle modification.

Start at a low dose and titrate approximately every 2 weeks to reach target response or tolerability. If partial response or dose-limiting AEs, consider combination.

Give medications an adequate trial of at least 8 weeks at target dose to optimize possibility of therapeutic response.

Establish realistic expectations/goals (50% reduction in frequency - 100% is not realistic).

Maximize adherence with patient education about dose adjustments, therapy expectations, common AEs.

Consider patient preference and shared decision making.

Onabotulinumtoxin A (Botox): for Chronic Migraine (≥15 headache days per month). Injected every 12 weeks. It may be covered by public Ontario Drug Benefit and private plans once patient has been failed by at least 2 or 3 oral preventatives.

Calcitonin Gene Related Peptide (CGRP) Monoclonal antibodies (mAbs) and receptor antagonists (gepants): These medications specifically target migraine pathways. Includes subcutaneous erenumab (Aimovig), galcanezumab (Emgality), fremanezumab (Ajovy), intravenous eptinezumab (Vyepti) and oral atogepant (Qulipta). Demonstrated efficacy, safety and tolerability for the prevention of migraine in RCTs. They may be covered by private insurance and possibly Ontario Drug Benefit plan once patient has been failed by at least 2 or 3 prior oral preventives/Botox.

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