Prescribing Guidelines for Prescription Contraceptives

Contraceptive Pathway

Assessment Tools:

Medical eligibility for contraceptive use

Prescription Contraceptive Options:

Implant and IUDs

Injectable progestins

Pills

Patch and vaginal ring

Emergency contraceptives

PARTNERS FOR KIDS | NATIONWIDE CHILDREN'S

When your child needs a hospital, everything matters.

Prescribing Guidelines for Contraceptives

This document was developed by Nationwide Children's Hospital in conjunction with Partners For Kids using evidence-informed clinical guidelines and drug information resources. It is designed to help primary care practitioners provide timely and effective contraceptives for sexually active adolescent females. This document should not be considered a substitute for sound clinical judgment. Clinicians are encouraged to seek additional information if questions arise.

Teen Pregnancy Prevention and the Role of the Pediatrician

Unlike pregnancies in older women, the vast majority of teen pregnancies are unintended. The current downward trend of teen pregnancy has been linked to decreases in sexual activity and increased use of birth control. The Centers for Disease Control (CDC) has identified teen pregnancy as a "Winnable Battle" and recommends strengthening effective clinical interventions and promoting the use of contraception, including IUDs and contraceptive implants, to reduce teen pregnancy in the United States. Poor access to contraceptive counseling and highly effective contraceptives is a barrier for many teens. Pediatricians are well positioned as trusted health care providers to provide accurate information to patients and their families in a developmentally appropriate matter and to prescribe or provide many contraceptives on site.

Counseling and Provision of Contraception

Clinicians should address an adolescent's sexual activity status at each well visit and initiate pregnancy prevention efforts or preconception care, according to patient interest. The CDC, along with the American Congress of Obstetricians and Gynecologists, recommends assessing pregnancy intention in females of reproductive age. As important as this discussion, is the follow through. Same-day access to method of choice, including IUDs and contraceptive implants, decreases risk of unintended pregnancy. The following elements should be assessed during an encounter for contraceptive counseling:

Menstrual history	Sexual history	Body mass index
Past medical hisory	Obstetric history	Weight
Problem list	Contraceptive history	Blood pressure
Current medications	Family medical history	

Contraception counseling should be respectful of patients' and families' unique cultural traditions, be non-coercive and utilize shared decision making that prioritizes the patient's values and priorities. Respect for patients' reproductive autonomy includes access to all available methods. Patients should also be counseled that they may choose to switch methods or stop a method. Adolescents who want to discontinue the use of an implant or an IUD should not face undue barriers to removal. Removals, when requested, should be conducted as expeditiously as possible.

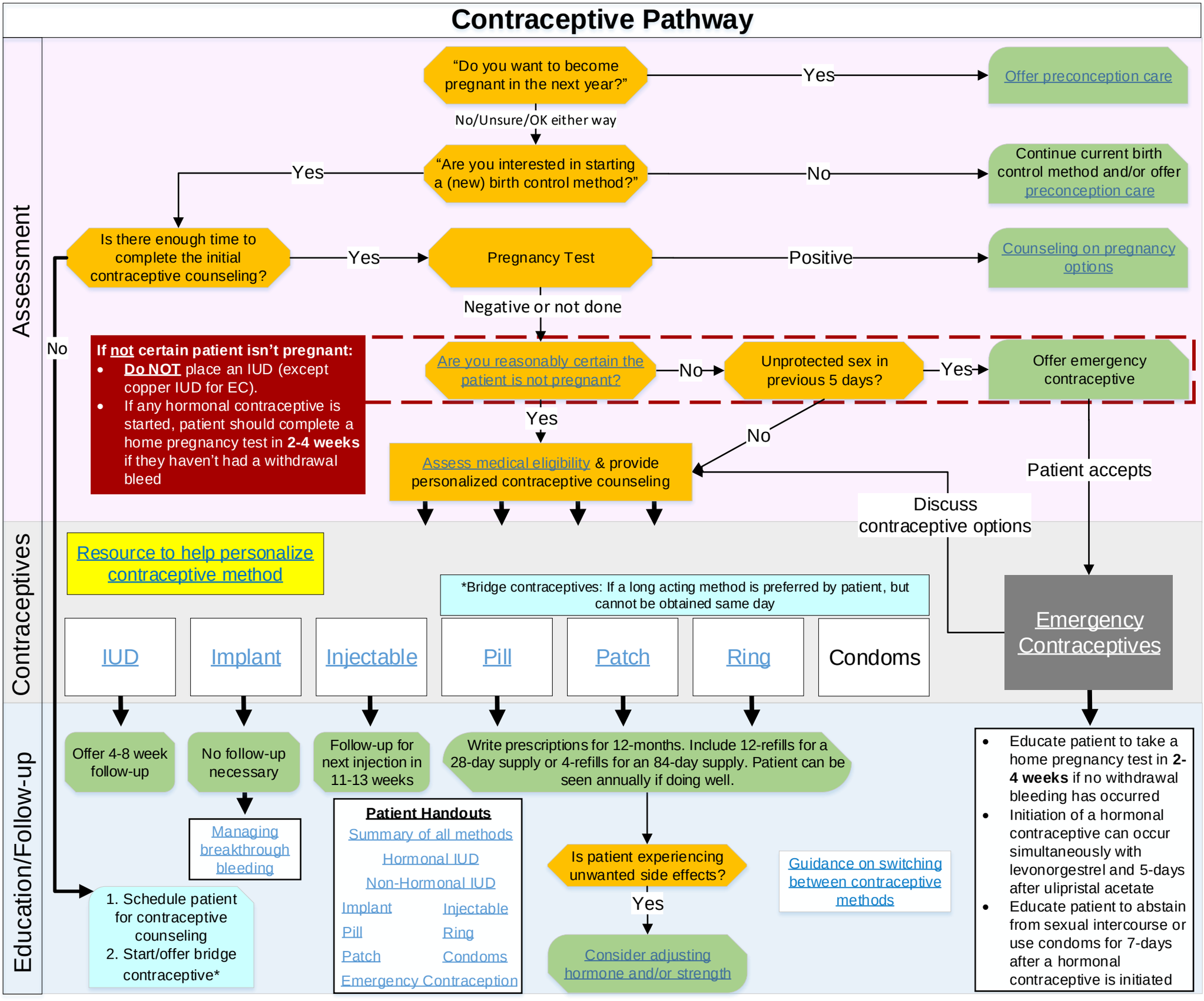
Additional Considerations

Conversations around selecting the right contraceptive is a great opportunity to:

- Counsel on the importance of condom use if sexually active
- Determine the need for a routine sexually transmitted infection (STI) screen
- Consider provision of pre-exposure prophylaxis (PrEP) for high risk patients

Return to Pathway

Contraceptive Pathway



Hormonal Implant and Intrauterine Devices

	Nexplanon®	Kyleena™	Liletta®	Mirena ®	Skyla®	ParaGard®
Contraceptive Type/Location	Hormonal Implant (Upper Arm)	Hormonal Intrauterine Device				Copper Intrauterine Device
Shape and Size	4 cm semi-rigid plastic rod	Flexible, plastic, T-shape; 28 mm horizontally and 30 mm vertically	Flexible, plastic, T-shape; 32 mm both horizontally and vertically		Flexible, plastic, T-shape; 28 mm horizontally and 30 mm vertically	T-shaped, copper wire; 32 mm horizontally and 36 mm vertically
Hormone & Dosage	etonogestrel 68 mg	levonorgestrel 19.5 mg	levonorgestrel 52 mg		levonorgestrel 13.5 mg	None
Duration	3 years	5 years	8 years	8 years	3 years	10 years
% Efficacy	> 99%					
Potential Adverse Effects Related to Bleeding	May experience unpredictable bleeding patterns. Managing breakthrough bleeding	May cause oligomenorrhea or amennorhea. Levonorgestrel containing IUDs are preferable for women with history of heavy menstrual bleeding. May also cause prolonged or unscheduled bleeding.				May cause heavy menstrual bleeding and dysmenorrhea. Avoid in women with history of heavy bleeding.
Back-up Contraception After Initial Placement	• Insertion ≤ 5 days of menstruation onset: back-up contraception not needed • Insertion > 5 days of menstruation onset: use back-up contraception or abstinence for 7 days post-insertion	• Insertion ≤ 7 days of menstruation onset: back-up contraception not needed • Insertion > 7 days of menstruation onset: use back-up contraception or abstinence for 7 days post-insertion				Back-up contraception is not needed with proper insertion. May also be inserted as an emergency contraceptive up to 5 days after unprotected intercourse.

Guidance on switching prescription contraceptive method to or from implant or IUD

Return to Pathway

Progestin-only Injectable Contraceptive

The medroxyprogesterone acetate injection is a highly effective contraceptive option (94% effective). It is available as a 150 mg intramuscular dose and 104 mg subcutaneous dose; the subcutaneous product is brand name only, thus availability, cost and coverage for the subcutaneous product can be an issue. Non-contraceptive benefits include treatment for dysmenorrhea, heavy menstrual bleeding, polycystic ovary syndrome and premenstrual tension syndrome.

Mechanism of Delivery	Drug Name	Dose and Frequency	Delay in administration	Non-contraceptive benefits	Side effects (Incidence > 10%)
Intramuscular (IM)*	Medroxyprogesterone 150 mg (Depo-Provera®)	150 mg IM every 11-13 weeks	If > **15 weeks** from last injection, pregnancy must be ruled out and back-up contraception is required for 7-days	Treatment for dysmenorrhea and heavy menstrual bleeding	Irregular bleeding Weight gain Headaches Abdominal pain
Subcutaneous (SubQ)	Medroxyprogesterone 104 mg (Depo-SubQ Provera® 104)	104 mg SubQ every 12-14 weeks			

* IM formulation needs to be administered in clinic.

Click here for guidance on switching prescription contraceptive method to or from injectable medroxyprogesterone

Return to Pathway

Oral Contraceptives

Oral contraceptives are 91% effective with typical use. Assess for contraindications to estrogen-containing hormonal contraceptives (e.g., thromboembolic disorder, migraines with aura, severe hypertension) and pregnancy status prior to prescribing.

Hormone activity of COCs:
Most estrogen-containing COCs have ethinyl estradiol (EE) in varying strengths. The progestin within COC products can vary and have distinct hormone effects, contributing to or lessening particular side-effects. Strength and type of hormones may need adjustment depending on patient factors including conditions and side effects listed in Tables 2 and 3 below. Non-contraceptive benefits include treatment for dysmenorrhea, heavy menstrual bleeding, polycystic ovary syndrome and premenstrual tension syndrome.

Starting Regimen:
The recommended starting COC is a monophasic option (i.e., ethinyl estradiol ≤ 35 mcg plus levonorgestrel 0.15 mg or norgestimate 0.25 mg) for a good balance of safety and efficacy (options in table 1 below). It is recommended COCs are started on the same day as the contraceptive assessment, if possible. Multiphasic agents have no clinical advantage over monophasic agents and can be confusing to patients due to differing tablet strengths and colors.

Additional oral contraceptive resources:

Progestin-only oral contraceptives	Extended or continuous cycle	Missed dose guidance	Patient factors and COC switching	Switching between contraceptives

Table 1: Recommended starting combined oral contraceptive

Interval	Recommended Starting Strengths	Example Product Names
21 active tablets; 7 inert tablets	Ethinyl Estradiol 30 mcg / Levonorgestrel 0.15 mg	Levonorgestrel/EE, Kurvelo®, Lillow®, Marlissa®, Portia-28®
	Ethinyl Estradiol 35 mcg / Norgestimate 0.25 mg	Norgestimate/EE, Estarylla®, Mili®, Previfem®, Sprintec®

Return to Pathway

Extended Cycle or Continuous Cycle

Extended cycle or continuous cycle regimens may be considered for any patient that prefers an extended cycle. These regimens can be especially helpful for patients with:

- Menstruation-related problems (anemia, menorrhagia, bloating, dysmenorrhea, endometriosis, menstrual headache), premenstrual dysphoric disorder or hyperandrogenism

Prescribing:

- Extended cycle:
  - Brand names: Seasonique®, LoSeasonique®, Jolessa®, Introvale®
  - These have 84 active tablets and 7 inactive tablets, so a patient should expect to have a period every 3-months. Write prescriptions with 3-refills to provide a 1-year supply.
- Continuous cycle:
  - Prescribe extended cycle brands and instruct patient to skip hormone-free pills.
  - Write prescriptions with 4-refills to provide a 1-year supply.

Progestin-only Oral Contraceptives

Medication	Brand	Half-life	Missed doses
Drosperinone 4mg	Slynd®	30-hours	Follow missed dose guidance table for COCs
Norethindrone 0.35 mg	Multiple (e.g. Jencycla®, Ortho Micronor®)	8-hours	If taken ≥ 3 hours late, use back-up contraception for 48-hours

Return to OCPs

Return to Pathway

Missed Dosing Guidance for Combination Oral Contraceptives (COCs)

When a dose is missed or vomited, many women need guidance on what to do in regards to emergency contraception. COCs need seven days of consistent use to prevent ovulation. This table provides guidance on what steps to take when doses are missed.

Missed COC Pills	When to Take Missed Doses	Backup Contraception	Emergency Contraception
One pill: Late (< 24 hours) or missed (24 to < 48 hours)	As soon as remembered. Resume taking remaining pills at usual time, even if it means taking two pills in the same day	No	May consider if other doses missed in past month
Two or more pills missed consecutively (≥ 48 hours since pill should have been taken) during **1st and 2nd week** of hormonal pills	Take the most recent missed pill as soon as remembered. Throw out any other pills that were missed. Resume taking remaining pills at usual time, even if it means taking two pills in the same day.	Yes, until hormonal pills have been taken for 7 consecutive days	Should consider if during the first week of cycle
Two or more pills missed consecutively during **3rd week** (e.g. day 15-21 for 28-day pill packs) of hormonal pills	Same as two pills above PLUS skip placebo pills and start new pack. Use backup contraception if cannot start new pack immediately.	Yes, until 7 active pills taken IF new pack is not started right away	May consider

Reference: Curtis KM, Jatlaoui TC, Tepper NK, et al. US selected practice recommendations for contraceptive use, 2016. MMWR Recomm Rep. 2016a;65(4):1-66

Return to OCPs

Return to Pathway

Table 2: Dose-Related Effects of Estrogen and Progestin

Hormone	Too Much	Too Little
Estrogen	• Nausea • Breast tenderness • Headache • Increased blood pressure • Melasma (gray-brown patches on face)	• Spotting • Breakthrough bleeding early/mid-cycle
Progestin	• Weight Gain • Breast tenderness • Acne • Headache • Fatigue • Mood changes • Hirsutism • Increased LDL • Decreased HDL	• Breakthrough bleeding late cycle

Click here for guidance on which oral contraceptive to switch to if patient presents with specific side-effects

Return to OCPs

Return to Pathway

Table 3: Recommendations for oral contraceptive hormone or strength change based upon patient factors

Patient Factor	Recommendation	Products	Example Brand
Acne	Switch to higher estrogen dose or progestin with less androgenic activity.	Desogestrel 0.15 mg/EE 30 mcg	Apri®
		Drospirenone 3 mg/EE 20 mcg	Nikki®
		Drospirenone 3 mg/EE 30 mcg	Syeda®
		Norgestimate 0.25 mg/EE 35 mcg	Sprintec®
Breast Tenderness	Switch to lower estrogen dose	Drospirenone 3 mg/EE 20 mcg	Nikki®
		Drospirenone 3 mg/EE 30 mcg	Syeda®
		Levonorgestrel 0.1 mg/EE 20 mcg	Vienva®
		Norethindrone acetate 1 mg/EE 20 mcg/75mg ferrous fumarate	Junel® FE 1/20
Breakthrough bleeding (early or mid-cycle) after the first three months of therapy	Switch to higher estrogen dose	Desogestrel 0.15 mg/EE 30 mcg	Apri®
		Drospirenone 3 mg/EE 30 mcg	Syeda®
		Ethynodiol diacetate 1 mg/EE 35 mcg	Kelnor® 1/35
		Ethynodiol diacetate 1 mg/EE 50 mcg	Kelnor® 1/50
		Norethindrone acetate 1.5 mg/EE 30 mcg/75mg ferrous fumarate	Junel® FE 1.5/30
		Norethindrone 0.4 mg/EE 35 mcg	Briellyn®
		Norethindrone 0.5 mg/EE 35 mcg	Nortrel® 0.5/35
		Norethindrone 1 mg/EE 35 mcg	Alyacen® 1/35
		Norgestrel 0.3 mg/EE 30 mcg	Low-Ogestrel®

EE stands for Ethinyl Estradiol

Patient factors and recommendations continue on the next page

Return to OCPs

Return to Pathway

Table 3 cont: Recommendations for oral contraceptive hormone or strength change based upon patient factors

Patient Factor	Recommendation	Products	Example Brand
Breakthrough bleeding (late cycle) after the first three months of therapy	Switch to higher dose progestin or progestin with higher progestin activity	Desogestrel 0.15 mg/EE 30 mcg	Apri®
		Levonorgestrel 0.1 mg/EE 20 mcg	Vienva®
		Levonorgestrel 0.15 mg/EE 30 mcg	Kurvelo®
Headache	Switch to lower estrogen dose, progestin with less progestin activity or progestin-only contraceptive*	Drospirenone 3 mg/EE 20 mcg	Nikki®
		Drospirenone 3 mg/EE 30 mcg	Syeda®
		Levonorgestrel 0.1 mg/EE 20 mcg	Vienva®
		Norethindrone acetate 1 mg/EE 20 mcg/75mg ferrous fumarate	Junel® FE 1/20
		Drosperinone 4 mg	Slynd®
		Norethindrone 0.35 mg	Jencycla®
Migraines	If migraines develop or worsen, switch to progestin-only contraceptive*	Drosperinone 4 mg	Slynd®
		Norethindrone 0.35 mg	Jencycla®
Nausea	Switch to lower estrogen dose or progestin-only contraceptive*	Levonorgestrel 0.1 mg/EE 20 mcg	Vienva®
		Norethindrone acetate 1 mg/EE 20 mcg/75mg ferrous fumarate	Junel® FE 1/20
		Drosperinone 4 mg	Slynd®
		Norethindrone 0.35 mg	Jencycla®
Weight Gain	Switch to lower estrogen dose, progestin with less androgenic activity or progestin-only contraceptive*	Drospirenone 3 mg/EE 20 mcg	Nikki®
		Drospirenone 3 mg/EE 30 mcg	Syeda®
		Levonorgestrel 0.1 mg/EE 20 mcg	Vienva®
		Norethindrone acetate 1 mg/EE 20 mcg/75mg ferrous fumarate	Junel® FE 1/20
		Drosperinone 4 mg	Slynd®
		Norethindrone 0.35 mg	Jencycla®

*May also consider injectable progestin, implant or IUD for patient factors

EE stands for Ethinyl Estradiol

Return to OCPs

Return to Pathway

Patch or Ring

The combined hormonal contraceptive skin patch and vaginal ring are 91% effective with typical use. Assess for contraindications to estrogen-containing hormonal contraceptives (e.g., thromboembolic disorder, migraines with aura, severe hypertension) and pregnancy status prior to prescribing.

Combined Hormonal Patch

Medication (Daily dose)	Brand	Frequency	Clinical Pearls
Ethinyl estradiol (35 mcg) and Norelgestromin (150 mcg)	Zafemy® Xulane®	1 patch every 7 days for 3 consecutive weeks followed by a patch-free week	Contraindicated in women with a BMI ≥ 30 kg/m^2 due to increased VTE* risk Efficacy may be reduced in patients that are > 90 kg
Ethinyl estradiol (30 mcg) and Levonorgestrel (120 mcg)	Twirla®		

Guidance for delayed attachment/reattachment of patch or insertion/reinsertion of ring

Guidance on switching prescription contraceptive method to or from ring/patch

Combined Hormonal Vaginal Ring

Medication (Daily dose)	Brand	Frequency	Clinical Pearls
Ethinyl estradiol (15 mcg) and Etonogestrel (120 mcg)	NuvaRing® EluRyng® Haloette®	1 ring inserted for 21 days followed by removal for 7 days	
Ethinyl estradiol (13 mcg) and Segesterone acetate (150 mcg)	Annovera®	1 ring inserted every 21 days followed by removal for 7 days	One ring can be used for 13-cycles (1-year) when used 3 weeks in and 1 week out per cycle

**VTE: venous thromboembolism*

Return to Pathway

Recommendations for delayed application or detachment of patch				
Delayed Application OR Patch Detachment*	When to Apply or Reapply	Patch Change Day	Backup Contraception	Emergency Contraception
< 48 hours since patch should have been applied or reattached	Apply a new patch as soon as possible (if < 24 hours since original patch was applied, try reapplying same patch or replace with new patch)	Keep the same patch change day	No additional contraceptive protection is needed	Usually not needed but can be considered if delayed application or detachment occurred early in current cycle or in last week or previous cycle
≥ 48 hours since patch should have been applied or reattached	- Apply a new patch as soon as possible - If delayed application or detachment occurred in third patch week, omit hormone-free week by finishing the third week of patch use (keep same patch change day) and start a new patch immediately	Keep the same patch change day	Use backup contraception (e.g. condoms) or avoid sexual intercourse until a patch has been worn for 7 consecutive days	- Should be considered if delayed application or detachment occurred within first week of patch use and unprotected sexual intercourse occurred in the previous 5 days - May also be considered at other times as appropriate

Recommendations for delayed insertion or reinsertion of vaginal ring				
Delayed Insertion OR Reinsertion*	When to Apply or Reapply	Patch Change Day	Backup Contraception	Emergency Contraception
< 48 hours since ring should have been inserted or reinserted	Insert ring as soon as possible	Keep ring in until scheduled ring removal day	No additional contraceptive protection is needed	Usually not needed but can be considered if delayed insertion or reinsertion occurred early in current cycle or in last week of previous cycle
≥ 48 hours since ring should have been inserted or reinserted	- Insert ring as soon as possible - If ring removal occurred in third week of ring use, omit hormone-free week by finishing the third week of ring use and start a new ring immediately	Keep ring in until scheduled ring removal day	Use backup contraception (e.g. condoms) or avoid sexual intercourse until a ring has been worn for 7 consecutive days	- Should be considered if delayed insertion or reinsertion occurred within first week of ring use and unprotected sexual intercourse occurred in the previous 5 days - May also be considered at other times as appropriate

Return to Ring/Patch

Return to Pathway

Emergency Contraceptives

Emergency contraception (EC) should be offered to patients who have experienced unprotected sex within the last 5 days (120 hours) who do not desire a pregnancy. These methods are most effective if used as soon as possible after unprotected sex. There are no contraindications to the use of oral EC other than known pregnancy, however, a pregnancy test is NOT required prior to taking an oral EC. A pregnancy test is recommended if a woman has not resumed menses within 3 weeks of EC. Decisions about which EC to use, including potential delay of chosen contraceptive method, should be balanced with the risk of a patient not starting her chosen contraceptive method and the risk of pregnancy. Use the table below to help guide decision-making for what EC is the best option for the patient.

Medication	Brand	Dosage and Frequency	Timing	Start/resume hormonal contraceptive	Bridging contraception	Weight > 75 kg	Nausea and Vomiting
Ulipristal acetate (UPA) 30 mg	Ella®	Take 1 tablet (30 mg) as a one-time dose	As soon as possible but within 5-days of unprotected sex	5-days after dose*	Abstain or use barrier contraception for 7-days after starting/resuming hormonal contraception	Ulipristal acetate may be more effective than levonorgestrel	**If vomiting occurs within 3 hours of taking an oral EC another dose should be taken as soon as possible.
Levonorgestrel 1.5 mg	E.g. Plan B One-Step®, My Choice®, others	Take 1 tablet (1.5 mg) as a one-time dose	As soon as possible but within 3-days of unprotected sex	Immediately			
Copper IUD	Paragard®	As soon as possible but within 5-days of unprotected sex		Ongoing contraceptive upon placement	Not necessary	Does not impact efficacy	Not relevant for this method

* Drug interaction with hormonal contraceptives exist. UPA may diminish the effect of hormonal contraceptives and likewise, hormonal contraceptives may reduce efficacy of UPA during the first 5-days.

**Routine pretreatment with an antiemetic is not recommended, but may be effective if patient has a history of vomiting after oral ECs

Return to Pathway

Preconception Care

When discussing the risk of pregnancy with an adolescent, consider the following:

1. A dialogue regarding the patient's readiness for pregnancy
2. An evaluation of her overall health and opportunities for improving her health
3. Education about the significant impact that social, environmental, occupational, behavioral, and genetic factors have in pregnancy
4. Identification of women at high risk for an adverse pregnancy outcome

To optimize health and reduce risk prior to conception, focus on the following health factors:

1. Undiagnosed, untreated, or poorly controlled medical conditions
2. Immunization history
3. Medication and radiation exposure in early pregnancy
4. Nutritional issues
5. Family history and genetic risk
6. Tobacco and substance use and other high-risk behaviors
7. Occupational and environmental exposures
8. Social issues
9. Mental health issues

Reference: Committee on Gynecologic Practice. *ACOG Committee Opinion: The Importance of Preconception Care in the Continuum of Women's Health Care.* 313, 2015.

Return to Pathway

Counseling about pregnancy options

Pregnant adolescents have the right to be informed and counseled on all legal pregnancy options. Pediatricians should take the following steps:

1. Inform the pregnant adolescent of the options, which include carrying the pregnancy to delivery and raising the infant, carrying the pregnancy to delivery and making an adoption or kinship care plan, or terminating the pregnancy.

2. Be prepared to provide a pregnant adolescent with basic, accurate information about each of these options in a developmentally appropriate manner, support her in the decision-making process, and assist in making connections with community resources that will provide her with quality services during and after her pregnancy.

3. Examine their own beliefs and values to determine if they can provide nonjudgmental, factual pregnancy options counseling. If they cannot, they should facilitate a prompt referral for counseling by another knowledgeable professional in their practice setting or community who is willing to have such discussion with adolescent patients.

Reference: AMERICAN ACADEMY OF PEDIATRICS, COMMITTEE ON ADOLESCENCE; Options Counseling for the Pregnant Adolescent Patient. Pediatrics August 2022; 150 (3)

Return to Pathway

How to be reasonably certain a woman is not pregnant

A contraceptive method may be started at any time in a woman's menstrual cycle as long as a health care provider is reasonably certain she is not pregnant. A provider can be reasonably certain a woman is not pregnant if she meets any 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, or
- Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥ 85%] of feeds are breastfeeds), amenorrheic, and < 6 months postpartum.

Reference: Centers for Disease Control and Prevention. U.S. Selected Practice Recommendations for Contraceptive Use. MMWR 2016a;65(4):1-66.

Return to Pathway

Assessing medical eligibility for contraceptive use

A healthy adolescent female who has normal menstruation, no active or previous medical conditions or congenital anomalies, has never been pregnant, takes no medications or supplements, and does not have a sexually transmitted infection is eligible for any reversible contraceptive method.

Does the patient have any of the following conditions?		
Condition	**Category**	**Consideration**
Migraine with aura*	Category 4 for CHC	Consider a contraceptive other than CHC
Current PID, purulent cervicitis, chlamydial infection, gonorrheal infection	Category 4 for Cu-IUD and LNG-IUD	Consider an option other than IUD
Certain anticonvulsants*: phenytoin, carbamazepine, barbiturates, primidone, topiramate and oxcarbazepine	Category 3 for CHC and POP	Consider an option other than CHC and POP
Certain anticonvulsants*: lamotrigine	Category 3 for CHC	Consider an option other than CHC
History of deep venous thrombosis – High risk for recurrence (i.e. DVT, PE)*	Category 4 for CHC	Consider an option other than CHC
History of deep venous thrombosis – Lower risk for recurrence (i.e. DVT, PE)*	Category 3 for CHC	Consider an option other than CHC
History of cerebrovascular accident	Category 4 for CHC Category 3 for DMPA	Consider an option other than CHC or DMPA
Hypertension*: adequately controlled and systolic 140-159 or diastolic 90-99	Category 3 for CHC	Consider an option other than CHC
Hypertension*: systolic ≥ 160 or diastolic > 100	Category 4 for CHC	Consider an option other than CHC
Hypertension*: vascular disease	Category 4 for CHC	Consider an option other than CHC
Known thrombogenic mutations (e.g. factor V Leiden; prothrombin mutation, and protein S, protein C and antithrombin deficiencies)*	Category 4* for CHC	Consider an option other than CHC
Post-partum < 21 days	Category 4 for CHC	Consider an option other than CHC
*please see complete guideline for a clarification of this classification		

If an adolescent female has a known or suspected medical condition or takes medications other than those listed above, the provider should further assess medical eligibility for contraceptive use prior to initiation.

Reference: U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 MMWR / July 29, 2016 / Vol. 65 / No. 3
https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html

Abbreviations:
Cu IUD – copper IUD
LNG IUG – Levonorgestrel IUD
DMPA – depot medroxyprogestrerone acetate
CHC – combined hormonal contraceptives
POP – progestin only pill

Condition Category	Definition for hormonal contraceptives
3	Theoretical or proven risks usually outweigh the advantages of using the method.
4	Represents an unacceptable health risk if the contraceptive method is used.

Return to Pathway

References

Allen RH. Combined estrogen-progestin oral contraceptives: Patient selection, counseling, and use. In: *UpToDate*, Post TW (Ed), UpToDate, Wlatham, MA. (Accesses January 09, 2023)

Curtis KM, Jatlaoui TC, Tepper NK, et al. US selected practice recommendations for contraceptive use, 2016. MMWR Recomm Rep. 2016a;65(4):1-66.

Grossman Barr N. Managing adverse effects of hormonal contraceptives. Am Fam Physician. 2010 Dec 15;82(12):1499-506.

Katzung BG. Properties of some progestational agents. McGraw-Hill.

Kelly A. The facts about intrauterine contraception. Association of Reproductive Health Professionals. 2022 Aug 30. http://www.arhp.org/Publications-and-Resources/Clinical-Fact-Sheets/The-Facts-About-Intrauterine-Contraception-

Laurie L. Hornberger, Committee On Adolescence. *Options Counseling for the Pregnant Adolescent Patient*. Pediatrics. Sep 2017, 140(3):e20172274; DOI: 10.1542/peds.2017-2274

Ott MA, Sucato GS; Committee on Adolescence. Contraception for adolescents. Pediatrics. 2014 Oct;134(4):e1257-81. http://pediatrics.aappublications.org/content/134/4/e1257#T3

Rice C. Selecting and Monitoring Hormonal Contraceptives: An Overview of Available Products. *US Pharm*. 2006;6:62-70. https://www.uspharmacist.com/article/selecting-and-monitoring-hormonal-contraceptives-an-overview-of-available-products

Beyond the Pill – self-paced training and recorded webinars. https://beyondthepill.ucsf.edu/new-online-training

Clinical Resource, Comparison of Oral Contraceptives and Non-Oral Alternatives. Pharmacist's Letter/Prescriber's Letter. March 2019.

Committee on Gynecologic Practice. *ACOG Committee Opinion: The Importance of Precontraception Care in the Continuum of Women's Health Care*. 313, 2015.

How to Switch Birth Control Methods. https://www.reproductiveaccess.org/wp-content/uploads/2014/12/switching_bc.pdf

PL Detail-Document, Choosing a Hormonal Contraceptive. Pharmacist's Letter/Prescriber's Letter. October 2015.

PL Detail-Document, Missed Doses of Hormonal Contraceptives: A Less Complicated Approach. Pharmacist's Letter/Prescriber's Letter. June 2014.

Return to Pathway