Effect of Atogepant for Preventive Migraine Treatment on Patient-Reported Outcomes in the Randomized, Double-blind, Phase 3 ADVANCE Trial

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Abstract

Background and Objectives

The oral calcitonin gene-related peptide receptor antagonist atogepant is indicated for the preventive treatment of episodic migraine. We evaluated changes in patient-reported outcomes with atogepant in adults with migraine.

Methods

In this phase 3, 12-week, multicenter, randomized, double-blind, placebo-controlled, parallel-group trial (ADVANCE), adults with 4-14 migraine days/month received atogepant 10, 30, or 60mg once daily, or placebo. Secondary endpoints included changes from baseline in Migraine-Specific Quality of Life Questionnaire (MSQ) v2.1 Role Function-Restrictive (RFR) domain at week 12 and mean monthly Activity Impairment in Migraine-Diary (AIM-D) Performance of Daily Activities (PDA) and Physical Impairment (PI) domains across the 12-week treatment period. Exploratory endpoints included change in MSQ Role Function-Preventive (RFP) and Emotional Function (EF) domains; AIM-D Total scores; and Headache Impact Test-6 (HIT-6) change scores.

Results

Of 910 participants randomized, 873 comprised the modified intent-to-treat population (atogepant 10mg [n=214]; 30mg [n=223]; 60mg [n=222]; placebo [n=214]). All atogepant groups demonstrated significantly greater improvements vs placebo in MSQ RFR that exceeded minimum clinically meaningful between-group difference (3.2 points) at week 12 (least-squares mean difference [LSMD] vs placebo: 10mg [9.9]; 30mg [10.1]; 60mg [10.8]; all p<0.0001). LSMDs in monthly AIM-D PDA and PI scores
across the 12-week treatment period improved significantly for atogepant 30 (PDA: −2.54; \( p=0.0003; \) PI: −1.99; \( p=0.0011 \)) and 60mg (PDA: −3.32; \( p<0.0001; \) PI: −2.46; \( p<0.0001 \)), but not 10mg (PDA: −1.19; \( p=0.086; \) PI: −1.08; \( p=0.074 \)). In exploratory analyses, atogepant 30 and 60mg were associated with nominal improvements in MSQ RFP and EF domains, other AIM-D outcomes, and HIT-6 scores at the earliest timepoint (week 4) and throughout the 12-week treatment period. Results varied for atogepant 10mg.

Discussion

Atogepant 30 and 60mg produced significant improvements in key patient-reported outcomes including MSQ-RFR scores and both AIM-D domains. Nominal improvements also occurred for other MSQ domains and HIT-6, reinforcing the beneficial effects of atogepant as a new treatment for migraine prevention.

Trial Registration


Classification of Evidence

This study provides Class II evidence that daily atogepant is associated with improvements in health-related quality of life measures in patients with 4-14 migraine days/month.
Glossary

AIM-D = Activity Impairment in Migraine-Diary; CGRP = calcitonin gene–related peptide; CM = chronic migraine; EF = Emotional Function; EM = episodic migraine; HA = headache [day]; HIT-6 = Headache Impact Test–6; HRQoL = health-related quality of life; ICHD-3 = International Classification of Headache Disorders, 3rd edition; LSMD = least-squares mean difference; mAb = monoclonal antibody; MID = minimally important difference; mITT = modified intent-to-treat; MHD = monthly headache day; MMD = monthly migraine days; MMRM = mixed models for repeated measures; MSQ v2.1 = Migraine-Specific Quality-of-Life Questionnaire version 2.1; nHA = non-headache [day]; PDA = performance of daily activities; PI = physical impairment; PRO = patient-reported outcome; QD = once daily; RFP = Role Function–Preventive; RFR = Role Function–Restrictive; SD, standard deviation.

INTRODUCTION

Migraine, a highly prevalent neurological disease defined by recurrent attacks of headache pain and associated symptoms (e.g., aura, photophobia, nausea, allodynia), is a leading cause of disease burden.\textsuperscript{1-5} Migraine reduces performance of daily activities, participation in social/leisure activities, physical/emotional functioning, and health-related quality of life (HRQoL), both during and between attacks.\textsuperscript{6-11} Preventive migraine treatments aim to reduce the frequency, intensity, and duration of attacks and should reduce activity limitations and improve HRQoL.\textsuperscript{12,13} Assessing the impact of migraine on HRQoL using patient-reported outcome (PRO) measures is important when evaluating preventive treatments.\textsuperscript{12-15}
Atogepant is a recently approved oral, small-molecule, calcitonin gene–related peptide (CGRP) receptor antagonist (gepant)\textsuperscript{16,17} that demonstrated efficacy, safety, and tolerability for preventive treatment of migraine in phase 2/3\textsuperscript{16} and phase 3 (ADVANCE) trials in people with 4–14 monthly migraine days (MMDs).\textsuperscript{18} In the ADVANCE trial, atogepant 10, 30, and 60mg once daily significantly reduced MMDs across the 12-week treatment period (primary endpoint) compared with placebo. Here, we emphasize results from PROs that were selected as alpha-controlled secondary endpoints in the ADVANCE trial, in accordance with US Food and Drug Administration (FDA) regulatory guidance.\textsuperscript{19} These endpoints included changes from baseline in Migraine-Specific Quality of Life Questionnaire version 2.1 (MSQ v2.1) Role Function–Restrictive (RFR) domain score at week 12 and mean monthly Activity Impairment in Migraine-Diary (AIM-D) Performance of Daily Activities (PDA) and Physical Impairment (PI) domain scores across the 12-week treatment period. We also present results from prespecified exploratory analyses of the MSQ v2.1 RFR and AIM-D PDA and PI domains at other time points, and other MSQ v2.1 domains, total AIM-D score, and the Headache Impact Test–6 (HIT-6). The primary research question was the effect of daily atogepant on health-related quality of life measures among patients with 4-14 migraine days per month.
METHODS

Trial design
Detailed methods of the ADVANCE trial have been published. This multicenter, randomized, double-blind, placebo-controlled, parallel-group phase 3 trial was conducted from 12/14/2018 to 6/19/2020 at 136 sites in the United States. Participants were randomized to receive placebo, atogepant 10, 30, or 60mg once daily (QD) at a 1:1:1:1 ratio. Randomization was stratified by prior exposure to a migraine prevention medication with proven efficacy. The randomization sequence was generated by an automated interactive web response system. Blinding was maintained by providing treatments in identical blister cards and masking treatment assignment from participants and site and sponsor personnel. The study included a 4-week baseline period, 12-week double-blind treatment period, and 4-week safety follow-up period. Participants were instructed to take study treatment once daily, orally, at approximately the same time each day.

Participants
Eligible participants were adults 18–80 years of age with 4–14 MMDs in the 3 months prior to screening and 4–14 migraine days recorded in an electronic diary (eDiary) during the 28-day baseline run-in period. Additional inclusion criteria required ≥1-year history of migraine with or without aura consistent with a diagnosis according to the International Classification of Headache Disorders, 3rd edition (ICHD-3) and migraine onset before 50 years of age. Participants were excluded if they had a current diagnosis of chronic migraine (CM), new persistent daily headache, trigeminal autonomic
cephalalgia (e.g., cluster headache), or painful cranial neuropathy as defined by ICHD-3; ≥15 monthly headache days (MHDs) on average across 3 months prior to visit 1 or during the 28-day baseline period; history of inadequate response to >4 medications (2 with different mechanisms of action) prescribed for preventive migraine treatment; use of opioids >2 days/month, triptans or ergots ≥10 days/month, or simple analgesics (e.g., aspirin, nonsteroidal anti-inflammatory drugs, acetaminophen) ≥15 days/month during the 3 months prior to screening or baseline period; or use of barbiturates >2 days/month in the 3 months prior to screening or any use within 30 days of screening.

**Outcome measures**

*Migraine-Specific Quality of Life Questionnaire version 2.1 (MSQ v2.1)*

Participants completed the MSQ v2.1 via electronic tablet (eTablet) at study sites at baseline (treatment day 1), and at weeks 4, 8, and 12. The MSQ v2.1, a 14-item questionnaire designed to measure migraine-specific HRQoL over the past 4 weeks, has 3 domains.\(^{20,21}\) The 7-item MSQ v2.1 RFR domain measures the degree to which migraine limits the performance of daily social and work-related activities. The 4-item MSQ v2.1 Role Function–Preventive (RFP) domain measures the degree to which migraine interrupts or prevents the performance of daily social and work-related activities. The 3-item Emotional Function (EF) domain assesses emotions associated with migraine. All MSQ v2.1 items use a 6-point ordinal scale with response options ranging from “None of the time” to “All of the time.” Raw domain scores were computed as a sum of item responses and rescaled to a 0–100 scale, based on the developer’s scoring scheme, where higher scores indicate better daily functioning (i.e., lesser impact
of migraine) and positive changes in scores reflect improvement in quality of life. The MSQ v2.1 has been shown to be reliable, valid, and sensitive to changes in migraine with treatment.\textsuperscript{20-22} The between-group minimally important difference (MID) for MSQ-RFR is 3.2 points, MSQ-RFP is 4.6 points, and MSQ-EF is 7.5 points.\textsuperscript{23} The meaningful within-group change for responder analyses is 5.0 points for the MSQ-RFR, 5.0–7.9 points for the MSQ-RFP, and 8.0–10.6 points for the MSQ-EF.\textsuperscript{18,23} Change from baseline in MSQ- v2.1 RFR domain score at week 12 was a prespecified alpha-controlled secondary efficacy endpoint. Changes from baseline in MSQ- v2.1 RFR domain score at weeks 4 and 8 and MSQ- v2.1 RFP and -EF domain scores at weeks 4, 8, and 12 were prespecified exploratory endpoints.

Per COVID-19–related protocol amendments, the MSQ v2.1 and HIT-6 at visit 7/week 12 were collected remotely by eTablet starting on 4/20/2020, according to the remote-visit procedure. A total of 10 participants (1.1%) missed ≥1 PRO assessment at week 12 due to COVID-19.

\textit{Activity Impairment in Migraine-Diary (AIM-D)}

Participants completed the AIM-D in eDiaries once daily throughout the entire study, including during the 4-week baseline period. The AIM-D is a novel, rigorously developed and psychometrically sound 11-item daily diary measure that assesses the impact of migraine.\textsuperscript{24} The AIM-D has 2 domains: PDA (7 items) and PI (4 items). Validation studies for the AIM-D have been published.\textsuperscript{24} Participants are asked to rate the level of difficulty experienced in the past 24 hours with PDA (i.e., difficulty with household
chores, errands, leisure activities at home, leisure or social activities outside the home, strenuous physical activities, concentrating, and thinking clearly) and PI (i.e., difficulty walking, moving body, bending forward, moving head) using a 6-point ordinal response scale ranging from “Not difficult at all” to “I could not do it at all.” Three items also include response options of “I did not…” (e.g., “I did not have errands planned.”) The AIM-D was developed with similar questions and content for headache (HA) and non-headache (nHA) day items; the only difference is the instruction provided to the patient with “during your headache” indicated for the HA-day version.

For both HA and nHA days, the daily AIM-D PDA domain score required availability of ≥4 item scores per day, otherwise the domain score was considered missing. A raw daily AIM-D PDA score was calculated based on summation of scores for individual items 1–5, 10, and 11. Each of the 7 items had scores of 0–5, so that raw domain scores were 0–35. If the response category “I did not have (errands, leisure or social, strenuous activities) planned” (items 2, 4, and 5) was selected, the response was considered missing. The raw daily AIM-D PDA score was the sum of non-missing item scores divided by the number of non-missing items, given >50% of items have responses, and then multiplied by 7. Raw daily scores were transformed to a 0–100 daily domain score by multiplying by 100 and dividing by the highest possible raw score (35). Higher scores indicate greater difficulty in performing daily activities. A similar approach was used for computing the raw daily score for AIM-D PI domain and required that ≥2 item scores were available; if not, the domain score was considered missing.
The raw daily AIM-D PI score (range: 0–20) was the sum of scores for individual items 6–9.

For both HA and nHA days, the daily total raw score (range: 0–55) was the sum of scores for individual items 1–11, if ≥6 items had non-missing responses. When the response category “I did not have (errands, leisure or social, strenuous activities) planned” (items 2, 4, and 5) was selected, the response was considered missing. The daily total raw score was transformed to a 0–100 scale by multiplying by 100 and dividing by the highest possible raw score (55), with higher scores indicating worse activity impairment. Monthly AIM-D PDA and PI domain and total scores were the average of daily scores, calculated by summing non-missing daily scores (HA and nHA days combined) and dividing by the number of non-missing daily scores, provided there were ≥14 non-missing daily scores (HA and nHA days combined) in the corresponding 28-day period; otherwise, the monthly total score was set to missing.

Changes from baseline in the mean monthly AIM-D PDA domain score and the mean monthly PI domain score across the 12-week treatment period were prespecified alpha-controlled secondary efficacy endpoints and have been previously reported. Changes from baseline in monthly PDA and PI domain scores of the AIM-D at weeks 1–4, 5–8, and 9–12 and in monthly AIM-D Total score at weeks 1–4, 5–8, 9–12, and average across the 12-week treatment period were prespecified exploratory efficacy endpoints.
Headache Impact Test–6 (HIT-6)

Participants completed the HIT-6 on an eTablet at study sites at baseline (day 1 of treatment) and at weeks 4, 8, and 12. The HIT-6 is a 6-item assessment used to measure the impact of headaches on normal daily life and ability to function on the job, at school, at home, and in social situations in the past 4 weeks. Responses are based on frequency using a 5-point verbal response scale ranging from “Never” to “Always.” The HIT-6 total score is the sum of all responses, each of which is assigned a score ranging from 6 points (never) to 13 points (always). HIT-6 total scores range from 36–78 and are interpreted as little or no impact (score ≤49), some impact (50–55), substantial impact (56–59), and severe impact (60–78) due to headache, with higher scores indicating greater impact and lower scores indicating improvement. The HIT-6 has been validated in people with episodic migraine (EM) and in those with CM. The between-group MID for HIT-6 in people with EM is –1.5 points and the within-patient MID for responder analyses is a score reduction of 5.0 points. Changes from baseline in HIT-6 total score at weeks 4, 8, and 12 and percentages of participants with ≥5-point reduction in HIT-6 (responders) at weeks 4, 8, and 12 were prespecified exploratory endpoints.

Statistical analysis

All analyses were conducted on participants in the modified intent-to-treat (mITT) population with available data for each outcome measure and time point. The mITT population included all participants who received ≥1 dose of study drug, had an evaluable baseline period of eDiary data, and ≥1 evaluable postbaseline 4-week period of eDiary data during the double-blind treatment period. Descriptive comparisons
between the atogepant and placebo groups are reported as differences in change from baseline and corresponding odds ratios. Secondary endpoints of change from baseline in MSQ v2.1 RFR domain score at week 12 and changes from baseline in mean monthly AIM-D domain scores across the 12-week treatment period were analyzed using mixed models for repeated measures (MMRM) that included treatment group, visit, prior exposure to a migraine prevention medication (yes/no), and treatment group by visit as categorical fixed effects; and baseline score and baseline-by-visit interaction as covariates. The overall type I error rate for multiple comparisons across the 3 atogepant doses and the secondary efficacy endpoints was controlled at the 0.05 level using a graphical approach with weighted-Bonferroni test procedure.\textsuperscript{34} Within each dose, testing started from the primary endpoint, followed by testing of the secondary endpoints in a prespecified order.\textsuperscript{18}

Continuous exploratory endpoints (i.e., changes from baseline in MSQ v2.1 domain scores, mean monthly AIM-D domain and total scores, and HIT-6 total scores) were analyzed using MMRM models that included treatment group, visit, prior exposure to a preventive migraine medication (yes/no), and treatment group by visit as categorical fixed effects; and baseline score and baseline-by-visit interaction as covariates. Binary exploratory endpoints (i.e., percentage of participants with \( \geq 5 \)-point improvement [decrease] from baseline in HIT-6 total score) were analyzed using a generalized linear mixed model that included treatment group, visit, prior exposure (yes/no) to a preventive migraine medication, and treatment group-by-visit interaction as categorical fixed effects; baseline value and baseline-by-visit interaction as covariates; and participants
as random effects. Post hoc exploratory analyses of the proportions of participants reaching the within-group MID for each MSQ v2.1 domain utilized a similar generalized linear mixed model. *P*-values from the tests between each atogepant dose group and the placebo group are reported. Except for secondary efficacy endpoints, all analyses were performed at the nominal significance level, without adjusting for multiplicity.

**Standard protocol approvals, registrations, and participant consents**

All participating sites obtained approval from a local or central Institutional Review Board. The trial was conducted according to Good Clinical Practice and the Declaration of Helsinki. Participants provided written informed consent before enrollment. The study is registered with ClinicalTrials.gov (NCT03777059). The study protocol and statistical analysis plan have been published.\(^18\)

**Data availability statement**

Clinical trial data can be requested by any qualified researchers who engage in rigorous, independent scientific research, and will be provided following review and approval of a research proposal and Statistical Analysis Plan and execution of a Data Sharing Agreement. Data requests can be submitted at any time and data will be accessible for 12 months, with possible extensions considered. For more information on the process, or to submit a request, visit the following link: https://www.abbvie.com/our-science/clinical-trials/clinical-trials-data-and-information-sharing/data-and-information-sharing-with-qualified-researchers.html.
RESULTS

Participants and baseline characteristics

Of 910 participants randomized, 902 took ≥1 dose of trial treatment (safety population), and 873 were included in the mITT population (placebo, n=214; atogepant 10mg, n=214; atogepant 30mg, n=223; atogepant 60mg, n=222; Figure 1). Demographic and baseline characteristics are shown in Table 1. In the mITT population, the mean (standard deviation [SD]) age was 41.7 (12.3) years. Most participants were female (89%) and White (84%). Participants had a mean (SD) of 7.6 (2.4) MMDs and 8.7 (2.6) MHDs during the baseline period.

MSQ v2.1

MSQ v2.1 domain scores at baseline were similar among treatment groups and were reflective of substantial to moderate impact on daily social and work-related activities with a mean MSQ-RFR score of 46, mean MSQ-RFP score of 61, and substantial emotional impact of migraine with a mean MSQ-EF score of 53 (Table 1). As reported previously, the change from baseline in MSQ- v2.1 RFR domain score at week 12 (secondary endpoint) demonstrated statistically significant and clinically meaningful (between-group difference exceeded MID of 3.2 points) improvements in the impact of migraine on daily social and work-related activities in all atogepant groups compared with placebo ($p < 0.0001$ for all comparisons after multiplicity adjustment; Figure 2).

Analysis of exploratory MSQ v2.1 endpoints demonstrated nominally greater ($p \leq 0.02$) improvements in all atogepant groups compared with placebo in MSQ- v2.1 RFR, -RFP,
and -EF scores on the least-squares mean difference (LSMD) scores from the earliest
time point assessed (week 4) and throughout the 12-week double-blind treatment period
(Figure 2). The LSMD between each atogepant group vs placebo in MSQ- v2.1 RFR, -
RFP, and -EF scores achieved the between-group MID at all doses and time points
evaluated, except for the EF domain in the 10mg group at week 4 (Figure 2). Nominally
greater proportions of participants in the atogepant groups than placebo had
improvements in MSQ v2.1 scores that exceeded the established within-group MID
(reflective of clinically meaningful improvement) for all 3 domains of the MSQ v2.1 at
weeks 4, 8, and 12 (p ≤ 0.04), except for the RFP and EF domains at week 4 in the
10mg group (Table 2).

AIM-D

At baseline, mean AIM-D domain scores were similar among groups and reflected
modest impairment in PDA (mean scores: 15–17) and PI (mean scores: 11–13; Table
1). As reported previously, changes from baseline in mean monthly AIM-D PDA and PI
scores across the entire 12-week double-blind treatment period (secondary endpoints)
showed statistically significant improvement with atogepant 30 and 60mg compared
with placebo (p ≤ 0.002 after multiplicity adjustment); the 10mg group also showed
improvement in both AIM-D domains but the mean change was not statistically
significant compared with placebo (PDA, p = 0.086; PI, p = 0.074; Figure 3).

Analysis of exploratory AIM-D endpoints demonstrated nominally greater improvements
in mean monthly AIM-D PDA and PI domain scores and Total scores vs placebo in all
atogepant groups over the first month of treatment (weeks 1–4, \( p \leq 0.012 \)), and for the 30 and 60mg atogepant groups at weeks 5–8 (\( p \leq 0.040 \)) and 9–12 (\( p \leq 0.009 \); Figure 3). Improvements in AIM-D scores increased with atogepant dose, with the largest improvements in AIM-D PDA, PI, and Total scores consistently observed with atogepant 60mg at each time point (Figure 3).

HIT-6
Mean baseline HIT-6 total scores were similar among treatment groups and reflective of a severe impact of headaches (HIT-6 total score >60; Table 1). All atogepant groups had nominal improvement (\( p \leq 0.006 \)) vs placebo in HIT-6 total score at the earliest time point assessed (week 4) and throughout the double-blind treatment period (exploratory endpoints; Figure 4A). The LSMD in change from baseline for atogepant vs placebo exceeded the between-group MID (1.5 points) in all atogepant groups at weeks 4, 8, and 12. Greater proportions of atogepant- vs placebo-treated participants were HIT-6 responders (≥5-point improvement from baseline) with all atogepant doses at all time points (\( p \leq 0.03 \)), with the exception of the atogepant 30mg at week 4 (\( p = 0.07 \); Figure 4B).

Classification of evidence
This study provides Class II evidence that in people with 4–14 MMDs, atogepant treatment is associated with improvement in migraine-specific HRQoL in the RFR domain of the MSQ v2.1 at week 12, a prespecified alpha-controlled secondary efficacy endpoint, for all 3 doses. Additionally, atogepant is associated with reductions (i.e.,
improvements) in other alpha-controlled secondary efficacy endpoints (e.g., AIM-D PI and PDA across 12 weeks of treatment) for the 30 and 60mg doses. Although atogepant 10mg produced reductions on these outcomes, the differences were not uniformly significant.

**DISCUSSION**

Atogepant is a daily oral CGRP receptor antagonist for the preventive treatment of migraine. The ADVANCE trial compared 3 doses of atogepant vs placebo for the preventive treatment of migraine in participants with 4–14 MMDs. A prior publication reported significant reductions in MMDs with corresponding significant increases in 50% responder rates, low discontinuation rates, and evidence of safety and tolerability for all 3 doses of atogepant vs placebo. In addition to decreasing MMDs, reducing the impact of migraine on functioning in daily activities and improving overall HRQoL are important goals of migraine treatment from the perspectives of the patient, their family, employers, and payers. Our results demonstrated significant improvements in PROs that assessed functioning in daily social and work-related activities and performance of daily activities, as well as emotional impact, physical impairment, and overall impact of headaches. Atogepant 30 and 60mg were associated with significant improvements in key alpha-controlled secondary endpoints (MSQ v2.1 RFR and AIM-D PDA and PI) over the 12-week treatment period; for the 10mg dose differences were statistically significant for MSQ v2.1 RFR but not for AIM-D among the alpha-controlled endpoints. Atogepant was also associated with nominal improvements in a series of exploratory endpoints as early as week 4.
For the MSQ v2.1, change in the RFR domain from baseline to week 12 was a key secondary endpoint, and earlier time points for the RFR domain and all time points for the RFP and EF domains were exploratory endpoints. At week 12, each of the 3 atogepant groups demonstrated statistically significant and clinically meaningful improvement compared with placebo in the impact of migraine on daily social and work-related activities as measured by the MSQ v2.1 RFR domain. In addition, all 3 doses of atogepant achieved nominal improvements relative to placebo for all 3 MSQ v2.1 domains at weeks 4 and 8. All atogepant groups achieved the between-group MID vs placebo for mean improvement in each MSQ v2.1 domain as early as week 4 and throughout the double-blind treatment period, except for the EF domain in the 10mg group at week 4. The proportion of individuals with clinically meaningful improvements (i.e., responders with score improvement exceeding the within-group MID) in the MSQ v2.1 at week 12 was 85–88% with atogepant 10–60mg (vs 71% placebo) for the MSQ-RFR; 82–84% (vs 71% placebo) for the MSQ-RFP; and 68–73% (vs 57% placebo) for the MSQ-EF.

The AIM-D, a novel migraine-specific PRO, provides a daily diary-based assessment of performance of daily activities and reduction of physical impairment related to migraine. The 1-day recall period and daily diary format of the AIM-D are intended to minimize the bias that influences measures with longer recall intervals. The other validated daily diary PRO for migraine, the Migraine Physical Function Impact Diary, was not available at the time this study was planned, as exemplified by the 4-week recall interval of the MSQ v2.1 and the 3-month recall interval of the Migraine Disability Assessment Scale.15,38
Both the MSQ v2.1 and the AIM-D contribute valuable information regarding the effect of migraine on functioning and performance of daily activities and, therefore, provide a more complete evaluation of migraine burden and treatment benefits. In particular, the AIM-D’s assessment of difficulty in performance of daily activities and physical impairment provides complimentary measurement to the MSQ v2.1 RFR domain’s evaluation of the frequency of migraine impact on daily social and work activities. The AIM-D PDA and PI domains and Total score demonstrated good internal consistency reliability, test-retest reliability, construct validity, known-groups validity, and responsiveness. In the ADVANCE trial, changes from baseline in mean monthly AIM-D PDA and PI domain scores across the 12-week treatment period were alpha-controlled secondary endpoints, and PDA and PI domain scores at monthly time points and AIM-D Total scores were exploratory endpoints. Atogepant 30 and 60mg demonstrated statistically significant improvements from baseline compared with placebo in mean monthly AIM-D PDA and PI scores across the 12-week treatment period; the 10mg group also showed improvement in both domains but the mean change was not significantly different from placebo. The 30mg and 60mg atogepant groups had numerically greater improvements than the placebo group in exploratory endpoints of AIM-D PDA, PI, and Total Scores across weeks 1-4 that were maintained through the end of the trial.

Changes from baseline in HIT-6 total score (exploratory endpoint) showed that each atogepant dose was associated with nominal and clinically meaningful reductions in headache impact vs placebo at first assessment (week 4) and throughout the double-
blind treatment period. The HIT-6 responder rate (proportion of individuals ≥5-point improvement) at week 12 was 63–65% across atogepant dose groups compared with 52% with placebo.

Previous studies have demonstrated that preventive migraine treatments from various drug classes, including oral preventives and injectable CGRP-targeted monoclonal antibodies (mAbs), improved HRQoL and functioning, and reduced headache impact and disability in people with EM.\textsuperscript{39-43} Multiple placebo-controlled clinical trials of CGRP-targeted mAbs in participants with EM demonstrated significant and clinically meaningful improvements in the MSQ v2.1 RFR, RFP, and EF domains and in HIT-6 scores with mAbs vs placebo for up to 6 months of treatment.\textsuperscript{41-46} Methodological differences limit cross-study comparisons. However, all CGRP-targeted treatments were associated with improvements in MSQ v2.1 domains and HIT-6 total scores. This is the first randomized controlled trial to assess treatment benefits using AIM-D.

This trial has strengths and limitations. This rigorously designed double-blind placebo-controlled trial used established validated PRO instruments that measure changes in functional ability, activity impairment, and headache impact over time. The trial was not powered for key secondary endpoints, including the change from baseline in MSQ v2.1 RFR at week 12 and AIM-D PDA and PI across the 12-week treatment period, although these were prespecified alpha-controlled secondary efficacy endpoints. The MSQ v2.1 RFR measure has been included in US labeling for migraine preventives; however, the
HIT-6 has not. The National Institute of Neurological Disorders and Stroke highly recommends both the MSQ v2.1 and HIT-6 for headache studies. The MSQ v2.1 and HIT-6 have 4-week recall periods, raising recall bias as a potential limitation. There are other recall-based PROs which were not included or available at the time of the study, including the Migraine Functional Impact Questionnaire. In contrast, as a daily diary, the AIM-D has a same-day recall period. The AIM-D, which was specifically constructed based on FDA guidance for PRO development for use in clinical trials of migraine treatments, provides some unique insights into the effects of atogepant on migraine-related activity impairment. The lack of statistically significant changes in AIM-D scores in the 10mg dose group is surprising considering the significant changes with MSQ v2.1 and HIT-6. AIM-D scores are averaged across the month for HA and nHA days. In an EM study, by definition, participants do not have headaches on most days, truncating the potential range of AIM-D scores and creating a potential for floor effects. The baseline AIM-D total score for the overall population was 14.3 (range: 13.6–15.4), on a scale with a maximum value of 100. In addition, the benefits of atogepant might be greater on HA days than on nHA days. Combining HA days and nHA days may generate an AIM-D metric that is less sensitive than an HA day measure, particularly for a lower dose of a preventive treatment. The AIM-D has not been compared directly to other diary data or scales. Finally, the duration of follow-up was only 12 weeks; some PRO outcomes may continue to improve beyond 12 weeks, so longer studies could be helpful. Future work should separately score HA and nHA days to distinguish the benefits of atogepant on ictal and interictal burden. Only participants with 4–14 MMDs
were included in the ADVANCE trial, but a phase 3 atogepant trial in people with CM is ongoing (NCT03855137).

In conclusion, atogepant demonstrated significant and clinically meaningful improvements in functioning in daily social and work-related activities and performance of daily activities, as well as reductions in emotional impact, physical impairment, and overall impact of headaches. Improvements were observed at the earliest assessment point (4 weeks) and throughout the 12-week double-blind treatment period for the 30 and 60mg doses. In addition, atogepant 10mg, the lowest dose assessed, improved MSQ v2.1 domain and HIT-6 scores. The early onset of improved functioning is important to patients, as well as payers. Together, these results reinforce the beneficial effects of atogepant as a promising new treatment for the prevention of migraine.
### Appendix 1

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard B. Lipton, MD</td>
<td>Albert Einstein College of Medicine, Bronx, NY, USA</td>
<td>Designed and conceptualized study; analyzed and interpreted the data; drafted and revised the manuscript for intellectual content</td>
</tr>
<tr>
<td>Patricia Pozo-Rosich, MD</td>
<td>Headache Unit, Neurology Department, Vall d’Hebron University Hospital, Barcelona, Spain</td>
<td>Revised the manuscript for intellectual content</td>
</tr>
<tr>
<td></td>
<td>Headache Research Group, VHIR, Departamento de Medicina, Universitat Autonoma of Barcelona, Barcelona, Spain</td>
<td></td>
</tr>
<tr>
<td>Andrew M. Blumenfeld, MD</td>
<td>Headache Center of Southern California, Carlsbad, CA, USA</td>
<td>Revised the manuscript for intellectual content</td>
</tr>
<tr>
<td>Ye Li, PhD*</td>
<td>AbbVie, Madison, NJ, USA</td>
<td>Revised the manuscript for intellectual content</td>
</tr>
<tr>
<td></td>
<td>*Employee at the time of this study.</td>
<td></td>
</tr>
<tr>
<td>Lawrence Severt, MD</td>
<td>AbbVie, Madison, NJ, USA</td>
<td>Revised the manuscript for intellectual content</td>
</tr>
<tr>
<td></td>
<td>*Employee at the time of</td>
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</tbody>
</table>
Jonathan Stokes, MBA

**AbbVie, Madison, NJ, USA**

- Analyzed and interpreted the data; revised the manuscript for intellectual content

Lela Creutz, PhD*

**Peloton Advantage, an OPEN Health company, Parsippany, NJ, USA**

*Employee at the time of manuscript development.

- Drafted and revised the manuscript under the guidance of the authors

Pranav Gandhi, PhD

**AbbVie, Madison, NJ, USA**

- Designed study; analyzed and interpreted the data; drafted and revised the manuscript for intellectual content

David W. Dodick, MD

**Department of Neurology, Mayo Clinic, Scottsdale, AZ, USA; Atria Institute, New York, NY.**

- Revised the manuscript for intellectual content

References


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Table 2 Migraine-Specific Quality of Life Questionnaire version 2.1 (MSQ v2.1) responder rates
Figure 2 Change in Migraine-Specific Quality-of-Life Questionnaire version 2.1 (MSQ v2.1) scores

Least-squares (LS) mean changes from baseline in MSQ v2.1 (A) Role Function-Restrictive (RFR), (B) Role Function-Preventive (RFP), and (C) Emotional Function (EF) scores at weeks 4, 8, and 12. The LSMD for each atogepant group vs placebo was at least the between-group minimally important difference for each domain (MSQ-RFR: 3.2; MSQ-RFP: 4.6, and MSQ-EF: 7.5)\textsuperscript{23} at each time point evaluated, with the exception of the EF domain at week 4 in the 10mg group. Data for change from baseline MSQ v2.1 RFR at week 12 have been published previously.\textsuperscript{18}
LSM, least-squares mean; LSMD, least-squares mean difference; QD, once daily; SE, standard error.
Figure 3 Change in Activity Impairment in Migraine–Diary (AIM-D) scores

Least-squares (LS) mean changes from baseline in average monthly AIM-D (A) Performance of Daily Activities, (B) Physical Impairment, and (C) Total Score. Data for Performance of Daily Activities and Physical Impairment across the 12-week treatment period (month 1–3; secondary endpoint) have been published previously.\textsuperscript{18}

\( *p < 0.05 \) vs placebo. LSMD, least-squares mean difference; QD, once daily; SE, standard error.
Figure 4 Change in Headache Impact Test–6 (HIT-6) score

(A) Mean changes from baseline in HIT-6 total score. The between-group MID for HIT-6 is 1.5 points.31 (B) Percentage of participants with ≥5-point improvement (responders) from baseline in HIT-6 total score.

*p < 0.05 vs placebo. LSMD, least-squares mean difference; QD, once daily; SE, standard error.
A. HIT-6 total score: Change from baseline

- Week 4: Placebo QD (n = 214), Ateogepant 10 mg QD (n = 214), Ateogepant 30 mg QD (n = 223), Ateogepant 60 mg QD (n = 232)
- Week 8: Placebo QD (n = 206/207), Ateogepant 10 mg QD (n = 203/204), Ateogepant 30 mg QD (n = 209/209), Ateogepant 60 mg QD (n = 204/204)
- Week 12: Placebo QD (n = 198/199), Ateogepant 10 mg QD (n = 107/109), Ateogepant 30 mg QD (n = 106/100), Ateogepant 60 mg QD (n = 201/201)

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<tr>
<th>Week</th>
<th>Placebo QD</th>
<th>Ateogepant 10 mg QD</th>
<th>Ateogepant 30 mg QD</th>
<th>Ateogepant 60 mg QD</th>
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<tr>
<td>4</td>
<td>-1.87 (95% CI: -3.20, -0.54)</td>
<td>-3.23 (95% CI: -4.68, -1.78)</td>
<td>&lt;0.0001</td>
<td>-3.17 (95% CI: -4.66, -1.69)</td>
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<td>8</td>
<td>-1.85 (95% CI: -3.17, -0.54)</td>
<td>-3.03 (95% CI: -4.45, -1.62)</td>
<td>&lt;0.0001</td>
<td>-2.85 (95% CI: -4.30, -1.40)</td>
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<td>12</td>
<td>-3.00 (95% CI: -4.32, -1.68)</td>
<td>-3.87 (95% CI: -5.30, -2.45)</td>
<td>&lt;0.0001</td>
<td>-3.96 (95% CI: -5.42, -2.50)</td>
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B. HIT-6 responder rate

- Week 4: Placebo QD (n = 214), Ateogepant 10 mg QD (n = 214), Ateogepant 30 mg QD (n = 223), Ateogepant 60 mg QD (n = 232)
- Week 8: Placebo QD (n = 206/207), Ateogepant 10 mg QD (n = 203/204), Ateogepant 30 mg QD (n = 209/209), Ateogepant 60 mg QD (n = 204/204)
- Week 12: Placebo QD (n = 198/199), Ateogepant 10 mg QD (n = 107/109), Ateogepant 30 mg QD (n = 106/100), Ateogepant 60 mg QD (n = 201/201)

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<th>Week</th>
<th>Placebo QD</th>
<th>Ateogepant 10 mg QD</th>
<th>Ateogepant 30 mg QD</th>
<th>Ateogepant 60 mg QD</th>
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<tr>
<td>4</td>
<td>38.3%</td>
<td>48.6%</td>
<td>56.2%</td>
<td>60.4%</td>
</tr>
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<td>8</td>
<td>47.3%</td>
<td>62.2%</td>
<td>64.7%</td>
<td>64.7%</td>
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<td>12</td>
<td>52.0%</td>
<td>62.7%</td>
<td>65.2%</td>
<td>64.7%</td>
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</table>

<table>
<thead>
<tr>
<th>Week</th>
<th>Placebo QD</th>
<th>Ateogepant 10 mg QD</th>
<th>Ateogepant 30 mg QD</th>
<th>Ateogepant 60 mg QD</th>
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<tbody>
<tr>
<td>4</td>
<td>1.52 (95% CI: 1.03, 2.18)</td>
<td>1.79 (95% CI: 1.19, 2.80)</td>
<td>1.79 (95% CI: 1.19, 2.80)</td>
<td>1.79 (95% CI: 1.19, 2.80)</td>
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<td>8</td>
<td>1.43 (95% CI: 0.97, 2.12)</td>
<td>1.95 (95% CI: 1.31, 2.90)</td>
<td>1.95 (95% CI: 1.31, 2.90)</td>
<td>1.95 (95% CI: 1.31, 2.90)</td>
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<td>12</td>
<td>1.47 (95% CI: 2.27, 3.25)</td>
<td>2.25 (95% CI: 2.68, 3.37)</td>
<td>2.25 (95% CI: 2.68, 3.37)</td>
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<td>0.037</td>
<td>0.007</td>
<td>0.0001</td>
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<td>0.005</td>
<td>0.001</td>
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<td>&lt;0.0001</td>
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<td>12</td>
<td>0.009</td>
<td>0.033</td>
<td>0.006</td>
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## Tables

### Table 1 Demographics and baseline characteristics (modified intent-to-treat population)

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<tr>
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<th>Placebo (n = 214)</th>
<th>10mg QD (n = 214)</th>
<th>30mg QD (n = 223)</th>
<th>60mg QD (n = 222)</th>
<th>Total (N = 873)</th>
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<td><strong>Age, y</strong></td>
<td>40.3 (12.9)</td>
<td>41.5 (12.0)</td>
<td>42.2 (11.7)</td>
<td>42.8 (12.3)</td>
<td>41.7 (12.3)</td>
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<td><strong>Female, n (%)</strong></td>
<td>190 (88.8)</td>
<td>193 (90.2)</td>
<td>199 (89.2)</td>
<td>191 (86.0)</td>
<td>773 (88.5)</td>
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<td><strong>Race, n (%)</strong></td>
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<tr>
<td>White</td>
<td>188 (87.9)</td>
<td>176 (82.2)</td>
<td>181 (81.2)</td>
<td>184 (82.9)</td>
<td>729 (83.5)</td>
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<td>Black or African American</td>
<td>22 (10.3)</td>
<td>32 (15.0)</td>
<td>37 (16.6)</td>
<td>27 (12.2)</td>
<td>118 (13.5)</td>
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<td>Asian</td>
<td>2 (0.9)</td>
<td>2 (0.9)</td>
<td>1 (0.4)</td>
<td>7 (3.2)</td>
<td>12 (1.4)</td>
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<td>Other or unknown</td>
<td>2 (0.9)</td>
<td>4 (1.9)</td>
<td>4 (1.8)</td>
<td>4 (1.8)</td>
<td>14 (1.6)</td>
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<td><strong>Ethnicity, non-Hispanic, n (%)</strong></td>
<td>192 (89.7)</td>
<td>193 (90.2)</td>
<td>205 (91.9)</td>
<td>209 (94.1)</td>
<td>799 (91.5)</td>
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<td><strong>Monthly migraine days (MMDs)</strong></td>
<td>7.5 (2.4)</td>
<td>7.5 (2.5)</td>
<td>7.9 (2.3)</td>
<td>7.8 (2.3)</td>
<td>7.6 (2.4)</td>
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<tr>
<td><strong>Monthly headache days (MHDs)</strong></td>
<td>8.4 (2.6)</td>
<td>8.4 (2.8)</td>
<td>8.8 (2.6)</td>
<td>9.0 (2.6)</td>
<td>8.7 (2.6)</td>
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<td><strong>Monthly acute medication use days</strong></td>
<td>6.5 (3.2)</td>
<td>6.6 (3.0)</td>
<td>6.7 (3.0)</td>
<td>6.9 (3.2)</td>
<td>6.7 (3.1)</td>
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<td><strong>MSQ v2.1</strong></td>
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<td>Role Function-Restrictive</td>
<td>46.8 (19.7)</td>
<td>44.9 (21.4)</td>
<td>44.0 (19.6)</td>
<td>46.8 (20.4)</td>
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<td>Role Function-Preventive</td>
<td>63.0 (21.9)</td>
<td>60.9 (23.4)</td>
<td>57.6 (24.0)</td>
<td>61.1 (24.2)</td>
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<td>Emotional Function</td>
<td>54.0 (26.1)</td>
<td>53.5 (28.3)</td>
<td>49.9 (27.0)</td>
<td>53.3 (29.4)</td>
<td>52.6 (27.8)</td>
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<td><strong>AIM-D</strong></td>
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<td>Performance of Daily Activities</td>
<td>15.2 (8.3)</td>
<td>15.5 (8.9)</td>
<td>16.9 (8.0)</td>
<td>15.9 (8.3)</td>
<td>15.9 (8.4)</td>
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<td>Physical Impairment</td>
<td>11.2 (8.1)</td>
<td>11.7 (8.5)</td>
<td>13.0 (8.0)</td>
<td>11.6 (7.9)</td>
<td>11.9 (8.1)</td>
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<tr>
<td>Total score</td>
<td>13.6 (7.9)</td>
<td>14.0 (8.4)</td>
<td>15.4 (7.7)</td>
<td>14.2 (7.9)</td>
<td>14.3 (8.0)</td>
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<td><strong>HIT-6 total score</strong></td>
<td>(n = 213)</td>
<td>(n = 212)</td>
<td>(n = 223)</td>
<td>(n = 222)</td>
<td>(n = 870)</td>
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<td>64.5 (4.6)</td>
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<td>64.3 (4.7)</td>
<td>63.8 (5.5)</td>
<td>64.2 (5.0)</td>
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Abbreviations: AIM-D = Activity Impairment in Migraine–Diary; HIT-6 = Headache Impact Test–6; MSQ v2.1 = Migraine-Specific Quality-of-Life Questionnaire version 2.1; QD = once daily.

Data represent mean (SD) unless otherwise indicated.
### Table 2. Migraine-Specific Quality of Life Questionnaire version 2.1 (MSQ v2.1) responder rates

<table>
<thead>
<tr>
<th>Role Function–Restrictive domain (≥ 5-point improvement from baseline)</th>
<th>Placebo (N = 214)</th>
<th>Atogepant 10mg QD (N = 214)</th>
<th>Atogepant 30mg QD (N = 223)</th>
<th>Atogepant 60mg QD (N = 222)</th>
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<tr>
<td>Week 4, n/N (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>135/205 (65.9)</td>
<td>159/208 (76.4)</td>
<td>177/217 (81.6)</td>
<td>179/217 (82.5)</td>
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<tr>
<td>Odds ratio vs placebo</td>
<td>1.63</td>
<td>2.22</td>
<td>2.54</td>
<td>2.54</td>
</tr>
<tr>
<td>(95% CI)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(1.03, 2.59)</td>
<td>(1.38, 3.57)</td>
<td>(1.57, 4.11)</td>
<td>(1.57, 4.11)</td>
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<tr>
<td>p Value</td>
<td>0.036</td>
<td>0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
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<td>Week 8, n/N (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>146/202 (72.3)</td>
<td>162/187 (86.6)</td>
<td>179/208 (86.1)</td>
<td>178/206 (86.4)</td>
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<tr>
<td>Odds ratio vs placebo</td>
<td>2.44</td>
<td>2.36</td>
<td>2.43</td>
<td>2.43</td>
</tr>
<tr>
<td>(95% CI)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(1.43, 4.18)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>(1.40, 3.96)</td>
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<tr>
<td>Week 12, n/N (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>141/198 (71.2)</td>
<td>158/186 (84.9)</td>
<td>178/203 (87.7)</td>
<td>172/201 (85.6)</td>
</tr>
<tr>
<td>Odds ratio vs placebo</td>
<td>2.22</td>
<td>2.79</td>
<td>2.44</td>
<td>2.44</td>
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<tr>
<td>(95% CI)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(1.33, 3.69)</td>
<td>(1.66, 4.71)</td>
<td>(1.47, 4.03)</td>
<td>(1.47, 4.03)</td>
</tr>
<tr>
<td>p Value</td>
<td>0.002</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Role Function–Preventive domain (≥ 5-point improvement from baseline)</th>
<th>Placebo (N = 214)</th>
<th>Atogepant 10mg QD (N = 214)</th>
<th>Atogepant 30mg QD (N = 223)</th>
<th>Atogepant 60mg QD (N = 222)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 4, n/N (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>133/205 (64.9)</td>
<td>154/208 (74.0)</td>
<td>178/217 (82.0)</td>
<td>171/217 (78.8)</td>
</tr>
<tr>
<td>Odds ratio vs placebo</td>
<td>1.49</td>
<td>2.33</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>(95% CI)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(0.95, 2.33)</td>
<td>(1.45, 3.75)</td>
<td>(1.26, 3.16)</td>
<td>(1.26, 3.16)</td>
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<tr>
<td>p Value</td>
<td>0.082</td>
<td>&lt;0.001</td>
<td>0.003</td>
<td>0.003</td>
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<tr>
<td>Week 8, n/N (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>141/202 (69.8)</td>
<td>158/187 (84.5)</td>
<td>168/208 (80.8)</td>
<td>168/206 (81.6)</td>
</tr>
<tr>
<td>Odds ratio vs placebo</td>
<td>2.35</td>
<td>1.66</td>
<td>1.75</td>
<td>1.75</td>
</tr>
<tr>
<td>(95% CI)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(1.39, 3.98)</td>
<td>(1.02, 2.70)</td>
<td>(1.08, 2.84)</td>
<td>(1.08, 2.84)</td>
</tr>
<tr>
<td>p Value</td>
<td>0.002</td>
<td>0.041</td>
<td>0.024</td>
<td>0.024</td>
</tr>
<tr>
<td>Week 12, n/N (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>140/198 (70.7)</td>
<td>153/186 (82.3)</td>
<td>170/203 (83.7)</td>
<td>169/201 (84.1)</td>
</tr>
<tr>
<td>Odds ratio vs placebo</td>
<td>1.85</td>
<td>2.04</td>
<td>2.05</td>
<td>2.05</td>
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<tr>
<td>(95% CI)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(1.10, 3.08)</td>
<td>(1.22, 3.42)</td>
<td>(1.23, 3.41)</td>
<td>(1.23, 3.41)</td>
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<tr>
<td>p Value</td>
<td>0.019</td>
<td>0.007</td>
<td>0.006</td>
<td>0.006</td>
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</table>

<table>
<thead>
<tr>
<th>Emotional Function domain (≥ 8-point improvement from baseline)</th>
<th>Placebo (N = 214)</th>
<th>Atogepant 10mg QD (N = 214)</th>
<th>Atogepant 30mg QD (N = 223)</th>
<th>Atogepant 60mg QD (N = 222)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 4, n/N (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>110/205 (53.7)</td>
<td>130/208 (62.5)</td>
<td>142/217 (65.4)</td>
<td>144/217 (66.4)</td>
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<tr>
<td>Odds ratio vs placebo</td>
<td>1.49</td>
<td>1.56</td>
<td>1.80</td>
<td>1.80</td>
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<tr>
<td>(95% CI)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(0.97, 2.30)</td>
<td>(1.01, 2.40)</td>
<td>(1.17, 2.78)</td>
<td>(1.17, 2.78)</td>
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<tr>
<td>p Value</td>
<td>0.069</td>
<td>0.043</td>
<td>0.008</td>
<td>0.008</td>
</tr>
<tr>
<td>Week 8, n/N (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>109/202 (54.0)</td>
<td>137/187 (73.3)</td>
<td>149/208 (71.6)</td>
<td>138/206 (67.0)</td>
</tr>
<tr>
<td>Odds ratio vs placebo</td>
<td>2.42</td>
<td>2.15</td>
<td>1.85</td>
<td>1.85</td>
</tr>
<tr>
<td>(95% CI)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(1.51, 3.88)</td>
<td>(1.36, 3.39)</td>
<td>(1.18, 2.91)</td>
<td>(1.18, 2.91)</td>
</tr>
<tr>
<td>p Value</td>
<td>&lt;0.001</td>
<td>0.001</td>
<td>0.007</td>
<td>0.007</td>
</tr>
<tr>
<td>Week 12, n/N (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>112/198 (56.6)</td>
<td>129/186 (69.4)</td>
<td>148/203 (72.9)</td>
<td>137/201 (68.2)</td>
</tr>
<tr>
<td>Odds ratio vs placebo</td>
<td>1.69</td>
<td>1.92</td>
<td>1.70</td>
<td>1.70</td>
</tr>
<tr>
<td>(95% CI)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(1.07, 2.67)</td>
<td>(1.22, 3.03)</td>
<td>(1.09, 2.67)</td>
<td>(1.09, 2.67)</td>
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<tr>
<td>p Value</td>
<td>0.025</td>
<td>0.005</td>
<td>0.020</td>
<td>0.020</td>
</tr>
</tbody>
</table>

Abbreviation: QD = once daily.

<sup>a</sup> Percentages are relative to the number of participants available for analysis at a specific time point in the modified intent-to-treat population.

<sup>b</sup> Analyses are based on a generalized linear mixed model for repeated measures. The model includes baseline as a covariate, prior exposure to migraine prevention medications (Y/N), treatment group and visit (month) as fixed factors, and treatment group-by-visit and baseline-by-visit as interaction terms. Participants are included as random effects with unstructured covariance matrix in the model.
Effect of Atogepant for Preventive Migraine Treatment on Patient-Reported Outcomes in the Randomized, Double-blind, Phase 3 ADVANCE Trial
Richard B. Lipton, Patricia Pozo-Rosich, Andrew Blumenfeld, et al.
Neurology published online November 17, 2022
DOI 10.1212/WNL.0000000000201568

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