MIGRAINE FOUNDATION
Aotearoa New Zealand
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Feedback to the Pharmacology and Therapeutics Advisory Committee (PTAC) on their decision regarding the funding of erenumab

Contact

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This feedback from Migraine Foundation Aotearoa New Zealand pertains to the published PTAC meeting notes from 19-20 August 2021. The Foundation would welcome further discussion and input into any decisions made by Pharmac relevant to the management of migraine disease.

- In section 11.8, "The Committee considered that it was reasonable to estimate migraine prevalence of 1.8% in New Zealand." This may in fact represent the Committee's estimate of **chronic** migraine in New Zealand, but this needs to be clarified. It would be unreasonable and unscientific for the Committee to estimate an **overall migraine prevalence** of 1.8% in New Zealand.
- In section 11.8, PTAC states "that migraine prevalence (including tension-type headache) in New Zealand was reported to be about 17% of the 2016 population by a systematic analysis of migraine and tension-type headache for the Global Burden of Disease Study 2016 (GBD 2016 Headache Collaborators. Lancet Neurol. 2018;17:954-976), however this overestimated the size of the migraine population by including tension-type headache." This is **incorrect**. The estimate was in actual fact, 15.5% in 2016 (https://ghdx.healthdata.org/gbd-results-tool), and this is purely for the prevalence of migraine. The prevalence of tension-type headache was estimated to be 31.2% in 2016, and the combined prevalence of headache disorders was 38.6%. This is comparable to the global prevalence of headache disorders (34.6%), migraine (15.1%) and tension-type headache (26.8%) in 2016.
- Also in section 11.8, "The Committee … not[ed] that there is poor data for the prevalence of migraine in New Zealand and to inform whether there is any difference in prevalence between Māori, Pacific peoples or non-Māori and non-Pacific populations." The Committee does not acknowledge New Zealand-specific information on migraine prevalence. From the 2006/07 New Zealand Health Survey, the prevalence of migraine in women was estimated at 13% for women and 5.5% for men.[1] Rates were similar for Māori but lower for Pacific and Asian people (ethnic-specific data from this survey are available online at https://www.health.govt.nz/publication/portrait-health-online-data-tables-2006-07-new-zealand-health-survey-results). Lower rates for Pacific people could be due to a lower rate of migraine diagnosis amongst Pacific patients with headache, as has been shown in a study from South Auckland.[2] More current data on ethnic-specific migraine prevalence would be advantageous, but from this existing data, there is no reason to think there is a lower prevalence in Māori.

- The Committee failed to acknowledge the gender inequality of migraine disease (three times more common in women) and the unequal impact on working-age people.[3] A recent analysis from Australia estimated the total economic cost of migraine to be A$35.7 billion, including health system and productivity costs.[4] Assuming similar conditions in New Zealand, the economic cost is likely to run into the billions. A more comprehensive assessment of the economic cost and disability burden of migraine may have led the Committee to assign a higher priority to the funding of erenumab.
- In section 11.20, "the Committee considered that the most appropriate use of erenumab would be for patients with episodic or chronic migraine who have trialled three prophylactic agents previously... The Committee considered that, patients with chronic migraine would have a greater health need and may receive greater benefit from funded access to erenumab compared with episodic migraine." This is a very vague justification for restricting access to only those with chronic migraine. NICE guidance recommends erenumab as an option for those with 4 or more migraine days a month, i.e. includes those with both episodic and chronic migraine.[5] The evidence considered by NICE supported a cost-effective treatment effect in those with moderate-high frequency episodic migraine.
- In section 11.23.2, the Committee reflected on the possible impact of prescribing erenumab on primary care, commenting that "the effects of having to manage a monoclonal antibody like erenumab could affect that sector's capacity to treat patients with other conditions." It is not clear what the Committee is basing this comment on. From our patients' experience, we would argue that the difficulty of managing a patient with chronic migraine who is not responding to other prophylactic medications would be at least as great if not greater than managing a patient with chronic migraine who is trialling erenumab. This comment could be understood to mean that the Committee is arguing against the provision of erenumab because this might mean patients with other conditions are not so well served, with an implicit assumption that migraine is not as deserving of treatment as other conditions. It would be helpful if the Committee were more explicit in the intent and implication behind this comment.
- In section 11.23, the Committee also commented about the experience and capability of GPs to manage monoclonal antibody (mab) treatments. Variable experience and comfort among GPs in overseeing mab treatment should not be a barrier to providing these treatments. Again, the intent and implications of these comments were not clear. GPs are in general quick to adapt to new treatments and are increasing in confidence with managing mabs, and erenumab has few side effects or serious issues to be aware of.
- 11.24 "The Committee considered that syringe disposal by pharmacies or GP clinics may not be feasible therefore disposal requirements and costs, in the absence of a supplier-led disposal programme, may fall on secondary care." Disposal of syringes at pharmacies is not usually a problem, see commentary from Diabetes NZ (https://www.diabetes.org.nz/safe-sharps-disposal). In the case of erenumab, which is administered via a pre-filled syringe with a retractable needle, this is extremely unlikely to be a significant issue or a burden for secondary care services.

Recommendations

- That the Committee review, revise and clarify their estimates of migraine prevalence in New Zealand, including ethnic-specific estimates.

- That the Committee include a fuller consideration of the disability burden and economic costs of migraine in their funding priority decisions.
- That the Committee provide a clear and evidence-based justification for excluding people with moderate-high frequency episodic migraine from funded erenumab or else expand the criteria to include people with moderate-high frequency episodic migraine.
- That the Committee seek further advice from the Neurology Subcommittee on the proposed Special Authority criteria, the impact on secondary services and the burden of syringe disposal. We support the proposal that referral to a neurologist is NOT required to access erenumab, due to the concerns around equity that the Committee discussed.
- That the Committee consult with relevant patient groups, to improve their understanding of the patient impacts of new medicines.

References

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3. Stovner LJ, Nichols E, Steiner TJ, et al. 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. doi:10.1016/S1474-4422(18)30322-3
4. Deloitte Access Economics. *Migraine in Australia Whitepaper*.; 2018.
5. National Institute for Health and Care Excellence (NICE). *Erenumab for Preventing Migraine. Technology Appraisal Guidance 682*.; 2021. www.nice.org.uk/guidance/ta682