Pharmacists Prescribing Contraception: Are You Ready?

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Financial Disclosures

Krystalyn Weaver and Amber Darr have no financial conflicts to disclose.

Objectives

At the completion of this activity, the participant will be able to:

- Identify states who have granted pharmacists with prescriptive authority for contraceptives and the different policy approaches taken
- Assess pregnancy status and when it is appropriate to start a contraceptive product
- Identify contraindications to the use of contraceptive products according to CDC Medical Eligibility Criteria (MEC) guidelines
- Select an appropriate contraceptive product and provide patient counseling and education

Presentation Overview

National Policy Overview

Clinical Details

Available Resources

Continuum of Pharmacist Prescriptive Authority

Collaborative Prescribing

Autonomous Prescribing

Patient-Specific CPA

Population-Specific CPA

Statewide Protocol

Unrestricted (Category-Specific)

Most Restrictive

Least Restrictive


Statewide Protocols 101

Allows pharmacists to prescribe

Statewide authority

Address public health goals

Do not require differential diagnosing
Current Applications

Naloxone (11)
General Authority (4)
TB Testing (2)
Fluoride (2)
Immunizations (17)
Tobacco Cessation (6)
EpiPen (1)
Limited Formulary (2)
Contraceptives (6)

Statewide Protocol

- Does not require a partnering prescriber
- Issued by an authorized body of the state
- Product or category specific
- Apply to patient populations
- Used for conditions that do not require a specific diagnosis

Statewide Standing Order

- Does not require a partnering prescriber
- Issued by a prescriber who is a state official
- Product specific
- Apply to patient populations
- Used for conditions that do not require a specific diagnosis

Who will be listed as the prescriber?

Statewide Standing Order

Why Pharmacists Should Prescribe Contraceptives

2.8 million
There is a public health need
Pharmacists are medication experts!

Where can pharmacists prescribe contraceptives now?

California
- Law passed in 2013
- Legislation specifically includes contraceptives
- Includes self-administered hormonal contraceptives
- Medicaid payment
Where can pharmacists prescribe contraceptives now?

**Oregon**
- Law passed in 2015
- Legislation specific to contraceptives
- Standard procedures algorithm
- Includes patches and oral hormonal contraceptives

**Colorado**
- Law passed in 2016
- Provided general authority
- Regulations jointly issued: Boards of Pharmacy, Medicine, and Nursing

**New Mexico**
- Legislative authority for many years
- Contraceptive prescribing authority in 2017
- Regulations issued by Boards of Pharmacy and Medicine

**Maryland and Hawaii**
- Legislation passed in 2017
- Regulations not yet developed

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**Presentation Overview**

- National Policy Overview
- Clinical Details
- Available Resources
Review of the Menstrual Cycle

Review of the Menstrual Cycle
- Follicular Phase
- Luteal Phase
- Menses
Review of the Menstrual Cycle

Let’s Get Clinical!

- Menstrual Cycle/Family Planning Review
  - Clinical Guidelines
  - Example Treatment Algorithm
  - Counseling Points
  - Side Effect Management
  - Practice Cases

CDC Select Practice Recommendations (SPR) for Contraceptive Use, 2016

Companion to document to the MEC.

Provides guidance on how contraceptive methods can be used:

https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6506a.pdf

CDC Medical Eligibility Criteria (MEC) for Contraceptive Use, 2016

Provides guidance on who can use various methods of contraception:

https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf

Free CE available!

Let’s Get Clinical!

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  - Practice Cases
Example Treatment Algorithm

**Health & History**

- MEC Category 3 or 4?
  - Yes: Refer
  - No: Pregnancy Screening - Possibly Pregnant?
    - Yes: Refer
    - No: Medication Screening - Contraindicated Medications?
      - Yes: Refer
      - No: Blood Pressure Screening - BP > 140/90?
        - Yes: Refer
        - No: Select Contraceptive Method!

**Contraindications to Contraceptive Use**

- Focus on Categories 3 & 4
  - 3 = Theoretical or proven risks usually outweigh the advantages
    - Ex: Smoking
  - 4 = Unacceptable health risk (method not to be used)
    - Ex: IUD's while pregnant

**Obtain Background Information**

- Have you ever experienced a bad reaction to using BC?
- What was the first day of your last menstrual cycle?
- What have you used in the past (if applicable)?
- Do you think you may be pregnant?
- Do you smoke?

**Health & Medical History**

- Have you given birth in the past 6 weeks?
- Are you currently breastfeeding?
- What chronic medical conditions are you currently being treated for?
- Do you have a history of a heart attack, stroke or do you have heart disease?
- Have you ever had a blood clot?
- Have you ever had, or do you have breast cancer?
- What contraceptive method do you prefer?

Which of the following is/are contraindications to combined oral contraceptive products (COC)?

- A. A nursing mom with a 2 month old
- B. A 36 year old woman who smokes 1 pack per day
- C. A 24 year old woman with depression
- D. All of the above
Which of the following patients could you be reasonably certain is NOT pregnant?

A. A 28 year old female who is 5 days after the start of normal menses and last had intercourse 10 days ago
B. A 32 year old female who is on day 12 of her cycle and had unprotected intercourse 2 days ago
C. A 26 year old female who is 4 months postpartum and is occasionally breastfeeding
D. A 22 year old female who is 6 weeks postpartum
**Blood Pressure Screening**
- Stroke risk and birth control
- 140/90

**Example Treatment Algorithm**

1. Healthy History Screening: MEC Category 3 or 4?
   - Yes: Refer
   - No: Pregnancy Screening Possible Pregnancy?
   - No: Medication Screening Contraindicated Medications?
     - Yes: Refer
     - No: Blood Pressure Screening BP>140/90?
       - Yes: Refer
       - No: Select Contraceptive Method

**Considerations when Choosing a Method**
- Background & Med History
- Adverse Events & Safety
- Risk for STDs
- Pattern/Frequency of Sexual Activity
- Concomitant Disease States
- Convenience
- Cost
- Culture

**Counseling Points**
- When to start taking product
- Importance of adherence
- Side effects and how to manage
- Encourage routine health screenings!

**Let’s Get Clinical!**

- Menstrual Cycle/ Family Planning Review
- Example Treatment Algorithm
- Counseling Points
- Side Effect Management
- Practice Cases

**When to start taking?**
- Anytime!
- Might need a “back up” method
- Reminder: check patient’s blood pressure before starting a combo product

**Counseling Points**

- When to start taking product
- Importance of adherence
- Side effects and how to manage
- Encourage routine health screenings!
When could a patient start a newly prescribed CHC pill?

A. On the Sunday of the start of their next menses
B. Anytime, if reasonably certain they are not pregnant
C. Within 5 days after menses started
D. All the above

Too Much Estrogen?
- Breast cystic changes/tenderness
- Dysmenorrhea
- Chloasma (discoloration of skin)

Too Little Estrogen?
- Spotting (days 1-9)
- Continuous bleeding/spotting
- Hypomenorrhea
- Atrophic vaginitis

Too Much Progestin?
- Increase in appetite
- Depression
- Fatigue
- Libido decrease
- Weight gain (non-cyclic)
- Hypertension

Too Little Progestin?
- Break through bleeding (days 10-21)
- Delayed withdrawal bleeding
- Dysmenorrhea
- Hypomenorrhea

Excess Androgen Activity
- Acne
- Increase in libido
- Hirsutism
- Oily skin/scalp
- Edema

Side Effect Overview

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>- 1 estrogen</td>
<td>Androgen effect</td>
<td>- 2 estrogen, 4 progestin, low dose levonorgestrel or etonogestrel implant</td>
</tr>
<tr>
<td>Amenorrhea</td>
<td>- 1 estrogen</td>
<td>IUD, heavy patient counseling</td>
<td>- 1 estrogen, 1 progestin or 2 progestins</td>
</tr>
<tr>
<td>Breast/tear ducts/patch</td>
<td>- 1 estrogen</td>
<td>- 1 estrogen or 2 progestins</td>
<td>- 1 estrogen</td>
</tr>
<tr>
<td>Spotting (days 1-9)</td>
<td>- 1 estrogen</td>
<td>- 1 estrogen, 4 progestin, low dose levonorgestrel or etonogestrel implant</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>- 1 estrogen</td>
<td>- 1 estrogen, 4 progestin, low dose levonorgestrel or etonogestrel implant</td>
<td>- 1 estrogen</td>
</tr>
</tbody>
</table>

Let’s Get Clinical!

Menstrual Cycle/ Family Planning Review
Clinical Guidelines
Example Treatment Algorithm
Counseling Points
Side Effect Management
Practice Cases
Which one of the following would least likely cause acne/oily skin?

A. Levonorgestrel  
B. Norgestrel  
C. Desogestrel  
D. Norgestimate

Pharmacological Effects of Progestins Used in Oral Contraceptives

<table>
<thead>
<tr>
<th>Progestin</th>
<th>Category effect</th>
<th>Progestin effect</th>
<th>Antiestrogen effect</th>
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</thead>
<tbody>
<tr>
<td>Levonorgestrel</td>
<td>Progesterone-like</td>
<td>Progestin-like</td>
<td>Antiprogestin-like</td>
</tr>
<tr>
<td>Norgestrel</td>
<td>Progesterone-like</td>
<td>Progestin-like</td>
<td>Antiprogestin-like</td>
</tr>
<tr>
<td>Desogestrel</td>
<td>Progesterone-like</td>
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<td>Antiprogestin-like</td>
</tr>
<tr>
<td>Norgestimate</td>
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<td>Progestin-like</td>
<td>Antiprogestin-like</td>
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</tbody>
</table>

Please turn to your handout!

Monophasic Products – Hormonal Activity

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Hormonal Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levonorgestrel</td>
<td>Progesterone-like</td>
</tr>
<tr>
<td>Norgestrel</td>
<td>Progesterone-like</td>
</tr>
<tr>
<td>Desogestrel</td>
<td>Progesterone-like</td>
</tr>
<tr>
<td>Norgestimate</td>
<td>Progesterone-like</td>
</tr>
</tbody>
</table>

Chart continues: please turn to your handout!

Multi-phase Product – Hormonal Activity

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Hormonal Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levonorgestrel</td>
<td>Progesterone-like</td>
<td>Progesterone-like</td>
<td>Progesterone-like</td>
<td>Progesterone-like</td>
</tr>
<tr>
<td>Norgestrel</td>
<td>Progesterone-like</td>
<td>Progesterone-like</td>
<td>Progesterone-like</td>
<td>Progesterone-like</td>
</tr>
<tr>
<td>Desogestrel</td>
<td>Progesterone-like</td>
<td>Progesterone-like</td>
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</tr>
<tr>
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Let’s Get Clinical!

Menstrual Cycle/ Family Planning Review  
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Practice Cases

Case #1

A 28 year old female presents to your pharmacy requesting birth control. She states she is 6 weeks post-partum and is currently fully breastfeeding her daughter. She is in a monogamous relationship.

Should you proceed with contraceptive screening for this patient or refer?
Case #2

A 37 year old female presents to your pharmacy for birth control. She has just relocated to the area. Her PMH is significant for depression, which she takes sertraline 100mg once daily. She also smokes 2 packs per day of cigarettes. She has been on Ortho Tri Cyclen (EE 35mcg and norgestimate 0.18mg x 7d, 0.215mg x7d, 0.25mgx7d) for the past 5 years and is happy with it. She just needs a new prescription until she finds a provider. She states she never misses a dose and takes her pill every morning before taking her shower. She weighs 215 pounds and is in a monogamous relationship.

What would you recommend for the patient with regards to her birth control?

Case #3

A 27 year old female presents to your pharmacy. You prescribed Aviane-28 (ethinyl estradiol 20mcg and levonorgestrel 0.1mg) 14 weeks ago for contraception. She complains today of early break through bleeding occurring during the 2nd week of her cycle. She is unhappy with this side effect and no longer wants to remain on it.

Which of the following is the BEST to recommend for this patient?
A. Continue her current COC
B. Change to a COC with less estrogen
C. Change to a COC with more estrogen
D. Change to a COC with more progestin
E. Change to a progestin-only product

Presentation Overview

From the CDC: Mobile App: Contraception

- iOS and Android
- User-friendly
- Navigate between MEC and SPR
- Links to CDC guidance
- Easy to use in everyday practice
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