Interventions of a Telepharmacy Service with Migraine Disorder Patients-Strengthening the Linkage of Care Between Provider and Patient

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Background

Migraines impose a substantial burden on daily functioning. Patients with chronic migraine—defined as ≥15 headache days per month—frequently experience reduced productivity, diminished quality of life, and increased financial strain on both families and the healthcare system.[1,2] Calcitonin gene-related peptide (CGRP) inhibitors have demonstrated meaningful clinical benefit, reducing monthly headache frequency by approximately 50% in about half of treated patients when used appropriately.[3,4]

Since the COVID-19 pandemic, telehealth has become an accessible and effective modality for outpatient care. In 2025, Memorial Specialty Pharmacy (MSP), a health system specialty pharmacy within Memorial Healthcare System, implemented pharmacist-led neurology telehealth visits for patients with migraine disorders. Through high-touch services, MSP pharmacists facilitate medication access, provide counseling, monitor therapeutic outcomes, and address adherence barriers. This study evaluates the types and acceptance rates of pharmacist interventions and describes the workflow of this novel telehealth service.

Methods

This single-center, prospective interventional study included patients treated at the Memorial Neuroscience Institute and enrolled into Memorial Specialty Pharmacy's Medication Management Program (MMP) between March 1, 2025, and March 1, 2026.

Pharmacists conducted 15 to 30-minute video or audio telehealth visits at therapy initiation (upon first CGRP dispensation), followed by a telephone-based new-therapy check-in within 90 days, and subsequent telehealth visits approximately every 12 months for maintenance CGRP medications (Table 1). During these encounters, patient-reported migraine control (Table 2) was assessed using a 1–10 Likert scale (1 = uncontrolled; 10 = well controlled). Patients also reported the number of days (0–30) they were able to complete activities of daily living (Table 2).

Patient Care Representatives conducted monthly refill assessment calls, while Medication Access Specialists performed benefits investigations and facilitated medication access. Adherence and access issues were escalated to pharmacists as needed.

Pharmacists documented clinical interventions in the electronic medical record (Epic®, Compass Rose module) across four domains: adherence, effectiveness, indication, and safety (Table 3). Medication-related needs were further categorized by medication-related problem type and corresponding rationale.

Percentage of Days Covered (Table 4) was captured within the health-system specialty pharmacy dispensing platform (Epic® Willow Ambulatory module).

Inclusion Criteria	Exclusion Criteria
• Seen by Memorial Neuroscience Institute provider • Diagnosis of Migraine Disorder in patients 18-89 years of age and prescribed a CGRP • Enrolled in medication management program with Memorial Specialty Pharmacy and completed ≥ 1 telehealth visit and obtained ≥ 2 medication refills through Memorial Specialty Pharmacy	• Patients who declined enrollment into Memorial Specialty Pharmacy's medication management program or did not complete ≥ 2 medication refills through Memorial Specialty Pharmacy • Clinical interventions without provider response

IRB approved, Memorial Healthcare Systems Institutional Review Board
Disclosures: The authors report no conflict of interest and nothing to disclose.

Results

Table 1: CGRPs Dispensed of Patients Enrolled into MMP, March 2025-2026 (N=13,610)

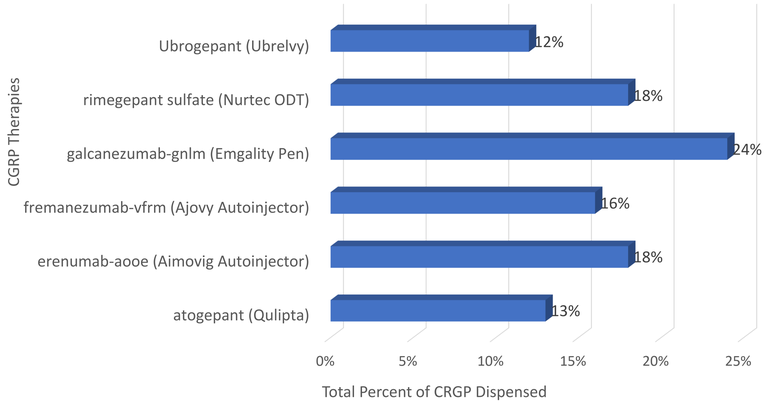

Table 2	Patient-Reported Migraine Control	Patient-Reported Activities of Daily Living
Pre-Intervention	4 out of 10	25
Post-Intervention	9 out of 10	29

Table 4: Proportion of Days Covered	
Pre-Intervention	0.83
Post-Intervention	0.85

Provider Acceptance Rate of Pharmacist's Clinical Interventions
98.4%

Table 3: Clinical Interventions by Pharmacist (N=4,033)

Medication Need, (n)	Medication Problem Category	Medication Problem Rationale
Indication (n=1,087)	Unnecessary medication therapy	Duplicate therapy
		No medical indication at time
		Non-medication therapy more appropriate
		Treating avoidable adverse medication reaction
	Needs additional medication therapy	Preventative therapy
		Untreated condition
		Synergistic therapy
Effectiveness (n=509)	Ineffective medication	More effective medication available
		Condition refractory to medication
		Dosage form inappropriate
	Dosage too low	Dose too low
		Frequency inappropriate
		Incorrect administration
		Medication interaction
		Incorrect storage
		Duration inappropriate
	Needs additional monitoring	Medication requires monitoring
Safety (n=1,53)	Adverse medication event	Undesirable effect
		Unsafe medication
		Medication interaction
		Incorrect administration
		Allergic reaction
		Dosage increase/decrease too fast
	Dosage too high	Dose too high
		Frequency inappropriate
		Duration inappropriate
		Medication interaction
	Needs additional monitoring	Medication requires monitoring
Adherence (n=854)	Adherence	Does not understand instructions
		Patient forgets to take
		Patient prefers not to take
		Medication not available
		Cannot swallow/administer
	Cost	More cost-effective medication available
		Cannot afford medication

Conclusion

Our findings suggest that a collaborative physician–pharmacist telehealth model can achieve high acceptance of clinical interventions while improving patient-reported outcomes and medication adherence in individuals with migraine disorders.

References