

DRUG CLASS: 5HT₁ agonists
BRAND NAME: Relpax tablet 20 mg
(Generic) (eletriptan) 40 mg

FDA INDICATIONS:

Oral eletriptan is indicated for the acute treatment of migraine with or without aura in adults. The 5-HT₁ agonists are not intended for the prophylactic therapy of migraine or for use in the management of hemiplegic or basilar migraine. Safety and effectiveness have also not been established for cluster headache.

ICD-9 Codes:

Migraine-with aura (“classic”): 346.0
Migraine-idiopathic/ without aura (“common”): 346.1

<u>QL CRITERIA:</u>	<u>Short Term:</u>	<u>Extended Supply:</u>
	320 mg per 30 days	960 mg per 90 days
Relpax 20 mg	16 tablets	48 tablets
Relpax 40 mg	8 tablets	24 tablets
<ul style="list-style-type: none"> <i>If patient requires amounts in excess of these numbers, please follow the <u>Quantity Limitations (QL)</u> criteria for Relpax.</i> 		

RATIONALE:

Relpax (eletriptan) tablets - Eletriptan has a maximum dose of 80 mg per day, and can be used for up to 4 migraine headaches per month, or 320 mg per month.

CRITERIA FOR EXCEEDING QUANTITY LIMITATIONS:

1. Convey to physician the amount of the drug that the patient has already received (refer to QL criteria) and ask if the patient needs more than that amount. **AND**
2. Patient must have diagnosis of moderate to severe migraine headache. (Tension type and chronic daily headaches are NOT appropriate diagnoses). **AND**
3. Must have tried and failed at least 2 other abortive migraine therapy. Examples of medications used for abortive therapy include:
 - Ibuprofen (Motrin®)
 - Diclofenac (Voltaren®)
 - Flurbiprofen (Ansaid®)
 - Ergotamine containing products (Cafergot, Wigraine, Ergomar, etc.)
 - Isometheptene mucate/Dichloralphenazone/Acetaminophen. (Midrin, etc.) **AND**
4. If patient experiences >4 migraine headaches per month, prophylactic therapy should be considered (see Table below). **AND**
5. The possibility of medication-induced, rebound, or chronic daily headache should be considered. **AND**
6. **Deny** if to be used in combination with another triptan (e.g., Zomig, Amerge, Imitrex, Frova, Maxalt, Axert) or an ergotamine (e.g., Migranal, Cafergot) due to possibility of increased blood pressure effect.

BLACK BOX WARNINGS:

None

RATIONALE:

- Aspirin, acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs) and combination products containing these key ingredients are generally considered first line abortive therapy for migraine.
- Prophylactic migraine therapy may reduce the frequency and severity of migraine attacks.
- Quantity limitations criteria are intended to prevent inappropriate use of the triptans.

NURSING ASSESSMENT:

1. Gather a complete medical history; note any contributing factors (i.e., smoker, diet, alcohol consumption, use of OTC medications, stress, etc.). Include migraine history and any precipitating factors.
2. Determine any history of cardiac problems or evidence of ischemic cardiovascular disease, as drug is contraindicated.
3. Ensure that a neurological examination has been performed to identify appropriate migraine category.
4. Obtain baseline ECG, liver (AST, ALT), and renal function tests.

PROVIDER EDUCATION:

1. Review appropriate method for administration (oral).
2. Dizziness, paresthesia, headache, dry mouth, fatigue, and flushing are the most common adverse effects.
3. Pfizer Medical Information: 800-438-1985

MISUSE AND CHRONIC DAILY HEADACHE:

Chronic Daily Headache (CDH) is a syndrome that consists of a group of disorders that can be sub-classified into primary and secondary types. Drug-induced daily headache frequently arises during headache therapy. It can result from the daily use of ergotamines and excessive amounts of common analgesics. CDH usually manifest itself as a constant dull pressure in the frontal and occipital areas. Most of the patients will complain of headache upon awakening in the morning. The symptomatic medications used for the immediate relief of headache may actually perpetuate the headache if used frequently and in excessive quantities. Therapy of drug-induced headache is withdrawal of the responsible medication.

CLINICAL OUTCOME:

Reversal of acute migraine attack and relief of associated symptoms.

DOSAGE AND ADMINISTRATION:

The eletriptan dose for the treatment of acute migraine in adults is 20 mg or 40 mg. A second dose may be taken no sooner than 2 hours after the initial dose. The total daily dose should not exceed 80 mg. There is no evidence that a second dose of eletriptan is effective in patients who do not respond to a first dose of the drug for the same headache. NOTE: In patients who do not respond to the first dose of eletriptan, the diagnosis of migraine should be reconsidered before administration of a second dose and the possibility of an evolving cerebrovascular event considered.

RISK FACTORS/CONTRAINDICATIONS:

1. Do not use with ergotamine-containing or ergot-type products or MAO-A inhibitors.
2. Do not use with patients with ischemic heart disease or uncontrolled blood pressure.
3. Do not use as a prophylactic agent.
4. Give only where diagnosis of migraine is clearly established.
5. Contraindications to the use of 5-HT₁ agonists: pregnancy, peripheral vascular disease (i.e., thromboangitis, leucic arteritis, Raynaud's Syndrome, thrombophlebitis, arteriosclerosis), hepatic or renal impairment, coronary artery disease, uncontrolled hypertension.
6. Do not give eletriptan within 72 hours of the following CYP3A4 inhibitors: ketoconazole, itraconazole, nefazodone, clarithromycin, TAO, ritonavir, nelfinavir.

DRUG INTERACTIONS:

- Ergot-containing drugs have been reported to cause prolonged vasospastic reactions. Because there is a theoretical basis that these effects may be additive, use of ergotamine-containing or ergot-type medications (like dihydroergotamine) and 5-HT₁ agonists within 24 hours of each other should be avoided.
- MAO-A inhibitors increase the systemic exposure of the 5-HT₁ agonists and concomitant use is contraindicated.
- Concomitant use of more than one 5-HT₁ agonist within 24 hours of each other is not recommended.
- Potent CYP3A4 enzyme inhibitors including ketoconazole, itraconazole, nefazodone, clarithromycin, ritonavir, nelfinavir, or troleandomycin within 72 hours of eletriptan increase eletriptan's adverse effects.
- Selective serotonin reuptake inhibitors (SSRIs) have been reported to cause weakness, hyperreflexia, and incoordination when coadministered with 5-HT₁ agonists.

Migraine therapy options:

Table. Prophylactic therapy for migraine headache

DRUG CLASS	NAME
• Beta Blockers	Propranolol Atenolol Metoprolol Timolol
• Antidepressants	Amitriptyline Fluoxetine
• Calcium Channel Blockers	Nifedipine Verapamil Diltiazem
• Anticonvulsants	Divalproex sodium/sodium valproate Carbamazepine Gabapentin Topiramate
• NSAIDs	Naproxen Aspirin Ketoprofen
• Other	Feverfew Magnesium Vitamin B2 (Riboflavin)

Initial Date: June 2003

Review Date: 8/30/06

REFERENCES:

1. Relpax (eletriptan). Product Information. Pfizer, Inc. December 2002.
2. Snow V, Weiss K, Wall EM et al. Pharmacologic Management of Acute Attacks of Migraine and Prevention of Migraine Headache. *Annals of Internal Med.* 2002;137(10):840-849.
3. Silberstein SD et al. "Practice Parameter: Evidence based guidelines for migraine headache (an evidence-based review). Report on the Quality Standards Subcommittee of the American Academy of Neurology." *Neurology* 2000;55:754-63.
4. Seema M and Lowder DM. Medications for Migraine Prophylaxis. *Am Fam Physician* 2006;73:72-8.
5. Edmeads JG, Gawel MJ, Vickers J. Strategies for diagnosing and managing medication-induced headache. *Can Fam Physician.* 1997; 43: 1249-1254.
6. Mathew NT. Transformed migraine, analgesic rebound, and other chronic daily headaches. *Neurologic Clinics.* 1997; 15 (1): 167-186.
7. Weitzel KW, Thomas ML, Small R, Goode VG. Migraine: a comprehensive review of new treatment options. *Pharmacotherapy* 2000; 19:957-973.

8. Tfelt-Hansen P, DeVries P, Saxena P. Triptans in migraine: a comparative review of pharmacology, pharmacokinetics and efficacy. *Drugs* 2000; 60:1259-1287.

References supporting average number of migraine attacks per month:

9. Solomon GD, et al. *Neurology* 1997;49:1219-25 (n=327) study ~3 +/- 1.37 per month.
10. Zagami AS, et al *Neurology* 1997;48(suppl 3):S25-8 (n = 2,058) and Geraud GEA.
11. *Eur Neurol* 1996;32(suppl 2):24-7 (n=606) ~2.9-3.2 per month
12. Fletcher PE, et al. *Headache Treatment: Trial Methodology and New Drugs*. Lippincott-Raven Publishers, 1997 (n = 701) ~ 2.9 to 3.2 per month
13. Visser WH, et al. *Neurology* 1996;46:522-6 (n = 84) ~ 3-4 per month
14. Dowson A. *Eur Neurol* 1996;36(suppl 2):28-31 (n=40) ~ 2 per month

General References:

16. Beckett B. Headache disorder, in Dipiro J (ed): *Pharmacotherapy: a pathophysiologic approach*. Stamford, Simon & Schuster, 1997; pp1279-91.
17. Diener HC, Limmroth V. A practical guide to the management and prevention of migraine. *Drugs* 1998;56:811-24.
18. Peroutka S. Drugs effective in the therapy of migraine, Hardman J, Goodman A, Gilman, Limbird L (eds): *Goodman & Gilman's The pharmacological basis of therapeutics*, New York, 1996, pp487-502.
19. Silberstein SD. Practice parameter: evidenced based guidelines for migraine headache (an evidenced- based review): Report of the quality standards subcommittee of the American Academy of Neurology. *Neurology* 2000;55(6):754-63.
20. <http://headaches.about.com/bl-glossary-b.htm>