contraindications to triptans.[76] Repeated acute treatment with rimegepant does not appear to be associated with medication-overuse headache,[66,67] which makes it similar to ubrogepant[65] and may distinguish it from lasmiditan.[68]

Ubrogepant

Ubrogepant, the first drug in the gepant class to receive FDA approval for the acute treatment of migraine, has shown efficacy in two randomized controlled clinical trials.[34,35] In a 1-year open-label trial, 50 and 100 mg doses of ubrogepant used intermittently (one or two doses per attack) had good safety and tolerability, and the most common AEs were nausea, somnolence, and dry mouth; there was no evidence of medication-overuse headache, hepatotoxicity, or serious AEs.[77] In clinical practice, a substantial subset of patients may require two doses of ubrogepant to treat their attacks, as approximately 40% of ubrogepant-treated patients in clinical trials took an optional second dose of study treatment.[34,35]

To achieve cost-effective care while ensuring access to those most appropriate for these treatments, it is important that the criteria for initiating treatment with novel acute treatments are widely understood and closely followed (Table 3). To determine efficacy and tolerability, at least three attacks should be treated, and response to treatment should be evaluated using a validated acute treatment patient-reported outcome questionnaire or clinical assessment of improvement by the prescribing clinician.

Measuring response to acute treatment

The efficacy endpoints typically used in clinical trials may not fully reflect the outcomes valued by patients[78–80] or the importance of ease of use in forming patient perceptions of treatment. Failure to understand patient preferences may reduce adherence, discourage patients from continuing treatment, and limit the ability to match treatment with patient needs. Patient-oriented, validated outcome measures of acute treatment success can help to verify that patients have experienced a meaningful response and identify the need for adjustments to a therapeutic regimen (Appendix A).

PREVENTIVE TREATMENT

Goals

The goals of migraine prevention are to[22–24]:

- Reduce attack frequency, severity, duration, and disability.
- Improve responsiveness to and avoid escalation in use of acute treatment.
- Improve function and reduce disability.
- Reduce reliance on poorly tolerated, ineffective, or unwanted acute treatments.
- Reduce overall cost associated with migraine treatment.
- Enable patients to manage their own disease to enhance a sense of personal control.
- Improve health-related quality of life (HRQoL).
- Reduce headache-related distress and psychological symptoms.

Preventive treatments—pharmacologic, interventional, biobehavioral, neurostimulation, nutraceuticals, and lifestyle modification—are important parts of the overall approach for a proportion of people with migraine, and multiple evidence-based guidelines are available.[20,23,25–28] None of the currently available oral preventive treatments was designed specifically for migraine, and many oral preventive treatments have limited to moderate efficacy, moderate to high rates of AEs, contraindications, or interactions that limit use. These factors explain in part why few patients with migraine use preventive treatment (3%–13%), even though it is believed that nearly 40% of those with migraine with or without aura, and almost all of those with chronic migraine, in the general population would benefit.[8,81]

Indications

Patients with migraine should be considered for preventive treatment in any of the following situations[22–24]:

- Attacks significantly interfere with patients' daily routines despite acute treatment.
- Frequent attacks (Table 4).
- Contraindication to, failure, or overuse of acute treatments, with overuse defined as follows:
  a. Ten or more days per month for ergot derivatives, triptans, opioids, combination analgesics, and a combination of drugs from different classes that are not individually overused.
  b. Fifteen or more days per month for nonopioid analgesics, acetaminophen, and NSAIDs.
- AEs with acute treatments.
- Patient preference.

TABLE 4 Criteria for identifying patients for preventive treatment[8]

Prevention should be …	Headache days/month	Degree of disability required[a]
Offered	6 or more	None
	4 or more	Some
	3 or more	Severe
Considered	4 or 5	None
	3	Some
	2	Severe

[a]As can be measured by the Migraine Disability Assessment Scale, Migraine Physical Function Impact Diary, or Headache Impact Test.