Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/neurofrontiers/rethinking-migraine-prevention-with-cgrp-therapies/49108/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Rethinking Migraine Prevention: Where CGRP-Targeting Therapies Fit

Dr. May:
This is *NeuroFrontiers* on ReachMD, and I'm Dr. Alexandria May. Joining me to discuss the role of CGRP-targeting therapies in optimizing migraine prevention is Dr. Nina Riggins. She's a board-certified neurologist and headache specialist at the Headache Center of Excellence in Palo Alto, California, specializing in headache medicine, migraine, and facial pain disorders. Dr. Riggins, welcome to the program.

Dr. Riggins:
Thank you so much for having me.

Dr. May:
Well, let's dive right in, Dr. Riggins. Recent meta-analyses from 2023 to 2025 suggest that CGRP-targeting therapies can match—or even exceed—oral preventives in reducing monthly migraine days, with improved tolerability and lower discontinuation rates. So what stands out to you the most from these findings, and how are they influencing your current approach to preventive therapy selection?

Dr. Riggins:
We are very happy that we now have specific migraine therapies, and we have an American Headache Society position statement from 2024 led by headache specialists who published that we don't have to wait until everything else fails to work for our patients living with migraine and other headache disorders to try newer therapies. CGRP-blocking antibodies or small molecules can be comparable in efficacy for many people with migraine, and they also can have fewer side effects than some of the older therapies.

Dr. May:
Building on that, updated guidelines from major neurological societies now position CGRP-targeting therapies as appropriate after failure of one or two oral preventives, and they could even be used earlier in select patients. From your vantage point, how are these evolving recommendations changing real-world treatment sequencing?

Dr. Riggins:
So based on this 2024 position statement from the American Headache Society and what we're learning after that in real life and in publications, we're collecting information which all supports that we should be using it not at the end of our toolbox, but sometimes in the beginning—for example, when we have contraindications to older therapies, this would make sense for multiple people.

One of the points I wanted to bring up is that with big molecules or CGRP-blocking antibodies—and we now have four of them available to use in clinical practice—we can use and think about them when there are many other medications on board because there is no significant medication-to-medication interaction. So they don't go through the liver the way small molecules do. And because they don't do that, we don't usually have to dwell on drug-drug or medication-to-medication interactions with our big CGRP-blocking antibodies. We still have to do it with CGRP-blocking small molecules; they're called gepants. So for those, we do check medication-to-medication interactions in people who are also taking medications for other conditions or even for the same condition.

Dr. May:
Now, even with comparable efficacy across options, treatment decisions are rarely based on efficacy alone. So what other factors do you consider when choosing between traditional oral preventives and CGRP-targeting therapies for these patients?

Dr. Riggins:
It's an important moment in our conversation with patients and in patient-centered medicine to identify if there are other comorbidities or

situations when a person in the clinic room is preparing to start school or work and wants to try to avoid cognitive side effects, for example. Or maybe there is a situation when we want to work on weight loss, and some of our medications can help with that as an additional benefit in addition to migraine management.

In patient-centered medicine, we're trying to address all comorbidities and symptoms, preferably with fewer medications. So in addition to consultation about lifestyle and about what's available on the scope of headache medications, we take into consideration their goals. We do have a warning on CGRP-blocking medications that we have to keep an eye on people not developing constipation. We have to keep an eye on people not having elevated blood pressure.

So it's all part of the discussion, and we need to know that the medications we recommend are not contraindicated. And when we can, we would choose a medication that would help other comorbidities and conditions. An example would be the use of medications for blood pressure and migraine to decrease blood pressure or the use of medications that belong to an antidepressant class to help with sleep and mood for some people.

And of course, we work in collaboration with our colleagues—mental health, primary care, women's health, and many others, such as endocrinology—as appropriate to help our patients.

Dr. May:
As a follow-up to that, real-world data suggests that adherence to daily oral preventives often declines within the first six months, while longer-interval dosing with monoclonal antibodies may improve persistence. Given that data, how do you weigh adherence patterns when deciding between daily oral options and our less frequent CGRP-targeting therapies?

Dr. Riggins:
It's very important that a person feels comfortable enough to take a medication side effect-wise. And sometimes, side effects will prevent people from continuing their medications. It's also important to have a more comfortable schedule. Getting medications once a month or once every three months can help patients be adherent to the regimen.

An example of a side effect that is mostly unwanted nowadays would be valproic acid-associated weight gain. An example of a medication people liked for losing weight in the past would be topiramate. But now, we have data that one of the newer medications—atogepant—shows statistically significant weight loss for many people. When people get help losing weight, they have the ability to exercise more, and their lifestyle improves. We do have multiple studies showing how exercise can help manage migraine, and part of lifestyle is, of course, doing stress reduction techniques and a better sleep schedule. And if a headache doesn't wake up people at night, that's very beneficial.

So it's a whole complex conversation we have when we incorporate our medications in the treatment plan.

Dr. May:
For those just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm Dr. Alexandria May, and I'm speaking with Dr. Nina Riggins about integrating CGRP-targeting therapies into migraine preventive care.

Now, as therapeutic options expand, patient preference has become more central to the decision-making process. In your experience, Dr. Riggins, what factors seem to matter the most to patients, and in what ways do those preferences influence your final selection?

Dr. Riggins:
Headache and migraine are not the same. Migraine is not just a headache. We should be treating the whole person, not just pain. We should be treating and addressing the other symptoms that can come with migraine. An example would be cognitive symptoms. We have to address dizziness.

We do have this conversation with our patients who live with migraine that we have to keep headache diaries, and we use them as a way of giving control back to the patients with migraine. So they can see which medication, lifestyle modification, or device was helping them, and then we continue things that are helpful and discontinue things that don't help us. We review the headache diary at our appointments, and just listening to our patients is the most impactful and important thing in headache medicine.

Dr. May:
Lastly, Dr. Riggins, based on the evidence and experience you've shared with us today, which patients may benefit most from earlier intervention with CGRP-targeting therapies, and where do you still see a role for traditional oral preventives?

Dr. Riggins:
We believe that addressing all questions about how frequently a person has migraine and, above the pain, addressing the other symptoms that come with headache is very important. If a patient reports different conditions that come with that, we try to choose the

medication that could be helpful with those conditions too, as we did with the example of blood pressure. Regarding side effects, what a person would like to achieve can help us choose between medications of older classes but also move on to newer medications whenever possible.

And we can explain that in the letter, and even attaching the headache diary to insurance companies could help. At times, we need to say that I could not recommend a medication that decreases blood pressure because this person already has low blood pressure. So that's helpful. Medical documentation is extremely important. We document everything after listening to the patient—comorbidities, frequency of migraine, and what they tried in the past that was helpful and what was not.

And moving newer migraine medications into first-line therapy would be nice when we can achieve it and when appropriate. We've been using them really comfortably now for a few years, and it changes life for the better for many people.

Dr. May:
With those final comments in mind, I want to thank my guest, Dr. Nina Riggins, for joining me to discuss the evolving role of CGRP-targeting therapies in migraine prevention. Dr. Riggins, it was great having you on the program.

Dr. Riggins:
Thank you so much for having me.

Dr. May:
For ReachMD, I'm Dr. Alexandria May. To access this and other episodes in our series, visit *NeuroFrontiers* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.