

The Polish Headache Society and the Headache Section of the Polish Neurological Society Consensus Statement: update on new pharmacological therapies for migraine in clinical practice and public medication reimbursement program for chronic migraine

Izabela Domitrz¹, Wojciech Kozubski², Jacek J. Roźniecki³, Adam Stępień⁴,
Magdalena Boczarska-Jedynak⁵

¹Department of Neurology, Faculty of Medical Sciences, Medical University of Warsaw, Warsaw, Poland

²Department of Neurology, Poznan University of Medical Sciences, Poznan, Poland

³Department of Neurology, Stroke, and Neurorehabilitation, Medical University of Lodz, Lodz, Poland

⁴Department of Neurology, Military Institute of Medicine, Warsaw, Poland

⁵Health Institute, Neurology and Restorative Medicine, Oswiecim, Poland

Submitted: 15 August 2022; **Accepted:** 9 September 2022

Online publication: 7 November 2022

Arch Med Sci 2022; 18 (6): 1705–1707

DOI: <https://doi.org/10.5114/aoms/153955>

Copyright © 2022 Termedia & Banach

Corresponding author:

Izabela Domitrz
Department of Neurology
Faculty of Medical Sciences
Medical University of Warsaw
80 Ceglowska St
01-809 Warsaw, Poland
Phone: +48 22 569 05 92
E-mail: izabela.domitrz@wum.edu.pl

The latest paper concerning the management of migraine in Poland was published in 2021 [1] and the previous one (in Polish) in 2019. The Polish recommendations were based on the guidelines of migraine treatment developed by the European Headache Federation (EHF, 2019) [2] and the American Headache Society (AHS) published in 2021 [3]. The Polish guidelines took into consideration special Polish conditions and therapeutic options available in Poland, in regard to the Summary of Product Characteristics of the drugs with indication for use in migraine, the evidence-based medicine approach, good clinical practice rules, and the knowledge and experience of the experts of the Polish Headache Society (PHS/PTBG), the Headache Section of the Polish Neurological Society (HSPNS/SBGPTN), and the Polish Pain Society (PPS) [1]. It should be underlined that both the EHF and the AHS have also updated the migraine treatment guidelines/statements recently [4, 5].

Both the above-mentioned societies have approved the use of monoclonal antibodies (mAbs) against calcitonin gene related peptide and its receptor (CGRP/CGRP-R) for the prevention of migraine in patients aged 18 years or older who are diagnosed with chronic migraine according to the criteria of the International Classification of Headache Disorders, third edition (ICHD-3) [6], or who have episodic migraine with at least 4 headache days per month [6]. Initially, in the publications from 2021 (AHS) [3] and 2019 (EHF) [2] mAbs against CGRP/CGRP-R were recommended in those who had contraindications, did not tolerate or had no response to at least 6-week treatment courses with at least two of the following medications (combining/including recommendations in episodic and chronic migraine): topiramate, valproic acid, β -blockers (metoprolol, propranolol, timolol, atenolol, nadolol), tricyclic antidepressants (amitriptyline, nortriptyline), serotonin reuptake inhibitors (venlafaxine,

duloxetine) or other level A or B treatments, and, in the case of chronic migraine specifically, onabotulinum toxin type A (ONA-BoNTA), as well. In the light of the reimbursement program in Poland mentioned below [7, 8] it needs to be stressed that ONA-BoNTA is obligatory therapy used first before a patient changes the treatment to mAbs in the prophylaxis of chronic migraine. What is interesting, the latest AHS/EHF statements from this year [4, 5] clearly emphasize that the mAbs anti-CGRP/CGRP-R may be the first choice medications and there is no need for any prior treatment with the above-mentioned substances. It is important to state that many experts, including Polish national experts (PHS/PTBG, HSPNS, PPS), maintain and stated that a very good safety profile and high clinical efficacy make mAbs against CGRP/CGRP-R the first-line treatment for chronic migraine, and even for episodic pain with frequent attacks [1]. The Polish reimbursement program for the treatment of chronic migraine announced by the Ministry of Health on July 22, 2022, however, has some specific regulations. For economic reasons, this new program is based on “two lines” of treatment; however, in fact, there

is a three-step therapeutic approach (Figure 1). The initial line of chronic migraine treatment includes unsuccessful treatment with at least two “classical” oral medications (out of three: valproic acid and its derivatives, topiramate, amitriptyline) and documented failure of treatment with these oral medications recommended in Polish conditions. The first line of treatment in the reimbursement program is ONA-BoNTA in the dose of up to 195 U, according to the PREEMP (PREEMPT – Phase III Research Evaluating Migraine Prophylaxis Therapy) protocol. If this therapy fails (which is evaluated after 3 cycles of therapy every 12 weeks), patients can be treated with the “second line medications” – mAbs: erenumab 140 mg s.c. monthly or fremanezumab 225/675 mg s.c. monthly/quarterly. The other two mAbs are currently not reimbursed, but galcanezumab will probably be included in this program soon, followed by eptinezumab, the only one administered intravenously every 3 months. Table I shows the drugs recommended by the PHS/HSPNS.

Treatment efficacy should be assessed and the decision about the continuation of the treatment should be made after 3 administrations (9 months) of ONA-BoNTA or 3 months from the first administration of mAb anti-CGRP/CGRP-R. Treatment is considered to be effective if reduction in monthly headache/migraine days reaches at least 50%, relative to the pre-treatment baseline month, based on the obligatory patient’s headache diary. Functional deterioration of the patient assessed as a Migraine Disability Assessment (MIDAS) score of at least 30% is a reason to restart the therapy, after the end of treatment in accordance with the program’s regulations.

All details of the chronic migraine reimbursement program are available on websites of the Ministry of Health and the National Health Fund [7, 8], and a detailed description and interpretation with possible misinterpretation considering any doubts will be published by PHS/HSPNS in Polish, just before the program enters into force.

It is worth adding that more new medications will probably be included in the migraine recommendations soon. The small-molecule CGRP re-

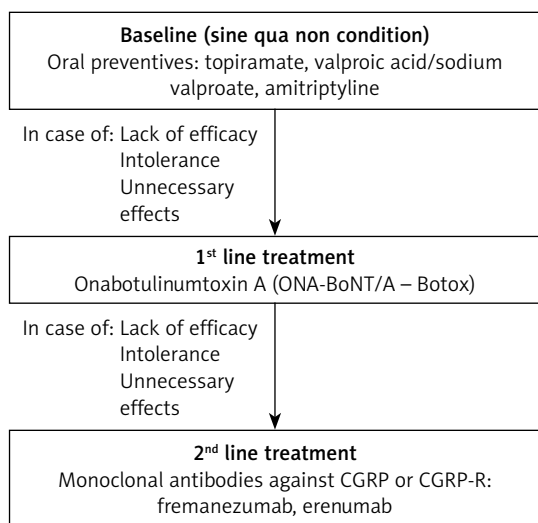


Figure 1. Public medication reimbursement program for chronic migraine strategy for treatment of chronic migraine

Table I. Drugs used for prophylactic treatment in chronic migraine, doses, and class according to PHS/HSPNS recommendation

Drug	Dose	Recommendation
Valproic acid/sodium valproate	500–1500 mg daily	A
Topiramate	50–200 mg daily	A
Amitriptyline	50–150 mg daily	B
ONA-BoNTA	155–195 IU every 12 weeks	A/B
mAbs-CGRP/CGRP-R	1×/4 weeks or 12 weeks	A

PHS – Polish Headache Society, HSPNS – Headache Section of Polish Neurological Society, ONA-BoNTA – onabotulinum toxin type A, mAbs – monoclonal antibodies.

ceptor antagonists known as gepants, which have shown efficacy in acute (rimegepant, ubrogepant, zavegepant) or prophylactic (atogepant, rimegepant) migraine treatment, are approved by the US Food and Drug Agency (FDA) and one of them (rimegepant) by the European Medicines Agency (EMA) for the treatment of episodic (but not chronic) migraine. Recently, rimegepant has become available in Europe and Poland in oral disintegrated tablets in the dose of 75 mg every 2 days prophylactically, or 75 mg daily as an abortive rescue.

Ditans are the next new option in abortive therapy of migraine. This novel acute migraine treatment class of medications targets the 5-HT_{1F} receptor, but until now, the whole group has not been approved by the EMA.

Summing up, it should be emphasized that the first reimbursed migraine advanced medication treatment program is a real milestone in the attitude to migraineurs in Poland. Although it is based on economic compromise, experts in the treatment of migraine, including the chronic form of the disease, emphasize that we now have increasingly effective tools to cope with migraine, and this would significantly increase the number of people who benefit among those suffering from migraine, especially its chronic form – the most severe form of this disabling condition. Innovative drugs with higher efficacy and a superior safety profile, although also with higher costs, than standard-of-care drugs are to be promoted as they produce an indirect economic benefit by reducing loss of efficiency or work absence [9] and healthcare resource use costs. Some authors [10] observed a high discontinuation rate for migraine prophylaxis which is related to an increase in healthcare resource use and costs for non-persistent patients. Those [9, 10] recent results suggest that the standard-of-care treatment adherence implies a clinical benefit, a reduction in health resource use and costs. New therapeutic options in several years' observation, including in real life, show high effectiveness and a better safety profile than antiepileptics and antidepressants used in CM, although it is worth emphasizing the fact of the lack of comparative studies between the options level A treatment for chronic migraine, except for topiramate [11], and the potential benefits of choosing the first drug based on other comorbidities and other factors as is considered in the American Academy of Neurology.

Acknowledgments

Izabela Domitrz and Wojciech Kozubski equally the first authors and both conceived and designed the paper.

Conflict of interest

ID has served as an expert on advisory boards and as a lecturer for the following companies: Allergan AbbVie, Novartis, Teva, Elli Lilly; WK has served as an expert on advisory boards and as a lecturer for the following companies: Allergan AbbVie, Novartis, Teva, Elli Lilly; AS has served as an expert on advisory boards and as a lecturer for the following companies: Allergan AbbVie, Novartis, Teva, Elli Lilly; JJR has served as an expert on advisory boards and as a lecturer for the following companies: Allergan AbbVie, Novartis, Teva, Elli Lilly. MBJ has contracted advisory boards, consultations and lectures for Allergan AbbVie, Novartis and Teva.

References

1. Stępień A, Kozubski W, Roźniecki JJ, Domitrz I. Migraine treatment recommendations developed by an Expert Group of the Polish Headache Society, the Headache Section of the Polish Neurological Society, and the Polish Pain Society. *Neurol Neurochir Pol* 2021; 55: 33-51.
2. Sacco S, Bendtsen L, Ashina M, et al. European headache federation guideline on the use of monoclonal antibodies acting on the calcitonin gene related peptide or its receptor for migraine prevention. *J Headache Pain* 2019; 20: 6.
3. Ailani J, Burch RC, Robbins MS; Board of Directors of the American Headache Society. The American Headache Society Consensus Statement: Update on integrating new migraine treatments into clinical practice. *Headache* 2021; 61: 1021-39.
4. Sacco S, Amin FM, Ashina M, 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: 67.
5. Burch RC, Ailani J, Robbins MS. The American Headache Society Consensus Statement: update on integrating new migraine treatments into clinical practice. *Headache* 2022; 62: 111-2.
6. Headache Classification Committee of the International Headache Society (IHS). The International Classification of Headache Disorders, 3rd edition. *Cephalalgia* 2018; 38: 1-211.
7. <https://www.gov.pl/web/zdrowie/obwieszczenia-ministra-zdrowia-w-sprawie-wykazu-refundowanych-lekow-srodkow-spozywcznych-specjalnego-przeznaczenia-zywniowego-oraz-wyrobow-medycznych-ktory-wejdzie-w-zycie-1-lipca-2022-r>
8. <https://www.nfz.gov.pl/zarzadzenia-prezesa/zarzadzenia-prezesa-nfz/zarzadzenie-nr-912022dgl,7546.html>
9. Shimizu T, Sakai F, Miyake H, et al. Disability, quality of life, productivity impairment and employer costs of migraine in the workplace. *J Headache Pain* 2021; 22: 29.
10. Irimia P, García-Azorín D, Núñez M, et al. Persistence, use of resources and costs in patients under migraine preventive treatment: the PERSEC study. *J Headache Pain* 2022; 23: 78.
11. Reuter U, Ehrlich M, Gendolla A, et al. Erenumab versus topiramate for the prevention of migraine – a randomised, double-blind, active-controlled phase 4 trial. *Cephalalgia* 2022; 42: 108-18.