

Migraine prevention in the real world: Exploring the role of anti-CGRP antibodies

Key causes of treatment failure in migraine



"We have three main causes of treatment failures: one is poor adherence, possibly due to side effects...the second one is incorrect timing or inadequate dosing of treatment, and the third one is suboptimal efficacy or insufficient response." – Prof. Christian Lampl

Recognizing and evaluating treatment failure



When to evaluate after treatment initiation

2 months

Oral preventive treatments^{1,2}

3 months

Monthly anti-CGRP antibodies^{1,3}

6 months

Quarterly anti-CGRP antibodies¹



How to evaluate

- MMDs, migraine severity, acute medication use and migraine-related disability^{1,2}
- Headache diary, functional capacity and QoL^{1,2}
- AEs and adherence²

Faculty and topics



Prof. Christian Lampl presented insights and guidance on managing treatment failure in migraine



Dr Simy Parikh presented practical management advice on using anti-CGRP antibodies in migraine

Key goals of preventive migraine treatment¹



- 1 Improve functioning and HRQoL
- 2 Reduce attack frequency, severity and duration
- 3 Improve responsiveness to acute treatment and reduce overuse

AE, adverse event; CGRP, calcitonin gene-related peptide; HRQoL, health-related QoL; MMD, monthly migraine day; QoL, quality of life.

1. Ailani J, et al. *Headache*. 2021;61:1021–39; 2. Eigenbrodt AK, et al. *Nat Rev Neurol*. 2021;17:501–14; 3. Sacco S, et al. *J Headache Pain*. 2022;23:67.

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Pausing and restarting anti-CGRP antibodies



Evidence is limited for **optimal therapy duration**; adapt on a **case-by-case** basis¹



Consider **pausing** treatment **after 12–18 months**¹



Restart treatment if migraine worsens after withdrawal, **continue as long as required**¹



Involve patients in decisions to pause and restart treatments to **optimize outcomes**²



Switching between anti-CGRP antibodies



Insufficient evidence to recommend **switching** between anti-CGRP antibodies, **but switching can be an option**¹



Recent RWD suggest **switching** anti-CGRP therapy following initial treatment failure on a different anti-CGRP antibody may **improve patient outcomes**^{3,4}



Combining treatments with anti-CGRP antibodies



Insufficient evidence to make suggestions on **combining** anti-CGRP antibodies **with other preventive treatments**¹



Recent RWD suggest **concurrent use of agents such as BTX-A or a gepant** may **improve patient outcomes** with anti-CGRP antibodies^{5,6}

Patient-centred goal setting, evaluation of treatment failure and shared decision making underpin effective anti-CGRP antibody treatment.^{1,2} While insufficient evidence exists to recommend switching between antibodies or combining anti-CGRP antibodies with other preventive migraine treatments,¹ available RWD suggest that these approaches are associated with clinically meaningful benefits for some patients.^{3–6}

BTX-A, onabotulinumtoxinA; CGRP, calcitonin gene-related peptide; RWD, real-world data.

1. Sacco S, et al. *J Headache Pain*. 2022;23:67; 2. Ailani J, et al. *Headache*. 2021;61:1021–39; 3. Iannone LF, et al. *Cephalalgia*. 2023;43:1–11;

4. Overeem LH, et al. *Cephalalgia*. 2022;42:291–301; 5. Hutchinson S, et al. Presented at: 65th AHS Annual Scientific Meeting, Austin, TX, USA. 15–18 June 2023. P-163;

6. Hennessy E, et al. Presented at: 65th AHS Annual Scientific Meeting, Austin, TX, USA. 15–18 June 2023. P-183.