Migraine Medications in Workers' Comp.

Continuing Education Webinar

May 19, 2026

3:00 PM ET

All attendees are in listen-only mode.

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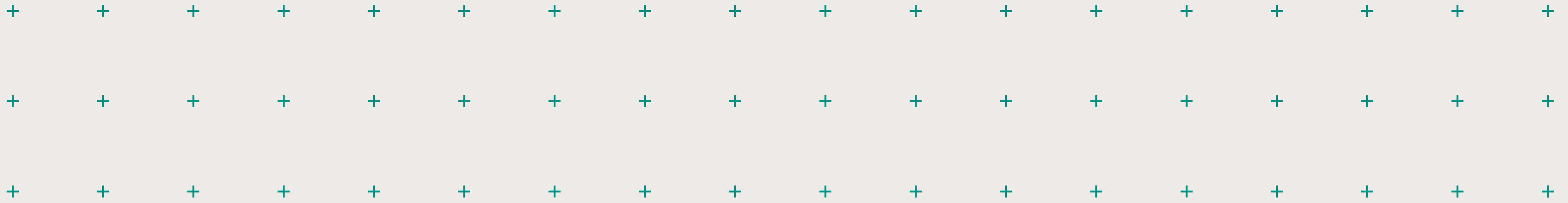

Agenda

Defining migraines and their impact

Acute migraine treatment

Migraine prevention

Takeaways

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Defining migraines and their impact

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Migraine headaches are a neurological disease caused by a combination of environmental, medical, and genetic factors

- If a biological parent experiences migraines, there is a **50-70% chance** their children will experience migraines.
  There is no medical test or diagnostic tool to determine if a patient will inherit the condition.
- Migraines triggers may include stress, irregular sleep, hormones, caffeine and alcohol, changes in the weather, diet, dehydration, lighting, scents/smells, and medication overuse

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Migraine burden in the United States

Migraine is the **leading cause** of disability

6% of men and 18% of women suffer from migraine headaches

Migraines effect **1 in 4 households** and more than a billion people globally

Migraines cost employers **≈$13 billion annually**

Missed workdays and impaired work function

Source: Migraine 101 - American Migraine Foundation, accessed Jan 2026

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Differences between a migraine and headache

Migraines are different and more debilitating than typical, regular headaches

	Migraine	Headache
Pain Type	Throbbing, pulsating	Dull, steady pressure
Location	Usually one side of the head	Both sides or generalized
Duration	4–72 hours	Minutes to a few hours
Severity	Moderate to severe	Mild to moderate
Associated Symptoms	Nausea, vomiting, light/sound sensitivity, aura, often made worse with physical activity	Rarely any other symptoms
Impact	Can be debilitating, affects daily life activities and quality of life	Usually manageable

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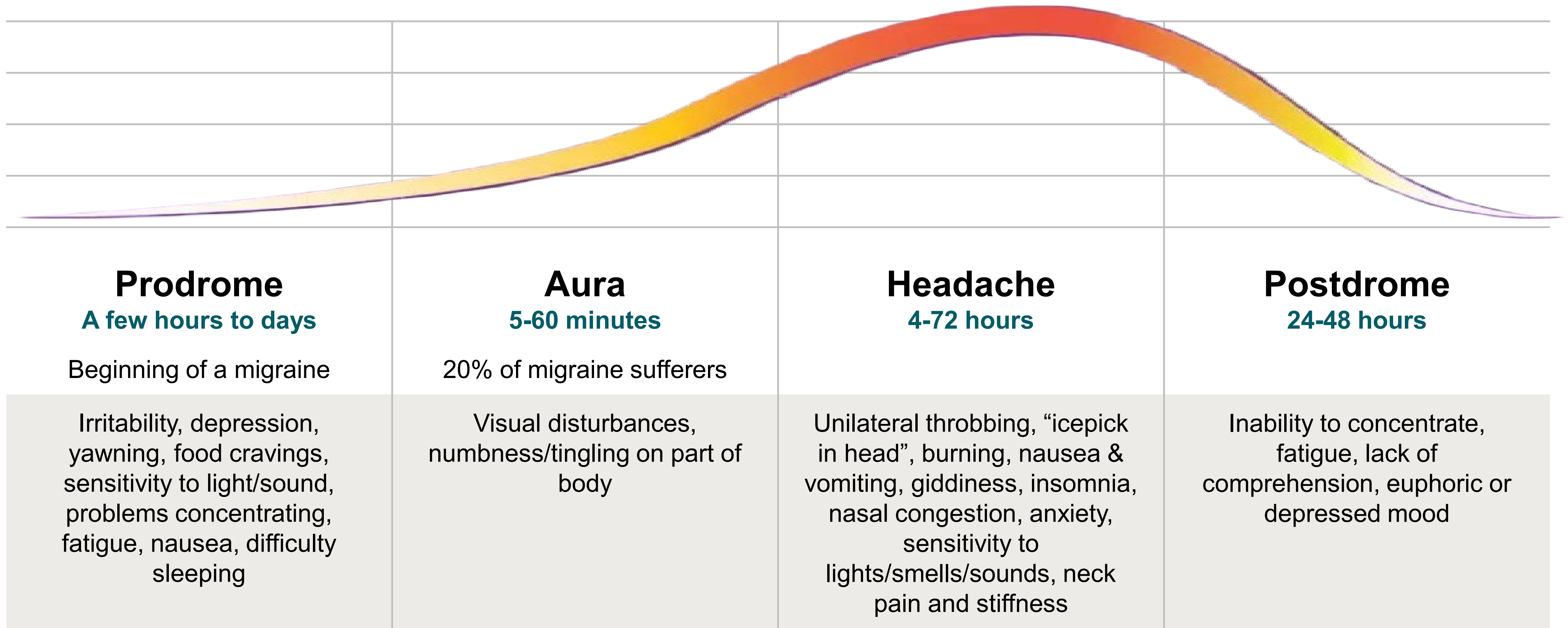
Timeline of a migraine attack

Symptoms of each migraine headache can last for several days



Source: https://americanmigrainefoundation.org/migraine-signs-symptoms/ , accessed Jan 2026

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Acute vs. chronic migraine headaches

Acute Migraine	Chronic Migraine
+ Treatment focuses on alleviating the symptoms/pain as the headache is happening or is about to happen (aura is present).	+ Defined as a history of 15 or more headache days per month, at least 8 days of which have migraine characteristics, for at least three months + Can develop due to ineffective treatment, overuse of certain medications, certain medical conditions (anxiety, sleep disorders, and chronic pain conditions), stressful life events + Treatment focuses on reducing the number of headache days experienced or preventing/decreasing the number of migraine episodes + Patients are more likely to have other conditions such as chronic pain, arthritis, and depression

2) When migraine turns chronic | NIH MedlinePlus Magazine 2) Migraine - Symptoms and causes - Mayo Clinic, accessed Jan 2026

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Migraine considerations in workers' compensation

Migraines in workers' compensation usually present following:

+ Traumatic Brain Injury (TBI)
+ Post concussion disorders
+ Secondary/exacerbated by injuries involving the head, neck and shoulder area, or other environmental exposures

When migraine medications are requested on a claim:

1. Confirm migraine is injury related and compensable on the claim
2. Check if medication is prescribed for acute migraine or prevention.

   It may be useful to obtain a letter of medical necessity to confirm the prescribed/indication for use or send to Utilization Review, if applicable.

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Things to question/confirm about migraine medications

- Medication is prescribed by a primary care physician and/or prescriber that has not been involved in the injury treatment previously.
- First migraine medication request on a claim is a **preventative** migraine medication with no history of acute migraine medication use.
- Is the request for duplicate therapies – two acute migraine medications in the same class or two preventative medications in the same class

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Acute Migraine Treatment

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Acute migraine treatment goals

Rapid and consistent freedom from pain and associated symptoms without recurrence

Restored ability for function

Minimal need to repeat dosing or utilize rescue medications

Optimal self care and reducing subsequent use of resources
(e.g., emergency room visits, diagnostic imaging, clinician and ambulatory infusing center visits

Minimal or no adverse events

Cost considerations

Derived from: AHS Consensus Statement (Headache. 2021;61:1021–1039).

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Acute migraine treatment drugs

Analgesics	**Triptans**	**CGRP Antagonists**
Reyvow* **(lasmitidan)**	**Dihydroergotamine**	**Antiemetics**

**Discontinued by manufacturer and distribution ends 5/31/2026. Excluded from rest of acute migraine treatment discussion.*

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Analgesics

- Acetaminophen
- Nonsteroidal Anti-Inflammatory Drugs (NSAIDs): ibuprofen, naproxen, aspirin, etc.
- Combination Analgesics: acetaminophen + aspirin + caffeine, etc.

Place in Therapy

- Recommended **first-line** for mild-to-moderate migraine
- Use in combination with triptans for moderate-to-severe migraine

Dosing

- Take at headache onset, then as needed
- Do not exceed maximum daily doses
- Avoid using more than 15 days/month

Contraindications and Warnings

Acetaminophen: Severe hepatic impairment

NSAIDs: Active GI bleeding/ulcer, severe renal impairment, heart failure

Side Effects

Acetaminophen: Rare

NSAIDs: Stomach pain, heartburn, high blood pressure

Clinical Pearls

Alternate doses of acetaminophen and NSAID for around-the-clock relief

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Triptans

Place in Therapy

+ First-line for moderate-to-severe attacks
+ Used for mild-to-moderate attacks that respond poorly to analgesics

Dosing

+ Take at headache onset and, if needed, repeat 1x in 1-4 hours
  (wait time depends on triptan and formulation)
+ To decrease risk of medication overuse headache
  - Do not use more than 2 doses in 24 hours
  - Limit use to 2-3 days/week and no more than 10 days/month

Side Effects

Dizziness, fatigue, chest tightness, flushing

Contraindications and Warnings

Ischemic heart disease, stroke, peripheral vascular disease, coronary artery disease, ischemic bowel disease, **uncontrolled hypertension**

Clinical Pearls

+ Patients who do not respond to one triptan might respond to another
+ Consider **injection or nasal formulations** for patients with severe nausea and vomiting, migraines that intensify quickly, or migraine on awakening

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Triptan tablets

Formulation	Cost per dose*	Notes	Utilizing Patients in 2025
Sumatriptan Tablet	Generic: $25 Imitrex: $91	+ Most cost-effective	**52%**
Naratriptan	Generic: $29	+ Favorable safety and tolerability + Long lasting (consider for patients with a history of recurrence)	3%
Rizatriptan oral tablet or ODT	Generic: $32 Maxalt: $56	+ Fastest onset	36%
Almotriptan Tablet	Generic: $42	+ Favorable safety and tolerability	1%
Zolmitriptan oral tablet or ODT	Generic: $55	+ Good choice for patients with nausea + Quick onset	2%
Eletriptan tablet	Generic: $62 Relpax: $97	+ Favorable safety and tolerability + Safest for women who are breastfeeding and patients with kidney disease	5%
Frovatriptan tablet	Generic: $72 Frova: $188	+ Consider for patients with a history of recurrence (longest half-life) + Preferred for PMS migraine	1%

Most cost-effective triptan is most utilized

*Based on AWP in January 2026

Clinical Resource, *Drugs for Acute Migraine*. *Pharmacist's Letter/Pharmacy Technician's Letter/Prescriber Insights*. June 2025.

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Triptan non-oral formulations

Triptan tablets are utilized 95% of the time - far more than non-oral formulations

Formulation	Cost per dose*	Notes	Utilizing Patients in 2025
Sumatriptan nasal spray	Generic: $60 Imitrex: $112 Tosymra: $136	+ Taste and nasal route not acceptable to some patients.	1%
Sumatriptan nasal powder	Onzetra: $71	+ Patient blows into device to deliver medication to the back of nose. + 20% of patients report bad taste	1%
Zolmitriptan nasal spray	Generic: $103 Zomig: $137	+ About half of patients achieve no or mild pain relief within 2 hours. + Taste may be more tolerable than sumatriptan nasal spray	1%
Sumatriptan subcutaneous injection	Generic: $210 Zembrace: $481 Imitrex: $579	+ Fastest and most effective treatment + Higher rate of adverse effects.	**2%**

Most expensive is most utilized

*Based on AWP in January 2026

Clinical Resource, *Drugs for Acute Migraine*. *Pharmacist's Letter/Pharmacy Technician's Letter/Prescriber Insights*. June 2025.

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Dihydroergotamine

Place in Therapy

Second-line as alternative to non-oral triptan for:

- Patients with severe nausea and vomiting
- Patients who poorly responded to triptans
- Patients with prolonged migraines

Dosing

- Take at headache onset
- Repeat dose instruction vary by product
- To decrease risk of medication overuse, limit use to 10 days/month

Contraindications and Warnings

Ischemic or vasospastic heart disease, **uncontrolled hypertension**, peripheral vascular disease, **if triptan or other dihydroergotamine product used within 24 hours**, and severe renal or hepatic impairment

Side Effects

Nausea, vomiting, dizziness, nasal congestion/sore throat (with sprays)

Clinical Pearls

Patients with multiple cardiovascular risk factors, **evaluate for coronary artery disease or vasospasm before use**

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Dihydroergotamine products

Used for <0.2% of acute migraine treatments in 2025

Formulation	Cost per dose*	Dosing
Dihydroergotamine injection ampule	$94	1mg injection May repeat after 1 h. Max dose: 3 mg in 24 h.
Dihydroergotamine nasal spray	$130	1 mg (one 0.5 mg spray in each nostril), May repeat in 15 minutes. Max dose: 3 mg (six sprays) in 24 h.
Brekiya subcutaneous autoinjector	$1,050	1mg injection May repeat after 1 h. Max dose: 3 mg in 24 h.
Trudhesa nasal spray	$1,477	1.45 mg (one 0.725 mg spray in each nostril). May repeat after 1 h. Max dose: Four sprays (two doses) in 24 hrs.

*Based on AWP in January 2026

Clinical Resource, *Drugs for Acute Migraine*. *Pharmacist's Letter/Pharmacy Technician's Letter/Prescriber Insights*. June 2025.

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Calcitonin Gene-Related Peptide (CGRP) Antagonists

Place in Therapy

Second-line for moderate-to-severe attacks for patients that failed two triptans or have contraindications to triptans

Dosing

- Take at headache onset
  - Nurtec ODT (rimegepant) and Zavzpret nasal (zavegepant): **Do not repeat** for 24 hours
  - Ubrelvy (ubrogepant): May repeat after **2 hours**
- No limitations of monthly use; not associated with medication overuse headache

Side Effects

Nurtec ODT and Ubrelvy: **Nausea**

Zavzpret nasal spray: Taste disorders, nausea/vomiting, and nasal discomfort

Contraindications and Warnings

N/A

Clinical Pearls

- No vasoconstriction and subsequently viewed as **safe and well-tolerated**
- Shown to be **less effective than triptans** in treatment of acute migraine

  CGRPs: positive outcome in 1 out of 10 patients

  Sumatriptan: positive outcome in 1 out of 5 patients

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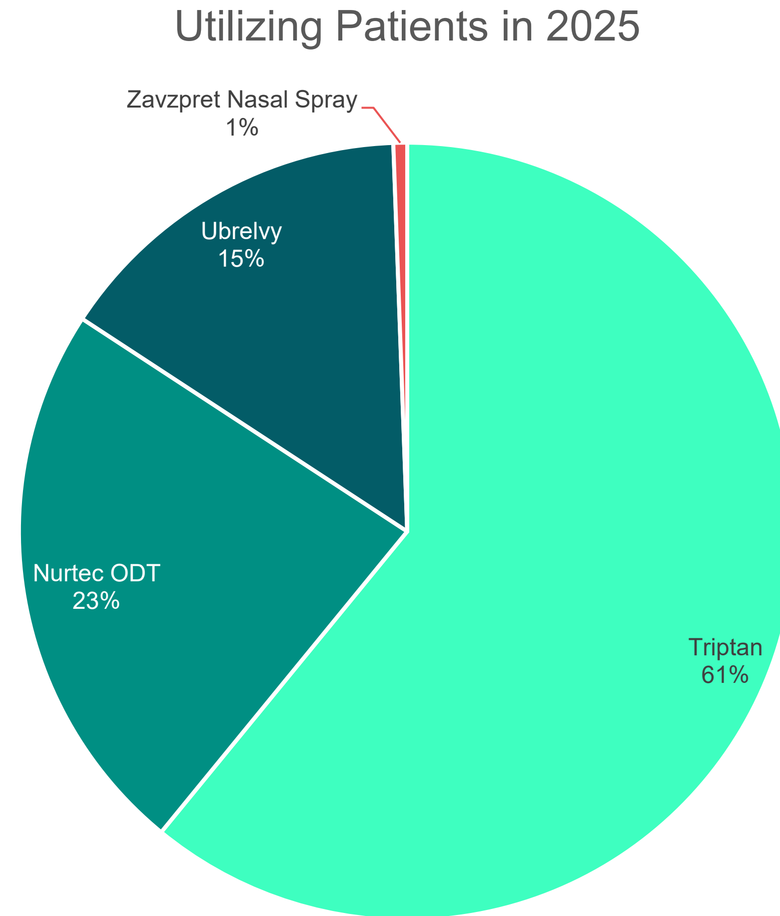
Costs for CGRP antagonists remained stable since put on market

Triptan utilization (i.e., first-line therapy) at 61% is far greater utilization than CGRP antagonists

Formulation	Cost per dose*	Utilizing Patients in 2025
Rimegepant (Nurtec ODT)	$161	23%
Ubrogepant (Ubrelvy)	$137	15%
Zavegepant **nasal spray** (Zavzpret)	$237	1%

*Based on AWP in January 2026



Clinical Resource, *Drugs for Acute Migraine*. *Pharmacist's Letter/Pharmacy Technician's Letter/Prescriber Insights*. June 2025.

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Antiemetics

- Metoclopramide
- Prochlorperazine
- Promethazine

Place in Therapy

- Adjunctive therapy for refractory headaches or for headaches with significant nausea and vomiting

Dosing

- Every 6-8 hours **as needed**

Contraindications and Warnings

- Presence of large amounts of **CNS depressants**
(e.g., alcohol, barbiturates, opioids)
- **Metoclopramide only**: GI obstruction, perforation, or hemorrhage, seizure disorder, history of tardive dyskinesia

Side Effects

Drowsiness, dizziness, dry mouth, blurred vision, nasal congestion

Clinical Pearls

Not recommended in the **older adult** population

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Cost-prohibitive acute migraine therapies

Drug	Cost per dose*	Cost-effective alternative	Cost per dose of alternative
Rizatriptan/meloxicam (Symbravo)	$153	Rizatriptan or sumatriptan tablets with meloxicam tablets taken separately	$30-$40
Sumatriptan/naproxen (Treximet)	$168	Sumatriptan tablets with naproxen tablets separately	$29
Diclofenac potassium 50mg oral packet (Cambia)	$118	Diclofenac potassium 50mg tablets	$2.25
Ondansetron	$30	Prochlorperazine, promethazine, metoclopramide	$0.06-$9.67

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Migraine prevention

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Effective migraine preventive therapy is defined as a **50% reduction** in frequency or severity

Initiate migraine prevention if patient has:

4-14 migraines/month,
with moderate disability

OR

15 or more migraines/month,
regardless of disability

Assess benefit after
3 months of treatment

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Migraine prevention treatment goals

Reduce attack frequency, severity, duration, and disability

Improve function and reduce disability

Reduce headache-related **distress and psychological** symptoms

Improve responsiveness to an **avoid escalation** in use of acute treatment

Reduce reliance on poorly tolerated, ineffective, or unwanted acute treatments

Reduce **overall cost** associated with migraine treatment

Derived from: AHS Consensus Statement (Headache. 2021;61:1021–1039).

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Migraine prevention drugs

All are considered first-line options by guidelines

Beta Blockers	**Candesartan**	**Serotonin/ Norepinephrine Reuptake Inhibitors (SNRIs)**	**Tricyclic Antidepressants (TCAs)**
Topiramate	**Valproic acid/divalproex**	**CGRP Antagonists***	**OnabotulinumtoxinA***

**Added as a first-line treatment in 2024*

AHS Position Statement Update (Headache. 2024;64:333–341).

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Non-CGRP first-line therapies

Drug Class	Average Cost Per Month*	Notes
TCAs (amitriptyline, nortriptyline)	$47	+ Especially useful if patient has **comorbid depression/insomnia** + Amitriptyline has the most data. + Nortriptyline is often used because it has a better side effect profile. + Notable side effects: dry mouth, dry eyes, constipation, vision disturbances, cardiac effects, memory impairment, dizziness, sedation, insomnia, mood changes, and weight gain.
Beta-blockers (propranolol, timolol, metoprolol, atenolol, nadolol)	$68	+ Especially useful if patient has comorbid hypertension + Notable side effects: fatigue, dizziness, exercise intolerance, sexual dysfunction, hypotension, constipation, worsening asthma, depression, sleep disorders, nightmares, memory impairment
Candesartan	$92	+ Especially useful if patient has comorbid hypertension + Do not take if pregnant
Valproic acid/divalproex	$145	+ First- or second-line option; consider with a beta-blocker in refractory patients + Do not take if pregnant
SNRIs (duloxetine, venlafaxine)	$226	+ Especially useful if patient has comorbid depression + Most evidence with venlafaxine
Topiramate IR/ER	$298	+ Most evidence for migraine prevention and similar efficacy to CGRP antagonists + Do not take if pregnant

*Based on AWP in January 2026

Clinical Resource, *Migraine Prophylaxis. Pharmacist's Letter/Pharmacy Technician's Letter/Prescriber Insights.* July 2025.

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CGRP antagonists

+ Gepants (small molecules)
+ mAbs (biologics)

Place in Therapy

+ **First-line** agents. Can be combined with non-CGRP therapies.
+ Gepants may be tried in mAb nonresponders
+ mAbs may be tried in gepant nonresponders

Dosing

Gepants: **Oral** dosing

mAbs: **Injectable** dosing (subQ and IV)

Contraindications and Warnings

N/A

Side Effects

Gepants: **nausea**, abdominal pain/dyspepsia, and constipation in Qulipta (atogepant)

mAbs**: Injection-site reactions** and constipation with erenumab

Clinical Pearls

Gepants: Some **drug-drug interactions**

mAbs: **Hypersensitivity reactions** can be delayed and/or prolonged, consider Vyepti (IV CGRP antagonist) for patients with injection site reactions

Concomitant use of a mAb and a gepant is NOT RECOMMNEDED by ODG or AHS

Clinical Resource, *Migraine Prophylaxis. Pharmacist's Letter/Pharmacy Technician's Letter/Prescriber Insights.* July 2025.

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CGRP antagonists and Botox®

	Drug	Route of Administration	Dose	Cost per month***
Biologics (mAbs)	Aimovig (erenumab)	SubQ	70 – 140 mg once monthly	$921
	Ajovy (fremanezumab)	SubQ	225 mg once monthly OR 675 mg every 3 months	$952
	Emgality (galcanezumab)	SubQ	120 mg once monthly	$917
	Vyepti (eptinezumab)**	IV	100-300 mg every 3 months	~$802-$2405
Small molecules (gepants)	Nurtec ODT (rimegepant)*	Oral	75 mg every other day	$2,415
	Qulipta (atogepant)	Oral	60 mg daily	$1,440
	Botox (onabotulinumtoxinA)	IM	155 units every 3 months	$432

*Also approved for acute migraine treatment

**Also approved for cluster headaches, which is a different condition, has different initiation criteria and different dosing

***Based on AWPs in January 2026

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CGRP antagonists added as first-line for migraine prevention

2024 Guideline Update

Historic First-Line Prevention Limitations

+ May not be consistently effective
+ Concerns with tolerability and safety
+ Lack clear predictors of treatment response
+ Decision of which treatment to implement often based on comorbidities (i.e., hypertension, insomnia, depression)
+ Medications have several contraindications
+ Adherence is poor due to lack of efficacy and tolerability

CGRP Antagonist Benefits

+ Evidence for the efficacy, safety, and tolerability for CGRP-targeting therapies is significantly greater than that for any established migraine preventive therapy.
+ The tolerability is a particularly positive feature
+ Substantial cost compared to other therapies; however, consider the costs to the individual and society if effective treatment is delayed

AHS Position Statement Update (Headache. 2024;64:333–341).

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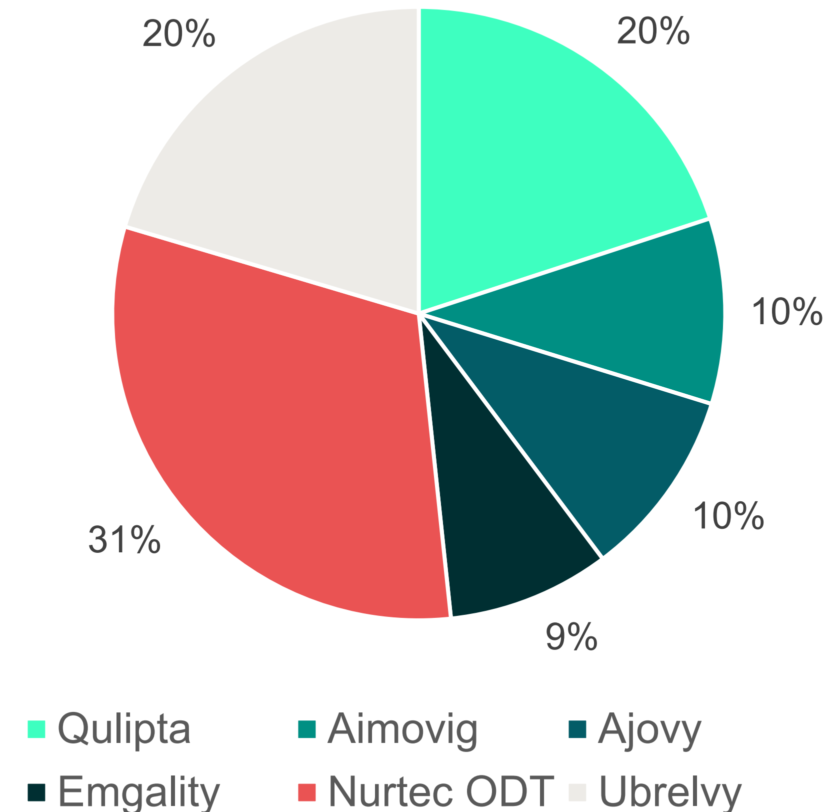
CGRP antagonist utilization

- More patients utilize gepants (Ubrelvy, Nurtec ODT, Qulipta) than mAbs
- Nurtec ODT, the most expensive CGRP antagonist on the market, is the most utilized
  - Approved for both acute migraine treatment AND migraine prevention



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Takeaways

Acute Migraine Treatment	Migraine Treatment
+ Assess migraine severity to determine first-line treatment + First-line treatments: analgesics, oral triptans + Other options available for patients with contraindications to first-line therapy or severe nausea/vomiting	+ Initiate prevention if patient has – 4-14 migraines/month with moderate disability OR – 15 or more migraines/month, regardless of disability + Historic first-line prevention options (e.g., topiramate, venlafaxine) are still valid options for patients with relevant comorbidities + Guidelines now recommend CGRP antagonists first-line due to established efficacy and safety; however, they are costly

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