

# CLINICAL GUIDELINES

<b>Physician Champion</b>	Dr. Kristin Brown, M.D.	<b>Date of QCEC Approval:</b>	July 2015
<b>Topic</b> <i>(Examples: Diabetes, Asthma, COPD, Women's Health, etc.)</i>	Migraine: Preventive Treatment		
<b>Guideline Source</b> <i>(Examples: ADA, USPSTF, HTW, NHLBI, etc.)</i>	<b>Source:</b> American Academy of Neurology, American Headache Society <b>Title:</b> "Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults" <b>Journal:</b> <i>Neurology</i> 2012;78;1337-45		
<b>Guideline Link</b>	<a href="http://www.neurology.org/content/78/17/1337.full.pdf+html">http://www.neurology.org/content/78/17/1337.full.pdf+html</a>		
<b>Guideline Original Date</b>	2000		
<b>Guideline Most Recent Revision Date</b>	April 2012		
<b>Quality Measures</b> <i>(for the year of QCEC review)</i>	N/A		
<b>HCC Documenting and Coding Tips</b> <i>(for the year of QCEC review)</i>	N/A		
<b>Guideline Summary</b> <i>(Summarize guideline and updated information)</i>	<p>Created by the Quality Standards Subcommittee of the American Academy of Neurology and the American Headache Society</p> <p><b>Objective:</b> The clinical question addressed was: What pharmacologic therapies are proven effective for migraine prevention?</p> <p><b>Background:</b> Approximately 38% of migraineurs need preventive therapy, but only 3-13% currently use it. The pharmacologic therapies were measured by reduced migraine attack frequency, reduced number of migraine days, or reduced attack severity.</p> <p><b>Recommendations:</b></p> <ol style="list-style-type: none"> <li>1. The following medications are established as effective and should be offered for migraine prevention (level A – at least two class I studies):             <ol style="list-style-type: none"> <li>a. Antiepileptics: divalproex sodium, sodium valproate, topiramate</li> <li>b. Beta blockers: metoprolol, propranolol, timolol</li> <li>c. Triptans: frovatriptan for short-term menstrually associated migraine prevention</li> </ol> </li> <li>2. The following medications are probably effective and should be considered for migraine prevention (level B – one class I or two class II studies):             <ol style="list-style-type: none"> <li>a. Antidepressants: amitriptyline, venlafaxine</li> <li>b. Beta blockers: atenolol, nadolol</li> <li>c. Triptans: naratriptan, zolmitriptan for short-term menstrually associated migraine prevention</li> </ol> </li> <li>3. The following medications are possibly effective and may be considered for migraine prevention (level C – once class II study or two class III studies):             <ol style="list-style-type: none"> <li>a. ACE inhibitors: Lisinopril</li> <li>b. Angiotensin receptor blockers: candesartan</li> <li>c. Alpha-agonists: clonidine, guanfacine</li> <li>d. Antiepileptics: carbamazepine</li> <li>e. Beta blockers: nebivolol, pindolol</li> </ol> </li> <li>4. The following medications is established as ineffective and should not be offered for migraine prevention (level A):             <ol style="list-style-type: none"> <li>a. Lamotrigine</li> </ol> </li> <li>5. The following medication is probably ineffective and should not be considered for migraine prevention (level B):             <ol style="list-style-type: none"> <li>a. Clomipramine</li> </ol> </li> <li>6. The following medications are possibly ineffective and may not be considered for migraine</li> </ol>		

prevention (level C):

- a. Acebutolol
  - b. Clonazepam
  - c. Nabumetone
  - d. Oxcarbazepine
  - e. Telmisartan
7. Evidence is conflicting or inadequate to support or refute the use of the following medications for migraine prevention:
- a. Antiepileptics: gabapentin
  - b. Antidepressants
    - i. SSRI/SNRIs: fluoxetine, fluvoxamine
    - ii. Tricyclics: protriptyline
  - c. Antithrombotics: acenocoumarol, Coumadin, picotamide
  - d. Beta blockers: bisoprolol
  - e. Calcium channel blockers: nifedipine, nimodipine, verapamil
  - f. Acetazolamide
  - g. Cyclandelate