30 April 2025

To whom it may concern

Re: Application to Pharmac for funding of fremanezumab

Migraine Foundation Aotearoa New Zealand is a charity supporting the estimated 753,000 people living with migraine in Aotearoa. Migraine is a leading cause of chronic pain and disability,[1] affecting people's ability to work and quality of life.[2]

Pre-anti-CGRP migraine preventives

Up until the first phase 3 trials of monoclonal antibodies targeting calcitonin gene-related peptide (CGRP) in 2017, none of the medications used for prevention of migraine had been specifically developed for migraine treatment. They were medications that had been accidentally or serendipitously discovered to have some efficacy for migraine prevention, but were primarily designed for other purposes, such as treating epilepsy, mood disorders and hypertension. As such, these medications have many unwanted side effects when used to treat migraine and are often poorly tolerated. Even among people with chronic migraine (experiencing 15 or more headache days a month), only 17-20% persist with oral preventive medications after 12 months.[3] These medications also have a slow onset of action, requiring a trial of at least 8 weeks at the maximally tolerated dose before efficacy can be assessed, and efficacy is defined as a 50% reduction in headache frequency,[4] an outcome that can still leave people with a significant pain and disability burden.

About anti-CGRP preventive medications

The new anti-CGRP medications represent a revolution in migraine treatment. Not only do they have a much improved safety and tolerability profile, they have an early onset of action, minimal interactions with other medications and are effective even in the presence of medication-overuse headache, in menstrual migraine and when multiple other preventive

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[1] Steiner, T.J., Stovner, L.J., Vos, T. et al. Migraine is first cause of disability in under 50s: will health politicians now take notice? J Headache Pain 2019;1(19):17

[2] Garrett, S.M.; Imlach, F. The Impact of Living with Migraine Disease in Aotearoa New Zealand. New Zealand Medical Journal 2024; 137: 54–76

[3] Hepp Z, Dodick DW, Varon SF, Gillard P, Hansen RN, Devine EB. Adherence to oral migraine-preventive medications among patients with chronic migraine. Cephalalgia. 2015 May;35(6):478-8

[4] Ailani J, Burch RC, Robbins MS; the 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: 1021–1039

medications have failed, all situations which have traditionally been very difficult to manage.[5] In addition, efficacy of anti-CGRP medications from clinical trials (measuring migraine frequency at 3 months) has been comparable or better than other preventive treatments but open-label studies over longer time frames have demonstrated not only sustained improvements but significant levels of remission (100% reduction in migraine frequency).[6]

For these reasons, anti-CGRP medications are now recommended as first line treatment options for migraine prevention by the American Headache Society[7] and the European Headache Federation.[8] In addition, for the anti-CGRP monoclonal antibodies (of which there are currently four, including fremanezumab), there is now evidence that switching between these medications for people who do not initially respond is an effective strategy, resulting in a significant reduction in migraine frequency.[9] Accordingly, to optimise treatment effectiveness, we need access to more than one and ideally all of the anti-CGRP monoclonal antibodies and gepants, because of differences in:

- their action (e.g. on the ligand or receptor),
- formulation (e.g. oral, subcutaneous or intravenous), and
- timing of administration (daily/every other day, monthly or quarterly).

Fremanezumab can be delivered quarterly, with three-monthly injections. Having a range of options allows for patient choice according to preferences.[10] For example:

- for people who are travelling frequently, a quarterly injection administration would be an advantage
- for people in Aotearoa who are using one of the currently available monthly monoclonal antibody injections, managing the injection during travel for work or

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[5] Kubota GT. It is time anti-CGRP monoclonal antibodies be considered first-line prophylaxis for migraine. Arq Neuropsiquiatr. 2022 May;80(5 Suppl 1):218-226

[6] Ibid

[7] Charles AC, Digre KB, Goadsby PJ, Robbins MS, Hershey A; American Headache Society. Calcitonin gene-related peptide-targeting therapies are a first-line option for the prevention of migraine: An American Headache Society position statement update. Headache. 2024 Apr;64(4):333-341

[8] Sacco S, Amin FM, Ashina M, et al. European Headache Federation guideline on the use of monoclonal antibodies targeting the calcitonin gene related peptide pathway for migraine prevention - 2022 update. J Headache Pain. 2022 Jun 11;23(1):67.

[9] Jaimes A, Gómez A, Pajares O, Rodríguez-Vico J. Effectiveness of switching strategies in CGRP monoclonal antibody therapy for migraine: A retrospective cohort study. Headache. 2025 Apr;65(4):619-630

[10] Schwedt TJ, Martin A, Kymes S, et al. Patient preferences for attributes of injected or infused preventive migraine medications: Findings from a discrete choice experiment. Headache. 2023; 63: 484-493

holidays is a frequent question and discussion point in our online support group, due to the need for this to be refrigerated, with a maximum seven day period at room temperature.

Impact of new preventive medications

From our survey of people with migraine in 2022, 43% of people who had frequent and disabling migraine attacks were not taking preventive medication, including over a quarter of people with chronic migraine, and poor tolerability and poor efficacy were common reasons for discontinuation of preventives.[11] Having new migraine medications on the horizon gave hope to those who had not had success with other preventives but cost was a significant barrier and will exacerbate inequities between people with migraine who can afford to access health care and self-fund treatment and those who cannot.

Access to effective migraine-specific preventive therapies like fremanezumab is not only a clinical issue but also an economic and societal one. Migraine is a leading cause of disability among people aged 15-49 years, the most economically productive age group.[12] International modelling studies have shown that effective migraine prevention reduces absenteeism, presenteeism, emergency department visits, and healthcare utilization costs.[13] Although there have been no studies in New Zealand on the economic cost of migraine, the total economic burden of migraine has been estimated at around £12 billion in the UK.[14] Because of the impact of migraine on productivity, the cost of migraine due to productivity loss is much greater even than direct healthcare costs.[15] Providing funded access to more effective treatments like fremanezumab could reduce this burden significantly, not only improving quality of life but also delivering meaningful economic benefits to the health system and society.

Support for fremanezumab and other new migraine-specific preventives

We are writing in support of Pharmac funding a range of new migraine medications, including fremanezumab, and to emphasise the importance of providing adequately funded

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[11] Imlach, F.; Garrett, S. Use of Medications for Migraine in Aotearoa New Zealand. New Zealand Medical Journal 2024, 137: 65–87

[12] Steiner TJ, Husøy A, Stovner LJ. GBD2021: headache disorders and global lost health - a focus on children, and a view forward. J Headache Pain 2024, 25:91

[13] Láinez MJ. The effect of migraine prophylaxis on migraine-related resource use and productivity. CNS Drugs. 2009;23(9):727-38

[14] Martins, R., Large, S., Russell, R., et al. The Hidden Economic Consequences of Migraine to the UK Government: Burden-of-Disease Analysis Using a Fiscal Framework. J Health Econ Outcomes Res 2023: 10:72.

[15] Linde, M. et al. The cost of headache disorders in Europe: the Eurolight project. Eur J Neurol 2021, 19, 703-e43.

evidence based treatments for all people with migraine, not only those that can afford to pay for them. These new anti-CGRP medications address a significant unmet need for effective, safe and well-tolerated migraine preventives in Aotearoa. The addition of more effective medications is an essential step towards New Zealanders with migraine having access to world-class, best practice healthcare. We urge Pharmac to consider the broader economic impact of funding new migraine-specific preventives, alongside clinical efficacy and patient quality of life.

Migraine Foundation Aotearoa New Zealand would be happy to present at the Pharmac meeting when the application for fremanezumab is considered, to provide a consumer perspective on the impact of migraine in Aotearoa and experiences of medication use from our community.

Sincerely

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On behalf of Migraine Foundation Aotearoa New Zealand and Clinical Advisory Group members:

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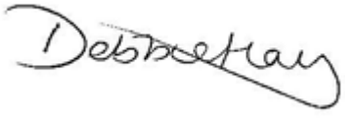
- Dr Ray Bose (Neurologist and Headache Specialist, Auckland)
- Dr Kiri Brickell (Neurologist, Auckland)
- Dr Jonathan Kennedy (General Practitioner, Wellington)

Also supported by:



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