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A PROSPECTIVE REAL-WORLD ANALYSIS OF INTRAVENOUS EPTINEZUMAB IN MIGRAINE MANAGEMENT: THE FIRST UK EXPERIENCE[1]

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VYEPTI (eptinezumab) is indicated for the prophylaxis of migraine in adults who have at least 4 migraine days per month.[2] The recommended dose is 100 mg administered by intravenous infusion every 12 weeks.[2]

CONTEXT[1,3]

In March 2023, eptinezumab 100 mg was approved in the UK for the prevention of migraine in adults with ≥4 migraine days a month who have failed ≥3 preventive treatments, following the publication of the National Institute of Care and Health Excellence (NICE) guidelines.[1,3]

This is a summary of a prospective, single-centre analysis to investigate the effectiveness of eptinezumab in a real-life UK setting.[1] Refer to the full publication for more details.

KEY QUESTION[1]

What is the effectiveness of VYEPTI 100 mg in migraine patients in a real-life setting who were treated for up to six months per the NICE guidelines in the UK?

METHODOLOGY[1]

- This is a registered, prospective clinical audit conducted at the Headache Service at Guy's and St Thomas' NHS Foundation Trust, London, UK[1]

PATIENTS[1]

N=130 patients received ≥1 dose of eptinezumab during the audit period.

KEY INCLUSION CRITERIA

- Adult patients meeting the IHS criteria for episodic migraine (EM) or chronic migraine (CM) who had failed ≥3 prior preventive treatments

TREATMENT FAILURE DEFINITIONS

For botulinum toxin A: Treatment failure was defined as failure to obtain ≥30% reduction in headache days after two sets of injections.

For other anti-CGRP mAbs: Treatment failure was defined as failure to obtain at least a 30% and 50% reduction in migraine days after ≥3 consecutive months of injections respectively for CM and EM.

ASSESSMENTS[1]

- A migraine-specific diary and the HIT-6 score were used to capture efficacy and disability measures
  - Patients were required to produce a baseline headache diary and HIT-6 score for ≥1 month prior to treatment initiation and to continue completing the diary on a daily basis along with HIT-6 scores every month for the duration of the study
- Blood pressure (BP) and heart rate were measured at baseline and every clinic visit thereafter

PRIMARY EFFICACY OUTCOME[1]

A 30% (CM) or 50% (EM) response rate (reduction in migraine days) for three months following treatment initiation.[1]

OTHER EFFICACY OUTCOMES[1]

- Changes from baseline in mean monthly migraine days (MMDs), mean monthly headache days (MHDs), mean monthly headache-free days, and changes in abortive treatment intake days
- Potential adverse events (AEs) in the 30 minutes following infusion

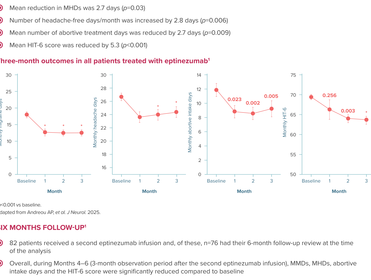
RESULTS[1]

- 119 patients (CM n=112; EM n=7) had their diary submitted to the clinic as part of their 3-month follow-up and were included in this analysis
- 67% of patients (n=80) had experienced a sub-optimal response to ≥1 alternative anti-CGRP mAb
- At baseline, 50% of patients (n=59) reported a daily headache pattern and 73% (n=87) reported ≥1 comorbidity

PRIMARY EFFICACY OUTCOME[1]

- At Months 1, 2 and 3, 50% (n=59), 53% (n=63) and 53% (n=63) of patients obtained ≥30% reduction in MMDs, respectively, and 36% (n=43), 39% (n=46) and 37% (n=44) achieved a ≥50% reduction in MMDs, respectively

Percentage of 30%, 50% and 75% responders and the overall responder rate[1]



Adapted from Andreou AP, *et al. J Neurol.* 2025.

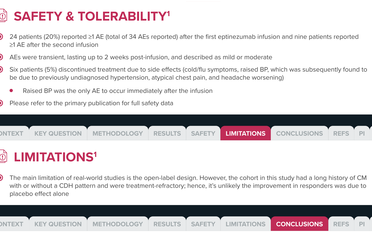
OTHER EFFICACY OUTCOMES[1]

THREE MONTHS FOLLOW-UP[1]

Compared to baseline, over the three-month period:

- Mean reduction in MMDs was 5.4 days (p<0.001)
- Mean reduction in MHDs was 2.7 days (p=0.03)
- Number of headache-free days/month was increased by 2.8 days (p=0.006)
- Mean number of abortive treatment days was reduced by 2.7 days (p=0.009)
- Mean HIT-6 score was reduced by 5.3 (p<0.001)

Three-month outcomes in all patients treated with eptinezumab[1]



*p<0.001 vs baseline.
Adapted from Andreou AP, *et al. J Neurol.* 2025.

SIX MONTHS FOLLOW-UP[1]

- 82 patients received a second eptinezumab infusion and, of these, n=76 had their 6-month follow-up review at the time of the analysis
- Overall, during Months 4–6 (3-month observation period after the second eptinezumab infusion), MMDs, MHDs, abortive intake days and the HIT-6 score were significantly reduced compared to baseline

Six-month outcomes in all patients treated with eptinezumab[1]

*p<0.001 vs baseline.
Adapted from Andreou AP, *et al. J Neurol.* 2025.

EFFECTIVENESS OF EPTINEZUMAB IN PATIENTS PREVIOUSLY TREATED WITH ≥1 ANTI-CGRP mAb[1]

- 40% of patients (n=32/80) who had previously failed to respond to ≥1 CGRP mAb achieved ≥30% reduction in mean MMD after their first eptinezumab infusion, and 33% of patients (n=26) continued to respond to eptinezumab after the second infusion
  - Of the CGRP-naïve patients (n=39/119), 74% (n=29, all CM) achieved ≥30% reduction in mean MMDs after the first infusion, and 56% of patients (n=22) continued to respond after the second infusion
- Anti-CGRP mAb-naïve patients were significantly more likely to achieve ≥30% reduction of MMD than those who failed to respond to previous anti-CGRP mAbs (p=0.0001)

EFFECTIVENESS OF EPTINEZUMAB IN PATIENTS WITH CDH[1]

- Of the patients who reported a CDH pattern at baseline (50%), 41% (n=24) and 31% (n=18) achieved at least a 30% and 50% reduction in their mean MMDs, correspondingly, after the first infusion of eptinezumab
- At 6 months, 37% (n=22) and 28% (n=17) of the CDH patients continue to have at least a 30% and 50% reduction in their mean MMDs
- No association was found between the baseline headache pattern (daily/non-daily) and responders rate following the first or second eptinezumab infusion (p=0.18)

SAFETY & TOLERABILITY[1]

- 24 patients (20%) reported ≥1 AE (total of 34 AEs reported) after the first eptinezumab infusion and nine patients reported ≥1 AE after the second infusion
- AEs were transient, lasting up to 2 weeks post-infusion, and described as mild or moderate
- Six patients (5%) discontinued treatment due to side effects (cold/flu symptoms, raised BP, which was subsequently found to be due to previously undiagnosed hypertension, atypical chest pain, and headache worsening)
  - Raised BP was the only AE to occur immediately after the infusion
- Please refer to the primary publication for full safety data

LIMITATIONS[1]

- The main limitation of real-world studies is the open-label design. However, the cohort in this study had a long history of CM with or without a CDH pattern and were treatment-refractory; hence, it's unlikely the improvement in responders was due to placebo effect alone

CONCLUSIONS[1]

Eptinezumab appears to be an effective and well-tolerated treatment in otherwise treatment-refractory migraine patients with or without a CDH pattern and with multiple comorbidities.

Eptinezumab could be offered as a treatment option in refractory patients who have experienced a suboptimal response to one or two anti-CGRP pathway mAbs; however, the data suggests considering this treatment earlier in the anti-CGRP mAb-naïve population.[1]

REFERENCES & ABBREVIATIONS

1. Andreou AP, *et al. Headache Pain.* 2025;26(1):235.
2. Lundbeck. VYEPTI. Summary of Product Characteristics.
3. National Institute for Health and Care Excellence. Technology Appraisal Guidance (TA871). Eptinezumab for preventing migraine. 01 March 2023. Available at: https://www.nice.org.uk/guidance/ta871 Accessed March 2026.

≥50%/≥75% responders, proportion of patients with a ≥50%/≥75% reduction in monthly migraine/headache days vs baseline; **AE,** adverse event; **BP,** blood pressure; **CDH,** chronic daily headache; **CGRP,** calcitonin gene-related peptide; **CM,** chronic migraine; **EM,** episodic migraine; **HIT-6,** Headache Impact Test-6; **IHS,** International Headache Society; **mAb,** monoclonal antibody; **MHD,** monthly headache day; **MMD,** monthly migraine day; **NHS,** National Health Service; **NICE,** National Institute for Clinical Care and Excellence; **UK,** United Kingdom.

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