

Information from LactMed® on migraine preventives

LactMed® (the Drugs and Lactation Database) is a peer-reviewed online database from the National Library of Medicine that provides information on the safety of drugs and chemicals for breastfeeding parents and health care professionals.

Erenumab

No information is available on the passage of erenumab into breastmilk. Because erenumab is a large protein molecule with a molecular weight of 150,000 Da, the amount in milk is likely to be very low. It is also likely to be partially destroyed in the infant's gastrointestinal tract and absorption by the infant is probably minimal. Two infants have been breastfed during maternal erenumab therapy without any adverse effects. Until more data become available, erenumab injection should be used with caution during breastfeeding, especially while nursing a newborn or preterm infant. Waiting for at least 2 weeks postpartum to resume therapy may minimize transfer to the infant.

Flunarizine

Flunarizine is not approved for marketing in the United States by the U.S. Food and Drug Administration, but is available in other countries. No information is available on the use of flunarizine during breastfeeding. Because of its long half-life of 19 days in children, expert opinion recommends that flunarizine not be used in migraine prophylaxis in nursing mothers. An alternate drug is preferred, especially while nursing a newborn or preterm infant.

Fremanezumab

No information is available on the clinical use of fremanezumab during breastfeeding. Because fremanezumab is a large protein molecule with a molecular weight of about 148,000 Da, the amount in milk is likely to be very low. It is also likely to be partially destroyed in the infant's gastrointestinal tract and absorption by the infant is probably minimal. Waiting for at least 2 weeks postpartum to resume therapy may minimize transfer to the infant.

Divalproex/valproic acid

Very little information is available on the clinical use of divalproex during breastfeeding. However, divalproex is rapidly metabolized in the body to the active drug valproic acid. Valproic acid levels in breastmilk are low and infant serum levels range from undetectable to low. Breastfeeding during valproic acid monotherapy does not appear to adversely affect infant growth or development, and breastfed infants had higher IQs and enhanced verbal abilities than nonbreastfed infants at 6 years of age in one study. A safety scoring system finds valproic acid possible to use during breastfeeding. If valproic acid is required by the mother, it is not necessarily a reason to discontinue breastfeeding.

No definite adverse reactions to valproic acid in breastfed infants have been reported. Theoretically, breastfed infants are at risk for valproic acid-induced hepatotoxicity, and a questionable case of thrombocytopenia has been reported. A rare case of infant baldness might have been caused by valproate in milk. Monitor the infant for jaundice and unusual bruising or bleeding. Combination therapy with sedating anticonvulsants or psychotropics may result in infant sedation or withdrawal reactions.

Eptinezumab

No information is available on the use of eptinezumab during breastfeeding. Because eptinezumab is a large protein molecule with a molecular weight of about 143,000 Da, the amount in milk is likely to be very low. It is also likely to be partially destroyed in the infant's gastrointestinal tract and absorption by the infant is probably minimal. Waiting for at least 2 weeks postpartum to resume therapy may minimize transfer to the infant.

Galcanezumab

No information is available on the clinical use of galcanezumab during breastfeeding. Because galcanezumab is a large protein molecule with a molecular weight of about 147,000 Da, the amount in milk is likely to be very low. It is also likely to be partially destroyed in the infant's gastrointestinal tract and absorption by the infant is probably minimal. Until more data become available, galcanezumab should be used with caution during breastfeeding, especially while nursing a newborn or preterm infant. Waiting for at least 2 weeks postpartum to resume therapy may minimize transfer to the infant.

Propranolol

Because of the low levels of propranolol in breastmilk, amounts ingested by the infant are small and would not be expected to cause any adverse effects in breastfed infants. Studies during breastfeeding have found no adverse reactions in breastfed infants clearly attributable to propranolol. No special precautions are required. Propranolol has been used successfully in cases of persistent pain of the breast during breastfeeding.

Metoprolol

Because of the low levels of metoprolol in breastmilk, amounts ingested by the infant are small and would not be expected to cause any adverse effects in breastfed infants. Studies on the use of metoprolol during breastfeeding have found no adverse reactions in breastfed infants. Monitor breastfed infants for symptoms of beta blockade such as bradycardia and listlessness due to hypoglycemia.

OnabotulinumtoxinA

Of the therapeutically used botulinum toxins, only onabotulinumtoxinA has been studied during breastfeeding and only in cosmetic doses. It was not detectable in the milk of two women and detectable in only minute amounts in 5 others after 40 to 92 units injected into the face. Many mothers have breastfed their infants after injection of onabotulinumtoxinA for migraine. International guidelines considers onabotulinumtoxinA acceptable in breastfeeding women with chronic migraine, and it is often used in nursing mothers by dermatologists. High doses for other conditions have not been studied.

Topiramate

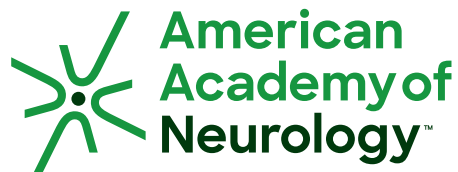
Maternal doses of topiramate up to 200 mg daily produce low levels in infant serum. Sedation and diarrhea have been reported occasionally in breastfed infants, but most infants tolerate the drug in milk well. In a few infants, no long-term adverse effects on growth and development have been seen. Monitor the infant for diarrhea, drowsiness, irritability, adequate weight gain, and developmental milestones, especially in younger, exclusively breastfed infants and when using combinations of anticonvulsant or psychotropic drugs.

Amitriptyline

Milk levels of amitriptyline and its metabolites are low. Immediate side effects have not been reported and a limited amount of follow-up has found no adverse effects on infant growth and development. Amitriptyline use during breastfeeding would usually not be expected to cause any adverse effects in breastfed infants, especially if the infant is older than 2 months. A safety scoring system finds amitriptyline use to be possible with caution during breastfeeding. However, rare sedation has been reported in a neonate. Other agents with fewer active metabolites may be preferred when large doses are required or while nursing a newborn or preterm infant.

Telmisartan

No information is available on the use of telmisartan during breastfeeding and the manufacturer advises avoidance of breastfeeding during telmisartan therapy. An alternate drug may be preferred, especially while nursing a newborn or preterm infant.



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This information is a supplement to the American Academy of Neurology and American Headache Society's, "Pharmacologic Treatment for Migraine Prevention in Adults Practice Guideline Recommendations," which was published in *Neurology*® online on August 31, 2026. Please refer to the full guideline at [AAN.com/guidelines](https://www.aan.com/guidelines) for more information, including the full systematic review of the evidence and practice recommendations.