analysis (PCA) was used to identify multidomain response patterns.

Results: All CGRP mAbs produced rapid and sustained improvements across migraine frequency, disability, and patient-reported outcomes over 12 months. Age did not significantly influence baseline severity, longitudinal trajectories, or responder status. Treatment differences were modest overall; however, at 12 months, fremanezumab and eptinezumab were associated with higher odds of response compared with erenumab, while galcanezumab showed consistently higher response odds

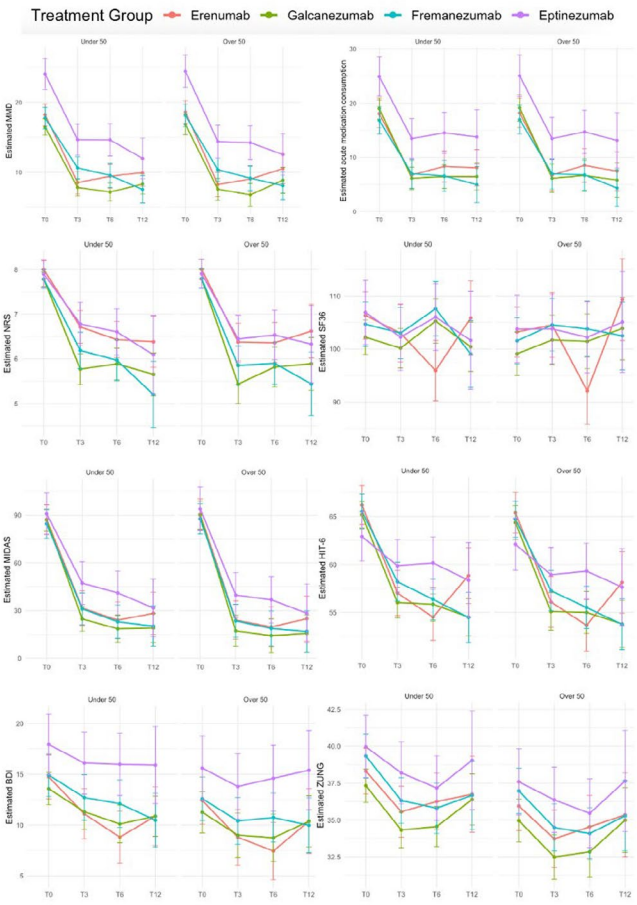


FIGURE 1 Clinical and migraine-related variables change over time across age and treatment groups.

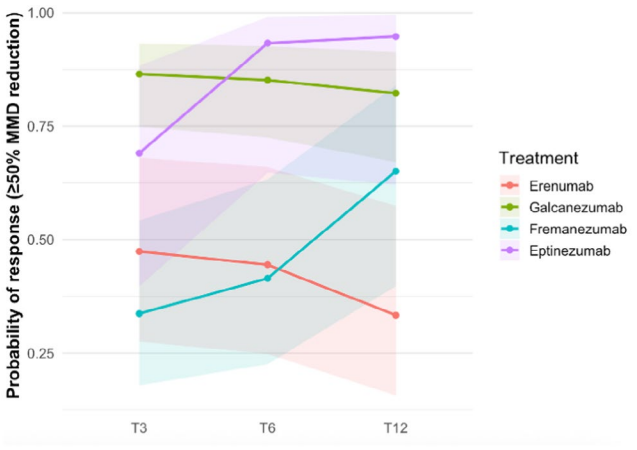


FIGURE 2 probability of response over time across treatment groups (MMD=monthly migraine days).

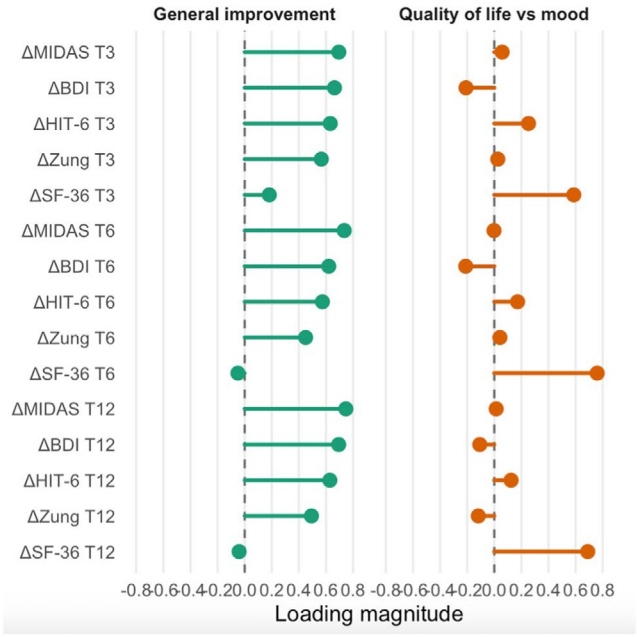


FIGURE 3 Component loadings from PCA.

independent of time. PCA identified a "General improvement" component capturing multidomain benefit, which was more pronounced in patients treated with eptinezumab.

Conclusion: In real-world clinical practice, CGRP mAbs demonstrate broadly comparable and durable effectiveness across age groups. Subtle long-term differences between agents may emerge, particularly for multidimensional clinical improvement, supporting individualized treatment selection.

Disclosure: IM has received support for conference participation from Allergan/AbbVie, Pfizer, and Lundbeck; has received funding for an advanced training course from Teva; and is currently enrolled in a DPhil program funded by GlaxoSmithKline (Oxford–GSK). GC and MDP has received support for conference participation from Allergan/AbbVie, Pfizer, Teva and Lundbeck. APa has served on the scientific advisory board of GE Healthcare, Eli-Lilly, and Actelion Ltd. Pharmaceuticals, and has received speaker honoraria from Nutricia, PIAM, Langstone Technology, GE Healthcare, Lilly, Lundbeck, UCB Pharma, and Chiesi Pharmaceuticals. RR has received speaker honoraria from Eli-Lilly, Novartis, Lundbeck, and Teva. All other authors declare no conflicts of interest.

EPO-0738 | Work productivity and indirect cost savings of atogepant versus topiramate: Results from the TEMPLE trial

J. Díaz de Terán[1]; P. Gandhi[2]; H. Guo[2]; F. Haile[2]; K. Nagy[2]; K. Carr[2]; J. Versijpt[3]; R. Gil-Gouveia[4]; D. Buse[5]; R. Lipton[5]

[1]La Paz University Hospital, Madrid, Spain; Hospital La Paz Institute for Health Research; [2]AbbVie Inc, North Chicago, USA; [3]Department of Neurology, Universitair Ziekenhuis Brussel, Brussels, Belgium; [4]Neurology Department, Hospital da Luz, Lisbon, Portugal; Center for Interdisciplinary Research in Health, Universidade Católica Portuguesa, Lisbon, Portugal; [5]Department of Neurology and Headache Center, Albert Einstein College of Medicine, Bronx, USA

Background and aims: Using the Work Productivity and Activity Impairment (WPAI): Migraine, we contrasted presenteeism, absenteeism, overall work productivity, and indirect cost savings of participants who received atogepant versus topiramate for the preventive treatment of migraine.

Methods: TEMPLE was a phase 3b, randomized, multicenter, double-blind (DB), double-dummy, active-controlled trial to evaluate tolerability, safety, and efficacy of atogepant compared with topiramate for the preventive treatment of migraine. WPAI:Migraine was evaluated at each 4-week time point during the 24-week DB period. An excel-based cost calculator used WPAI data to calculate the per-patient-per-year (PPPY) work productivity cost by multiplying the percent overall work productivity loss, weeks per year, standard weekly full-time work hours (40), and the average hourly wage in Canada, Portugal, United Kingdom, and United States. Productivity benefit from using atogepant was calculated as the difference between atogepant and topiramate productivity loss PPPY.

Results: Based on WPAI data from TEMPLE, atogepant demonstrated greater improvements in presenteeism and overall work productivity (Figures 1 and 2), and lower absenteeism and activity impairment versus topiramate. The cost calculator using overall work productivity data demonstrated atogepant provided greater productivity benefits and indirect cost savings compared with topiramate across all 4 countries (Table 1).

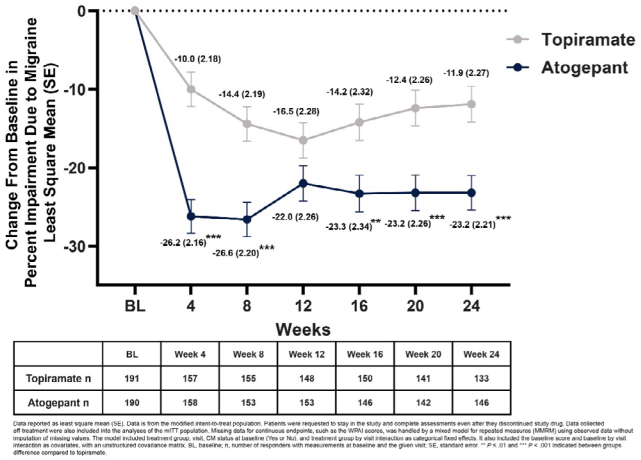
Conclusion: Atogepant consistently demonstrated greater improvement compared to topiramate across all four WPAI domains. Using TEMPLE WPAI data, atogepant demonstrated work productivity benefit compared to topiramate in Canada, Portugal, UK, and United States.

Disclosure: Disclosures Javier Díaz de Terán declares public research funding from the Instituto de Salud Carlos III (Ministry of Health, Spain), project PI24/01254, outside the submitted work; and reports honoraria for consultant and/or advisory boards from AbbVie, Almirall, Lilly, Lundbeck, Novartis, Organon, Pfizer, Boston Scientific, and Teva. Jan Versijpt received personal fees and nonfinancial support from Teva, Pfizer and Medtronic, personal fees from Novartis and Lundbeck, and grants and nonfinancial support from Allergan/AbbVie. Raquel Gil-Gouveia reports honoraria for consultant and/or advisory boards from Allergan/Abbvie, Astra Zeneca, Almirall, Bial, Biogen, Bristol-Myers Squibb, CMBE, FLOAT, Lilly, Lundbeck, Merk, Novartis, Novo Nordisk, Organon, Pfizer, Roche, Sanofi, Tecnifar and Teva; research funding from Fundação Ciência Tecnologia (Project 29675, MigN2Treat, 02/SAICT/2017); Learning-Health, Luz Saúde (LiON, Luz Innovation on Neurosciences); Novartis-Sociedade Portuguesa de Cefaleias; Bolsa–Projecto Centro de Investigação Interdisciplinar em Saúde and UCP. Dawn Buse has received research funding from the US Food and Drug Administration, the National Headache Foundation and Amgen and received consulting fees from Amgen, Allergan/AbbVie, Eli Lilly, Lundbeck and Teva. Richard B. Lipton has received research support from the National Institutes of Health, the FDA, and the National Headache Foundation. He serves as consultant for, advisory board member of, or has received honoraria or research support from AbbVie/Allergan, Aeon, Amgen, Axsome, Biohaven, Dr. Reddy's Laboratories, electroCore, Eli Lilly, GlaxoSmithKline, Linpharma, Lundbeck, Pfizer, Merck, Novartis, Teva, and Vector. He receives royalties from Wolff's Headache, 8th edition (Oxford University Press, 2009), and Informa. He holds stock/options in Biohaven, CoolTech, and NuVieBio. PG, HG, FH, KN, and KC are employees of AbbVie and may hold AbbVie stock.

TABLE 1 Work productivity benefit for Atogepant vs. Topiramate per patient per year.

	Canada	Portugal	United Kingdom	United States
Productivity Cost Benefit vs. Topiramate (PPPY)	CAD$ 6,892	€ 2,160	£ 4,052	$ 8,434
Productivity Cost Benefit Including Treatment Costs vs. Topiramate (PPPY)	CAD$ 419	€ 1,513	£ 1,726	$ 2,271

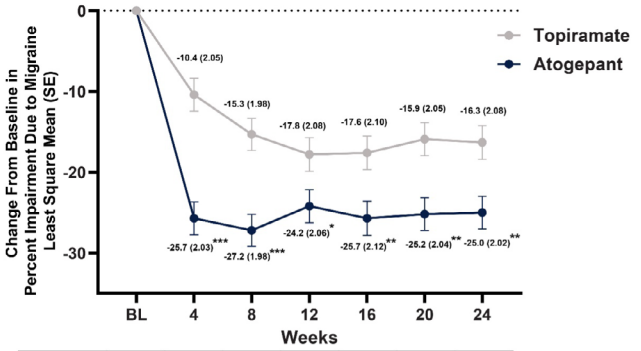
Productivity cost benefit is the difference between atogepant and topiramate. Incremental values are calculated relative to topiramate. Productivity cost benefits reflect improvement in overall productivity from WPAI. Treatment costs represent the annual drug cost difference of atogepant compared with topiramate. CAD$, Canadian dollars; PPPY, per-patient-per-year; WPAI, Work Productivity and Activity Impairment.



	BL	Week 4	Week 8	Week 12	Week 16	Week 20	Week 24
Topiramate n	191	157	155	148	150	141	133
Atogepant n	190	158	153	153	146	142	146

Data reported as least square mean (SE). Data is from the modified intent-to-treat population. Patients were requested to stay in the study and complete assessments even after they discontinued study drug. Data collected off treatment were also included into the analyses of the mITT population. Missing data for continuous endpoints, such as the WPAI scores, was handled by a mixed model for repeated measures (MMRM) using observed data without imputation of missing values. The model included treatment group, visit, CM status at baseline (Yes or No), and treatment group by visit interaction as categorical fixed effects. It also included the baseline score and baseline by visit interaction as covariates, with an unstructured covariance matrix. BL, baseline; n, number of responders with measurements at baseline and the given visit; SE, standard error. * $P < .01$ and *** $P < .001$ indicated between groups difference compared to topiramate.

FIGURE 1 Change from baseline in overall work productivity loss.



	BL	Week 4	Week 8	Week 12	Week 16	Week 20	Week 24
Topiramate n	191	157	155	148	150	141	133
Atogepant n	190	158	153	153	146	142	146

Data reported as least square mean (SE). Data is from the modified intent-to-treat population. Patients were requested to stay in the study and complete assessments even after they discontinued study drug. Data collected off treatment were also included into the analyses of the mITT population. Missing data for continuous endpoints, such as the WPAI scores, was handled by a mixed model for repeated measures (MMRM) using observed data without imputation of missing values. The model included treatment group, visit, CM status at baseline (Yes or No), and treatment group by visit interaction as categorical fixed effects. It also included the baseline score and baseline by visit interaction as covariates, with an unstructured covariance matrix. BL, baseline; n, number of responders with measurements at baseline and the given visit; SE, standard error. * $P < .05$, ** $P < .01$, and *** $P < .001$ indicated between groups difference compared to topiramate.

FIGURE 2 Change from baseline in presenteeism.