Preventive treatment of migraine

The AHS 2021 Consensus Statement recommends that preventive treatment should be considered for patients whose attacks significantly interfere with daily routines despite acute treatment; for those who have frequent attacks, intolerance or contraindication(s) to acute treatments, or failure or overuse of acute treatments; or based on patient preference[1a]

The AHS 2021 Consensus Statement[1] and the 2024 Updated Position Statement[2]

Use evidence-based treatments[1,2]

2024 Update: CGRP-targeting migraine therapies are a first-line option for migraine prevention. Initiation of these therapies should not require trial and failure of non-specific migraine preventive medication approaches.[2]

Classes of agents[b] with an FDA-approved indication for preventive treatment of migraine[c] include:

- **Oral treatments: anticonvulsants, beta-blockers, gepants**
- **Intramuscular injection: neuromuscular blocking agent**
- **Subcutaneous injection: anti-CGRP monoclonal antibodies**
- **Intravenous infusion: anti-CGRP monoclonal antibodies**

Allow an adequate trial before switching[1]

Oral treatments:
≥8 weeks at target therapeutic dose or usual effective dose

Neuromuscular blocking agent:
After ≥2 quarterly injections (6 months)

Anti-CGRP mAbs:
≥3 months (monthly administration) or ≥6 months (quarterly administration)

CGRP, calcitonin gene-related peptide; HIT, Headache Impact Test; IV, intravenous; mAb, monoclonal antibody; MIDAS, Migraine Disability Assessment; MHD, monthly headache day; MMD, monthly migraine day.
[a]Overuse defined as use of ergotamine derivatives, triptans, opioids or combination analgesics on ≥10 days/month for >3 months, or use of nonopioid analgesics, nonsteroidal anti-inflammatory drugs or simple analgesics on ≥15 days/month for >3 months. "Frequent attacks" includes ≥3 monthly headache days with severe disability, ≥4 monthly headache days with some disability or ≥6 monthly headache days without disability; [b]Only specific medications within each class are recommended in the AHS 2021 Consensus Statement[1]; [c]The 2021 AHS Consensus Statement identifies additional agents with evidence of efficacy in migraine prevention which do not possess FDA approval for that use; see the Consensus Statement for the full list.[1]

1. Ailani J, et al. Headache 2021;61:1021–39; 2. Charles AC, et al. Headache 2024; 64:333-41.