New Canadian Guidelines Change Recommendations for Migraine Treatment

Migraine Canada's Position Paper

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Migraine Canada's Call to Action: We call on healthcare insurers, government bodies, and policymakers to ensure that people living with chronic or high frequency episodic migraine can access CGRP-targeting medications as first-line treatment options, without the need for prior failure of older preventive treatments. People with chronic migraine should also have access to onabotulinumtoxinA as first line therapy. This will enable better management of migraine, improve patient quality of life, and reduce the broader societal costs associated with this debilitating condition.

It is Migraine Canada's position that CGRP-targeting medications and onabotulinumtoxinA are effective, well-tolerated, and essential treatment options for many patients with migraine. It is time to update existing treatment access policies. Insurance companies, public payers, and policymakers should align their coverage decisions with the evolving clinical evidence presented in the updated guidelines from the Canadian Headache Society and as recommended by several other leading headache societies. The document below provides the rationale for why Migraine Canada has taken this position.

Based on research studies and clinical experience in treating people with migraine, it is now well established that the new migraine preventive treatments targeting the calcitonin gene-related peptide (CGRP) system work as well as older traditional oral migraine preventive medications and tend to have fewer side effects. While the older preventive medications may work for some people, many patients stop them because they don't work well, or because of side-effects. A large American study found that after six months, only about 27% of patients started on an older medication were still taking it, and at 12 months, only 20% were.[1]

The newer CGRP-related preventive medications currently available in Canada include the CGRP monoclonal antibodies (CGRP mAbs) such as erenumab, fremanezumab, galcanezumab, and eptinezumab, and the gepant medications (atogepant). The older oral preventive medications include propranolol, topiramate, amitriptyline, and others.

Nevertheless, it is common practice for insurance companies and public payers to demand that patients with migraine fail one or more of the older traditional preventive medications before they can access coverage for CGRP-related medications or onabotulinumtoxinA.

Although the older medications are less expensive, they may not always be the best first choice. For individuals who suffer frequent disabling migraine attacks that result in missed work and family time, the cost of the newer medications may be justified as first line. This is likely true for patients with chronic migraine (CM), a disorder characterized by ≥15 headache days per month with at least 8 migraine days, that can cause significant disability and greatly reduce quality of life. The Canadian Headache Society has recently published updated migraine prevention guidelines for Canada that should change migraine treatment for the better[2]. After a thorough and rigorous review of the literature by experts in migraine management, the guidelines concluded that, given the high degree of disability experienced by those with CM and the efficacy and favourable side effect profile of onabotulinumtoxinA and the CGRP-related medications, they should "be considered first line among other treatments for chronic migraine and high frequency episodic migraine with moderate disability."

The American Headache Society agrees.[3] It stated in its 2024 position statement: "The CGRP-targeting therapies should be considered as a first-line approach for migraine prevention along with previous first-line treatments without a requirement for prior failure of other classes of migraine preventive treatment." This is another way of saying that, depending on the patient, it may be reasonable to prescribe a CGRP-related medication first, eliminating the need to try and fail older oral preventive medications first.

Interestingly, the Europeans came to this conclusion sooner than the Americans: they said much the same thing in the 2022 European Headache Federation Guideline.[4]

While CM represents the more severe end of the migraine spectrum, many of those with migraine who experience 8 to 14 migraine days a month (high-frequency) should also be considered for first line use of the CGRP-related medications for migraine attack prevention. Recent papers have highlighted that the disability burden experienced by migraine patients is driven by number of monthly migraine days and that many patients with episodic migraine who have 8 or more migraine days per month experience a high degree of disability comparable to patients with chronic migraine.[5,6,7,8]

Evidence from Canadian headache centers suggest that direct and indirect (missed workdays, etc.) costs were almost equivalent for patients experiencing high-frequency migraine versus CM.[9] Therefore the Canadian Headache Society has recommended that the CGRP-related medications also be first line among other treatments for high frequency episodic migraine patients with moderate disability.[2]

The Canadian Headache Society Migraine Prevention Guidelines are based upon the best available research evidence and practice experience and are aligned with international guidelines on the same topic. We strongly urge payers to follow the published guidelines in their approval process. People with migraine deserve nothing less.

References

1. Hepp Z et al. Adherence to oral migraine-preventive medications among patients with chronic migraine. Cephalalgia 2015; 35:478-88.
2. Medrea I, Cooper P, Langman M. et al. Updated Canadian Headache Society Migraine Prevention Guideline with Systematic Review and Meta-analysis. The Canadian Journal of Neurological Sciences, https://doi.org/10.1017/ cjn.2024.285.
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. Sacco S. et al. European Headache Federation guideline on the use of monoclonal antibodies targeting the calcitonin gene related peptide pathway for migraine prevention – 2022 update. J Headache Pain. 2022; 23(1): 67.
5. Chalmer MA, et al. Proposed new diagnostic criteria for chronic migraine. Cephalalgia. 2020 Apr;40(4):399-406.
6. Ishii R,et al. Chronic versus episodic migraine: The 15-day threshold does not adequately reflect substantial differences in disability across the full spectrum of headache frequency. Headache. 2021 Jul;61(7):992-1003.
7. Torres-Ferrús M, et al. When does chronic migraine strike? A clinical comparison of migraine according to the headache days suffered per month. Cephalagia. 2017 Feb;37(2):104-113.
8. Lipton RB, Reed ML, Fanning KM. Exploring the boundaries between episodic and chronic migraine: results from the cameo study. Headache. 2020;60(S1 suppl). 1—156. doi: 10.1111/head.13854.
9. 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.