Migraine Health System Toolkit

A Patient-Centric Approach to Migraine Care

Access the Toolkit

www.pfi.sr/migrainetoolkit

Migraine poses a significant burden on patients and health systems

It is estimated that

40 million people in the US suffer from **migraine**[1]

Prioritizing migraine management with practical enhancements for primary care

Migraine is an often misdiagnosed, underdiagnosed, and undertreated chronic condition.[2-4] Primary care providers (PCPs) need better-informed tools for optimal disease management.

In order to improve migraine management across health systems, consider adopting a standardized workflow that includes engagement materials for both health care professionals (HCPs) and patients across the migraine pathway.

1 in 6 Americans between the ages of **15 and 64 years** have experienced migraine or severe headache in the **last 3 months**[5]

Migraine is one of the **leading causes of disability** worldwide among people aged **<50 years**[6]

Contents

Migraine Pathway Examples

A care management pathway model to help health systems consider strategies to create and enhance workflows and standardize care delivery for undiagnosed and diagnosed patients with migraine.

Migraine Management Plan

A patient support guide that provides information on the diagnosis and treatment of migraine and includes a migraine diary and treatment plan to help patients track their experience.

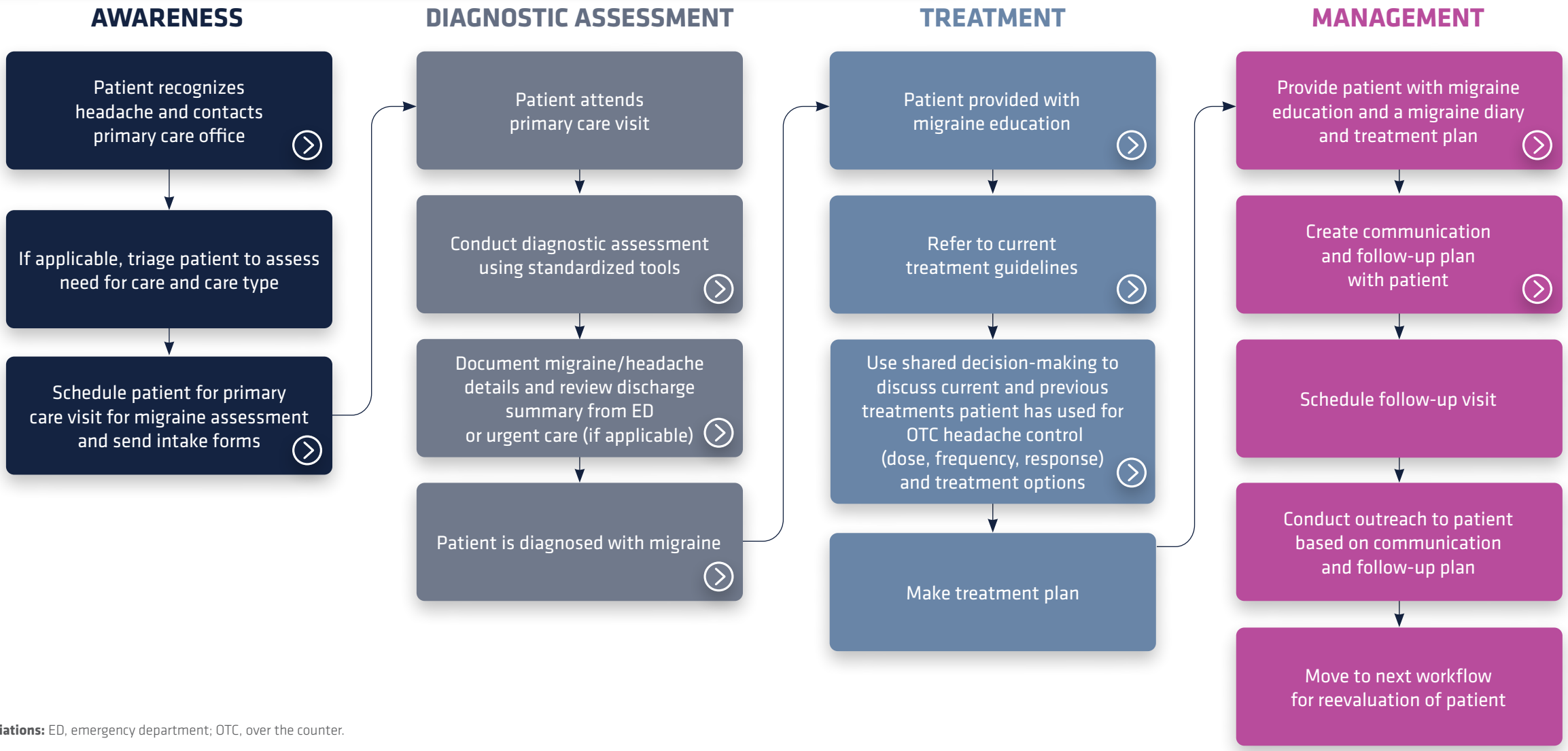
Migraine Patient Education Video

An educational video with 4 modules that provides patients with an overview of migraine and its symptoms and treatment/management options, as well as the importance of tracking their experience and working with their HCP to develop a treatment plan that's right for them.

Acknowledgments

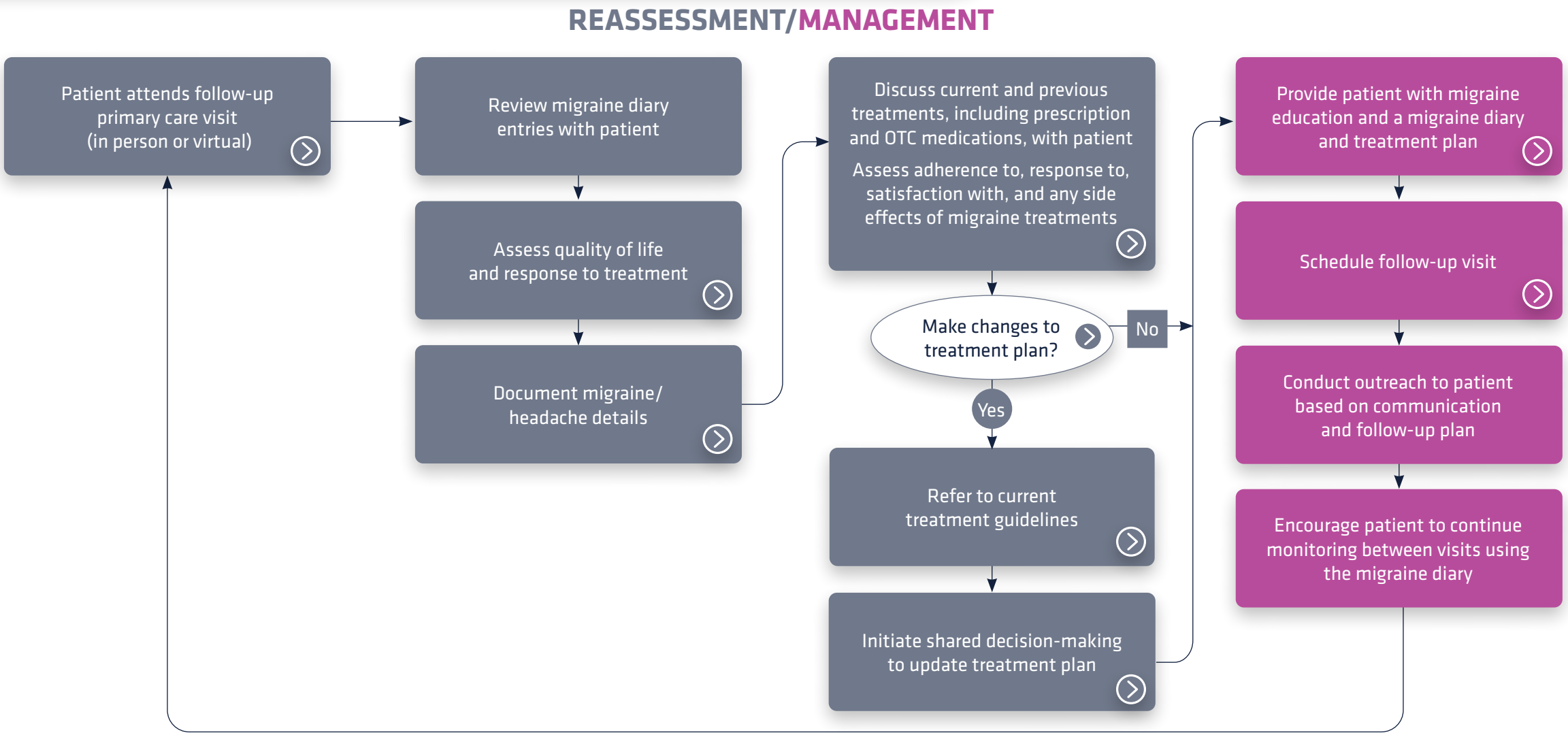
Optum and Pfizer codeveloped the resources in this toolkit in collaboration with subject matter experts with experience in primary care and neurology. These resources are aimed at helping health systems manage migraine in the primary care setting.

An example pathway for the assessment of headache and diagnosis of migraine in primary care



Abbreviations: ED, emergency department; OTC, over the counter.

An example pathway for the reassessment and management of migraine in primary care



Abbreviation: OTC, over the counter.

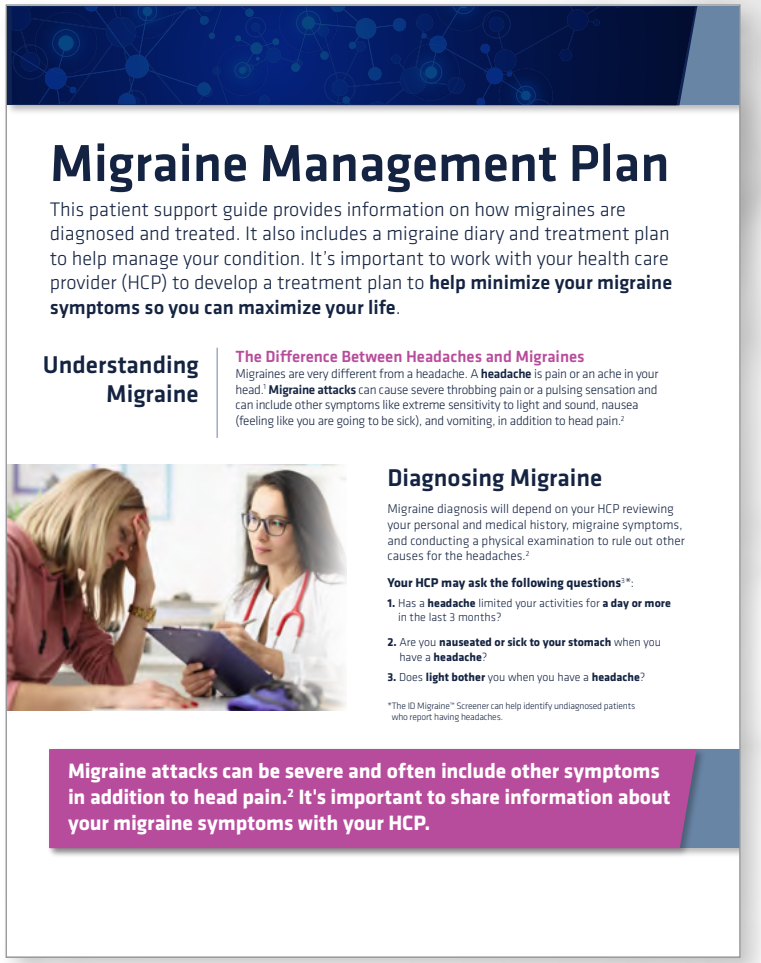
Migraine Management Plan

This patient support guide provides patients with an overview of migraine. It includes information on the diagnosis and treatment of migraine and a migraine diary and treatment plan to help patients track their experience.

This resource can be shared with patients digitally via the patient portal or printed and shared during an in-person visit.

Access the Migraine Management Plan:

www.pfi.sr/migraineptmgtplan



Migraine Management Plan

This patient support guide provides information on how migraines are diagnosed and treated. It also includes a migraine diary and treatment plan to help manage your condition. It's important to work with your health care provider (HCP) to develop a treatment plan to **help minimize your migraine symptoms so you can maximize your life**.

Understanding Migraine

The Difference Between Headaches and Migraines

Migraines are very different from a headache. A **headache** is pain or an ache in your head.[1] **Migraine attacks** can cause severe throbbing pain or a pulsing sensation and can include other symptoms like extreme sensitivity to light and sound, nausea (feeling like you are going to be sick), and vomiting, in addition to head pain.[2]

Diagnosing Migraine

Migraine diagnosis will depend on your HCP reviewing your personal and medical history, migraine symptoms, and conducting a physical examination to rule out other causes for the headaches.[2]

Your HCP may ask the following questions[3]*:

1. Has a **headache** limited your activities for **a day or more** in the last 3 months?
2. Are you **nauseated or sick to your stomach** when you have a **headache**?
3. Does **light bother** you when you have a **headache**?

*The ID Migraine™ Screener can help identify undiagnosed patients who report having headaches.

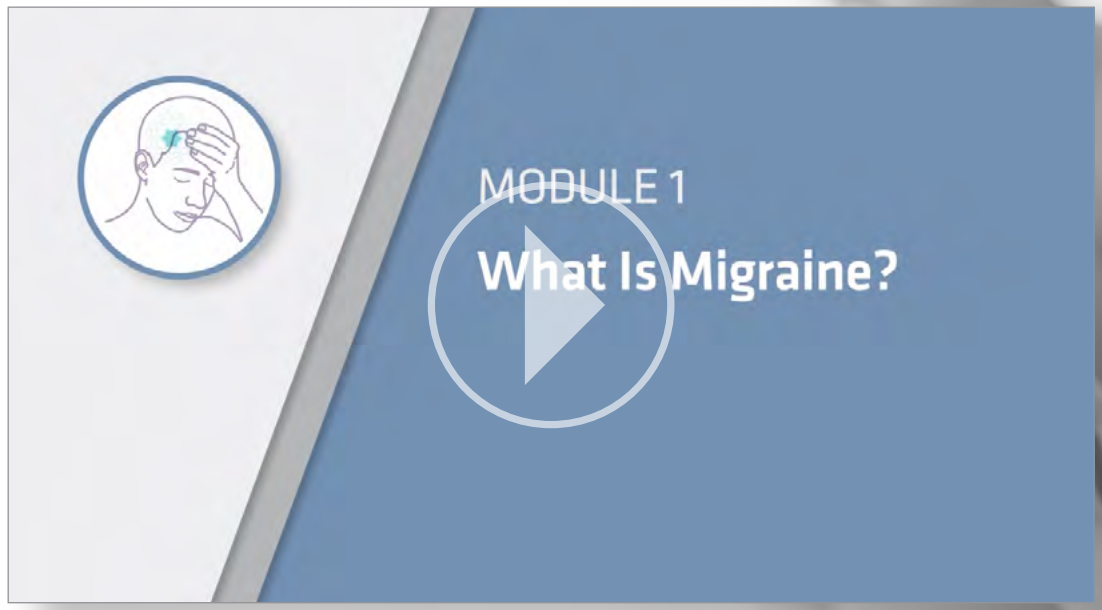
Migraine attacks can be severe and often include other symptoms in addition to head pain.[2] It's important to share information about your migraine symptoms with your HCP.

Migraine Patient Education Video

This educational video provides patients with an overview of migraine and its symptoms and treatment/management options, as well as the importance of tracking their experience and working with their HCP to develop a treatment plan that's right for them.

It includes 4 modules:

- **What Is Migraine?**
- **Understanding and Tracking Migraine Symptoms**
- **Managing and Tracking Your Migraine**
- **The Importance of Staying Connected**



Access the Migraine Patient Education Video:

www.pfi.sr/migraineptvideo

References: 1. Law HZ, Chung MH, Nissan G, Janis JE, Amirlak B. Hospital burden of migraine in United States adults: a 15-year National Inpatient Sample analysis. *Plast Reconstr Surg Glob Open*. 2020;8(4):e2790. doi:10.1097/GOX.0000000000002790 **2.** Durham PL. CGRP-receptor antagonists—a fresh approach to migraine therapy? *N Engl J Med*. 2004;350(11):1073-1075. doi:10.1056/NEJMp048016 **3.** Diagnosis. The Migraine Trust. Accessed November 14, 2023. https://migrainetrust.org/live-with migraine/healthcare/diagnosis/ **4.** Maurya A, Qureshi S, Jadia S, Maurya M. "Sinus headache": diagnosis and dilemma?? An analytical and prospective study. *Indian J Otolaryngol Head Neck Surg*. 2019;71(3):367-370. doi:10.1007/s12070-019-01603-3 **5.** Burch R, Rizzoli P, Loder E. The prevalence and impact of migraine and severe headache in the United States: updated age, sex, and socioeconomic-specific estimates from government health surveys. *Headache*. 2021;61(1):60-68. doi:10.1111/head.14024 **6.** GBD 2016 Headache Collaborators. Global, regional, and national burden of migraine and tension-type headache, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet Neurol*. 2018;17(11):954-976. doi:10.1016/S1474-4422(18)30322-3 **7.** Lipton RB, Dodick D, Sadovsky R, et al. A self-administered screener for migraine in primary care: the ID Migraine validation study. *Neurology*. 2003;61(3):375-382. doi:10.1212/01.wnl.0000078940.53438.83 **8.** Headache Classification Committee of the International Headache Society (IHS): the International Classification of Headache Disorders, 3rd edition. *Cephalalgia*. 2018;38(1):1-211 doi:10.1177/0333102417738202 **9.** Dodick DW. Pearls: headache. *Semin Neurol*. 2010;30(1):74-81. doi:10.1055/s-0029-1245000 **10.** Chou DE. Secondary headache syndromes. *Continuum (Minneap Minn)*. 2018;24(4, Headache):1179-1191. doi:10.1212/CON.0000000000000640 **11.** Ailani J, Burch RC, Robbins MS; Board of Directors of the American Headache Society. The American Headache Society Consensus Statement: update on integrating new migraine treatments into clinical practice. *Headache*. 2021;61(7):1021-1039. doi:10.1111/head.14153 **12.** Agency for Healthcare Research and Quality. The SHARE Approach: a model for shared decision making. AHRQ Pub. No. 14-0034-1-EF. April 2016. Accessed November 17, 2023. https://www.ahrq.gov/sites/default/files/publications/files/share-approach_factsheet.pdf **13.** Miller S. The acute and preventative treatment of episodic migraine. *Ann Indian Acad Neurol*. 2012;15(suppl 1):S33-S39. doi:10.4103/0972-2327.99998 **14.** Moreno-Ajona D, Villar-Martínez MD, Goadsby PJ. New generation gepants: migraine acute and preventive medications. *J Clin Med*. 2022;11(6):1656. doi:10.3390/jcm11061656 **15.** Stewart WF, Lipton RB, Whyte J, et al. An international study to assess reliability of the Migraine Disability Assessment (MIDAS) score. *Neurology*. 1999;53(5):988-994. doi:10.1212/wnl.53.5.988 **16.** Lipton RB, Kolodner K, Bigal ME, et al. Validity and reliability of the Migraine-Treatment Optimization Questionnaire. *Cephalalgia*. 2009;29(7):751-759. doi:10.1111/j.1468-2982.2008.01786.x

Appendix

The following pages provide additional information to support the example pathways for the management of migraine in primary care.

AWARENESS

Patient recognizes headache and contacts primary care office

Consider other routes for a primary care visit for migraine assessment, such as:

- Follow-up from wellness visit
- Referral from ED, urgent care clinic, or OB/GYN

Abbreviations: ED, emergency department; OB/GYN, obstetrics/gynecology.

AWARENESS

Schedule patient for primary care visit for migraine assessment and send intake forms

Consider documenting the following at intake:

- Number of migraine/headache days per month
- Migraine symptoms/headache severity
- Missed days of work/school
- Impairment of daily activities

Flag if patient was previously seen in urgent care or the ED.

Abbreviation: ED, emergency department.

DIAGNOSTIC ASSESSMENT

Conduct diagnostic assessment using standardized tools

ID Migraine | IHS Diagnostic Classification Criteria | Criteria for Secondary Headache Red Flags (SNOOP4)

Screener for Migraine in Patients Complaining of Headache: ID Migraine™[7]

To help identify undiagnosed patients who report having headaches, ask the following questions:

1. Has a headache limited your activities for a day or more in the last 3 months?
2. Are you nauseated or sick to your stomach when you have a headache?
3. Does light bother you when you have a headache?

If the patient answered "yes" to 2 or more of these questions, they may be suffering from migraine.

Two out of 3 symptoms: 93% positive predictive value*

Abbreviation: IHS, International Headache Society.

*A total of 563 patients presenting for routine primary care appointments and reporting headaches in the past 3 months completed a self-administered migraine screener. The 3-item ID Migraine Screener was found to have a sensitivity of 0.81 (95% CI, 0.77-0.85), specificity of 0.75 (95% CI, 0.64-0.84), and positive predictive value of 0.93 (95% CI, 89.9-95.8).

DIAGNOSTIC ASSESSMENT

Conduct diagnostic assessment using standardized tools

ID Migraine | **IHS Diagnostic Classification Criteria** | Criteria for Secondary Headache Red Flags (SNOOP4)

International Headache Society Diagnostic Classification Criteria[8]

Migraine with aura

A. At least 2 attacks fulfilling criteria B and C

B. At least 1 of the following fully reversible aura symptoms:

1. Visual
2. Sensory
3. Speech and/or language
4. Motor
5. Brainstem
6. Retinal

C. At least 3 of the following 6 characteristics:

1. At least 1 aura symptom spreads gradually over ≥5 minutes
2. Two or more aura symptoms occur in succession
3. Each individual aura symptom lasts 5–60 minutes
4. At least 1 aura symptom is unilateral
5. At least 1 aura symptom is positive
6. The aura is accompanied, or followed within 60 minutes, by headache

D. Not better accounted for by another ICHD-3 diagnosis

Migraine without aura

A. At least 5 attacks fulfilling criteria B–D

B. Headache attacks lasting 4–72 hours (when untreated or unsuccessfully treated)

C. Headache has at least 2 of the following 4 characteristics:

1. Unilateral location
2. Pulsating quality
3. Moderate or severe pain intensity
4. Aggravation by or causing avoidance of routine physical activity (eg, walking or climbing stairs)

D. During headache at least 1 of the following:

1. Nausea and/or vomiting
2. Photophobia and phonophobia

E. Not better accounted for by another ICHD-3 diagnosis

Chronic migraine

A. Headache (migraine-like or tension-type–like) on ≥15 days/month for >3 months, and fulfilling criteria B and C

B. Occurring in a patient who has had at least 5 attacks fulfilling criteria B–D for "Migraine without aura" and/or criteria B and C for "Migraine with aura"

C. On ≥8 days/month for >3 months, fulfilling any of the following:

1. Criteria C and D for "Migraine without aura"
2. Criteria B and C for "Migraine with aura"
3. Believed by the patient to be migraine at onset and relieved by a triptan or ergot derivative

D. Not better accounted for by another ICHD-3 diagnosis

Consider workup (eg, CBC, ESR, thyroid function tests) to rule out other conditions.

Abbreviations: CBC, complete blood count; ESR, erythrocyte sedimentation rate; ICHD-3, International Classification of Headache Disorders, 3rd edition; IHS, International Headache Society.

Conduct diagnostic assessment using standardized tools

Criteria for Secondary Headache Red Flags (SNOOP4)[9,10]

The following criteria are red flags to consider for referral to neurology or to rule out serious underlying conditions that may not be a migraine and may warrant further investigation:

- **S**ystemic Symptoms/Signs/Disease
  (fever, chills, rash, night sweats, myalgias, weight loss, HIV, immunocompromised state, malignancy, pregnancy or postpartum)
- **N**eurologic Symptoms/Signs
  (altered mental status or level of consciousness, diplopia, abnormal cranial nerve function, pulsatile tinnitus, loss of sensation, weakness, ataxia, history of seizure/collapse/loss of consciousness)
- **O**nset Sudden, Abrupt
  (onset sudden or first ever, severe or "worst" headache of life, thunder clap headache [pain reaches maximal intensity instantly after onset])
- **O**lder Age of Onset, Especially >50 Years
- **P**attern Change
  (progressive headache [eg, to daily, continuous pattern], precipitated by Valsalva maneuver, postural aggravation, papilledema)

Consider structural pathologies, vascular disorders, and infectious and inflammatory conditions when evaluating secondary headache syndromes.

DIAGNOSTIC ASSESSMENT

Document migraine/headache details and review discharge summary from ED or urgent care (if applicable)

Consider documenting the following at intake:

- Number of migraine/headache days per month
- Migraine symptoms/headache severity
- Missed days of work/school
- Impairment of daily activities

Flag if patient was previously seen in urgent care or the ED.

Abbreviation: ED, emergency department.

DIAGNOSTIC ASSESSMENT

Patient is diagnosed with migraine

Consider need for further evaluation (neurology/imaging/other evaluation) for atypical cases (eg, Criteria for Secondary Headache Red Flags [SNOOP4]).

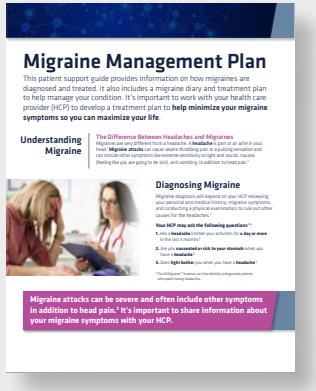
Official diagnosis may occur during the follow-up appointment:

- after receipt of labs to rule out other potential underlying reasons for severe headaches and/or
- after further evaluation for atypical cases requiring neurology/imaging/other evaluation

TREATMENT

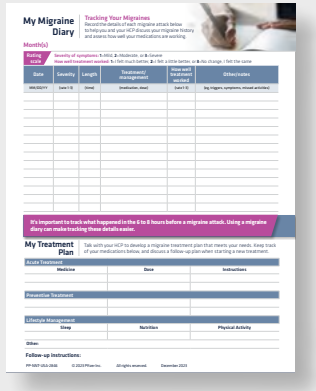
Patient provided with migraine education

Patient education resources:



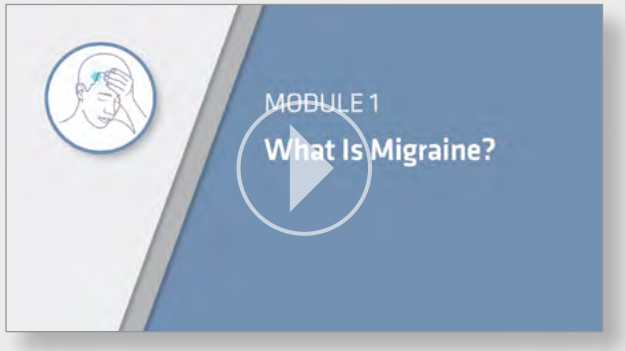
Migraine Management Plan

www.pfi.sr/migraineptmgtplan



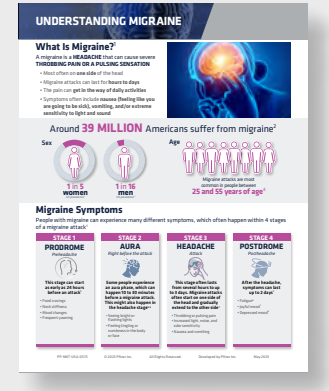
Migraine Diary/ Action Plan

www.pfi.sr/migraineptdiary



Migraine Patient Video

www.pfi.sr/migraineptvideo



Understanding Migraine Patient Education Leave-Behind

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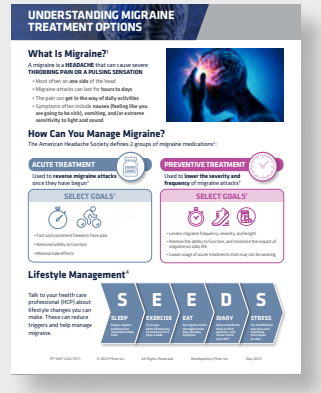

Understanding Migraine Treatment Options Patient Education Leave-Behind

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TREATMENT

Refer to current treatment guidelines

2021 AHS Acute Guidelines | 2021 AHS Preventive Guidelines

The American Headache Society (AHS) recommends that all patients who are with migraine should be offered acute treatment

The AHS Consensus Statement outlines goals and recommendations for integrating acute treatments into clinical practice[11]

GOALS	RECOMMENDATIONS
• Rapid and consistent freedom from pain without recurrence • Restored ability to function • Minimal need for repeat dosing or rescue medications • Optimal self-care and reduced subsequent use of resources • Minimal or no adverse events • Cost considerations	**All patients with a confirmed diagnosis of migraine should be offered acute pharmacologic and/or nonpharmacologic treatment** **Pharmacologic Treatment:** **1. Mild/moderate attacks** • NSAIDs, nonopioid analgesics, acetaminophen, or caffeinated analgesic combinations **2. For migraine attacks of greater severity** • Reference the AHS guidelines on acute pharmacologic migraine treatment **Nonpharmacologic Treatment:** A number of **nonpharmacologic** options may be used alone or as an adjunct to medication in the acute treatment of migraine.

Abbreviation: NSAIDs, nonsteroidal anti-inflammatory drugs.

TREATMENT

Refer to current treatment guidelines

2021 AHS Acute Guidelines | **2021 AHS Preventive Guidelines**

The American Headache Society (AHS) recommends that patients who are significantly impacted by migraines should be considered for preventive therapy

The AHS Consensus Statement outlines goals and recommendations for integrating preventive treatments into clinical practice[11]

GOALS	RECOMMENDATIONS
• Reduce attack frequency, severity, duration, and disability • Improve responsiveness to and avoid escalation in use of acute treatment • Improve function and reduce disability • Reduce reliance on suboptimal acute treatments • Reduce overall cost of migraine treatment • Enable patients to manage their own disease • Improve HRQOL • Reduce headache-related psychological symptoms	**Patients should be considered for preventive therapy in any of the following situations:** • Attacks significantly interfere with patients' daily routines despite acute treatment • Frequent attacks • Patient experiences 4 or 5 headache days per month with no disability, 3 headache days per month with some disability, or 2 headache days per month with severe disability • Contraindication to, failure of, or overuse of acute treatments • Adverse events with acute treatments • Patient preference Nonpharmacologic approaches to preventive treatment may be used alone or in combination with pharmacologic treatment.

Abbreviation: HRQOL, health-related quality of life.

Use shared decision-making to discuss current and previous treatments

Initiate shared decision-making to finalize treatment plan

Consider the AHRQ 5-step process for shared decision-making to ensure patients are engaged in their treatment plan[12]:

- **S**eek your patient's participation.
- **H**elp your patient explore and compare treatment options.
- **A**ssess your patient's values and preferences.
- **R**each a decision with your patient.
- **E**valuate your patient's decision.

Abbreviation: AHRQ, Agency for Healthcare Research and Quality.

TREATMENT

Use shared decision-making to discuss current and previous treatments

SHARE | **AHS Acute Therapy** | AHS Preventive Therapy

AHS select recommendations for acute therapy

Acute therapy: Intended to reduce pain, associated symptoms, and disability associated with attacks[13]

Patients: All patients with a confirmed diagnosis of migraine should be offered acute pharmacologic and/or nonpharmacologic treatment[11]

ACUTE THERAPY GOALS[11]	DRUGS USED IN THE ACUTE TREATMENT OF MIGRAINE[11]*
• Rapid and consistent freedom from pain without recurrence • Restored ability to function • Minimal need for repeat dosing or rescue medications • Optimal self-care and reduced subsequent use of resources • Minimal or no adverse events • Cost considerations	• Antiemetics • Ditans • Ergotamine/ergotamine derivatives • Gepants • Nonopioid analgesics • Triptans

When developing a treatment plan for patients with migraine, review the following:

- Reconciled patient medication list
- Adherence to, response to, satisfaction with, and tolerance of prescribed migraine treatments (if applicable)
- Patient use of OTC products (screen for potential medication-overuse headache)

Abbreviation: OTC, over the counter.

*Approved indications of the products listed may or may not specifically include treatment of migraine. Lists are nonexhaustive and are not intended to imply any clinical comparison among the products or classes mentioned. Products or classes should not be compared in the absence of head-to-head trials. For information regarding a specific product, please consult its Prescribing Information.

TREATMENT

Use shared decision-making to discuss current and previous treatments

SHARE | AHS Acute Therapy | **AHS Preventive Therapy**

AHS select recommendations for preventive therapy

Preventive therapy: Intended to **reduce the severity and frequency** of migraine attacks[13]

RECOMMENDATIONS[11]	SELECT PREVENTIVE THERAPY GOALS[11]	DRUGS USED IN THE PREVENTIVE TREATMENT OF MIGRAINE[11,14]*
Patients should be considered for preventive therapy in any of the following situations: • Attacks significantly interfere with patients' daily routines despite acute treatment • Frequent attacks • Patient experiences 4 or 5 headache days per month with no disability, 3 headache days per month with some disability, or 2 headache days per month with severe disability • Contraindication to, failure of, or overuse of acute treatments • Adverse events with acute treatments • Patient preference	• Reduce attack frequency, severity, duration, and disability • Enable patients to manage their own disease • Improve function/HRQOL and reduce disability • Improve responsiveness to and avoid escalation in use of acute treatment	• Antidepressants • Antihypertensives • Anticonvulsants • Botulinum toxin • CGRP monoclonal antibodies • Gepants • NMDA antagonists

When developing a treatment plan for patients with migraine, review the following:
- Reconciled patient medication list
- Adherence to, response to, satisfaction with, and tolerance of prescribed migraine treatments (if applicable)
- Patient use of OTC products (screen for potential medication-overuse headache)

Abbreviations: CGRP, calcitonin gene-related peptide; HRQOL, health-related quality of life; NMDA, N-methyl-D-aspartate; OTC, over the counter.

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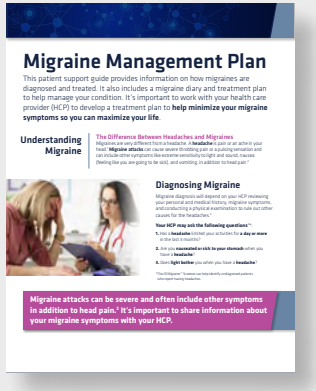
MANAGEMENT

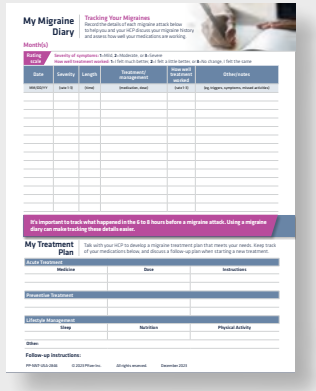
Provide patient with migraine education and a migraine diary and treatment plan

Patient education resources:



Migraine Management Plan

www.pfi.sr/migraineptmgtplan



Migraine Diary/ Action Plan

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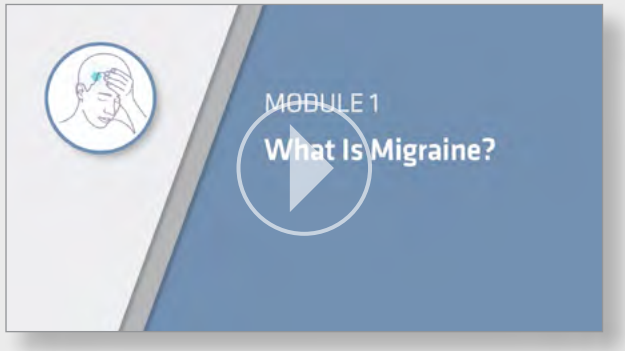
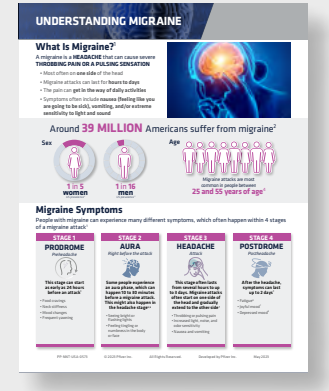


Migraine Patient Video

www.pfi.sr/migraineptvideo



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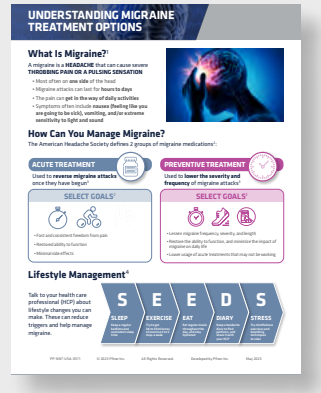


Understanding Migraine Treatment Options Patient Education Leave-Behind

www.pfi.sr/migrainetreatmentedunl

MANAGEMENT

Create communication and follow-up plan with patient

- Ensure that the patient has a follow-up plan when they start a new treatment and that they know when to contact the office
- Reinforce with the patient the importance of using a migraine diary to track their migraine symptoms/headache severity, attacks, and response to treatment

REASSESSMENT/MANAGEMENT

Patient attends follow-up primary care visit (in person or virtual)

Consider that patients may be returning from a neurology referral or may have had an interim visit to the ED, urgent care clinic, or OB/GYN.

Abbreviations: ED, emergency department; OB/GYN, obstetrics/gynecology.

REASSESSMENT/MANAGEMENT

Assess quality of life and response to treatment

MIDAS | mTOQ-5 | Refer to Neurology

The **Migraine Disability Assessment (MIDAS)** questionnaire can help assess a patient's level of pain and disability caused by a migraine headache.[15]

1. On how many days in the last 3 months did you miss work or school because of your headaches? _____ days

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.) _____ days

3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches? _____ days

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.) _____ days

5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches? _____ days

_____ Total

A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.) _____ days

B. On a scale of 0-10, on average how painful were these headaches? (Where 0=no pain at all, and 10=pain as bad as it can be.)

MIDAS Grade	Definition	MIDAS Score
I	Little or No Disability	0-5
II	Mild Disability	6-10
III	Moderate Disability	11-20
IV	Severe Disability	21+

REASSESSMENT/MANAGEMENT

Assess quality of life and response to treatment

MIDAS | **mTOQ-5** | Refer to Neurology

The **Migraine Treatment Optimization Questionnaire (mTOQ-5)** can assess efficacy of acute treatment.[16]

1. Can you count on your migraine medication to relieve your pain within 2 hours for most attacks?

❍ Yes ❍ No

2. Does one dose of your migraine medication usually relieve your headache and keep it away for at least 24 hours?

❍ Yes ❍ No

3. Are you able to quickly return to your normal activities (ie, work, family, leisure, social activities) after taking your migraine medication?

❍ Yes ❍ No

4. Is your migraine medication well tolerated?

❍ Yes ❍ No

5. Are you comfortable enough with your migraine medication to be able to plan your daily activities?

❍ Yes ❍ No

Scoring:
If all 5 questions are answered **"yes,"** treatment is satisfactory; an answer of **"no"** to any single question suggests that a change in treatment may need to be considered.

REASSESSMENT/MANAGEMENT

Assess quality of life and response to treatment

MIDAS | mTOQ-5 | **Refer to Neurology**

Referral to neurology for further evaluation of atypical cases (red flags)

- Unexpected/unusual change
- Poor response to multiple treatment strategies
- Increase or no change in frequency, symptoms, and/or disability

REASSESSMENT/MANAGEMENT

Document migraine/headache details

Consider documenting the following at intake:

- Number of migraine/headache days per month
- Migraine symptoms/headache severity
- Missed days of work/school
- Impairment of daily activities
- Response to treatment

REASSESSMENT/MANAGEMENT

Discuss current and previous treatments, including prescription and OTC medications, with patient

If discontinued, document reasons for failure (eg, lack of response, intolerance/adverse events).

Abbreviation: OTC, over the counter.

REASSESSMENT/MANAGEMENT

Make changes to treatment plan?

Consider referral for further evaluation (neurology/imaging/other evaluation) of atypical cases (eg, Criteria for Secondary Headache Red Flags [SNOOP4]) such as:

- Unexpected/unusual change
- Poor response to multiple treatment strategies

REASSESSMENT/MANAGEMENT

Refer to current treatment guidelines

2021 AHS Acute Guidelines | 2021 AHS Preventive Guidelines

The American Headache Society (AHS) recommends that all patients with migraine should be offered acute treatment

The AHS Consensus Statement outlines goals and recommendations for integrating acute treatments into clinical practice[11]

GOALS	RECOMMENDATIONS
• Rapid and consistent freedom from pain without recurrence • Restored ability to function • Minimal need for repeat dosing or rescue medications • Optimal self-care and reduced subsequent use of resources • Minimal or no adverse events • Cost considerations	**All patients with a confirmed diagnosis of migraine should be offered acute pharmacologic and/or nonpharmacologic treatment** **Pharmacologic Treatment:** **1. Mild/moderate attacks** • NSAIDs, nonopioid analgesics, acetaminophen, or caffeinated analgesic combinations **2. For migraine attacks of greater severity** • Reference the AHS guidelines on acute pharmacologic migraine treatment **Nonpharmacologic Treatment:** A number of **nonpharmacologic** options may be used alone or as an adjunct to medication in the acute treatment of migraine.

Abbreviation: NSAIDs, nonsteroidal anti-inflammatory drugs.

REASSESSMENT/MANAGEMENT

Refer to current treatment guidelines

2021 AHS Acute Guidelines | **2021 AHS Preventive Guidelines**

The American Headache Society (AHS) recommends that patients who are significantly impacted by migraines should be considered for preventive therapy

The AHS Consensus Statement outlines goals and recommendations for integrating preventive treatments into clinical practice[11]

GOALS	RECOMMENDATIONS
• Reduce attack frequency, severity, duration, and disability • Improve responsiveness to and avoid escalation in use of acute treatment • Improve function and reduce disability • Reduce reliance on suboptimal acute treatments • Reduce overall cost of migraine treatment • Enable patients to manage their own disease • Improve HRQOL • Reduce headache-related psychological symptoms	**Patients should be considered for preventive therapy in any of the following situations:** • Attacks significantly interfere with patients' daily routines despite acute treatment • Frequent attacks • Patient experiences 4 or 5 headache days per month with no disability, 3 headache days per month with some disability, or 2 headache days per month with severe disability • Contraindication to, failure of, or overuse of acute treatments • Adverse events with acute treatments • Patient preference Nonpharmacologic approaches to preventive treatment may be used alone or in combination with pharmacologic treatment.

Abbreviation: HRQOL, health-related quality of life.

REASSESSMENT/MANAGEMENT

Initiate shared decision-making to update treatment plan

Consider the AHRQ 5-step process for shared decision-making to ensure patients are engaged in their treatment plan[12]:

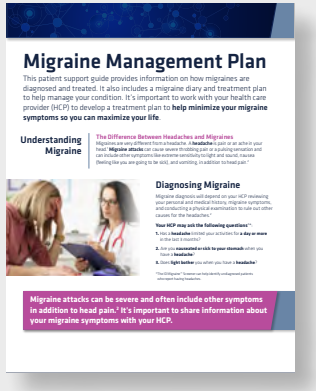
- **S**eek your patient's participation.
- **H**elp your patient explore and compare treatment options.
- **A**ssess your patient's values and preferences.
- **R**each a decision with your patient.
- **E**valuate your patient's decision.

Abbreviation: AHRQ, Agency for Healthcare Research and Quality.

REASSESSMENT/MANAGEMENT

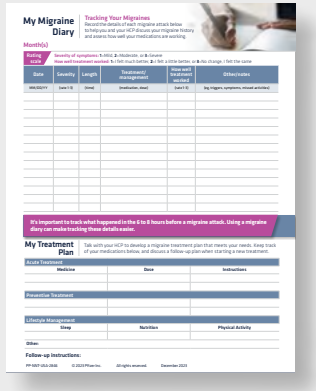
Provide patient with migraine education and a migraine diary and treatment plan

Patient education resources:



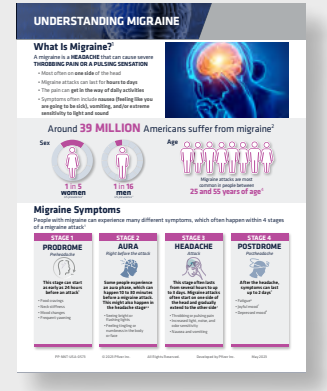
Migraine Management Plan

www.pfi.sr/migraineptmgtplan



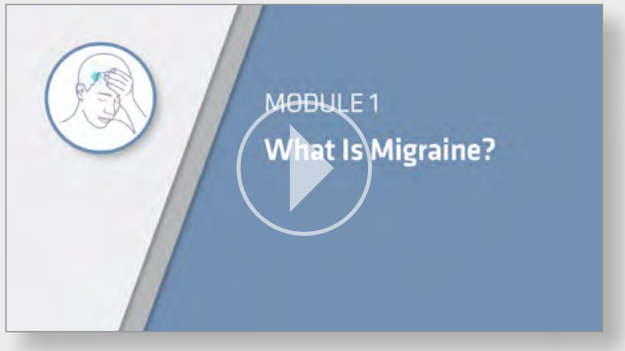
Migraine Diary/ Action Plan

www.pfi.sr/migraineptdiary



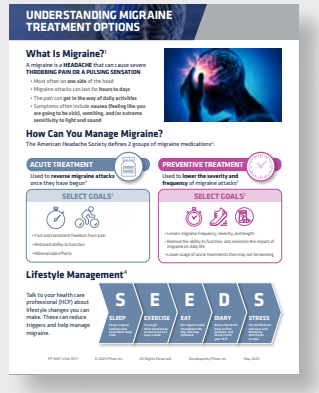
Understanding Migraine Patient Education Leave-Behind

www.pfi.sr/migrainepatientedunl



Migraine Patient Video

www.pfi.sr/migraineptvideo



Understanding Migraine Treatment Options Patient Education Leave-Behind

www.pfi.sr/migrainetreatmentedunl

REASSESSMENT/MANAGEMENT

Schedule follow-up visit

- Ensure that the patient has a follow-up plan when they start a new treatment and that they know when to contact the office
- Reinforce with the patient the importance of using a migraine diary to track their migraine symptoms/headache severity, attacks, and response to treatment