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Use of rimegepant as an alternative to triptans in migraine treatment

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ABSTRACT

Introduction and aim of study: Migraine is a chronic neurological disorder that is considered one of the leading causes of disability worldwide. Increasing evidence indicates that the calcitonin gene-related peptide (CGRP), a neuropeptide released during trigeminal nerve activation, plays a major role in pathophysiology and serves as an important therapeutic target. Rimegepant is an antagonist for the receptor of this peptide and an alternative to the commonly used triptans.

Materials and Methods: Two databases, Pubmed and Medline, were searched using the terms "rimegepant" and "migraine."

Results: By reducing the severity and frequency of migraine attacks, rimegepant significantly improves patients' daily functioning and quality of life. A single 75 mg dose of rimegepant provided better efficacy than placebo in the acute treatment of migraine. Two hours after dosing, significantly more patients in the rimegepant group than in the placebo group reported pain relief (59.3% vs. 43.3%). Rimegepant was also effective in the long term when taken every other day for preventive treatment of migraine and/or as needed for acute migraine treatment.

When used, rimegepant was well tolerated in both acute and preventive migraine treatment. The most common adverse events included nasopharyngitis, nausea, urinary tract infection, and upper respiratory tract infection.

Conclusions: Rimegepant is an effective drug for treating migraine attacks, offering quick and long-lasting pain relief with a favorable safety profile, especially for patients with contraindications to triptans. Therefore, rimegepant represents a valuable alternative for patients who do not respond adequately to other available migraine therapies.

Key words: rimegepant, migraine, CGRP antagonist, Calcitonin gene-related peptide (CGRP)

INTRODUCTION, OBJECTIVES, MATERIALS, AND METHODS

Migraine is a chronic neurological disorder characterized by severe headache attacks. It is considered one of the leading causes of disability worldwide, especially among individuals under the age of 50. [1, 2] Migraine is a complex, multifaceted disorder involving numerous pathways and various neurotransmitter systems. Common accompanying symptoms include nausea, vomiting, and sensitivity to light and sound. It is estimated to affect approximately 18% of women and 8% of men in the adult population. [3] Despite significant advancements in understanding migraine pathophysiology in recent years, it remains one of the least understood neurological disorders. Migraine is commonly perceived as a hereditary condition; however, genome studies have not identified high-risk genetic changes. It is highly likely that migraine is associated with interactions among multiple genes and epigenetic factors. [4, 5] Additionally, studies confirm that migraine is linked to extensive changes in brain function. Research has utilized resting-state functional MRI to examine connectivity changes in various brain regions before and during migraine attacks. [6] The activation of the trigeminovascular system, including brainstem nuclei, hypothalamus, thalamus, and cortex, plays a decisive role in disease pathogenesis. [7] The initial vascular theory was not confirmed, and changes in circulation, such as vascular bed dilation, are secondary phenomena that stimulate the nociceptive system and increase pain intensity. [8] Increasing evidence indicates that the calcitonin gene-related peptide (CGRP), a neuropeptide released during trigeminal nerve activation, plays a major role in pathophysiology and is a key therapeutic target. [9] Gepants are antagonists of the CGRP receptor. Pharmacological treatment of migraine includes acute treatment aimed at relieving pain and disability, and preventive treatment aimed at reducing the overall frequency and severity of attacks. [10] Triptans (selective serotonin receptor agonists) have long been the gold standard in treating migraine attacks, normalizing CGRP levels during effective treatment; however, some patients do not respond adequately to triptans, and over 20% have contraindications to their use due to cardiovascular diseases. [11, 12, 13] Gepants, non-peptidic small molecules that are CGRP receptor antagonists, and monoclonal antibodies targeting the CGRP peptide or receptor have become alternatives to triptans. [14]

This paper aims to review publications on rimegepant used for episodic migraine attacks and preventive treatment, serving as an alternative to commonly used triptans. Two databases, PubMed and Medline, were searched using the terms "rimegepant" and "migraine," yielding 169 results. Publications were analyzed concerning the mechanism of action, efficacy in migraine treatment, safety profile, benefits and risks of rimegepant use, and comparison of rimegepant efficacy with other available treatments, presenting key findings.

MECHANISM OF ACTION

Rimegepant, a second-generation gepant, is a G-protein-coupled CGRP receptor antagonist approved for the acute treatment of migraine with or without aura in adults and for the preventive treatment of episodic migraine in adults. [15, 16] Rimegepant is the only gepant available in an orally disintegrating tablet (ODT) form, offering convenience and potentially faster response time than conventional tablet forms. [17]

CGRP, a 37-amino acid neuropeptide primarily produced in the hypothalamus, was discovered in 1982.[18] Early studies of the calcitonin gene revealed alternative splicing in neural tissue, resulting in CGRP expression. [19] CGRP is one of several neuropeptides found in human sensory neurons of the trigeminal nerve, present in both perivascular cranial nerves and the trigeminal ganglion. [20] Functional studies have shown that CGRP is a potent vasodilator of cerebral arteries and arterioles through adenylate cyclase activation in smooth muscle cells and is involved in meningeal vasodilation. [21, 22] Over the years, the role of the neurovascular system in migraine has been analyzed, showing that trigeminovascular system irritation releases CGRP into extracerebral circulation. CGRP is selectively released from the trigeminal system during spontaneous migraine attacks, and intravenous administration of CGRP induces migraine attacks in migraine sufferers. [23, 24] The calcitonin gene-related peptide receptor, found in many areas implicated in migraine pathophysiology, including trigeminal ganglia, cerebral and meningeal vessels, brainstem (e.g., trigeminal nucleus caudalis), and brain (e.g., thalamus), is thus linked to migraine pathogenesis and has become an important therapeutic target. [25, 26]

DOSAGE

Rimegepant is indicated for the acute treatment of migraine with or without aura in adults and for the preventive treatment of episodic migraine in adults with ≥ 4 migraine attacks per month. [27] Rimegepant is not indicated for chronic migraine treatment. The recommended dose of rimegepant for acute migraine treatment is 75 mg as needed. [28] The recommended dose for preventive migraine treatment is 75 mg every other day. Rimegepant is available as an ODT that dissolves in saliva when placed on or under the tongue, which can be swallowed without additional liquid. Rimegepant ODT provides better absorption and a shorter time to maximum concentration (T_{max}), which may contribute to earlier onset of action. [29] Additionally, the convenience of a rapidly dissolving tablet that can be taken without water is particularly beneficial for patients experiencing nausea and vomiting with migraine. The available ODT formula thus offers convenience and potentially faster response time.

THERAPEUTIC EFFICACY OF RIMEGEPANT

The efficacy of rimegepant in migraine treatment was evaluated in randomized studies. A single 75 mg dose of rimegepant ODT provided better efficacy than placebo in acute migraine treatment. Two hours after dosing, significantly more patients in the rimegepant ODT group reported pain relief compared to the placebo group. Endpoints favored rimegepant. The percentage of patients with pain relief 2 hours post-dose (59.3 vs. 43.3%; risk difference 16.1; 95% CI 10.8–21.3; $p < 0.001$), ability to function normally 2 hours post-dose (38.1 vs. 25.8%; risk difference 12.3; 95% CI 7.4–17.2), no rescue medication use within 24 hours post-dose (85.8 vs. 70.8%; risk difference 15.0; 95% CI 10.7–19.3), sustained pain relief from 2 to 24 hours post-dose (47.8 vs. 27.7%; risk difference 20.1; 95% CI 15.1–25.2) and from 2 to 48 hours post-dose (42.2% vs. 25.2%; risk difference 16.9; 95% CI 12.0–21.9) were all higher with rimegepant. [29] Data is summarized in Figure 1. Rimegepant was significantly better than placebo at 60, 90, and 120 minutes. After 60 minutes, pain relief and improved function typically occurred, and after 90 minutes, complete pain relief and disappearance of the most bothersome symptoms were noted. [29]

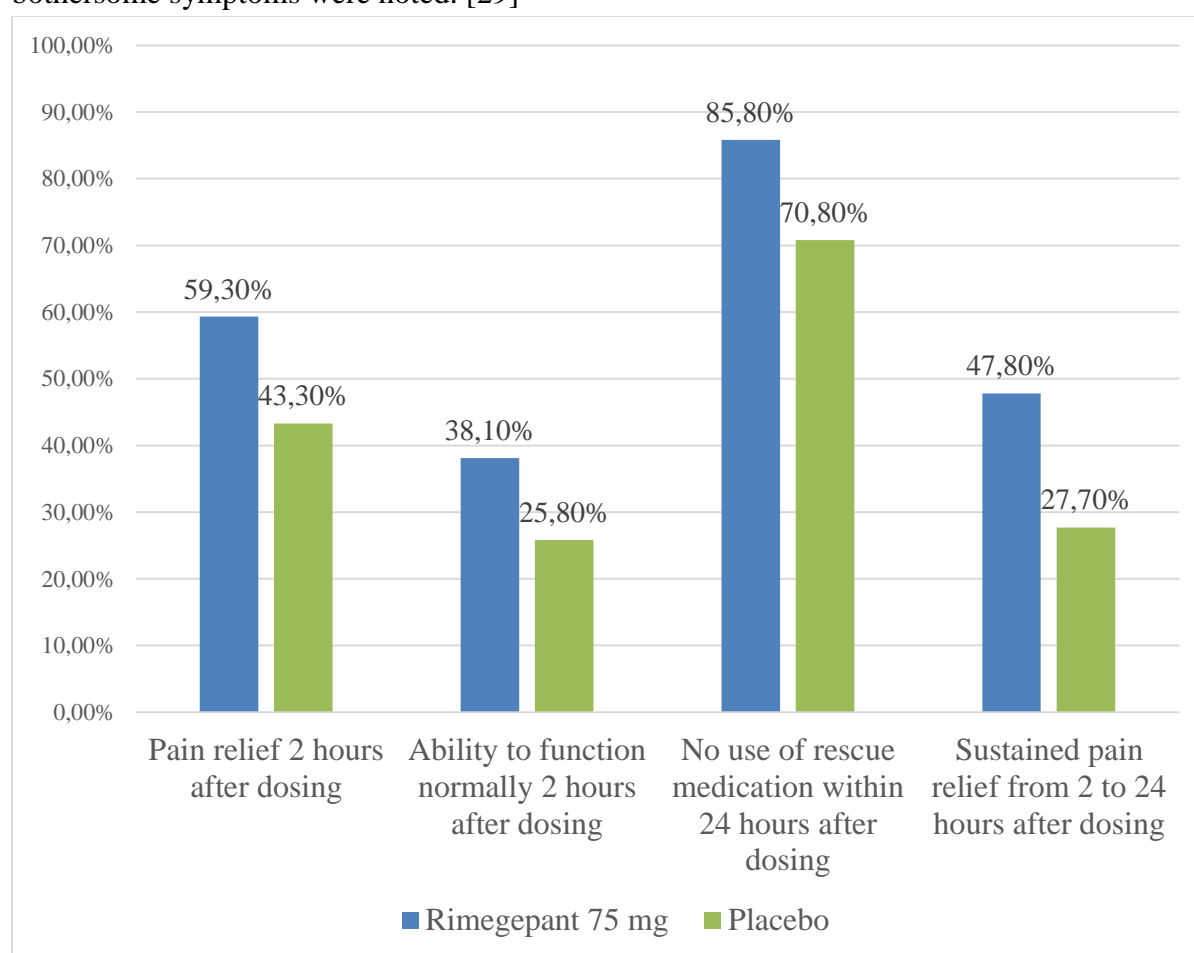


Figure 1. Comparison of the efficacy of 75 mg rimegepant vs. placebo.

Rimegepant was also effective in the long term when taken every other day for preventive treatment of migraine and/or as needed for acute treatment. Patients took 75 mg of rimegepant every other day for preventive migraine treatment for 52 weeks and could also take 75 mg of rimegepant as needed (up to once daily) on non-scheduled dosing days for acute migraine treatment. Every other day dosing results from the relatively long half-life of rimegepant (10-12 hours), contributing to its sustained effects up to 48 hours post-dose. Studies show that long-term preventive rimegepant treatment (52 weeks) consistently reduced migraine frequency. The percentage of patients with $\geq 50\%$ reduction in the mean number of moderate or severe migraine attacks ranged from 63.6% in weeks 1–4 to 80.9% in weeks 49–52. [30] It was also estimated that rimegepant use was associated with 16.9% more pain-free hours, 24.4% fewer hours with mild pain, 44.9% fewer hours with moderate pain, and 44.7% fewer hours with severe pain compared to continuing standard treatment from the study's start to week 52 (Figure 2). [31] Preventive and/or acute treatment of migraine with rimegepant over 52 weeks also improved quality of life (QOL) and reduced migraine-related disability. Thus, rimegepant is effective in both acute and preventive migraine treatment. [31]

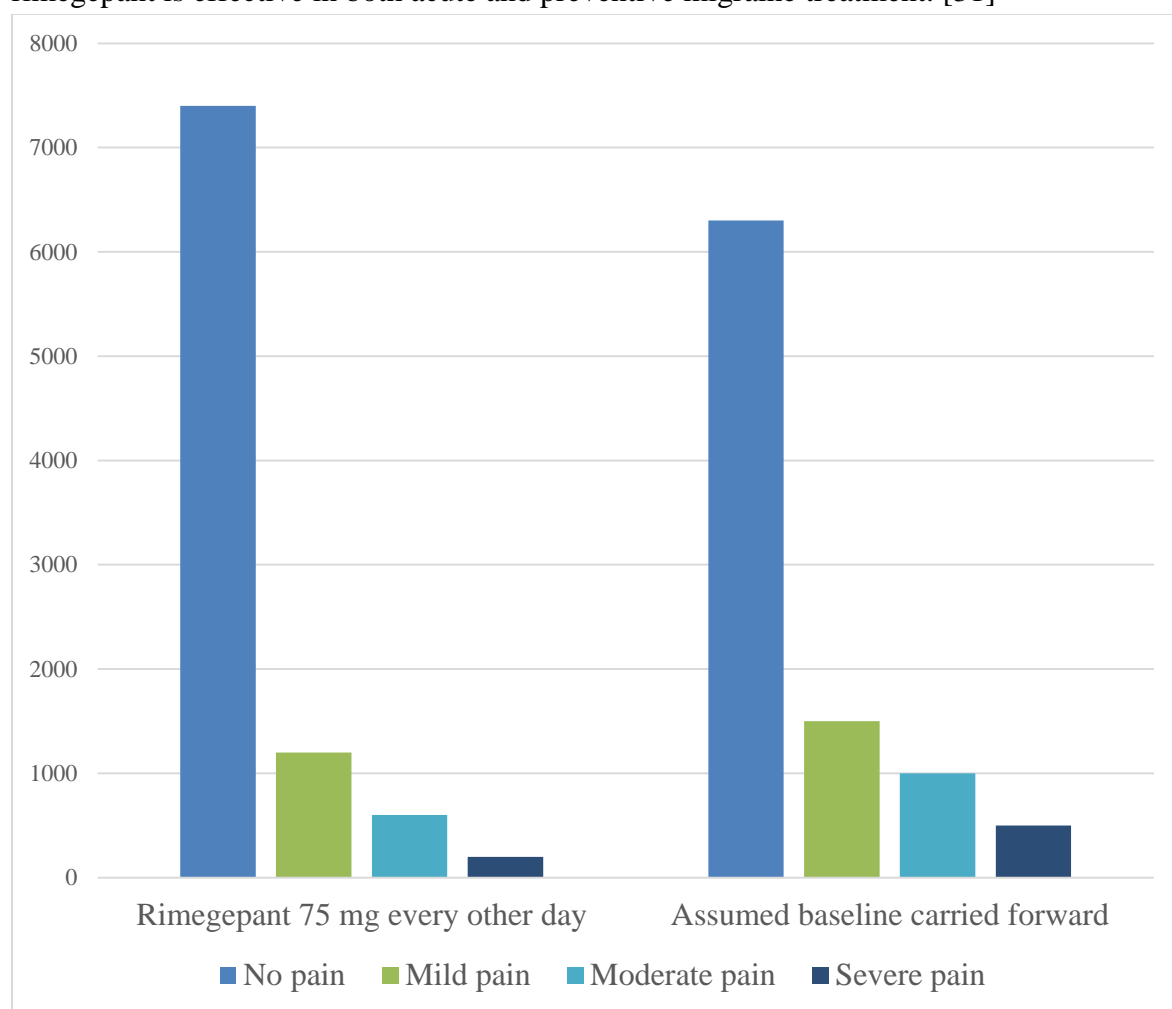


Figure 2. Cumulative pain and pain-free hours calculated over 52 weeks, for two scenarios.

SAFETY AND TOLERABILITY OF RIMEGEPANT

Rimegepant was generally well-tolerated when used as needed for acute migraine treatment or every other day for preventive migraine treatment. Most adverse events were mild to moderate in severity and resolved without additional treatment, with relatively few patients discontinuing treatment due to adverse events. [29] The incidence of adverse events was 14.2% for rimegepant and 11.7% for placebo. [32] The most common adverse events (incidence $\geq 2\%$) were nasopharyngitis (4% for rimegepant vs. 2% for placebo), nausea (3% vs. 1%), urinary tract infection (2% vs. 2%), and upper respiratory tract infection (2% vs. 3%). Adverse events occurred in 11% of patients receiving rimegepant and 9% of those receiving placebo, with serious adverse events occurring in 1% of patients in both treatment groups. In both groups, 1% of patients had ALT or AST levels $> 3 \times$ the upper limit of normal. [33] However, there was no evidence of hepatotoxicity, a significant concern with first-generation gepants. [34] No significant differences in rimegepant tolerance were observed concerning age, gender, or race. [35] After a single 75 mg oral dose of rimegepant, pharmacokinetic parameters were similar in older adults (aged 65 years and older) and younger adults, so no dose adjustment is necessary for older individuals. [36]

The tolerance profile of rimegepant was also similar to that of placebo when administered every other day for preventive migraine treatment. The incidence of adverse events was 36% in both treatment groups, with most adverse events being mild to moderate in severity. [33]

Cases of hypersensitivity reactions (including dyspnea and rash) have been reported in patients receiving rimegepant. Reactions may occur several days after administration, and delayed severe hypersensitivity reactions have also been reported, in which case rimegepant should be discontinued. In clinical trials, hypersensitivity reactions were observed in $< 1\%$ of patients receiving rimegepant. Rimegepant is contraindicated in patients with a history of hypersensitivity to rimegepant or any of its components. [27, 28]

Rimegepant is also safe and well-tolerated for long-term preventive and/or acute treatment of migraine in patients with a history of treatment failure with one triptan or ≥ 2 triptans [37], frequent migraines (≥ 15 days per month) [38], concurrent use of preventive migraine medications [39], history of depression or anxiety [40], concurrent use of selective serotonin reuptake inhibitors or other antidepressants [41], and cardiovascular risk factors [42]. Furthermore, unlike triptans, which are contraindicated in patients with cardiovascular diseases such as ischemic heart disease or previous myocardial infarction due to vasoconstrictive effects, rimegepant does not have vasoconstrictive properties and can be used in patients with cardiovascular concerns. [43]

Additionally, the results of a study evaluating the pharmacokinetics of a single 75 mg oral dose of rimegepant in healthy breastfeeding women showed that the estimated exposure of the infant to rimegepant through breast milk is very low, and rimegepant is safe and well-tolerated by breastfeeding women. [44]

COMPARISON WITH OTHER MIGRAINE MEDICATIONS

The introduction of rimegepant is associated with comparing its efficacy to other available migraine treatments.

New anti-migraine drugs vs. triptans

Triptans - selective agonists of the 5-hydroxytryptamine 1B/1D receptor (5-HT 1B/1D) - are considered the standard for acute migraine treatment. Due to vasoconstriction mediated by the 5-HT 1B receptor, they are contraindicated in patients with cardiovascular risk. Frequent use of triptans can also lead to medication-overuse headaches. These limitations necessitate the search for alternative migraine treatments.

Among new anti-migraine drugs, two classes stand out: ditans – targeting the 5-hydroxytryptamine 1F (5-HT 1F) receptors, and gepants - antagonists of the calcitonin gene-related peptide (CGRP) receptor. Both groups have shown efficacy and tolerability in the acute treatment of migraine in phase 2 or phase 3 randomized clinical trials (RCTs). A systematic review and network meta-analysis of RCTs, with the primary endpoint being the absence of pain two hours after treatment, compared the outcomes of new pharmacological agents such as lasmiditan, rimegepant, and ubrogepant with triptans in the acute treatment of migraine headaches. The analysis included a total of 64 RCTs (46,442 participants). [45] According to the review, lasmiditan, rimegepant, and ubrogepant were associated with higher odds ratios (OR) compared to placebo but lower OR compared to most triptans in terms of pain relief and pain absence two hours after dose administration. According to SUCRA, the highest probability of pain relief at 95.4% was shown by eletriptan at a 40 mg dose. In terms of pain relief, comparisons between lasmiditan, rimegepant, and ubrogepant were not significant; however, lasmiditan at a 100 mg dose was most likely associated with the highest OR for any adverse events (probability 95.1%). [45]

Despite the superiority of triptans in pain relief, new migraine treatments have shown better safety profiles, especially regarding cardiovascular risk. They can provide treatment options for individuals for whom standard medications have failed and for those with cardiovascular contraindications to traditional treatments. Rimegepant has a clear advantage over triptans as it does not cause vasoconstriction and is therefore not contraindicated in patients with cardiovascular diseases. Unlike triptans or the new class of anti-migraine drugs targeting the 5-HT 1F receptor, called ditans, gepants do not induce cutaneous allodynia, based on preclinical data supported by preliminary clinical results, suggesting no risk of medication-overuse headaches (MOH) with this class of drugs. [46]

Rimegepant vs. galcanezumab

A randomized, controlled clinical trial of two CGRP antagonists - galcanezumab (a monoclonal antibody) and rimegepant (a gepant) - compared their efficacy and safety in preventing episodic migraine. [47] In the double-blind trial, patients with episodic migraine were assigned to galcanezumab (subcutaneous injection of galcanezumab + orally dissolving placebo tablet) or rimegepant (orally dissolving tablet containing rimegepant + placebo injection) and treated for 3 months. Researchers aimed to determine the number of participants in each group who achieved at least a 50% reduction in monthly migraine headache days.

A total of 580 participants were randomly assigned to the galcanezumab group (n = 287) or the rimegepant group (n = 293). The percentage of participants with at least a 50% reduction in monthly migraine days over the 3-month period was 62.0% in the galcanezumab group and 61.0% in the rimegepant group, with no statistically significant difference between the groups (OR 1.1 (95% confidence intervals 0.8, 1.4; P = 0.70)). Sensitivity analyses were consistent with the main efficacy analysis. Comparing the incidence of adverse events in both groups, the number of participants reporting at least one adverse event was the same in the galcanezumab group (60; 20.9%) and the rimegepant group (60; 20.5%). No clinically significant differences in laboratory or vital sign changes were found between the groups. The study demonstrated that both galcanezumab and rimegepant were effective in patients with episodic migraine, with no superiority of either drug.

Rimegepant vs. erenumab

To date, no clinical trials have directly compared the efficacy of two drugs targeting the CGRP pathway in preventing episodic and chronic migraine. R. Mahon et al. used indirect matching-adjusted comparisons to compare the efficacy of rimegepant with erenumab. [48] Patients from two phase II/III clinical trials of erenumab (295 and STRIVE) were combined and weighted so that the weighted average effect modifiers at baseline (gender, age, race, baseline monthly migraine days [MMD], and chronic migraine history) matched the parameters reported in the phase II/III trial of rimegepant (NCT03732638). The analysis concluded that using erenumab at 70 mg every 4 weeks resulted in a greater reduction in monthly migraine days than rimegepant at 75 mg every 3 weeks. Thus, erenumab was considered to have a more favorable efficacy profile than rimegepant in reducing MMD in months 1 and 3 of migraine prevention. These results, though needing further confirmation in additional clinical trials and real-time studies, can already aid in making drug selection decisions in clinical practice.

Another indirect comparison noted the potential advantage of rimegepant over anti-CGRP monoclonal antibodies (galcanezumab and erenumab).[49] One study found that many patients prefer oral treatment to injections for migraine prevention.[50] Another aspect noted was the half-time of the respective drugs. For anti-CGRP monoclonal antibodies, it was 27-31 days compared to about 11 hours for rimegepant, limiting the possibility of immediate treatment discontinuation in cases of hypersensitivity reactions, serious adverse events, or pregnancy. This last aspect is significant given that migraine predominantly affects women of reproductive age. The short half-life of rimegepant used for migraine prevention thus provides particular flexibility, which is also useful in adjusting ongoing treatment to the changing severity of the disease (fluctuating frequency of MMD over the years).[49]

RIMEGEPANT AND CONTRACEPTION

The highest incidence of migraine is recorded in women of reproductive age. Hormonal level changes during the menstrual cycle trigger migraine attacks. Additionally, the use of combined contraceptives containing estrogen and progestogen can contribute to migraine occurrence. Therefore, it is necessary to determine the relationships and potential interactions between contraceptives and migraine treatment.

An open-label, single-center, phase 1 drug-drug interaction study evaluated the effect of a daily dose of 75 mg rimegepant on the pharmacokinetics of an oral contraceptive containing 0.035 mg ethinyl estradiol (EE) and 0.25 mg norgestimate (NGM) in healthy women of reproductive age or non-menopausal women with tubal ligation. [51] The study involved 25 participants. A single 75 mg dose of rimegepant co-administered with EE/NGM increased exposure to EE and NGMN by $\leq 16\%$ (geometric mean ratios [GMR] 1.03; 90% confidence interval [CI] 1.01–1.06; and GMR 1.16; 90% CI 1.13–1.20, respectively). After 8 days of concurrent administration of rimegepant with EE/NGM, the pharmacokinetic parameters of EE, $AUC_{0-\tau,ss}$ and $C_{ss(max)}$, increased respectively by 20% (GMR, 1.20; 90% CI, 1.16–1.25) and 34% (GMR, 1.34; 90% CI, 1.23–1.46) and the pharmacokinetic parameters of NGMN increased by 46% (GMR, 1.46; 90% CI, 1.39–1.52) and 40% (GMR, 1.40; 90% CI, 1.30–1.51), respectively.

The study demonstrated that repeated doses of rimegepant result in a slight increase in total exposure to EE and NGMN. The slight clinical significance of this increase in healthy women suffering from migraine was emphasized, designating the drug-drug interaction (DDI) between rimegepant and an oral contraceptive containing EE/NGM as insignificant.

RIMEGEPANT AND BREASTFEEDING

As highlighted above, a large target group due to the occurrence of migraine is young women. Many of them plan to become mothers, so an important area of interest is the effect of rimegepant on breastfeeding, primarily the penetration of the drug into the breast milk and its safety for the baby. Migraine attacks often subside or cease during pregnancy, but in most women who suffered from migraine before pregnancy, the discomfort returns within 4 weeks of delivery. [52] Because some migraine medications should not be used during breastfeeding or have not been evaluated for this purpose, concerns about infant exposure to maternally-administered medications may delay, limit or result in failure to breastfeed, which may be an unnecessary precaution that is detrimental to the baby. The objective of the open-label, single-center study was to determine whether rimegepant crosses into human milk and to characterize its concentrations in the plasma and milk of healthy breastfeeding women to determine the relative infant dose (RID).[53] The study included 12 lactating women aged 18-40 years, with an uncomplicated pregnancy of 37-42 weeks and an uncomplicated delivery of one healthy baby ≥ 2 weeks (14 days) and ≤ 6 months prior to study drug administration. Women took rimegepant in single oral doses of 75 mg. Plasma samples were collected 0, 1, 2, 4 and 8 hours after the rimegepant dose. Human milk samples were collected 0, 1, 2, 4, 8, 12, 16, 24, 32 and 36 hours after the drug dose to determine the drug concentration in milk at each time point (after both breasts had been completely emptied with a breast pump 15-30 minutes before the dose (time zero)). The drug concentration ratio in milk:plasma was estimated as the ratio of human milk:plasma area under the curve. RID (%) was calculated as 100 times the dose quotient for infants and mothers normalized against body weight. [53] After accounting for body weight, the mean RID for rimegepant was $<1\%$ of the maternal dose. The results of this phase I study showed that the estimated infant exposure to rimegepant from breast milk is very low, and that rimegepant is safe and well tolerated by breastfeeding women. [53]

RIMEGEPANT VS. GENDER

CGRP plays a key role in the pathophysiology of migraine, but CGRP-based therapies are not equally effective in all patients. This fact implies the need to understand which groups of patients respond preferentially and which are less likely to respond to CGRP-based therapies in order to facilitate the selection of effective treatments for individual patients. As mentioned above, women are much more likely to suffer from migraine compared to men, and female sex hormones and fluctuations in their levels during the monthly cycle are factors that favor migraine. This raises the question of whether migraine-promoting CGRP neurotransmission occurs equally in both sexes. These observations raise the suspicion that the effects of treatment targeting CGRP or CGRP-R may differ between men and women. In response to these considerations, clinical and statistical reviews conducted by the FDA's Center for Drug Evaluation and Research (CDER) for New Drug Applications (NDA) of ubrogepant, rimegepant and zavegepant in the treatment of both acute and preventive migraine were analyzed (a total of several thousand patients, in various configurations). Analysis of publicly available data reveals that gepants were always more effective in women than in men in acute treatment. This raises the possibility of sex differences in the role of CGRP in the pathogenesis of migraine headache and suggests the need for further studies of CGRP biology in both sexes. The authors emphasize the need for further studies to determine the efficacy of small molecule CGRP receptor antagonists in the treatment of acute migraine in men. In terms of preventive treatment, the following conclusions were made: in prevention, CGRP-targeted drugs are effective in both men and women suffering from chronic migraine, but the essence of gender differences in patients suffering from episodic migraine cannot be clearly established at this point.[54] Overall, the results, while needing to be supported and expanded with further in-depth studies, underscore the importance of considering sexual dimorphism when evaluating the efficacy of migraine treatment and selecting treatment for an individual patient. [54]

RIMEGEPANT AS FIRST-LINE MIGRAINE PREVENTION DRUG

According to the latest update from the American Headache Society (AHS), CGRP-targeted therapies should be considered first-line treatments for migraine prevention, along with previous first-line methods, without the requirement of prior failure of other preventive medication classes. These include monoclonal antibodies such as erenumab, eptinezumab, fremanezumab, and galcanezumab, as well as small molecules known as "gepants," specifically rimegepant and atogepant. This marks a significant shift in treatment guidelines, recognizing the robust evidence supporting these newer options. [54] Previous AHS statements recommended treatment with at least two classes of previous first-line drugs for migraine for ≥ 8 weeks before considering CGRP-targeted therapy. Since then, significant new evidence has been published on the efficacy, safety, and tolerability of CGRP-targeted therapies for migraine prevention, resulting in a revision of the AHS position statement. The updated guidelines reflect the growing confidence in these therapies' ability to reduce migraine frequency and severity, offering patients a potentially more effective and well-tolerated option earlier in their treatment journey. This change aims to enhance patient outcomes by providing access to advanced therapies sooner.

CONCLUSIONS:

In the effective treatment of acute migraine pain, the primary goals are to alleviate pain and bothersome symptoms, restore the ability to function, and reduce the need for additional doses of rescue medications. Migraines can be debilitating, significantly impacting daily life and overall well-being. Therefore, achieving these treatment goals is crucial for improving patients' quality of life. Rimegepant is an effective medication for treating migraine attacks, offering rapid and long-lasting pain relief with a favorable safety profile. It works by blocking the CGRP receptor, which is believed to play a critical role in the pathophysiology of migraines. Clinical studies have shown that rimegepant has comparable efficacy to triptans, the standard treatment for migraines. Triptans, although effective, are not suitable for all patients, particularly those with cardiovascular issues, due to their vasoconstrictive properties. Rimegepant, on the other hand, may be preferred for patients who cannot tolerate triptans or for whom triptans are contraindicated. This makes rimegepant a valuable alternative for patients who do not respond adequately to other available migraine therapies. By reducing the severity and frequency of migraine attacks, rimegepant significantly improves daily functioning and quality of life for patients. Unlike many other treatments, rimegepant is the first dual therapy indicated for both acute and preventive treatment of migraines, representing a new approach to migraine management. This dual indication is particularly beneficial as it allows for a more comprehensive management strategy, addressing both immediate pain relief and long-term prevention of migraine attacks. Such an integrated approach can help achieve common goals for treating and preventing migraine attacks. By doing so, it not only alleviates the immediate burden of migraine pain but also helps in reducing the overall frequency of migraine episodes. This can lead to fewer days lost to migraine and a reduction in the impact on patients' professional and personal lives, ultimately enhancing their overall quality of life. Therefore, rimegepant represents a significant advancement in the management of migraines, providing a versatile and effective option for both acute and preventive treatment.

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