Notes for GPs prescribing Rimegepant. Acute and preventative management

Background

Rimegepant was the first oral calcitonin gene-related peptide (CGRP) blocker and is part of the Gepant group of drugs. CGRP is an important transmitter involved in the migraine mechanism. Figure one shows CGRP antagonists that are currently available. The IM preparations are specialist prescription only. Rimegepant has few side effects and drug interactions. It costs around £200 a month.

Medication Class & Administration route	Indication	Brand Name
Gepants (oral)		
Rimegepant (wafer)	Acute migraine Episodic migraine prevention	**VYDURA**
Atogepant (tablet)	Migraine prevention	**QULIPTA**
Monoclonal Antibody Therapies (parenteral)		
Eptinezumab (IV)	Migraine prevention	**VYEPTI**
Erenumab (IM)	Migraine prevention	**AIMOVIG**
Galcanezumab (IM)	Migraine prevention	**EMAGALITY**
Fremenezumab (IM)	Migraine prevention	**AJOVY**

Figure 1. CGRP antagonists for migraine prevention

Clinical management

For acute intervention

One wafer is taken at onset of pain, up to once a day. It can be prescribed after two triptans have not worked or caused intolerable side effects. In practice, trying three triptans is more appropriate with consideration of nasal or injectable preparations if severe nausea or vomiting is present. Maximum 15 tablets a month. There is currently no evidence of medication overuse headache.

Prevention

One 75mg wafter is taken daily, every other day. Rimegepant comes in packs of 2, 8 and 16 tablets. For initiation, patients must have between 4 and 15 migraine attacks a month and have tried and not found effective three other tablet preventers.

- The effectiveness of Rimegepant should be reviewed at three months to determine if the frequency of migraine days has reduced by at least 50%. If the response to treatment meets these criteria, it can be continued*. If it has not, then switch to Atogepant and review again after three months.
    - **It is acceptable to continue therapy for another three months pending further review if a person who experiences migraine feels that they have benefitted from Rimegepant and have restored quality of life but have not achieved these criteria.*
- It is good practise to review at one year and consider withdrawal. Migraine sits within a complex biopsychosocial context and after a year of good control, the drug may no longer be required.
- Annual migraine review is also good practise.
- Routine blood monitoring is not required.
- Hepatic impairment: No dose adjustment in mild or moderate hepatic impairment. Avoid in severe hepatic impairment.
- Renal impairment: No dose adjustment in mild, moderate or severe renal impairment. Caution during frequent use in severe renal impairment.
- Avoid in severe hepatic impairment and end-stage renal impairment (CrCL< 15ml/min).

Side effects

- Hypersensitivity to drug.
- Nausea.

Drug interactions

CYP3A4 inhibitors

Inhibitors of CYP3A4 increase plasma concentrations of rimegepant. Concomitant administration of rimegepant with strong CYP3A4 inhibitors (e.g., clarithromycin, itraconazole, ritonavir) is not recommended Concomitant administration of rimegepant with itraconazole resulted in a significant increase in rimegepant exposure.

Concomitant administration of rimegepant with medicinal products that moderately inhibit CYP3A4 (e.g., diltiazem, erythromycin, fluconazole) may increase exposure to rimegepant.

CYP3A4 inducers

Inducers of CYP3A4 decrease plasma concentrations of rimegepant. Concomitant administration with strong CYP3A4 inducers (e.g., phenobarbital, rifampicin, St John's wort (*Hypericum perforatum*)) or moderate CYP3A4 inducers (e.g., bosentan, efavirenz, modafinil) is not recommended.

Pregnancy and breastfeeding.

Insufficient data to support prescribing in this group.