Expanding Access to Birth Control: Will Women Get the Care They Need?
Target Audience: Pharmacists
ACPE#: 0202-0000-18-045-L01-P
Activity Type: Application-based
This activity is supported by an independent educational grant from Merck & Co., Inc.
Disclosures

Dr. Stewart-Lynch’s spouse is an employee of Pfizer Medical, Inc.

The American Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Learning Objectives

At the completion of this application-based activity, participants will be able to:
1. Discuss the evolving roles of community pharmacists in managing women’s contraceptive care.
2. Explain the Centers for Disease Control and Prevention’s evidence-based recommendations for contraceptive safety and management when prescribing or dispensing contraceptives.
3. Demonstrate educational strategies regarding safe use of contraceptives.
4. Identify resources for additional information for health care providers and patients receiving contraceptives.
5. Discuss the significance of recent standardized protocols that allow pharmacists to prescribe or furnish hormonal contraceptives without a prescription from another provider.
1. Assessment Question (LO 1 and 5)

1. Pharmacists practicing in states with a “protocol” for pharmacist provided contraception, can:
   A. Furnish contraception limited to oral contraceptives
   B. Prescribe any form/method of contraception
   C. Prescribe or furnish some forms of hormonal contraceptives
   D. Furnish contraceptives after entering into CPA with a provider
2. Assessment Question (LO 2 and 3)

According to the CDC’s Medical Eligibility Criteria, selective serotonin reuptake inhibitors (SSRIs) are considered which eligibility category?

A. Category 1: No restriction (method can be used)
B. Category 2: Advantages generally outweigh theoretical or proven risks
C. Category 3: Theoretical or proven risks usually outweigh the advantages
D. Category 4: Unacceptable health risk (method not to be used)
3. Assessment Question (LO 3)

Which of the following is recommended prior to hormonal contraception initiation?

A. Pap smear  
B. Sexually transmitted infection screening  
C. Laboratory screening  
D. Blood pressure measurement
4. Assessment Question (LO 3,4)

1. You are counseling a woman who plans to begin using the combined hormonal contraceptive patch. Which one of the following tools would be most helpful to determine when the method can be started?

A. U.S. MEC
B. Lexicomp®
C. Quality Family Planning
D. U.S. SPR
States with Pharmacist Prescribed/Furnished Contraception
California

“Self-Administered Hormonal Contraception Protocol for Pharmacists”

- Pharmacists may furnish self-administered hormonal contraceptives per protocol
- Includes: oral, transdermal, vaginal, depot injection
- Self-screening tool with blood pressure measurement
- Counseling and education
- Documentation in shared electronic medical record
- Requires completion of a one-hour board-approved continuing education program
  - Self-administered hormonal contraception
  - Application of the USMEC
  - CDC guidance on contraception

Oregon

“Oregon Pharmacists Prescribing of Contraceptive Therapy”

- Pharmacist may prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives
- Self-screening tool
- Board developed standard procedures
- Referral to primary care or women’s health provider
- Requires completion of a board approved training program related to prescribing hormonal contraceptive patches and self-administered oral hormonal contraceptives.

Opportunities for Pharmacists

- Patient education and counseling
  - Prior to product selection
  - Upon initiation
  - Managing drug interactions
  - Managing adverse effects

- Team-based care
  - Choosing an agent
  - Switching methods
  - Avoiding drug interactions
  - Monitoring

- Pharmacist provided contraception
  - Assess a woman's eligibility for hormonal contraception
  - Provide contraceptive counseling in the selection of a contraceptive
  - Provide access to contraceptive products within the scope of practice
  - Provide counseling related to side effects, drug interactions and missed doses
Practice Tools
Guidelines for providing hormonal contraceptives

The Centers for Disease Control publish evidence-based guidelines and practice recommendations for clinicians regarding contraceptive use.

- The Medical Eligibility Guidelines for Contraceptives (MEC)
- The Selected Practice Recommendations (SPR)

https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm
How effective are birth control methods?

The effectiveness of birth control methods is critically important for reducing the risk of unintended pregnancy. Effectiveness can be measured during "perfect use," when the method is used correctly and consistently as directed, or during "typical use," which is how effective the method is during actual use (including inconsistent and incorrect use).

The best way to reduce the risk of unintended pregnancy among women who are sexually active is to use effective birth control correctly and consistently. Among reversible methods of birth control, intrauterine contraception and the contraceptive implant remain highly effective for years once correctly in place. The effectiveness of the contraceptive shot, pills, patch and ring, and barrier and fertility awareness-based methods, depends on correct and consistent use—so these methods have lower effectiveness with typical use.

For each method of birth control, effectiveness with typical use is provided below. We present this as the percent of women who experience an unintended pregnancy within the first year of typical use (also known as the failure rate).
CDC Medical Eligibility Criteria (MEC)
CDC Medical Eligibility Criteria for Contraceptive Use (MEC)

U.S. Medical Eligibility Criteria for Contraceptive Use, 2016

http://www.cdc.gov/mmwr/volumes/65/rr/rr6503.pdf, Accessed 12/1/17
## Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
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<tbody>
<tr>
<td><strong>Age</strong></td>
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<td></td>
<td>Menarche to &lt;20 yrs</td>
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<tr>
<td></td>
<td>Menarche to ≥20 yrs</td>
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<tr>
<td></td>
<td>Menarche to &lt;18 yrs</td>
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<td>1</td>
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<tr>
<td></td>
<td>Menarche to ≥18 yrs</td>
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</tr>
<tr>
<td>Anatomical abnormalities</td>
<td>a) Distorted uterus cavity</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>b) Other abnormalities</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<td>2</td>
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</tr>
<tr>
<td>Anemias</td>
<td>a) Thalassemia</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<td></td>
<td>b) Sickle cell disease</td>
<td>2</td>
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<td>2</td>
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<td>2</td>
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<td></td>
<td>c) Iron-deficiency anemia</td>
<td>2</td>
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<td>2</td>
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<td>2</td>
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<td>(including cysts)</td>
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<tr>
<td>Benign ovarian tumors</td>
<td>a) Undiagnosed mass</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>b) Benign breast disease</td>
<td>2</td>
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<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>c) Family history of cancer</td>
<td>2</td>
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<td>2</td>
<td>2</td>
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<td>2</td>
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<tr>
<td></td>
<td>d) Breast cancer</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Breast disease</td>
<td>i) Current</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>ii) Past and no evidence of current disease for 5 years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>a) &lt;31 days postpartum</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
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<tr>
<td></td>
<td>b) 21 to ≤30 days postpartum</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td></td>
<td>c) With other risk factors for VTE</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
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<tr>
<td></td>
<td>d) Without other risk factors for VTE</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>a) Uniradiated non-pregnant</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td></td>
<td>b) Decreasing β-hCG levels</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td></td>
<td>c) Persistently elevated β-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td></td>
<td>d) Persistently elevated β-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
</tr>
</tbody>
</table>

### Conditions requiring referrals

- Diabetes
  - a) History of gastroparesis disease
  - b) Non-obstructive disease
    - i) Non-insulin dependent
    - ii) Insulin dependent
  - c) Nephropathy/stroke/other hypertension
  - d) Other vascular disease or diabetes of >20 years duration
  - e) Severe
  - Endometrial cancer
  - Endometrial hyperplasia
  - Endometriosis
  - Epilepsy
  - Gallbladder disease
  - Gastrointestinal trophoblastic disease
  - Headaches
    - a) Migraine
  - History of bariatric surgery
    - a) Restrictive procedures
    - b) Malabsorptive procedures
  - History of cholestasis
    - a) Pregnancy related
    - b) Past CDC related
  - History of high blood
CDC MEC: Legends

- Provides guidance on which contraceptive methods are safe
- Provides guidance regarding potential drug interactions with contraception

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>A condition for which there is no restriction for the use of the contraceptive method</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>A condition for which the advantages of using the method generally outweigh the theoretical or proven risks</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>A condition for which the theoretical or proven risks usually outweigh the advantages of using the method</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>A condition that represents an unacceptable health risk if the contraceptive method is used</td>
</tr>
</tbody>
</table>

US Medical Eligibility Criteria for Contraceptive Use, 2016
## CDC MEC: Legends

- **I**: Initiating
- **C**: Continuing

### Key:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>No restriction (method can be used)</td>
</tr>
<tr>
<td>2</td>
<td>Advantages generally outweigh theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks usually outweigh the advantages</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk (method not to be used)</td>
</tr>
</tbody>
</table>
### CDC MEC: How To Interpret

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<td>I</td>
<td>C</td>
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<td>C</td>
</tr>
</tbody>
</table>

- **Cu-IUD**: copper-containing intrauterine device
- **LNG – IUD**: levonorgestrel-releasing intrauterine device
- **DMPA**: depot medroxyprogesterone acetate
- **POP**: progestin-only pill
- **CHC**: combined hormonal contraceptives
CDC MEC: How To Interpret

- Criteria are organized according to:
  - Contraceptive method
  - Patient characteristics (age, smoking status, etc.)
  - Preexisting conditions (hypertension, epilepsy, etc.)
  - Example:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>a) Body mass index (BMI) ≥30 kg/m²</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>b) Menarche to &lt;18 years and BMI ≥ 30 kg/m²</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
CDC MEC: How To Interpret

- Become familiar with how medical conditions are listed:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benign ovarian tumors</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>(including cysts)</td>
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</tbody>
</table>

**Liver tumors**

| a) Benign             |               | 1      | 2       | 2       | 2    | 2   | 2   |
| i) Focal nodular hyperplasia |           | 1      | 3       | 3       | 3    | 3   | 4   |
| ii) Hepatocellular adenoma |            | 1      | 3       | 3       | 3    | 3   | 4   |
| b) Malignant (hepatoma) |             | 1      | 3       | 3       | 3    | 3   | 4   |
## Selected Conditions Covered in the MEC

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding</td>
<td>Migraine headaches</td>
</tr>
<tr>
<td>Given birth within 6 weeks</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Smoking</td>
<td>Current of history of DVT/PE</td>
</tr>
<tr>
<td>Age</td>
<td>Breast Disease</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Hepatic disease</td>
</tr>
<tr>
<td>HIV</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Cancer</td>
<td>Recent surgery or planning surgery soon</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Current therapy with certain medications</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>Autoimmune disease</td>
</tr>
<tr>
<td>Organ transplantation</td>
<td>Hyperlipidemia</td>
</tr>
<tr>
<td>Stroke</td>
<td>STI’s</td>
</tr>
</tbody>
</table>
# Postpartum and Breastfeeding

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum (nonbreastfeeding women)</td>
<td>a) &lt;21 days</td>
<td></td>
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<td>b) 21 days to 42 days</td>
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</tr>
<tr>
<td></td>
<td>i) With other risk factors for VTE</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii) Without other risk factors for VTE</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) &gt;42 days</td>
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<tr>
<td>Postpartum (in breastfeeding or non-breastfeeding women, including cesarean delivery)</td>
<td>a) &lt;10 minutes after delivery of the placenta</td>
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</tr>
<tr>
<td></td>
<td>i) Breastfeeding</td>
<td>1*</td>
<td>2*</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii) Nonbreastfeeding</td>
<td>1*</td>
<td>1*</td>
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<td>b) 10 minutes after delivery of the placenta to &lt;4 weeks</td>
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<td>2*</td>
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<td>c) ≥4 weeks</td>
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<td>1*</td>
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<td></td>
<td>d) Postpartum sepsis</td>
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<td>4</td>
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## Breastfeeding

<table>
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<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) &lt;21 days postpartum</td>
<td></td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td></td>
<td>4*</td>
<td></td>
</tr>
<tr>
<td>b) 21 to &lt;30 days postpartum</td>
<td>i) With other risk factors for VTE</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td></td>
<td>3*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii) Without other risk factors for VTE</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td></td>
<td>3*</td>
<td></td>
</tr>
<tr>
<td>c) 30-42 days postpartum</td>
<td>i) With other risk factors for VTE</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td></td>
<td>3*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii) Without other risk factors for VTE</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td></td>
<td>2*</td>
<td></td>
</tr>
<tr>
<td>d) &gt;42 days postpartum</td>
<td></td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td></td>
<td>2*</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Cu-IUD</td>
<td>LNG-IUD</td>
<td>Implants DMPA</td>
<td>POP</td>
<td>CHCs</td>
<td>Clarification</td>
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<tr>
<td><strong>Breastfeeding</strong></td>
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<td><strong>Risk factors</strong></td>
<td></td>
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<tr>
<td>a. &lt;21 days postpartum</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4  Breastfeeding provides important health benefits for mother and infant. The U.S. Department of Health and Human Services recommends increasing the proportion of infants initially breastfed, exclusively breastfed through 6 months of life, and continuing breastfeeding through at least 1 year of life as key public health goals (1).</td>
<td></td>
</tr>
<tr>
<td>b. 21 to &lt;30 days postpartum</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3  Breastfeeding provides important health benefits for mother and infant. The U.S. Department of Health and Human Services recommends increasing the proportion of infants initially breastfed, exclusively breastfed through 6 months of life, and continuing breastfeeding through at least 1 year of life as key public health goals (1).</td>
<td></td>
</tr>
<tr>
<td>i. With other risk factors for VTE (e.g., age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, peripartum cardiomyopathy, BMI ≥30 kg/m², postpartum hemorrhage, postcesarean delivery, preeclampsia, or smoking)</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3  Breastfeeding provides important health benefits for mother and infant. The U.S. Department of Health and Human Services recommends increasing the proportion of infants initially breastfed, exclusively breastfed through 6 months of life, and continuing breastfeeding through at least 1 year of life as key public health goals (1).</td>
<td></td>
</tr>
<tr>
<td>ii. Without other risk factors for VTE</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3  Breastfeeding provides important health benefits for mother and infant. The U.S. Department of Health and Human Services recommends increasing the proportion of infants initially breastfed, exclusively breastfed through 6 months of life, and continuing breastfeeding through at least 1 year of life as key public health goals (1).</td>
<td></td>
</tr>
<tr>
<td>c. 30-42 days postpartum</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3  Breastfeeding provides important health benefits for mother and infant. The U.S. Department of Health and Human Services recommends increasing the proportion of infants initially breastfed, exclusively breastfed through 6 months of life, and continuing breastfeeding through at least 1 year of life as key public health goals (1).</td>
<td></td>
</tr>
<tr>
<td>i. With other risk factors for VTE (e.g., age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, peripartum cardiomyopathy, BMI ≥30 kg/m², postpartum hemorrhage, postcesarean delivery, preeclampsia, or smoking)</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3  Breastfeeding provides important health benefits for mother and infant. The U.S. Department of Health and Human Services recommends increasing the proportion of infants initially breastfed, exclusively breastfed through 6 months of life, and continuing breastfeeding through at least 1 year of life as key public health goals (1).</td>
<td></td>
</tr>
<tr>
<td>ii. Without other risk factors for VTE</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2  Breastfeeding provides important health benefits for mother and infant. The U.S. Department of Health and Human Services recommends increasing the proportion of infants initially breastfed, exclusively breastfed through 6 months of life, and continuing breastfeeding through at least 1 year of life as key public health goals (1).</td>
<td></td>
</tr>
<tr>
<td>d. &gt;42 days postpartum</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2  Breastfeeding provides important health benefits for mother and infant. The U.S. Department of Health and Human Services recommends increasing the proportion of infants initially breastfed, exclusively breastfed through 6 months of life, and continuing breastfeeding through at least 1 year of life as key public health goals (1).</td>
<td></td>
</tr>
</tbody>
</table>
# Drug interactions

Summary Chart for U.S. CDC Medical Eligibility Criteria for Contraceptive Use

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiretroviral therapy</td>
<td>Fosamprenavir (FPV)</td>
<td>1/2*</td>
<td>1*</td>
<td>1/2*</td>
<td>1*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td>Anticonvulsant therapy</td>
<td>a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)</td>
<td>1</td>
<td>1</td>
<td>2*</td>
<td>1*</td>
<td>3*</td>
<td>3*</td>
</tr>
<tr>
<td></td>
<td>b) Lamotrigine</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3*</td>
</tr>
<tr>
<td>Antimicrobial therapy</td>
<td>a) Broad spectrum antibiotics</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>b) Antifungals</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>c) Antiparasitics</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>d) Rifampin or rifabutin therapy</td>
<td>1</td>
<td>1</td>
<td>2*</td>
<td>1*</td>
<td>3*</td>
<td>3*</td>
</tr>
<tr>
<td>SSRIs</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>St. John’s wort</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Selected Practice Recommendations (SPR)
Summary

The 2016 U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR) addresses a select group of common, yet sometimes controversial or complex, issues regarding initiation and use of specific contraceptive methods. These recommendations for health care providers were updated by CDC after review of the scientific evidence and consultation with national experts who met in Atlanta, Georgia, during August
Initiating Hormonal Contraception in the Pharmacy Setting

- Health History (required)
  - Screening questionnaire
    - Include the categories and conditions from the MEC
    - Assess Pregnancy risk
    - Other information
- Measurement of Blood Pressure (required)
- Weight (optional)
- Physical Exam (not required)
- Laboratory Studies (not required)

https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm
U.S. SPR: Exams and tests prior to initiation

- Unnecessary tests may create barriers to starting contraception
  - Women (adolescents) may not be comfortable with pelvic exam
  - Coming back for a second (or more) visit to receive test results

- Recommendations address exams and tests needed prior to initiation
  - Class A = essential and mandatory
  - Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context
  - Class C = does not contribute substantially to safe and effective use of the contraceptive method

https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html
How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html
### SPR Assessments for Initiating HC

<table>
<thead>
<tr>
<th>Exam or Test</th>
<th>Progestin Only Injection and Oral Tablets</th>
<th>Combined Hormonal Contraceptives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>C</td>
<td>A†</td>
</tr>
<tr>
<td>Weight</td>
<td>§</td>
<td>§</td>
</tr>
<tr>
<td>Breast exam</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Bimanual exam/cervical inspection</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Blood glucose</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Serum lipids</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Liver enzymes</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Thrombogenic mutations</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Papanicolaou (PAP) test</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>STD Screening</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>HIV Screening</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

† In instances in which blood pressure cannot be measured by a provider, blood pressure measured in other settings can be reported by the woman to her provider.

§ Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. MEC 1) or generally can be used (U.S. MEC 2) among obese women.

**Class A**: essential and mandatory in all circumstances for safe and effective use of the contraceptive method.

**Class C**: does not contribute substantially to safe and effective use of the contraceptive method.
# US SPR Exams and tests prior to initiation

<table>
<thead>
<tr>
<th>Examination or test</th>
<th>LNG and Cu-IUD</th>
<th>Implant</th>
<th>Injectable</th>
<th>CHC</th>
<th>POP</th>
<th>Condom</th>
<th>Diaphragm or cervical cap</th>
<th>Spermicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A*</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td>__†</td>
<td>_†</td>
<td>__†</td>
<td>__†</td>
<td>__†</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Bimanual examination and cervical inspection</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A</td>
<td>C</td>
</tr>
<tr>
<td>Laboratory test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Lipids</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Liver enzymes</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Thrombogenic mutations</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Cervical cytology (Papanicolaou smear)</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>STD screening with laboratory tests</td>
<td>__⁵</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>HIV screening with laboratory tests</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>
Assessing Blood Pressure

- Uncontrolled hypertension may be a contraindication to the use of estrogen containing hormonal contraceptives.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td></td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
</tr>
<tr>
<td>a) Adequately controlled hypertension</td>
<td></td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>2*</td>
<td>1*</td>
<td>3*</td>
</tr>
<tr>
<td>b) Elevated blood pressure levels <em>(properly taken measurements)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Systolic 140-159 or diastolic 90-99</td>
<td></td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>2*</td>
<td>1*</td>
<td>3*</td>
</tr>
<tr>
<td>ii) Systolic ≥160 or diastolic ≥100*</td>
<td></td>
<td>1*</td>
<td>2*</td>
<td>2*</td>
<td>3*</td>
<td>2*</td>
<td>4*</td>
</tr>
<tr>
<td>c) Vascular disease</td>
<td></td>
<td>1*</td>
<td>2*</td>
<td>2*</td>
<td>3*</td>
<td>2*</td>
<td>4*</td>
</tr>
</tbody>
</table>
Evidence: BP measurement

- **6 case-control studies**
  - Women who did not have blood pressure check prior to COC initiation had higher odds of acute myocardial infarction and ischemic stroke than women who had blood pressure check
  - No increased risk for hemorrhagic stroke based on whether or not blood pressure measured

- **No evidence identified on other hormonal methods**

Tepper NK, Curtis KM, Steenland MW, Marchbanks PA. Blood pressure measurement prior to initiating hormonal contraception: a systematic review. Contraception 2013; 87(5): 631-638
Pelvic Exam before Initiating CHCs

- Is not necessary before starting CHCs
- No conditions for which CHCs would be unsafe would be detected by pelvic exam

Evidence:
- Two case-control studies
- Delayed versus immediate pelvic exam before contraception
- No difference in risk factors for cervical neoplasia, incidence of STDs, incidence of abnormal Papanicolaou smears, or incidence of abnormal wet mounts.

US SPR: Take Home Messages

- U.S. SPR can help providers decrease medical barriers to initiating and using contraception
- Most women can start most methods anytime
- Few, if any, exams or tests are needed
- Routine follow-up generally not required
- Regular contraception should be started after emergency contraception
- Recommendations for anticipatory counseling for potential bleeding problems and proper management are provided
Accessing the MEC and SPR in everyday practice
CDC Contraceptive Guidance for Health Care Providers

U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (US MEC)

The 2016 U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC) comprises recommendations for the use of specific contraceptive methods by women and men who have certain characteristics or medical conditions. The recommendations in this report are intended to assist health care providers when they counsel women, men, and couples about contraceptive method choice.

U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (US SPR)

The 2016 U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR) addresses a select group of common, yet sometimes controversial or complex, issues regarding initiation and use of specific contraceptive methods. The recommendations in this report are intended to serve as a source of clinical guidance for health care providers and provide evidence-based guidance to reduce medical barriers to contraception access and use.

Quality Family Planning

Providing Quality Family Planning Services (QFP) recommends how to provide family planning services so that individuals can achieve their desired number and spacing of children, increase the chances that a baby will be born healthy, and improve their health even if they choose to not have children.

http://wwwdev.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm
2016 U.S. MEC and SPR App

MEC by Condition

MEC by Method

SPR

Select Method (MEC)

Intrauterine Contraception

Progestin-only Contraceptives

Combined Hormonal Contraceptives

Barrier Methods

Fertility Awareness-based Methods

Lactational Amenorrhea Method

Coitus Interruptus

SPR

How To Be Reasonably Certain That A Woman Is Not Pregnant

Cu-IUD

LNG-IUD

Implants

Injectables

Combined Hormonal Contraceptives

Progestin Only Pills
Using the U.S. SPR App

Late or Missed Doses and Side Effects from Combined Hormonal Contraceptive Use

For the following recommendations, a dose is considered late when <24 hours have elapsed since the dose should have been taken. A dose is considered missed if ≥24 hours have elapsed since the dose should have been taken. For example, if a COC pill was supposed to have been taken on Monday at 9:00 a.m. and is taken at 11:00 a.m., the pill is late; however, by Tuesday morning at 11:00 a.m., Monday’s 9:00 a.m. pill has been missed and Tuesday’s 9:00 a.m. pill is late. For COCs, the recommendations only apply to late or missed hormonally active pills and not to placebo pills. Recommendations are provided for late or missed pills (Figure 2), the patch (Figure 3), and the ring (Figure 4).
Summary tables and charts

- MEC summary table in English, Spanish
- SPR quick reference charts
  - When to start contraceptive methods and routine follow up
  - What to do for late, missed or delayed combined hormonal contraception
  - Management of IUD when PID is found
  - Management of women with bleeding irregularities while using contraception
Other Tools and Resources

- MEC Wheel
- Continuing Education Activities
- Speaker-ready slides
- Contraceptive Effectiveness Charts
- Online alerts to receive updates
- eBook for SPR

Quality Family Planning (QFP)
Quality Family Planning

Providing Quality Family Planning Services

Recommendations of the CDC and the U.S. Office of Population Affairs

Providing Quality Family Planning Services (QFP) recommends how to provide family planning services so that individuals can achieve their desired number and spacing of children, increase the chances that a baby will be born healthy, and improve their health even if they choose to not have children. The recommendations describe:

- **What** services should be offered in a family planning visit—i.e., contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and STD services.
- **How** these services should be provided by drawing upon existing recommendations and filling gaps where needed.
- Services available for female and male clients and special populations, such as adolescents, and provide detailed guidance on contraceptive services.
- Using the family planning visit to provide selected preventive health services, such as breast and cervical cancer screening.

Learn more about tools to help providers obtain the resources and support needed to implement the recommendations. For more information, visit [Family Planning National Training Centers](https://www.cdc.gov/reproductivehealth/contraception/qfp.htm).

Download the Quality Family Planning Services Mobile App
Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs

Recommendations and Reports
April 25, 2014 / 63(RR04);1-29

FIGURE 1. Family planning and related and other preventive health services

- Family planning services
  - Contraceptive services
  - Pregnancy testing and counseling
  - Achieving pregnancy
  - Basic infertility services
  - Preconception health
  - Sexually transmitted disease services

- Related preventive health services
  (e.g., screening for breast and cervical cancer)

- Other preventive health services
  (e.g., screening for lipid disorders)

https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w
Appendix C: Principles for Providing Quality Counseling

Establishing Rapport

Assess Client’s Needs

Personalize Discussion

Establish Plan

Provide accurate nonjudgmental information

Confirm Client Understanding

https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a4.htm#AppendixC
Contraceptive Services: Counseling

Step 1. Establish and maintain rapport with the client. Providers should strive to establish and maintain rapport. Strategies to achieve these goals include:

- using open-ended questions;
- demonstrating expertise, trustworthiness, and accessibility;
- ensuring privacy and confidentiality;
- explaining how personal information will be used;
- encouraging the client to ask questions and share information;
- listening to and observing the client; and
- being encouraging and demonstrating empathy and acceptance.

Suggested Questions

- **Contraceptive experiences and preferences.** Method-specific experiences and preferences should be assessed by asking questions such as, “What method(s) are you currently using, if any?”; “What methods have you used in the past?”; “Have you previously used emergency contraception?”; “Did you use contraception at last sex?”; “What difficulties did you experience with prior methods if any (e.g., side effects or noncompliance)?”; “Do you have a specific method in mind?”; and “Have you discussed method options with your partner, and does your partner have any preferences for which method you use?” Male clients should be asked if they are interested in vasectomy.

https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w
Practice Tools: Summary

- The MEC provides guidelines for the safety of hormonal contraceptives under a broad range of conditions.
- The SPR provides recommendations for managing common contraceptive situations.
- The QFP recommends how to provide family planning services.
- The selection of a contraceptive method includes medical considerations and personal preferences of the patient.
- Pharmacists can play an important role in facilitating access to contraception.
Applying the Tools In Patient Care
JCPP Pharmacists’ Patient Care Process

Pharmacists’ Patient Care Process
Pharmacists use a patient-centered approach in collaboration with other providers on the health care team to optimize patient health and medication outcomes.

Using principles of evidence-based practice, pharmacists:

Collect
The pharmacist assures the collection of the necessary subjective and objective information about the patient in order to understand the relevant medical/medication history and clinical status of the patient.

Assess
The pharmacist assesses the information collected and analyzes the clinical effects of the patient’s therapy in the context of the patient’s overall health goals in order to identify and prioritize problems and achieve optimal care.

Plan
The pharmacist develops an individualized patient-centered care plan, in collaboration with other health care professionals and the patient or caregiver that is evidence-based and cost-effective.

Implement
The pharmacist implements the care plan in collaboration with other health care professionals and the patient or caregiver.

Follow-up: Monitor and Evaluate
The pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed.

Figure 1: Pharmacists’ patient care process
JCPP Pharmacists’ Patient Care Process: Collect and Assess

- Collect
  - Standardized assessment form
  - Patient Interview
  - Physical assessment
    - Blood pressure
    - Weight

- Assess
  - Review gathered information
  - Use the CDC’s U.S. MEC to determine eligibility for contraception
    - Furnish contraception
    - Referral?
  - Compare potential options with patient’s preferences and needs
JCPP Pharmacists’ Patient Care Process: Plan, Implement and Follow-up

- **Plan**
  - Use shared decision making to assist patient in choosing a specific product or method
  - Pharmacist should consider and discuss:
    - Method
    - Efficacy
    - Bleeding
    - Reversibility
    - Accessibility
JCPP Pharmacists’ Patient Care Process: Plan, Implement and Follow-up

- **Implement**
  - Patient counseling and education
  - Use the CDC U.S. SPR to guide initiation
    - How to use
    - When to start
    - Back-up method?
    - Switching between methods
  - Ensure patient has adequate supply and information
  - Preventative health measures

- **Follow-up**
  - Monitor for adherence, adverse effects
  - Evaluate patient satisfaction with regimen
Application

- Melanie is a 30 year-old woman requesting pharmacist provided contraception
- See handout for her completed “Self-Screening Questionnaire”
- What states or conditions on the US MEC does Melanie have?
- What additional information do you need to obtain?
Hormonal Contraceptive Self-Screening Questionnaire

Name: Melanie Smith  Date of Birth: 1-10-1988  Age: 30
Address: N924 Main St, Centreville  Phone: 292-0825-6060

Physician Name: Baker  Physician Phone: 292-0825-6060

Do you have any allergies to medications?  Yes ☐  No ☐
If yes, list below: penicillin

Do you currently take any of the following medications?  Yes ☐  No ☐
If yes, select all that apply:
☐ Barbiturates  ☐ Lamotrigine  ☐ Primidone  ☐ St. John’s Wort
☐ Carbamazepine  ☐ Oxicarbamazepine  ☐ Rifabutin  ☐ Topiramate
☐ Fosamprenavir  ☐ Phenytoin  ☐ Rifampin
List any additional medications that you currently take below, including prescription, over the counter, and herbal: Naproxen, Flonase, nasal spray, women’s one-a-day

1. When was the first day of your last menstrual period?  3/1/18
2. Have you had sexual intercourse since the first day of your last menstrual period?  Yes ☐  No ☐
3. Do you always use a reliable method of contraception during sexual intercourse?  Yes ☐  No ☐
4. Do you smoke cigarettes? If so, how many do you smoke daily?  Yes ☐  No ☐
5. Have you ever been told by a medical professional that you are at risk of developing a blood clot?  Yes ☐  No ☐
6. Have you ever been told by a medical professional NOT to take hormones?  Yes ☐  No ☐
7. Have you given birth in the last 6 weeks?  Yes ☐  No ☐
8. Are you currently breastfeeding an infant less than 1 month old?  Yes ☐  No ☐
9. Are you currently experiencing, or have you experienced in the past, any of the following conditions? Check all that apply.
☐ Bariatric/stomach reduction surgery  ☐ Gallbladder disease  ☐ Stroke
☐ Blood clot in leg or lung  ☐ Liver cancer  ☐ Surgery – recent
☐ Blood disorder  ☐ Liver disease  ☐ Unusually heavy
☐ Breast cancer  ☐ Lupus  ☐ menstrual bleeding
☐ Diabetes  ☐ Rheumatoid arthritis  ☐ Hydramnios
10. Do you experience any of the following? Check all that apply.
☐ Migraine WITH aura  ☐ Headache with sensitivity to light
☐ Migraine WITHOUT aura  ☐ Headache with loss of vision
☐ Headaches with nausea/vomiting  ☐ Headache with numbness

11. Have you ever taken, or do you currently take, any hormonal birth control?
☐ No ☐ Yes
What are the names of the products you have used? ____________________________
Have you ever had a bad reaction to a birth control product?
☐ No ☐ Yes
Which product was it and what reaction occurred? ____________________________
Do you currently use hormonal birth control?
☐ No ☐ Yes
What is the name of the birth control product? ____________________________
Would you like to continue using the same product?
☐ No ☐ Yes
What is your preferred method?
☐ No preference  ☐ Oral pill (take once daily)
☐ Skin patch (change once weekly)  ☐ Vaginal ring (change once monthly)
☐ Injection (every 3 months)  ☐ Implant or intrauterine device (last 3 – 5 years)
☐ I acknowledge that the above information is correct and that this information may be shared with my primary care provider

Patient Signature: Melanie Smith  Date: 3-15-18

Pharmacist use only: reports high BP during pregnancy
Blood Pressure: 128/74  2nd Reading (if necessary): __/____  Weight (may be self-reported): 150 lbs
☐ Patient is NOT eligible for pharmacist hormonal contraceptive services (list reason and referral information)
☐ Patient IS eligible for pharmacist hormonal contraceptive services (fill out below prescription information)
### Melanie’s Conditions on the U.S. MEC

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td>Menarche to &lt;20 yrs: 2</td>
<td>Menarche to &lt;20 yrs: 1</td>
<td>Menarche to &lt;18 yrs: 1</td>
<td>Menarche to &lt;18 yrs: 2</td>
<td>Menarche to &lt;18 yrs: 1</td>
<td>Menarche to &lt;40 yrs: 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>≥20 yrs: 1</td>
<td>≥20 yrs: 1</td>
<td>≥18 yrs: 1</td>
<td>≥18 yrs: 1</td>
<td>≥18 yrs: 1</td>
<td>≥18 yrs: 1</td>
</tr>
<tr>
<td>Gallbladder disease</td>
<td>a) Symptomatic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i) Treated by cholecystectomy</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>ii) Medically treated</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>iii) Current</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>b) Asymptomatic</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Headaches</td>
<td>a) Nonmigraine (mild or severe)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1*</td>
</tr>
<tr>
<td></td>
<td>b) Migraine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i) Without aura (includes menstrual migraine)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2*</td>
</tr>
<tr>
<td></td>
<td>ii) With aura</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4*</td>
</tr>
</tbody>
</table>
The U.S. MEC App

Select Condition
- Age
- Anatomical abnormalities
- Anticonvulsant therapy
- Antimicrobial therapy
- Antiretroviral therapy
- Benign ovarian tumors (including cysts)
- Breast disease
- Breastfeeding
- Cervical cancer (awaiting treatment)
- Cervical ectropion
- Cervical intraepithelial neoplasia
- Clefts

Headaches
b. Migraine
i. Without aura (this category of migraine includes menstrual migraine)

<table>
<thead>
<tr>
<th>Method</th>
<th>Category</th>
<th>Clarity</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cu-IUD</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LNG-IUD</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMPA</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POP</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHCs</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clariifications
Classification depends on accurate diagnosis of those severe headaches that are migraines and those headaches that are not, as well as diagnosis of ever-experiencing aura. Aura is a specific focal neurologic symptom. For more information about headache classification, see The International Classification of Headache Disorders, 2nd edition (http://ihc-classification.org/en). Any new headaches or marked changes in headaches should be evaluated.

Classification is for women without any other risk factors for stroke (e.g., age, hypertension, and smoking).

Evidence
Among women with migraine, oral contraceptive use is associated with a threefold increased risk.
What about Melanie’s Blood Pressure?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-JUD</th>
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<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td></td>
<td>C I</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
</tr>
<tr>
<td>a) Adequately controlled hypertension</td>
<td></td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>2*</td>
<td>1*</td>
<td>3*</td>
</tr>
<tr>
<td>b) Elevated blood pressure levels (properly taken measurements)</td>
<td></td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>2*</td>
<td>1*</td>
<td>3*</td>
</tr>
<tr>
<td>i) Systolic 140-159 or diastolic 90-99</td>
<td></td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>2*</td>
<td>1*</td>
<td>3*</td>
</tr>
<tr>
<td>ii) Systolic ≥160 or diastolic ≥100‡</td>
<td></td>
<td>1*</td>
<td>2*</td>
<td>2*</td>
<td>3*</td>
<td>2*</td>
<td>4*</td>
</tr>
<tr>
<td>c) Vascular disease</td>
<td></td>
<td>1*</td>
<td>2*</td>
<td>2*</td>
<td>3*</td>
<td>2*</td>
<td>4*</td>
</tr>
<tr>
<td>History of high blood pressure during pregnancy</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Application

- Based on the U.S. MEC and Melanie’s preferences, which contraceptive methods is she a candidate for?

- Melanie likes the idea of less frequent menses as her headaches usually occur just before or during the first few days of her period.

- The pharmacist selects an oral combined hormonal contraceptive with Ethinyl Estradiol 20mcg and Levonorgestrel 0.1mg for 84 days followed by 7 days of Ethinyl Estradiol 10mcg alone daily.
When can Melanie begin her new method of contraception?

- Take 1 tablet by mouth daily at the same time every day
- Active and inactive pills
- When to expect a period

1. When was the first day of your last menstrual period?
2. Have you had sexual intercourse since the first day of your last menstrual period?
3. Do you always use a reliable method of contraception during sexual intercourse?

☐ Yes ☐ No
☐ Yes ☐ No Sometimes Condoms
Patient Counseling for CHC’s

- Take 1 tablet by mouth daily at the same time every day
- Active and inactive pills
- When to expect a period
- Missed pills
- Common side effects (nausea, headache, or breast tenderness)
- Severe adverse effects to report (abdominal pain, severe leg pain or headaches, chest pain)
- HIV or other sexually transmitted disease protection

**Use strategies to establish and maintain rapport**
Missed Pills

Recommended Actions After Late or Missed Combined Oral Contraceptives

- **If one hormonal pill is late (<24 hours since a pill should have been taken):**
  - Take the late or missed pill as soon as possible.
  - Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
  - No additional contraceptive protection is needed.
  - Emergency contraception is not usually needed but can be considered (with the exception of UPA) if hormonal pills were missed earlier in the cycle or in the last week of the previous cycle.

- **If one hormonal pill has been missed: (24 to <48 hours since a pill should have been taken):**
  - Take the most recent missed pill as soon as possible (any other missed pills should be discarded).
  - Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
  - Use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills have been taken for 7 consecutive days.
  - If pills were missed in the last week of hormonal pills (e.g., days 15-21 for 28-day pill packs):
    - Omit the hormone-free interval by finishing the hormonal pills in the current pack and starting a new pack the next day.
    - If unable to start a new pack immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills from a new pack have been taken for 7 consecutive days.
  - Emergency contraception should be considered (with the exception of UPA) if hormonal pills were missed during the first week and unprotected sexual intercourse occurred in the previous 5 days.
  - Emergency contraception may also be considered (with the exception of UPA) at other times as appropriate.
Routine Follow-up

- Any time to discuss side effects or a desire to change
- Assess satisfaction and concerns
- Assess for any changes in health status or medications on the U.S. MEC
  - What if Melanie begins to smoke cigarettes?
- Assess blood pressure and consider monitoring weight
Implications on practice

- Pharmacists in all 50 states have an opportunity to help patients with contraception
- Provide guidance in the selection, use and monitoring of contraceptive therapy
- U.S. MEC and U.S. SPR are useful resources for common questions/problems
- Pharmacists are encouraged to be proactive as a resource
1. Pharmacists practicing in states with a “protocol” for pharmacist-provided contraception, can:
   A. Furnish contraception limited to oral contraceptives
   B. Prescribe any form/method of contraception
   C. Prescribe or furnish some forms of hormonal contraceptives
   D. Furnish contraceptives after entering into CPA with a provider
2. Assessment Question (LO 2 and 3)

According the CDC’s Medical Eligibility Criteria, selective serotonin reuptake inhibitors (SSRIs) are considered which eligibility category?

A. Category 1: No restriction (method can be used)
B. Category 2: Advantages generally outweigh theoretical or proven risks
C. Category 3: Theoretical or proven risks usually outweigh the advantages
D. Category 4: Unacceptable health risk (method not to be used)
3. Assessment Question (LO 3)

Which of the following is recommended prior to hormonal contraception initiation?
A. Pap smear
B. Sexually transmitted infection screening
C. Laboratory screening
D. Blood pressure measurement
1. You are counseling a woman who plans to begin using the combined hormonal contraceptive patch. Which one of the following tools would be most helpful to determine when the method can be started?
A. U.S. MEC
B. Lexicomp®
C. Quality Family Planning
D. U.S. SPR