North Central London
Joint Formulary Committee

Prevention of Migraine (Chronic and Episodic) Prescribing Pathway in Adults

Document control

Date	Version	Amendments
Oct 2025	1.0	New pathway

Groups / Individuals who have overseen the development of this guidance:	NCL HCD Team, NCL Specialist Clinicians and Pharmacists, NCL Joint Formulary Principal Pharmacist
Groups which were consulted and have given approval:	NCL wide consultation (NCL Formulary Pharmacists, NCL Specialist Clinicians), NCL Joint Formulary Committee (Sept 2025)
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Review date:	October 2028 (or sooner if updates required e.g. NICE TAs)

Disclaimer

This guideline is registered at North Central London (NCL) Joint Formulary Committee (JFC) and is intended solely for use by healthcare professionals to aid the treatment of patients within NCL. However, clinical guidelines are for guidance only, their interpretation and application remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Clinicians are advised to refer to the manufacturer's current prescribing information before treating individual patients.

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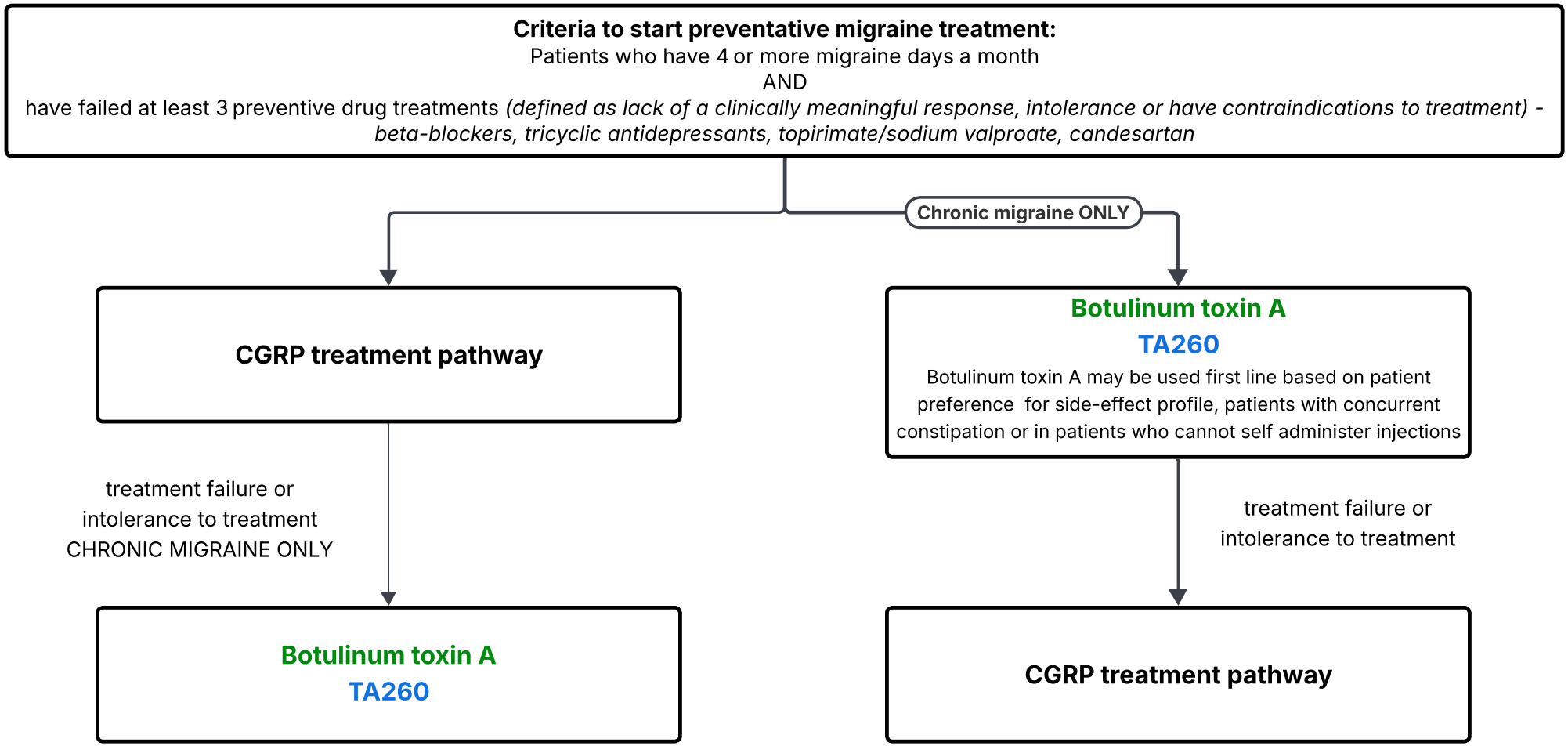
Prevention of migraine (chronic and episodic) in adults

Green: lowest cost Amber: moderate cost Red: highest cost.
If more than one treatment is suitable, the least expensive treatment should be used.



Commissioning notes:

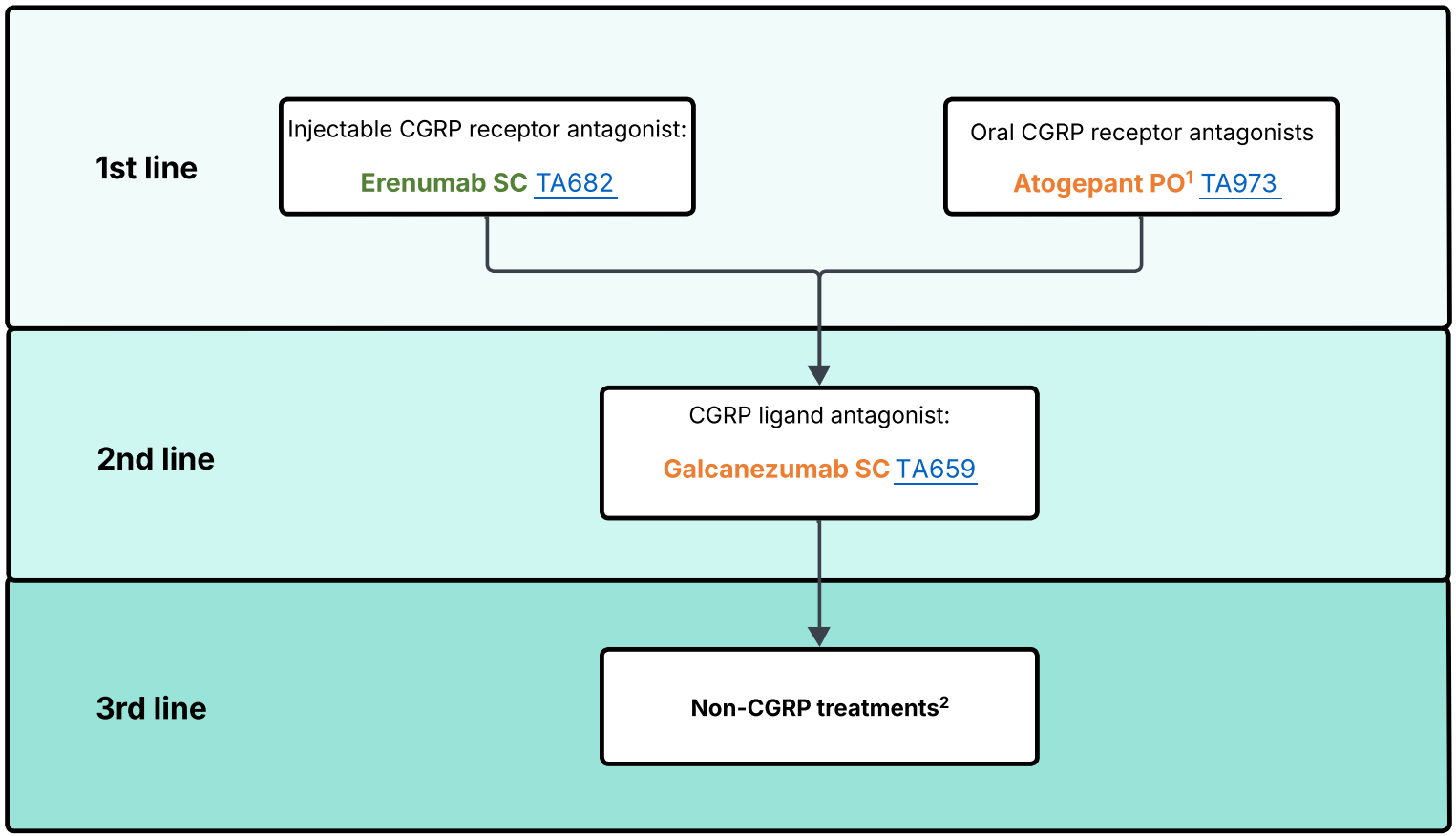
Sequential treatments routinely commissioned: Up to one drug per mechanism of action. If more than one treatment is suitable, the least expensive treatment should be used (see RAG rating above).

Continuation of biologic treatment - Treat for 12 months or until treatment failure. Reassess in line with NICE criteria to determine whether ongoing treatment is still clinically appropriate.

Adverse drug reactions (ADRs) – For patients who experience an immediate ADR [within 1 month] or have responded to treatment but experience an ADR within 6 months of treatment initiation, another treatment option within the same mechanism of action (if available and appropriate) can be accessed. Where the ADR is likely to be a drug class effect, an alternative mechanism of action is preferable.

CGRP treatments for prevention of migraine

Green: lowest cost **Amber**: moderate cost **Red**: highest cost.
If more than one treatment is suitable, the least expensive treatment should be used.



[1] Atogepant is preferred if an oral treatment is needed.
- After 12 week initiation and stabilisation period, prescribing can be transferred to primary care.
- Consider prospective GP agreement to transfer prescribing once stabilised.
- For episodic migraine, atogepant preferred over rimegepant

Criteria to change to alternative mode of action/second line treatment:
- Treatment not effective (primary loss of efficacy)
- Treatment not tolerated
- Waning of treatment effect following initial response (secondary loss of efficacy)

[2] Non-CGRP treatments include:
- botulinum toxin A (if not previously tried prior to CGRP treatment) or
- occipital nerve stimulation NICE IPG452
- both treatments for chronic migraine only

Commissioning notes:

Fremanzeumab (TA764), Eptinezumab (TA871), Rimegepant (TA906) also available but not preferred. See clinical considerations notes below

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Commissioned treatments with RAG rating based on cost:

Drug	Mode of action	Price	Usual maintenance	Dose escalation
Botulinum toxin type A (Chronic migraine only)		£	155-195 units every 12 weeks (as per specialist)	Not available
Erenumab	CGRP receptor antagonist	£	140mg every 4 weeks Note: 70mg every 4 weeks also licensed but NOT recommended by NICE/commissioned	Not available
Rimegepant (Episodic migraine only)	CGRP receptor antagonist	££	75mg oral daily on alternate days	Not available
Atogepant	CGRP receptor antagonist	££	60mg oral daily	Not available
Galcanezumab	CGRP ligand antagonist	££	120mg SC once a month	Not available
Fremanezumab	CGRP ligand antagonist	££	225mg SC once a month, alternatively 675mg SC every 3 months	Not available
Eptinezumab	CGRP ligand antagonist	£££	100mg every 12 weeks	Not available

* **Green (£)**: lowest cost **Amber (££)**: moderate cost **Red (£££)**: highest cost

Glossary

Episodic migraine	Less than 15 headache days per month
Chronic migraine	15 or more headache days a month for more than 3 months with at least 8 of those having features of migraine
CGRP	Calcitonin Gene-Related Peptide

Other preventative treatments available for secondary care initiation:

- Duloxetine (if depression co-morbidity)
- Sodium valproate
- Pizotifen
- Flunarazine (if none of above suitable)

Preventative treatment should be tried for at least 3 months at the maximum tolerated dose

Assessment of response:

Assess initial induction response after 12 weeks (as per NICE guidance):

Drug	Episodic	Chronic	Eligible for transfer to GP if adequate response after 12 weeks
Rimegepant (not commissioned for Chronic migraine)	≥50% reduction in migraine frequency	≥30% reduction in migraine frequency	✓
Atogepant			✓
Erenumab			×
Galcanezumab			×
Fremanezumab			×
Eptinezumab			×

For all treatments stop treatment after 12 weeks of treatment if patient's migraine frequency does not meet NICE continuation criteria.

Criteria to change to alternative mode of action/second line treatment:

- Treatment not effective (primary loss of efficacy)
- Treatment not tolerated
- Waning of treatment effect following initial response (secondary loss of efficacy)

Clinical considerations

Risk of hypertension (NCL JFC Oct 2021)

- All patients initiated on a CGRP inhibitor should be advised of a small risk of hypertension. Patients to agree to monitor their blood pressure at baseline, Day 1, 2, 7, 28 and 84.
- For patients who have controlled or poorly controlled hypertension, a choice of first line CGRP inhibitor should be offered.
- Patients who are severely hypertensive should not receive CGRP inhibitors (erenumab, galcanezumab or fremanezumab).

Constipation

- Constipation with serious complications has been reported with erenumab. History of constipation or the concurrent use of medicinal products associated with decreased gastrointestinal motility may increase the risk for more severe constipation and the potential for constipation-related complications. Treatments other than erenumab may be preferred in these cases.
- Patients should be warned about the risk of constipation and advised to seek medical attention in case constipation does not resolve or worsens. Patients should seek medical attention immediately if they develop severe constipation.
- For severe constipation, discontinuation of treatment should be considered.

Patients already established on non-preferred treatment privately (NCL JFC Apr 2021)

- Patients already established on treatment with a non-NCL preferred CGRP inhibitor from a private provider should be encouraged to switch to the preferred NCL product when NHS treatment commences. However, after discussion between clinician and patient, treatment may continue the treatment established privately providing the patient meets NICE criteria.

Fremanezumab

- Fremanezumab can be administered at 4 weekly or 12 weekly intervals. 12 weekly dosing interval may be considered for patients preferring a longer dosing interval – those that travel frequently or who require the injection to be administered for them.

Eptinezumab

- Eptinezumab has practical implications for administration- IV route and associated healthcare resource implications.

Botulinum A toxin

- Botulinum toxin has practical implications of administration - 12 weekly attendance for multiple injections required. Waiting time to access may also be a factor.

Oral CGRP inhibitors

- Rimegepant and atogepant for prevention of migraine:
  - Rimepegpant has **alternate day** dosing
  - Atogepant has **daily** dosing
  - For both medications consider prospective GP agreement to transfer prescribing once stabilised
- Dose reduction to 10mg daily is required for atogepant if concomitant use with strong CYP3A4 inhibitors (e.g., clarithromycin, itraconazole, ritonavir). Concurrent use with rimegepant not recommended. See relevant SmPC for full drug interaction guidance.

When to stop oral or injectable CGRP therapy after successful treatment

Where oral or injectable CGRP therapy has been used effectively (as defined by NICE criteria) for prevention of migraine and efficacy is maintained, treatment can be stopped after a period of 1-2 years.

Audit standards

Audit standards provide a framework for monitoring clinical effectiveness, financial accountability, and governance of NCL High Cost Drugs Pathways. These standards have been agreed across clinical teams in NCL Trusts and NCL ICB and are to be monitored on agreed timescales. Embedding audit standards into routine practice allows outcomes to be tracked, variations to be identified, and pathways to be continuously improved, ensuring both high-quality patient care and the sustainable use of NHS resources.