Transcript Details
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NP & Neurologist Migraine Experts Discuss the Role of Anti-CGRP Monoclonal Antibodies in Migraine Prevention

ReachMD Announcer:
Welcome to ReachMD.

This medical industry feature, titled "NP & Neurologist Migraine Experts Discuss the Role of Anti-CGRP Monoclonal Antibodies in Migraine Prevention," is sponsored by Amgen. This program is intended for healthcare providers.

Here's your host, Dr Charles Turck.

Dr Turck:
Coming to you from ReachMD studios in Fort Washington, Pennsylvania, I'm Dr Charles Turck. Joining me to discuss where anti-CGRP monoclonal antibodies fit into the preventive migraine treatment journey are Dr Obinna Moneme and Ms Emily Hosler. Dr Moneme has been in practice for 12 years as a board-certified neurologist with the sub-specialty in clinical neurophysiology and he treats many patients with migraine and headache syndromes. Ms Hosler has 13 years experience as a neurology Nurse Practitioner and is currently with a private neurology practice in Southfield, Michigan, where she has a focus on patients with migraine. Both my guests have extensive experiences in the treatment of migraine, and they'll be sharing their expertise with us. Thank you, so much for joining me, today.

Dr Moneme:
It's a pleasure to be here.

Ms Hosler:
Yes, thank you for inviting us.

Dr Turck:
I'd love to begin by understanding a little bit more about your roles in migraine management. Could we start with you, Ms Hosler?

Ms Hosler:
Sure. As an NP, I do a lot of patient evaluations. I gather together the history of their migraine, including not just their migraine calendar or diary, but also all the medications they've already tried. I'm also a patient educator, so I counsel on lifestyle modifications, medication options, avoiding medication overuse, managing triggers and setting treatment expectations. I do have some longer visit times than the neurologists that I work with, 30 minute intervals, which allows me to do the counseling and in-depth evaluations.

Dr Moneme:
I think there's a lot of overlap between the roles of neurologists and the neurology nurse practitioners, like with evaluating patients and setting treatment expectations. In general, I'm responsible for getting my patient's history and based on that, diagnosing and assessing their condition. I'll also discuss treatment options with them, develop their treatment plans and set expectations for that treatment. Monitoring how my patients are doing, along with the side effects and efficacy of their treatment is also an important responsibility of mine, since it allows me to assess if their migraine management plan is working for them.

Dr Turck:
You've both mentioned the importance of evaluating your patients with migraine to make sure their treatment is working for them, so, when a patient comes in with migraine, how do you personally evaluate the efficacy of their current treatment?

Ms Hosler:

Well, I assess acute medication usage, the impact of migraine on the patient and of course, the reduction in migraine days. I think it's helpful to ask open-ended questions and ask how long each episode lasts to understand the migraine impact on the patient's everyday life. I ask them, "From the moment you know it's a migraine attack to when you say, 'Ah, I'm over it,' how long is that?" That's the true length of the migraine episode and it can be several days long. I sometimes also ask, "How many days out of the month do you feel like yourself, without any of the associated symptoms of migraine?"

Dr Moneme:
I'm glad we're talking about this, Dr Turck. I evaluate at every visit whether my patient's treatment is really working for them, beginning with finding out how they're affected by their migraine. In my practice, we use validated tools like MIDAS or HIT-6, as well as talking to our patients because even if their attacks are infrequent, they can still be very debilitating.

Dr Turck
So, if you've determined that the patient is still really impacted by their migraine and that their current preventive treatment isn't working, how do you decide which preventive treatment they should try next?

Ms Hosler:
As healthcare providers, we need to know when it's time to change a patient's migraine treatment plan. Unfortunately, currently there aren't any predictors for who will respond to what medication, so we have to use trial and error to find the treatment that is appropriate for the patient.

Dr Moneme:
That's a great point, Emily. We don't have individualized medicines for migraine, and I want to use my best judgement to avoid continuing on medicines that aren't working for a particular patient. Based on American Headache Society Guidance, I'll start a patient on an oral preventive medication, titrate to target or maximum dose and give a trial period that's appropriate for that medication. Then, if there's no response, or the patient can't tolerate it, I'll start the process again with a different therapy. If I determine that my patient's treatment is ineffective and they've already tried two different oral preventive therapies, I'll refer to the American Headache Society's recommendations and consider an anti-CGRP monoclonal antibody.

Dr Turck:
What can you tell us about those therapies?

Ms Hosler:
Well, the anti-CGRP monoclonal antibodies were specifically designed to target molecular pathways involved in migraine pathophysiology and they're delivered by injection or intravenous infusion.

Dr Moneme:
I find myself having to hold my tongue a bit with patients about the monoclonal antibodies and have worked on how to share my excitement but not overpromise. In my hands, they've been effective.

Dr Turck:
Ms Hosler, have you had a similar experience with anti-CGRP monoclonal antibodies?

Ms Hosler:
I have. We'd been waiting for additional developments in migraine and now we have another option for patients. As opposed to cycling back to a medicine they already tried using a different dose, or trying something else within the same class of medication, the anti-CGRP monoclonal antibodies don't work for everyone, but I've seen a lot of success with them, which gives me hope.

Dr Turck:
For those just tuning in, you're listening to ReachMD. I'm Dr Charles Turck and here to talk about where anti-CGRP monoclonal antibodies fit into the migraine preventive landscape are Dr Obinna Moneme and Nurse Practitioner, Ms Emily Hosler.

So, while it sounds like you've both had some positive experiences with this treatment class, I've heard that it can be difficult to start a patient on these therapies. Is that true, Ms Hosler?

Ms Hosler:
Access to therapy is a big piece of it. There is some insurance paperwork to complete, but we're used to handling that, just as we would with any specialty medication. Knowing that a patient has to fail two different oral preventive medications in order to try the anti-CGRP monoclonal antibodies, I make sure their chart notes capture in detail the patient's experience with the treatment. That can be time-consuming, but I think, ultimately, it's worthwhile.

Dr Turck:
And how about you, Dr Moneme. Is access something you consider, too?

Dr. Moneme:
It is. It is. In our practice, to make getting access easier, we've created smart phrases in our EMR to help us document the medications that patients have tried. I can go through quickly, find the information and utilize it. Like Ms Hosler said, I think it is worthwhile.

Dr Turck:
Dr Moneme, you mentioned earlier in our conversation, the importance of managing patient expectations with migraine medications, how do you do that when you start a patient on an anti-CGRP monoclonal antibody?

Dr Moneme:
I like to encourage my patients to give anti-CGRP monoclonal antibodies a sufficient trial and I talk about the data. I'll tell my patients that some people can see an earlier response, but it can take longer for others, so it's important to give them an adequate trial. According to the American Headache Society, the trial period for an anti-CGRP monoclonal antibody should be at least 3 months of treatment for those administered monthly and 6 months for those administered quarterly.

Ms Hosler:
I agree. It's about sharing the data and establishing what success looks like. You know, when I can develop an effective migraine treatment plan for a patient, it's incredible. I end up feeling like a hero. It's not always easy, but it is really rewarding.

Dr Moneme:
Emily, you said it perfectly. I have nothing else to add.

Dr Turck:
Well, that's a wonderful thought to take with us as we come to the end of today's program. I want to thank you, Dr Moneme and Ms Hosler for joining me to share your insights. It was wonderful speaking with you today.

Dr Moneme:
Thanks for having us.

Ms Hosler:
Thank you so much.

ReachMD Announcer:
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