# PRIMARY CARE GUIDE FOR
## MIGRAINE THERAPIES

Canadian Headache Society

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

### Goals of Acute Therapy:

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

| Attack Severity & Disability | Medication and Adult Dosing | Best Practices |
|---|---|---|
|  **"I can GO."** | **Diclofenac K+ for oral solution (dissolved in SMALL amount of water)**<br>**Diclofenac Na+ 50mg**<br>**Indomethacin 25-50mg**<br>**Mefenamic acid 500mg**<br>**Nabumetone 500mg**<br>**Naproxen 440-550mg**<br>**Rimegepant‡ ODT 75mg**<br>**Ubrogepant‡ 50, 100mg tab** | **Treating EARLY at the first sign of a migraine attack is critical for best results.**<br><br>**Some GREEN attacks don't need treatment if resolve on own with no recurrence. If GREEN usually progresses to YELLOW consider triptan at GREEN** |
|  **"I have to SLOW DOWN."** | **Almotriptan*† 12.5mg tab**<br>**Eletriptan 40mg tab**<br>**Frovatriptan 2.5mg tab**<br>**Naratriptan* 2.5mg tab**<br>**Rizatriptan* 10mg tab or RPD**<br>**Sumatriptan* 100mg tab, 6mg SC, 20mg nasal spray**<br>**Sumatriptan 85mg + naproxen 500mg combined in 1 tab**<br>**Zolmitriptan 5mg nasal spray (2.5mg oral may be under-dosed)**<br>**Rimegepant‡ ODT 75mg**<br>**Ubrogepant‡ 50, 100mg tab** | **Both triptans and gepants can be effective.**<br><br>**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."**<br>***OR migraine upon awakening*** | **Triptan or gepant + NSAID combination *(early morning attack, consider non-oral triptan)***<br><br>**OR**<br><br>**Sumatriptan 85mg + naproxen 500mg combined in 1 tab** | **Limit triptan use to an average of 2 days per week to avoid medication overuse / induced headache.**<br><br>**If therapy is ineffective or suboptimal, switch to a different medication.** |

- 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; they contribute to worsening headache and ineffectiveness of migraine therapy.

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

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**References:**
1. The American Headache Society Consensus Statement: Update on Integrating New Migraine Treatments into Clinical Practice. *Headache* 2021; 61:1021-1039. 2.Canadian Headache Society Acute Migraine Treatment Guideline Development Group. Canadian Headache Society Acute Drug Therapy for Migraine Headache. *Can J Neurol Sci.* 2013; 40: 5(Suppl 3): S1-79. 3. Lagman-Bartolome, A.M, Lay, C. The Traffic Light of Headache: Simplifying Acute Migraine Management for Physicians and Patients Using the Canadian Headache Society Guidelines. *Headache* 2019; 59: 250-252.

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## Who should receive preventive treatment?

a) ≥ 4 headache days/month not responding to acute medication.
b) ≥8 headache days /month, even when acute medications are effective (risk of medication overuse headache).
c) May be ≤ 3 days/month if the impact is severe despite good acute Rx, trigger avoidance, lifestyle modification etc.

## What constitutes an adequate preventive trial?

a) At least two months at target dose for older oral preventive medications (OOPMs)
b) For OOPMs start at low dose and build up slowly q 2 weeks to target response and as tolerated
c) For CGRP targeted mAbs, 3 months for majority but 6 months suggested in treatment-resistant chronic migraine
d) For onabotulinumtoxinA, minimum of 2 quarterly injections
e) Aiming for 50% reduction in headache frequency or severity

### Recommended For Use in EPISODIC Migraine (Use)

| Drug | Recommendation Strength | Quality of Evidence | Dosage |
|---|---|---|---|
| Amitriptyline | Strong | High | 10-100mg hs |
| Erenumab | Strong | High | 70-140mg SC Q1mo |
| Metoprolol | Strong | High | 50 - 100mg bid |
| Propranolol | Strong | High | 40-120 mg bid |
| Atogepant | Strong | Moderate | 30-60mg |
| Candesartan | Strong | Moderate | 8–16 mg/d |
| Eptinezumab | Strong | Moderate | 100-300mg IV Q3mo |
| Fremanezumab | Strong | Moderate | 225mg SC Q1mo |
| Galcanezumab | Strong | Moderate | 120mg SC Q1mo |
| Nadolol | Strong | Moderate | 40-160mg/d |
| Coenzyme Q10 | Strong | Low | 100mg tid |
| Magnesium citrate | Strong | Low | 300mg bid |
| Riboflavin | Strong | Low | 400mg/d |
| Divalproex Sodium | Weak | High | 750-1500mg/d |
| Flunarizine | Weak | High | 5-10mg hs |
| Pizotifen | Weak | High | 1-2mg bid |
| Memantine | Weak | Moderate | 10 mg |
| Rimegepant | Weak | Moderate | - |
| Topiramate | Weak | Moderate | 25-100mg hs |
| Levetiracetam | Weak | Low | 500-1000mg |
| Lisinopril | Weak | Low | 10/20 mg/d |
| Venlafaxine | Weak | Low | 37.5-150 mg/d |
| Verapamil | Weak | Low | 80 mg bid |
| Enalapril | Weak | Very Low | - |
| Melatonin | Weak | Very Low | 3-10mg |

### Not Recommended Use in EPISODIC Migraine (Do Not Use)

| Drug | Recommendation Strength | Quality of Evidence | 2012 |
|---|---|---|---|
| Onabotulinum Toxin A | Strong | High | X |
| Ginger | Strong | High | |
| Feverfew | Strong | Moderate | X |
| Gabapentin | Weak | Very Low | |
| Stain alone or add on | Weak | Very Low | |

### Recommended For Use in CHRONIC Migraine (Use)

| Drug | Rec. Strength | Quality of Evidence | Dosage |
|---|---|---|---|
| Onabotulinum Toxin A | Strong | High | 155-195 U injected Q12w |
| Atogepant | Strong | High | 30-60mg |
| Eptinezumab | Strong | High | 100-300mg IV Q3mo |
| Erenumab | Strong | High | 70-140mg SC Q1mo |
| Fremanezumab | Strong | High | 225mg SC Q1mo |
| Galcanezumab | Strong | High | 120mg SC Q1mo |
| Propranolol | Strong | Moderate | 20-80mg bid |
| Topiramate | Weak | Very Low | 25- 100mg qhs |

*Payers are currently requiring that patients with migraine including Chronic Migraine (CM) and High Frequency Episodic Migraine (HFEM) fail at least two OOPMs before starting CGRP targeted agents or onabotulinum toxin A.

We are opposed to this due to the very high indirect cost to society of both CM and HFEM which has not been considered in their deliberations.

We recommend that CGRP targeted medications and onabotulinum toxin A be made available as first line amongst other first line treatments for CM and HFEM with moderate disability and that the choice be based on the treating practitioner's clinical impression and patient preference.

The recommendations of the Canadian Headache Society Migraine Prevention Guideline are based upon the best available research evidence and practice experience and is in line with international guidelines and consensus papers on the same topic. We strongly urge payers to follow the published guidelines in their approval process.

**References:**
1. Medrea I, et al. Canadian Headache Society Updated Guideline on Migraine Prevention. Can J Neurol Sci. 2024 Dec 1;455 . 2. Pringsheim, T et al, Canadian Headache Society Guideline for Migraine Prophylaxis, Can J Neurol Sci. 2012; 39: Suppl. 2 - S1-S2, 3.Charles A. C. et al. Calcitonin gene-related peptide-targeting therapies are a first-line option for the prevention of migraine: An American Headache Society position statement update. Headache 2024; 64: 333-341. 4. Amoozegar F et al. The Burden of Illness of Migraine in Canada: New Insights on Humanistic and Economic Cost. Can J Neurol Sci. 2022; 49: 249–262. 5. Sacco S. et al. European Headache Federation guideline on the use of monoclonal antibodies targeting thecalcitonin gene related peptide pathway for migraine prevention – 2022 update. J Headache Pain. 2022; 23(1): 67.