EPISODIC Migraine – SWL Drug Pathway

Version 3.1 (based on NICE with local agreements)

Does the adult patient have:
- <15 headache days per month for more than 3 months with at least 4 of those having features of migraine **(note 1) AND**
- failed at least 3 oral preventative treatments (defined as lack of a clinically meaningful response, intolerance or have contraindications to treatment) (**note 2**)

Yes

1st choice: Erenumab (140mg) (TA682) **or**
2nd choice: Galcanezumab (TA659)
3rd choice: Fremanezumab (TA764) **(note 3)**

Has treatment been withdrawn because of an adverse event within first 3 months of initiation? **(note 4)**

Yes

No

After 3 months of initiation:
Have migraine days / month reduced by ≥50% ?

Yes

No

Continue treatment for 9 months

Stop treatment and continue with best supportive care

REVIEW at month 12. Pause treatment for one month or longer as a trial drug holiday **(note 5)**

From month 13 onwards: Is there a recurrence of migraine symptoms?

No

Continue with drug holiday

Symptoms recur
Restart with same treatment as before drug holiday

Yes
Restart with same treatment as before drug holiday

Note 1: BASH recommends that particular attention is given to treatment of patients with high frequency episodic migraine (that is >8-10 migraine days/month) in whom treatment has the potential to prevent chronic migraine, a condition which carries particularly high levels of disability.
Attention to this patient population does not preclude clinicians from being able to offer CGRP mAbs to patients with fewer migraine days per month where other treatments have not worked or are contraindicated, or there are other clinical reasons for CGRP mAbs to be the most appropriate treatment for those patients.[1]

Note 2: At least 3 oral preventative treatments (beta blockers, antidepressants and anticonvulsants) have been given at maximum tolerated doses for a minimum of 3 months following dose titration.

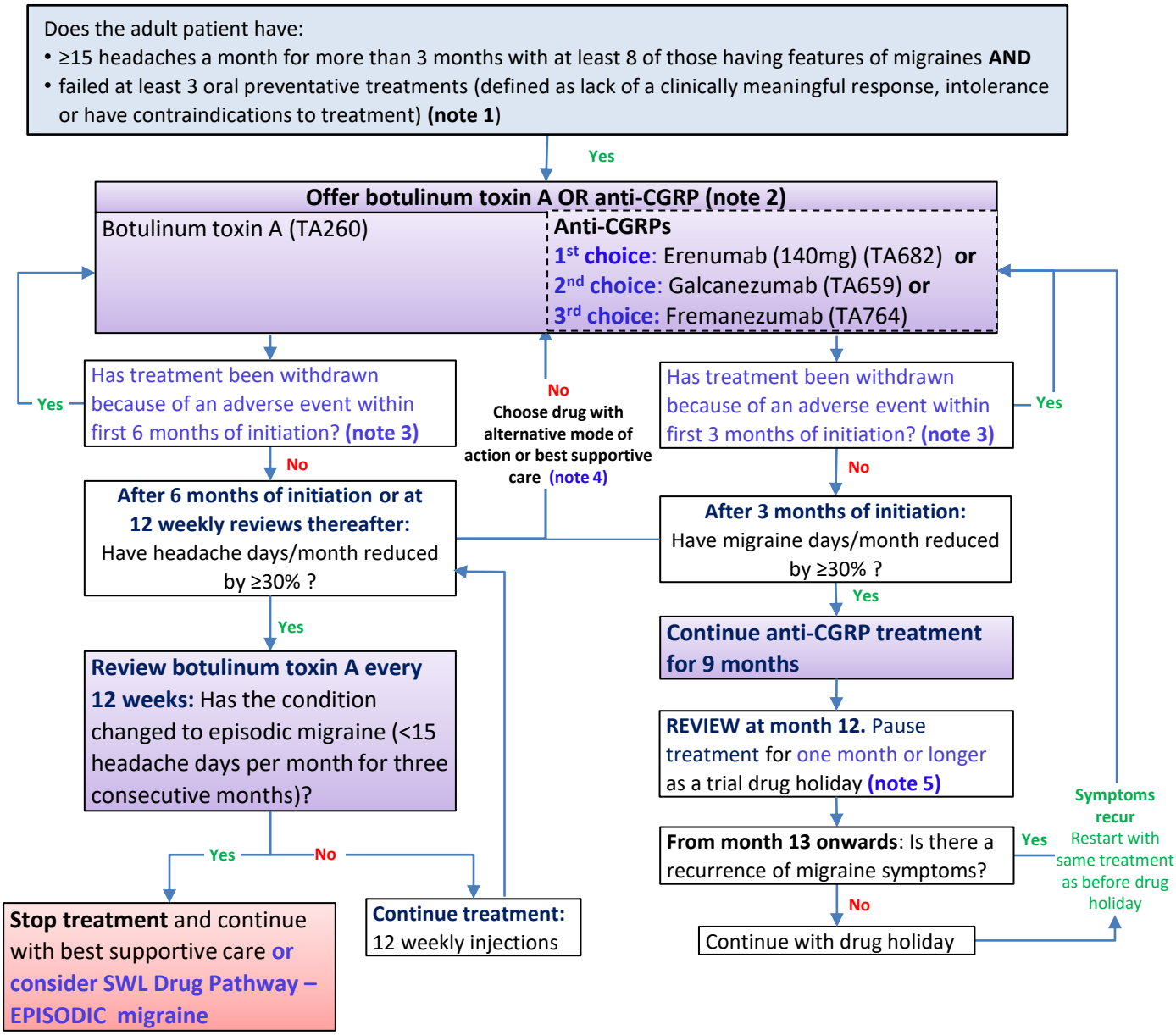
Note 3: The choice of agent should be guided by clinical factors, patient choice, and likely adherence.
If more than one treatment option is suitable, the least expensive anti-CGRP will be chosen (taking into account administration costs, dosage and price per dose) unless alternative is more suitable for the patient. The SWL drug choices in this algorithm are based on cost (using list price or nationally (NICE)/ locally (LPP) agreed contract prices).

Note 4: Consider alternative anti-CGRP if patient has responded to treatment but this had to be stopped due to an adverse event within 3 months of initiation.

Note 5: BASH recommends that the need for ongoing treatment should be assessed on at least an annual basis. Clinicians might consider a treatment pause at an appropriate juncture, as experience from other preventive migraine treatments suggests that a proportion of patients will revert to a stable and manageable form of episodic migraine, and not require ongoing treatment. If treatment is reinstituted, a set period should be agreed before another treatment pause is undertaken.[1]

CHRONIC Migraine - SWL Drug Pathway

Version 3.1 (based on NICE with local agreements)



Note 1: At least 3 oral preventative treatments (beta blockers, antidepressants and anticonvulsants) have been given at maximum tolerated doses for a minimum of 3 months following dose titration.

Note 2: The choice of agent should be guided by clinical factors, patient choice, and likely adherence.
If more than one treatment option is suitable, the least expensive will be chosen (taking into account administration costs, dosage and price per dose) unless alternative is more suitable for the patient. The SWL drug choices in this algorithm are based on cost (using list price or nationally (NICE)/ locally (LPP) agreed contract prices).

Note 3: Consider alternative anti-CGRP/ botulinum toxin A or best supportive care if patient has responded to but this had to be stopped due to an adverse event within the respective initiation period.

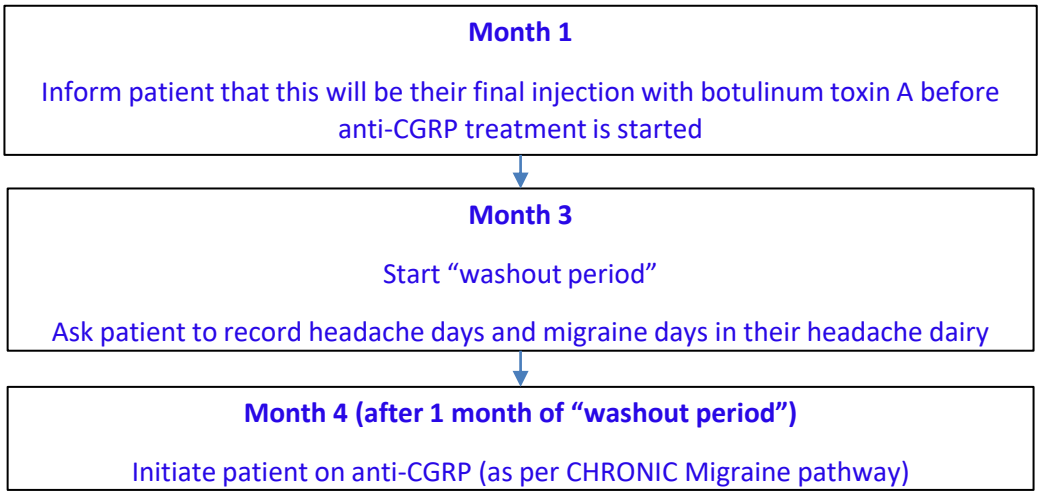
Note 4: One month washout period should be observed for patients switching from botulinum toxin A to anti-CGRP treatment (see appendix 1).

Note 5: BASH recommends that the need for ongoing treatment should be assessed on at least an annual basis. Clinicians might consider a treatment pause at an appropriate juncture, as experience from other preventive migraine treatments suggests that a proportion of patients will revert to a stable and manageable form of episodic migraine, and not require ongoing treatment. If treatment is reinstituted, a set period should be agreed before another treatment pause is undertaken.[1]

CHRONIC Migraine - SWL Drug Pathway

Version 3.1 (based on NICE with local agreements)

Appendix 1: Washout period for botulinum toxin A



Acknowledgements:
Kent and Medway CCG: The use of Botulinum toxin type A and calcitonin gene-related peptide inhibitors for preventing migraine in adults guidance

References:

1. British Association for the Study of Headache. Statement from the British Association for the Study of Headache (BASH) on the Implementation of NICE guidance on CGRP monoclonal antibodies (mAbs) for the prevention of migraine. June 2021.
2. British National Formulary: https://bnf.nice.org.uk/drug/erenumab.html
3. British National Formulary: https://bnf.nice.org.uk/drug/fremanezumab.html
4. British National Formulary: https://bnf.nice.org.uk/drug/botulinum-toxin-type-a.html
5. British National Formulary: https://bnf.nice.org.uk/medicinal-forms/galcanezumab.html
6. CKS guidance: https://cks.nice.org.uk/topics/migraine/
7. NICE CG150 - https://www.nice.org.uk/guidance/cg150
8. NICE Clinical Knowledge Summaries. Migraine. Last revised in February 2018 https://cks.nice.org.uk/migraine
9. NICE TA260: https://www.nice.org.uk/guidance/ta260/chapter/1-Guidance
10. NICE TA631: https://www.nice.org.uk/guidance/ta631/chapter/1-Recommendations
11. NICE TA631: https://www.nice.org.uk/guidance/ta659/chapter/1-Recommendations
12. NICE TA682: https://www.nice.org.uk/guidance/ta682/chapter/1-Recommendations
13. NICE TA764: https://www.nice.org.uk/guidance/ta764/chapter/1-Recommendations

Version number	Main amendments	Approved by	Approval date
1.0	SWL Drug Pathway – EPISODIC and CHRONIC Migraines- New pathway developed with SWL Neurology Clinical Network (Headache Hub) (03/11/2021)	SWL IMOC	15/12/2021
2.0	Add fremanezumab (TA764) as 3rd choice option (local agreement) to Episodic Migraine pathway	SWL IMOC	16/03/2022
3.0	Improved presentation of chronic migraine pathway to clarify that patients who lose response to Botulinum toxin 6 months after initiation or at 12 weekly reviews thereafter can switch to anti-CGRP	SWL IMOC	15/06/2022
3.1	Typing error in addendum 2, sentence corrected to read 'rimegepant' not 'eptinezumab' Removal of 'no' in appendix 1 under month 4 box Version numbering changed to differentiate between amendments to pathway and general fixes to document	N/A	N/A
Date of next review: June 2024 (or earlier if indicated)			

ADDENDUM 1

(Approved by SWL Integrated Medicines Optimisation Committee on 28 March 2023)

NICE published TA871 (Mar 2023) – Eptinezumab for preventing migraine.

This addendum aims to inform clinicians that eptinezumab is available as a treatment option for episodic and chronic migraine as per NICE TA871 and existing local agreements as follows:

Following a discussion between the responsible clinician and patient about the advantages and disadvantages of each treatment (considering therapeutic need, and likely adherence to treatment), if more than one treatment option is suitable, start with the least expensive drug (taking into account administration costs, dose needed and product price per dose).

- Anti-CGRPs 4th Choice: Eptinezumab (TA871)

* The SWL drug choices in the "SWL Inflammatory Migraine Pathway" are based on cost (using list price or nationally (NICE) / locally (LPP) agreed contract prices).

ADDENDUM 2

(Approved by SWL Integrated Medicines Optimisation Committee on 20 September 2023)

NICE published TA906 (July 2023) – Rimegepant for preventing migraine.

This addendum aims to inform clinicians that rimegepant is available as a treatment option for episodic migraine as per NICE TA906 and existing local agreements.

Following a discussion between the responsible clinician and patient about the advantages and disadvantages of each treatment (considering therapeutic need, and likely adherence to treatment), if more than one treatment option is suitable, start with the least expensive drug (taking into account administration costs, dose needed and product price per dose). Based on relative cost rimegepant will be available as follows:

- 1st choice: Erenumab (140mg) (TA682)
- 2nd choice: Rimegepant (TA906)

  Galcanezumab (TA659)
- 3rd choice: Fremanezumab (TA764)
- 4th choice: Eptinezumab (TA871)

* The SWL drug choices in the "SWL Inflammatory Migraine Pathway" are based on cost (using list price or nationally (NICE) / locally (LPP) agreed contract prices).