New Zealand-Focused Adult Migraine Prescribing Summary For Clinician Use

Current to **August 2026**. I've prioritised bpacnz 2026 guidance and current NZ availability/access information. Doses are usual adult migraine doses rather than exhaustive NZF prescribing information.

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Acute Treatment

Drug	Typical adult regimen	Main adverse effects / contraindications	NZ access / practical pitfalls
Ibuprofen	**400–600 mg PO** early in attack; max 2.4 g/day	GI irritation/bleeding, renal impairment, fluid retention, asthma sensitivity	Funded/common. Avoid excessive headache use: analgesics should generally be **<15 days/month**.
Naproxen	**250–500 mg PO**; max 1 g/day	As for NSAIDs	Useful with a triptan for recurrence/partial response; combination overuse becomes an issue if frequent.
Diclofenac	**50–100 mg**; max 150 mg/day	GI/renal/CV adverse effects	Non-oral formulations can be useful with vomiting.
Aspirin	**900–1,000 mg PO**	Dyspepsia, bleeding, hypersensitivity	Effective high-dose option; avoid where NSAID risks dominate.
Paracetamol	**1 g PO**; max 4 g/day	Hepatotoxicity with overdose/risk factors	Less effective than NSAIDs for many attacks, but useful where NSAIDs inappropriate and commonly preferred in pregnancy.
Rizatriptan	**10 mg PO/ODT**; repeat after ≥2 h **only if initially effective then recurrence**; max 30 mg/day	Tingling, flushing, pressure/tightness; avoid significant ischaemic vascular disease, uncontrolled/severe HTN, hemiplegic migraine/brainstem aura	Common NZ triptan. **Important interaction with propranolol**; bpacnz recommends using another acute option rather than rizatriptan in patients on propranolol. Limit triptan use to **<10 days/month**.
Sumatriptan PO	**50–100 mg**; repeat ≥2 h if recurrence; max 300 mg/day	As above	Useful alternative when rizatriptan unsuitable.
Sumatriptan SC	**6 mg SC**; max 12 mg/day	More triptan adverse effects than oral route	Particularly useful for **rapidly escalating attacks, vomiting or failure of oral triptan**.
Metoclopramide	**10 mg**, usually PO; max 30 mg/day in bpac migraine table	Akathisia/dystonia, other EPS; QT considerations	Useful both for nausea and to improve gastric emptying/absorption.
Prochlorperazine	Commonly **10 mg PO**; buccal/parenteral routes depending preparation	EPS, sedation, QT prolongation	Buccal route useful with nausea/vomiting; some formulations only partly funded.

A useful rule is **treat early in the headache phase**, not during aura alone, and aim for pain freedom by about two hours. If a triptan works but the headache returns, a second dose may be appropriate; if the first dose has **no meaningful effect**, repeating it for that same attack is generally not useful.

Funded Conventional Prevention

Preventive	Starting → usual target	Main side effects / cautions	Particularly useful when…
Propranolol	**40 mg once or twice daily** → typically **80–160 mg/day** divided	Fatigue, postural symptoms, bradycardia; avoid/caution asthma, hypotension, marked bradycardia, uncontrolled HF	Hypertension, tremor/anxiety, tachyarrhythmia coexist. **Avoid pairing with rizatriptan** in usual NZ practice because propranolol raises rizatriptan exposure.
Metoprolol succinate	**47.5 mg daily → 95–190 mg daily**	Bradycardia, fatigue, hypotension; asthma caution	Hypertension/angina/arrhythmia and propranolol not preferred.
Candesartan *(off-label migraine indication)*	**4–6 mg daily** → increase ~4 mg/week to **16 mg daily**; up to 32 mg if concurrent HTN	Hypotension, dizziness, hyperkalaemia/renal considerations	Hypertension or HF; often well tolerated neurologically.
Amitriptyline *(off-label)*	**10 mg nocte** → commonly **50–75 mg nocte**; max 150 mg/day	Sedation, dry mouth, constipation, weight gain, anticholinergic burden; arrhythmia/QT issues	Insomnia, neuropathic pain/fibromyalgia or depression coexist.
Nortriptyline *(off-label)*	Usually titrated similarly at low nocturnal doses; individualise	Anticholinergic effects, cardiac effects, but often **less sedating** than amitriptyline	Amitriptyline works mechanistically but sedation/anticholinergic effects are limiting. bpacnz identifies it as an alternative.
Venlafaxine *(off-label)*	Dose according to co-existing mood disorder	Nausea, activation, withdrawal syndrome; avoid uncontrolled hypertension; cardiac cautions	Mainly when **a mood disorder independently warrants venlafaxine**.
Topiramate	**25 mg nocte for 1 week**, increase by 25 mg/week → usually **50–100 mg/day**, generally divided; max 200 mg/day	Paraesthesia, cognitive slowing/word-finding difficulty, weight loss, nephrolithiasis, mood effects; rare glaucoma/metabolic acidosis	Obesity/weight gain is a concern and cognition is not occupationally critical. NZ data sheet recommends **100 mg/day**, though some respond to 50 mg/day.
Sodium valproate *(off-label migraine indication)*	**200 mg BID** → typically **1.2–1.5 g/day** divided	Weight gain, tremor, sedation, alopecia, hepatotoxicity/thrombocytopenia; major reproductive toxicity	Usually a later/selective option rather than routine first-line prevention.
Pizotifen	Available/funded option but now less commonly used	Marked appetite/weight gain, sedation	Sometimes considered when conventional alternatives unsuitable, but evidence is weaker and NZ practice has moved away from it.

For conventional agents, use **low-and-slow titration** and generally assess efficacy after **2–3 months at the maximum tolerated therapeutic dose**. A **30–50% reduction in headache burden** is conventionally considered a worthwhile response, but functional improvement also counts.

Modern Migraine-Specific Prevention Available In NZ

Drug	NZ regimen	Key adverse effects / pitfalls	Funding & approximate private cost
Galcanezumab – Emgality	**240 mg SC loading** (two 120-mg injections), then **120 mg every 4 weeks**	Injection reactions, hypersensitivity; class caution with worsening hypertension/Raynaud phenomenon	**Medsafe-approved, unfunded.** Roughly **NZ$325 per injection**; first month costs about twice this because of loading.
Fremanezumab – Ajovy	**225 mg SC monthly or 675 mg SC every 3 months**	Injection reactions, hypersensitivity; class caution HTN/Raynaud	Available since **January 2026**, unfunded. Approximately **NZ$299–330 per 225-mg injection**; quarterly regimen requires three injections together.
Erenumab – Aimovig	**70 mg SC monthly**; 140 mg monthly may be used depending response	**Constipation** is particularly important; class hypertension/Raynaud concern	Medsafe-approved, unfunded. Current local information lists around **NZ$678 for 70 mg and $1,356 for 140 mg**, with restricted distribution compared with the other mAbs.
Atogepant – Aquipta	Generally **60 mg PO once daily** in NZ migraine practice	Constipation, nausea, fatigue, appetite/weight reduction; interaction issues, particularly CYP3A-related; renal/hepatic considerations	**Only gepant currently available in NZ**; prevention only. Unfunded. Current access programme price cited at **NZ$352.80/28 × 60-mg tablets**, plus delivery if applicable.
Onabotulinumtoxin A – Botox	**PREEMPT protocol every 12 weeks**, typically ≥31 injection sites; standard protocol begins with **155 U**	Neck pain/stiffness, local weakness, ptosis; operator technique matters	For **chronic migraine**, not routine episodic migraine. Mostly private; some hospital services fund it for selected severe chronic migraine patients, with major regional access variation. Allow **2–3 treatment cycles** before declaring failure.

As of August 2026, **galcanezumab, fremanezumab, erenumab and atogepant are available in NZ but not publicly funded**; all four sit on Pharmac's Options for Investment list. Eptinezumab remains unavailable/not Medsafe-approved according to current NZ sources. Acute gepants such as **ubrogepant, rimegepant and zavegepant are not currently NZ options**, so atogepant should not be mistaken for an acute rescue drug.

Pregnancy / Reproductive Prescribing: High-Yield Cautions

Situation	Practical approach
Pregnant with an acute attack	Non-pharmacological measures first where possible; **paracetamol and metoclopramide** are among the preferred pharmacological options in bpacnz guidance. A triptan may sometimes be considered after obstetric discussion.
Topiramate	**Do not regard as a routine option in women who may become pregnant.** Major fetal risk means reproductive planning and highly effective contraception are critical.
Sodium valproate	Even more problematic reproductively; should generally be avoided for migraine in people with pregnancy potential unless exceptional circumstances and stringent risk-management requirements apply. NZ guidance also flags effective contraception for men taking valproate.
CGRP mAbs / atogepant	Pregnancy safety remains insufficient to treat these as established safe options; because mAbs persist for months, conception planning needs to occur **before** treatment continuation.
Preventive therapy generally during pregnancy	bpacnz advises that prophylaxis is **usually not recommended during pregnancy/breastfeeding** without careful risk-benefit assessment and specialist/obstetric input.

Pragmatic NZ selection

In practice, I would frame the choice around phenotype and comorbidity: **propranolol/metoprolol** where cardiovascular indications help; **candesartan** when blood pressure allows and a cognitively neutral drug is desirable; **amitriptyline** with insomnia/neuropathic pain; **topiramate** where weight loss may be advantageous but cognitive and reproductive effects are acceptable; and a **CGRP-targeted agent** when efficacy/tolerability are prioritised and self-funding is feasible. Chronic migraine adds **Botox**, and refractory chronic disease increasingly leads to specialist consideration of Botox plus CGRP-directed treatment. NZ guidance recognises CGRP-targeted drugs as generally more effective and better tolerated than conventional agents, although access rather than evidence is currently the major limiting factor.

The two prescribing traps I would particularly highlight in NZ are **rizatriptan + propranolol** and inadvertent **topiramate/valproate exposure around pregnancy**. Also, irrespective of the acute drug chosen, actively screen for medication-overuse headache: keep **triptans <10 headache-treatment days/month and simple analgesics <15 days/month**.

A Pragmatic Approach to Treating and Preventing Migraine

Goal: reduce attack frequency, severity and disability; improve function and quality of life

S 1 FOUNDATION: CONFIRM DIAGNOSIS & ASSESS

- **History:** headache features, frequency, severity, duration, aura, precipitants, impact on life
- Exclude red flags (SNOOP10)
- Comorbidities: mood/anxiety, sleep, obesity, HTN, neck pain, medication overuse

Assess baseline

- Headache diary
- Disability: MIDAS or HIT-6
- Patient goals & treatment preferences

Educate & Empower

- Nature of migraine
- Treatment expectations
- Importance of adherence, lifestyle, and trigger management

2 STRATIFY: ATTACK FREQUENCY / DISABILITY & PATIENT PREFERENCE

EPISODIC MIGRAINE
<15 headache days/month

FREQUENT EPISODIC
15–22 headache days/month
or
SIGNIFICANT DISABILITY

CHRONIC MIGRAINE
≥15 headache days/month for >3 months
(≥8 migraine days)

3A PREVENTION: STEPWISE APPROACH

STEP 1
Start with high-evidence, well-tolerated options

- Topiramate
- Beta-blockers (propranolol, metoprolol, timolol)
- Amitriptyline
- Candesartan
- OnabotulinumtoxinA *(if chronic migraine)*

STEP 2
If inadequate response (after 2–3 months at effective dose)

- Switch to another class
  or
- Consider CGRP monoclonal antibodies (mAbs)
- Consider gepants (atogepant, rimegepant) for prevention

STEP 3
If still inadequate

- Combine preventives from different classes
- Optimize comorbidities
- Consider non-pharmacologic therapies

ADJUNCTIVE OPTIONS

- Neuromodulation devices*
- Magnesium, Riboflavin, CoQ10
- Cognitive behavioral therapy, biofeedback, mindfulness
- Regular exercise

Aim: ≥50% reduction in monthly migraine days and improved function

4 ACUTE TREATMENT: TREAT EARLY, TREAT EFFECTIVELY

Match treatment to attack severity & patient factors

MILD

- NSAIDs (e.g., ibuprofen, naproxen) or Acetaminophen

MODERATE–SEVERE

- Triptans (oral, nasal, SC)
- +/- NSAID (better efficacy)
- Gepants (ubrogepant, rimegepant, zavegepant nasal)
- Ditans (lasmiditan) if triptans contraindicated/not tolerated

REFRACTORY / SEVERE

- Triptan (SC) or Gepant
- Antiemetic (metoclopramide, prochlorperazine)
- NSAID or combination therapy

AVOID MEDICATION OVERUSE

- Triptans, ergot, opioids, combination analgesics: <10 days/month
- Simple analgesics/NSAIDs: <15 days/month

Status migrainosus / ED options

- IV fluids, antiemetic, NSAID, DHE, magnesium, valproate, steroids (short course) as appropriate

3B PREVENTION FOR CHRONIC MIGRAINE

First-line

- OnabotulinumtoxinA (PREEMPT protocol)
- CGRP mAbs (erenumab, fremanezumab, galcanezumab, eptinezumab)
- Consider gepant for prevention

If inadequate response

- Optimize/combination preventive therapy
- Address medication overuse
- Manage comorbidities aggressively

Refractory options

- Neuromodulation devices*
- Inpatient infusion therapies (e.g., DHE, lidocaine, ketamine, valproate)
- Multidisciplinary pain program

Aim: reduce disability, improve function and quality of life

5 LIFESTYLE, TRIGGERS & COMORBIDITY MANAGEMENT (FOUNDATION FOR ALL PATIENTS)

Sleep
Regular schedule, good sleep hygiene

Exercise
Regular aerobic activity

Nutrition
Regular meals, hydrate

Triggers
Identify & manage: stress, hormones, weather, certain foods, alcohol, sleep changes

Comorbidity care
Mood/anxiety, sleep disorders, obesity, HTN, neck pain

Avoid medication overuse
Educate & monitor

6 REVIEW & ADJUST

Review in 6–12 weeks
Assess: headache days, disability, acute med use, adverse effects

Adjust plan
Optimize dose, switch or add therapies, address adherence & barriers

Long-term goals
Sustained reduction in attacks, minimal disability, optimal quality of life

***Neuromodulation devices** (non-invasive options with evidence for selected patients):
Cefaly® (e-TNS), Nerivio® (REN), gammaCore® (nVNS), sTMS mini, non-invasive vagus nerve stimulation.

Individualize care
Shared decision-making
Regular follow-up