NHF InSights™: Primary Care/APP
Why Migraine Prevention Matters in Primary Care

Jaclyn Duvall, MD:
Welcome to the National Headache Foundation's podcast, NHF InSights. The NHF InSights podcast opens discussion on the latest research findings and treatments for primary care providers caring for people living with migraine attacks. I'm today's host, Dr. Jaclyn Duvall. I'm a board-certified neurologist, UCNS certified headache specialist, and founder of Headache Specialists of Oklahoma. I'm also a board member of the National Headache Foundation.

In today's episode, we're going to cover a lot of information quickly. We're going to start with why prevention matters, especially in a primary care office, where primary care providers will manage about 70% of people with migraine. We'll talk about how primary care providers who are busy and tasked with a lot of disease states and a lot of preventive maintenance get a quick start diagnosis for patients. Plus learn more about migraine, acute and preventive treatments following this podcast. We want to talk about the importance of migraine specific medications as first-line treatment, and what primary care's role can be in bringing care and hope to these patients. Lastly, how new research such as the TEMPLE Phase 3 study can inform primary care considerations.[i]

To help me explore these topics, I'd like to welcome Dr. Stewart Tepper, vice president of the New England Institute for Neurology and Headache in Stamford, Connecticut, who has published more than 520 articles and books on headache medicine, to this episode of InSights. Dr. Tepper, welcome.

Stewart Tepper, MD:
Thank you. Great honor to be here.

Jaclyn Duvall, MD:
I'd like to start, Dr. Tepper, with you please sharing a bit about your background and specifically examples of your connections with the primary care community.

Stewart Tepper, MD:
I'm a neurologist, but I'm married to a primary care practitioner. And so, I've certainly learned from her over the years of the trials and tribulations of providing primary care and some of the issues that affect the patients with migraine when going to primary care and those of the primary care practitioner in trying to help people with migraine. I've also over the years trained many primary care practitioners who became headache medicine specialists, so I have a real passion for teaching and working with primary care in helping patients get better, optimized care for their migraine.

Jaclyn Duvall, MD:
I love that, and of course, with all of the education and research that you have done, we know that your wealth of knowledge for your community. My community in Tulsa, Oklahoma is a bit different, where really we are on the ground providing care and really trying to help train and educate primary care providers here because there is such a lack of headache specialists and even neurologists who are willing to see people living with migraine. I found it really important to partner with our primary care providers here locally. We know that most individuals living with migraine will never see a neurologist like you or I, Dr. Tepper. In fact, it's estimated that about 70% of people living with migraine receive care through their primary care providers. Dr. Tepper, I want to start off today talking about why should primary care [providers] care about their patients with migraine.

Stewart Tepper, MD:
There are many reasons why I think you should care about taking care of patients with migraine and optimizing that care. Most important is because migraine has been listed as the second most disabling illness in the world by the World Health Organization, if one looks at years lived with disability. What happens is people have severe attacks that are disabling and have them across a lifetime.

And the impact on loved ones, on work, on social activities, and on the person with migraine. But the impact is huge, so there is an opportunity to help people turn their lives around. And what's happened in the last decade has been a revolution in treatment, which is to be able to offer patients the opportunity to get migraine free and get their lives back.

I use that term very explicitly because the International Headache Society published a paper in January of 2025 saying that we should be aiming for migraine freedom for our patients.[ii] And now we have the opportunity, and the opportunity is pretty straightforward for primary care practitioners. And I think Dr. Duvall and I can share with you some of this exciting news across today's podcast.

Jaclyn Duvall, MD:
I think that's so incredible hearing you say the words migraine freedom. I know that you have been practicing and in the throes of research much longer than my career. But even for me, when I first began in headache medicine, the idea of migraine freedom was sort of a needle in a haystack. And in today's world, it is an attainable goal that we're seeing and it's so exciting. I find myself just loving being able to treat patients living with migraine because of the reward we can see on the back end. We went into medicine to try to help and care for people and having really the tools in our toolbox now to be able to really do that and offer them hope for the future is pretty incredible.

Stewart Tepper, MD:
It is tremendously gratifying.

Jaclyn Duvall, MD:
Let's shift gears just a moment, Dr. Tepper. I personally cannot imagine being tasked with all that primary care clinicians face in a single office visit. Can you help these primary care providers? Do you have some recommendations for primary care [providers] for a quick start to initial diagnosis in a busy practice?

Stewart Tepper, MD:
Quick screeners. That's what a primary care practitioner needs in a busy practice with limited amount of time. There is a screener called ID Migraine.[iii] And ID Migraine is just three questions: With your headaches, are you nauseated? Does light bother you? And does the headache have some impact? (Does it limit your ability to work or study or do what you need to do?) Just those three things: headaches with nausea, sensitivity to light, and some impact or disability on activities.

And ID Migraine says, have you had it in the last three months? I like people to be stable for six months. Two out of three, probably is very likely to be migraine. And Dr. Vince Martin, who is the [past] head of the National Headache Foundation, actually found that asking if there's a stable pattern of headache, do you just have nausea, sick to your stomach with the headache, that is almost as sensitive as ID Migraine. So those three, bear it in mind, and you can cut right to the chase.

Jaclyn Duvall, MD:
I always heard in my training a sick headache. Someone complaining of a sick headache was certainly raising the concern for migraine. The other thing that I will encourage primary care [providers] in my area is that in the absence of red flag symptoms to bet on migraine. We see in the primary care setting that tension-type headache, sinus headache are far too commonly over diagnosed. In fact, we estimate around 90% of those headache types to in fact be migraine, so in the absence of red flag symptoms, bet on migraine is my encouragement.

I find in my community that typically preventive treatments are started in the primary care setting when headache, migraine frequency has really become too high around 3 to 4 days per week before we're starting preventive management. Can you share when you recommend preventive migraine treatment for a patient?

Stewart Tepper, MD:
I think that because the older treatments had so many side effects and such modest effectiveness that we didn't agree to try to prevent migraine with patients. We didn't suggest the older treatment until there was pretty significant disability and the frequency of headache days was high. We didn't feel like we had a choice at that point. And then we would try to strike the devil's bargain and see if we could get a patient to agree to take a medicine maybe that had a chance of doing a two for one and treating depression or anxiety or bipolar or hypertension at the same time. That was the old way of doing it.

And the new era is that we now have migraine preventive treatment without a lot of side effects. So, these were designed specifically for migraine. Patients tend to have no side effects. These medicines don't go into the brain. They work outside the brain to prevent migraine. And the cost-benefit analysis, the calculation, is completely different now. We can intervene much earlier.

The decision to when to offer the prevention has changed from being a number of days per week or the severe, severe disability to simply asking is the migraine affecting your life? Is it causing burden in between the attacks? Is the pervasive effect of migraine really having impact for you? And if it is your use of acute medicine going up over the counter medicine. Any of the answers to that is yes, you say, look, welcome to the 21st century. We have new treatments without the old therapeutic penalty

designed for migraine, where we can offer these to you early, when the migraine is having impact without requiring 3 or 4 days a week or some severe disability. And that is a big change.

And finally, I would just say, we also separate out now, so if somebody has comorbid depression, anxiety, hypertension, bipolar, we want to prescribe the best medicine for that. At the same time, you want to prescribe the migraine specific medicine for migraine, and we no longer go for a two for one.

Jaclyn Duvall, MD:
Absolutely. I think a big concept that you're really bringing across is the effectiveness of a treatment, which is really a balance between both the efficacy of a medication reducing migraine frequency but equally balancing its tolerability. And when I'm explaining that to my patients, I sort of take it down a bit. I tell them I want to work squared equation, I want one that works, but also that you can take at work or in the midst of your day. You just keep going regardless of side effects, because we don't tend to see those as much with our newer migraine preventives.

Last year, the American Headache Society published updated guideline recommendations regarding the importance of migraine specific medications as first-line in migraine preventive treatments.[iv] This was corroborated by recommendations from the International Headache Society. Dr. Tepper, can you elaborate on these recommendations in more detail?

Stewart Tepper, MD:
Right. That's what I was just talking about. It's that we now have the opportunity to intervene for prevention early with well-tolerated, migraine specific medicines. And when we talk about migraine specific medicines, we mean two categories of anti-CGRP medicine. CGRP of course calcitonin gene-related peptide. And the two categories are monoclonal antibodies that either suck up the CGRP or block the CGRP receptor, or what are called gepants, which are small molecules that block the CGRP receptor. These two categories of medicines don't go into the brain and have wonderful tolerability. Tolerability is one of the hallmarks. And as Dr. Duvall just said, high efficacy and also high tolerability.

And what is important about what the American Headache Society physician paper stated and which, in fairness, the National Headache Foundation actually also published in 2022, is that patients should not have to take the older medicines that people did not like that cause side effects, that had only modest effectiveness. And by that, I mean tricyclic antidepressants and beta blockers and anti-blood pressure medicines and anti-epilepsy drugs and other antidepressants, that people should not have to step through those to get to migraine specific treatment.

Migraine is important. Migraine is common. Migraine is disabling. And we should be matching patient need to treatment by using the new treatments first-line when somebody is having significant impact from migraine. And since the American Headache Society Position paper was published in April of 2024, all three of the national pharmacy benefit managers (PBMs), all three of them (Express Scripts, CVS Caremark and Optum), as their national policy have taken away the step edits. So, you as a primary care practitioner can prescribe migraine specific medicine first-line, still may need a prior authorization, but first-line without having the patient go through step edits. And those PBMs provide the pharmacy benefits for 80 to 90% of people in the US. It’s a big, big change and really hopeful for patients.

Jaclyn Duvall, MD:
I think this is a huge change for our practice. I don't know about you. In my practice, it became very frustrating to have to step through these older generation of medications, in fact, sometimes deterring patients coming back in to see us. If I'm prescribing an antidepressant medication as a migraine preventive, but a patient is not fully understanding the purpose behind that preventive treatment, a lot of times they walk out and go oh, another provider who thinks it's all in my head. They just want to manage my anxiety or depression. When in fact I'm going, no, this is what I'm sort of forced in my hand to do for you. So having these recommendations as backing, really opens the door for us as providers to be able to actually offer these first-line.

I want to hear about your personal experience. I know that you've alluded a lot to the efficacy of these medications but tell me about your personal experience treating patients with these medications.

Stewart Tepper, MD:
You alluded to this. A decade ago, if I had one or two patients a month tell me their lives were completely changed, I was really doing very well. Now I hear it every day, every day. And sometimes multiple times a day I have people come in and say, game changer, my life is completely changed. These medicines are so easy to use in primary care that it has a chance to really revolutionize primary care practice with respect to migraine. I can't emphasize how gratifying, how wonderful it's been for practitioner and patient alike to suddenly have this large menu of potential migraine specific treatments with low side effects and high tolerability and quick onset of effect. Unlike where we would creep up the antidepressant or the anti-epilepsy drug over a month and then wait two months to see the benefit, these new medicines tend to work very rapidly.

Some of them you can just put the patient on it immediately and they're on the right dose and off to the races in oral form, some of them an injection once a month or treatment every three months. So, it's big, big difference for our patients. They don't even require blood monitoring.

Jaclyn Duvall, MD:
What is primary care's role in bringing care and hope to their patients? Do they need to be referring individuals to a neurologist for these medications?

Stewart Tepper, MD:
No, I think front-line, a primary care practitioner can prescribe gepant or a monoclonal. And because of the lack of need for blood monitoring and the likelihood that there aren't going to be side effects. These are perfect drugs in primary care, especially the gepants which are pills. So primary care is more comfortable with pills than teaching people the auto injector for once a month. But hey, with the GLP-1s, the auto injectors are becoming pretty commonly used as well. So, these are very, very easy to use medicines. I think they ought to be prescribed at the primary care level. I think primary care practitioners won't need to refer as many patients to neurologists. And I think they'll find it a really quite life changing experience to help people with migraine and see the turnaround.

I do think it's probably worth calling a special appointment for a patient if they are complaining about migraine to devote to this treatment rather than try to take it on at the end of another visit. But it shouldn't take long. And it sure is going to be easy, I think.

Jaclyn Duvall, MD:
I agree, I also think that our primary care colleagues are going to find this very rewarding disease state to treat. One that, as you mentioned, can be much simpler to manage having medications designed for migraine. Also, fewer calls back to the clinic. This is a major advantage that we see with lower side effects, higher efficacy.

I want to shift gears and talk about a study that I have been educating clinicians on recently. This is results from a recently published study called TEMPLE. TEMPLE is a Phase 3, multicenter, randomized, double-blind, head-to-head study. The study evaluated the safety, tolerability, and efficacy of a gepant atogepant, which is Qulipta marketed by AbbVie, compared to topiramate (Topamax) for the preventive treatment of migraine in adult patients who are appropriate for preventive treatment. The survey was supported by AbbVie. In this multi-center, double-blind active-controlled trial, 545 patients with episodic or chronic migraine were randomly assigned to either atogepant or topiramate for a 24-week treatment period, followed by an open label extension. So, I want to start by asking, Dr. Tepper, would this study be of importance to the migraine community?

Stewart Tepper, MD:
Oh, it's really important to both patients and practitioners alike. And this is a study that was worked out with the German regulatory authorities. But you can see it's a huge study and half the patients got atogepant and placebo topiramate and half got real topiramate that they worked up slowly over six weeks and a placebo atogepant 60 milligram pill. And then these two groups were followed for six months.

And the primary outcome measure was what percentage of people stopped the drug due to side effects, due to a lack of tolerability or safety issue. And the answer was almost three times as many patients stopped topiramate as stopping atogepant. And I think if you'd asked any neurologist, we would have told you that topiramate is poorly tolerated and 30 to 40% of people will stop it.

But this was the first comparison of [any] gepant to topiramate in a blinded manner to see what happened. And it turned out every endpoint was in favor of atogepant, not just who discontinued it, many fewer patients, but also effectiveness. And also, side effects, specific side effects like cognitive dysfunction, which is really common with topiramate.

Topiramate is still widely prescribed for migraine prevention. And the problem with it is, first of all, a third of the patients are going to stop it because of side effects. Second, the side effects are very significant, especially the cognitive dysfunction. And third, and here the U.S. is way behind Europe, topiramate has very significant effects on the fetus. And in Europe, the regulatory authorities for almost all of the European countries and the UK have suggested that the practitioners stop prescribing topiramate to women of childbearing age because of unplanned pregnancies and the potential effect on the fetus. So here you have a direct comparator trial that shows that for every end point, atogepant is superior to topiramate.

And given the severity of the problems with topiramate, the reason I think it's such an important study is I think people should stop prescribing topiramate. Certainly not prescribing at first-line, but I don't think they should be prescribing it for migraine prevention when they have a choice in women of childbearing age, for sure. So, a very important study.

Jaclyn Duvall, MD:
So, in fact, exactly what you had said was also corroborated in a U.S. retrospective claims analysis between 2008 and 2013.[v] We found that 75% of people who began an oral preventive medication, one of our historical preventives, have discontinued its use within six months, 84% of them stopped using it within a year. And what we know with these medications is we have this titration phase. So oftentimes it takes several weeks to actually get them to the therapeutic dose. But then it also typically has this sort of lack of efficacy for several weeks to months. And so oftentimes patients are waiting anywhere from two to four months or longer to start to see efficacy. And the problem is that many of them have stopped using it before that either because they didn't tolerate it or because they thought they should have seen results within the first week.

What's interesting about TEMPLE is that we can actually see if we sort of show these secondary endpoints that were evaluated, how quickly a medication like atogepant can work. In fact, majority of impact is seen within the first four weeks. And so, I want to hear from you what specifically can primary care clinicians learn or take away from these learnings of the TEMPLE study?

Stewart Tepper, MD:
First, significantly fewer treatment discontinuations because of side effects with atogepant compared to topiramate. And second, depending on what's important for a patient, quality of life was better with atogepant than topiramate, cognitive function was better with atogepant than topiramate. And on the secondary endpoints, depending on what patients want, a variety of outcome measures were superior for atogepant than topiramate: quality of life, cognitive function, headache impact, and the one I care about most, which is the patient global impression of change where people are asked are you better or are you not better. Are you much improved? Are you really much improved? Or are you no better or are you worse?

That PGIC (patient global impression of change) takes into account the full pervasive effects of migraine. So, for a primary care practitioner, what the study is saying is atogepant yes, topiramate no. It's a pretty easy message. And then one little interesting fact, one of the side effects that was evaluated for both drugs was weight loss. Both drugs cause weight loss, both atogepant and topiramate. If that's an issue, you're not sacrificing to use atogepant instead of topiramate.

Jaclyn Duvall, MD:
And that is something that patients care about. How often have you seen someone stay potentially on topiramate without having migraine reduction, but because of that weight loss. So, it's nice to kind of have that information supporting atogepant as well. Anything else that you'd like for primary care [providers] to consider? Any calls to action that you might have?

Stewart Tepper, MD:
Yeah, I was just going to say this is my call to action. You're the front lines and you are where most people are going to get migraine care, and you now have an incredible opportunity. It's the most exciting time in my whole professional career. I've been doing it for decades. This is really game changing. This truly is a time where with a simple prescription, for example a daily gepant or a monthly monoclonal, you can dramatically change people's lives relatively early in their migraine career before the migraine gets into chronic migraine and medication overuse and all of the problems that so many patients had.

And these medicines work rapidly as Dr. Duvall just said. Atogepant separated from placebo within a week in the pivotal trials for episodic and chronic migraine in the TEMPLE trial. The majority of patients noted some benefit within the first month. I mean, I saw somebody today. In a month, he was suddenly having a headache-free days and really feeling much, much better. So, this is a time of hope and opportunity, and I cannot stress that enough how great it would be if you were in primary care, to be able to prescribe these medicines first-line for patients where it's appropriate for their migraine.

Jaclyn Duvall, MD:
This has been a wonderful discussion. Thank you, Dr. Tepper, for your perspective and expert insights. Thank you all for your time. To learn more about migraine, recommendations will be provided in hardcopy at the end of this transcript. The recommendations will include both CME and non-CME education from the American Headache Society, a list of peer reviewed publications, other resources to help support your efforts in caring for people with migraine.[vi] You'll find all of these resources available for you on the National Headache Foundation website at headaches.org. Thank you.

This episode of NHF InSights™ was sponsored by AbbVie.

Resources:

1. CGRP Therapy Atogepant Outperforms Topiramate in Head-to-Head TEMPLE Trial https://www.neurologylive.com/view/cgrp-therapy-atogepant-outperforms-topiramate-head-to-head-temple-trial

2. ID Migraine https://headaches.org/resources/headache-tests

3. AHS and IHS Position Statements https://headaches.org/insurance-pharmacy-coverage/ahs-position-statements

4. NHF Primary Care Migraine - www.pcmigraine.org

5. AHS First Contact - https://americanheadachesociety.org/resources/primary-care

[i] CGRP Therapy Atogepant Outperforms Topiramate in Head-to-Head TEMPLE Trial https://www.neurologylive.com/view/cgrp-therapy-atogepant-outperforms-topiramate-head-to-head-temple-trial

[ii] IHS Position statement on setting higher standards for migraine prevention published https://ihs-headache.org/en/news/ihs-position-statement-on-setting-higher-standards-for-migraine-prevention-published

[iii] ID Migraine https://headaches.org/resources/headache-tests

[iv] AHS and HIS Position Statement, https://headaches.org/insurance-pharmacy-coverage/ahs-position-statements

[v] Hepp Z, Dodick DW, Varon SF, Chia J, Matthew N, Gillard P, Hansen RN, Devine EB. Persistence and switching patterns of oral migraine prophylactic medications among patients with chronic migraine: A retrospective claims analysis. Cephalalgia. 2017 Apr;37(5):470-485. doi: 10.1177/0333102416678382. Epub 2016 Nov 12. PMID: 27837173; PMCID: PMC5405847. https://pubmed.ncbi.nlm.nih.gov/27837173

[vi] NHF Primary Care Migraine - www.pcmigraine.org
AHS First Contact - https://americanheadachesociety.org/resources/primary-care