



**PHARMACY
VISION
20/20**

CSHP SEMINAR 20 • OCTOBER 21-25
Disneyland
RESORT

PILLS, PATCHES, GELS AND RINGS-NEW CONTRACEPTIVES!

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DISCLOSURE

Kathleen Besinque has nothing to disclose

Sarah McBane has nothing to disclose

PHARMACIST LEARNING OBJECTIVES

- Review the CDC Medical Eligibility Criteria and Selected Practice Recommendations
- Differentiate recently approved hormonal contraceptives from existing agents
- Describe the impact of body weight on the effectiveness of hormonal contraceptives including emergency contraceptives

TECHNICIAN LEARNING OBJECTIVES

- List the types of contraception available directly at the pharmacy
- Identify recently approved hormonal contraceptives
- Collaborate with pharmacists to provide contraceptive services to patients

FURNISHING CONTRACEPTIVES BY PHARMACISTS

2013 – SB 493 signed

2014 – SB 493 “in effect”

2016 – BOP HC regulations

2020 – what’s new?

Summary of State Policies

State	Available	Authority By	Birth Control Methods	Patient Age Restriction
Washington	1979	Collaborative Practice Agreement	Pill, Patch, Ring, Shot	All ages
Oregon	2016	Statewide Protocol	Pill, Patch, Ring, Shot	18 and older unless prior prescription
California	2016	Statewide Protocol	Pill, Patch, Ring, Shot	All ages
Colorado	2017	Statewide Protocol	Pill, Patch	18 and older
Hawaii	2018	Statewide Protocol	Pill, Patch, Ring	18 and older unless prior prescription
New Mexico	2018	Statewide Protocol	Pill, Patch, Ring, Shot, Nonhormonal Methods	All ages
Maryland	2019	Statewide Protocol	Pill, Patch, Ring, Shot	All ages
Utah	2019	Standing Order	Pill, Patch, Ring	18 and older
Others in Progress: Tennessee, New Hampshire, West Virginia, Washington D.C.				

This table reflects states that have implemented their policies for pharmacist prescribing of hormonal contraception, as well as those that have passed legislation and implementation is in progress.
Updated June 30, 2019



What is the law in your state?

Want to know how some states are making it easier to access birth control pills?
We chart some innovative ways the pill is being provided and covered by insurance.

Find out which states passed laws to guarantee increased access to birth control pills:

States with enhanced laws	Birth control coverage without a co-pay or deductible	Coverage of OTC medications without a prescription	Pharmacist-prescribed birth control pills*	Insurance coverage of one year's supply
California	X		X	X
Colorado			X	X
Connecticut	X			X
Delaware	X	X [†]		X
Hawaii			X	X
Idaho			X	
Illinois	X	X		X
Maine	X			X
Maryland	X	X	X	X
Massachusetts	X	X [†]		X
Nevada	X			X
New Hampshire	X		X	X
New Jersey	X	X		
New Mexico	X	X	X	
New York	X	X [†]		X
Oregon	X	X	X	X
Rhode Island				X
Tennessee			X	
Utah			X	
Vermont	X			X
Virginia				X
Washington	X	X	X	X
Washington, D.C.	X		X	X
West Virginia			X	X
Total	16	9	13	19

Got questions? Write us at freethepill@gmail.com

*In some of these states, pharmacists need a collaborative partnership with a physician or advanced practice clinician in order to prescribe birth control pills.

[†]OTC coverage limited to emergency contraceptives only

updated May 27, 2020

<http://freethepill.org/statepolicies/> accessed September 17, 2020

Downloads and Resources

US MEC US SPR

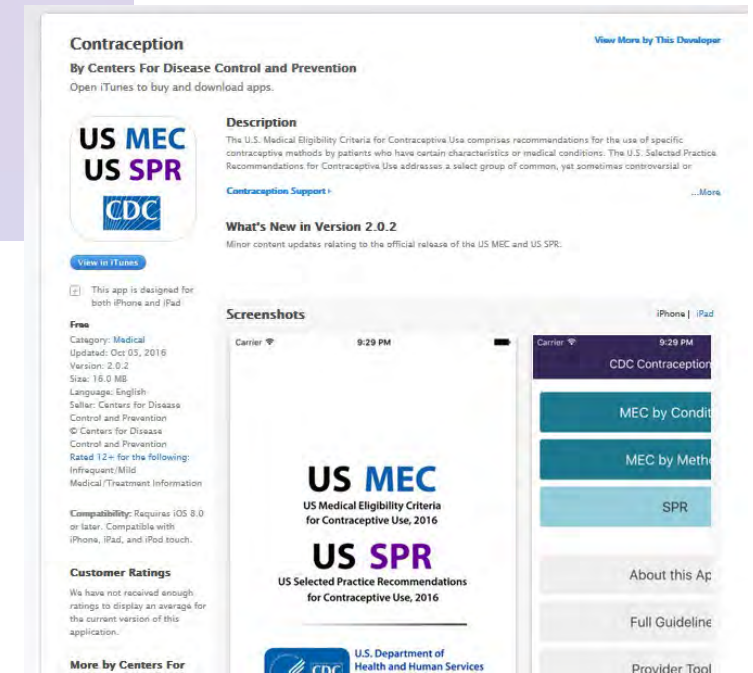
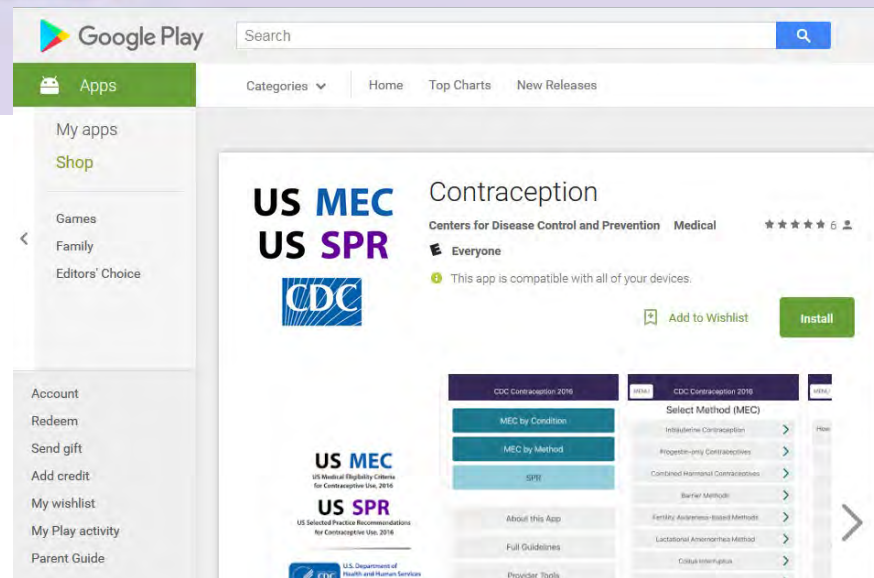


US MEC & US SPR App

Download the 2016 US MEC and US SPR app, an easy to use reference that combines information from the both CDC family planning guidance. It features a streamlined interface so providers can access the guidance quickly and easily. It is available for iOS and Android operating systems.

[iOS \(Apple Store\) App](#)

[Android \(Google Play Store\) App](#)



<https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html> accessed September 17, 2020

GUIDELINES FOR PROVIDING HORMONAL CONTRACEPTIVES

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

The Medical Eligibility Guidelines
for Contraceptives (MEC) 2016



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

The Selected Practice
Recommendations (SPR)



U.S. Selected Practice Recommendations for
Contraceptive Use, 2016

https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm accessed September 17, 2020

US MEDICAL ELIGIBILITY CRITERIA

Criteria are organized according to:

- Contraceptive method
- Patient characteristics (age, smoking status, etc.)
- Preexisting conditions (hypertension, epilepsy, etc.)
- Criteria use a numeric scheme to provide the recommendations for contraceptives being used for contraceptive purposes only, *not* for *treatment* of medical conditions

Safety/Risk Categories	
1	Method can be used without restriction
2	Advantages generally outweigh theoretical or proven risk
3	Method usually not recommended unless other, more appropriate methods are not available or not acceptable
4	Method not to be used

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes	a) History of gestational disease	1		1		1		1		1		1	
	b) Nonvascular disease												
	i) Non-insulin dependent	1		2		2		2		2		2	
	ii) Insulin dependent	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy [‡]	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration [‡]	1		2		2		3		2		3/4*	

REQUIRED TO FURNISH HORMONAL CONTRACEPTION

Medical history

Blood pressure

Self-screening tool

REQUIRED

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

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age	Menarche to <20 yrs:2												
	>20 yrs:1												
Anatomical abnormalities	a) Distorted uterine cavity	4	4										
	b) Other abnormalities	2	2										
Anemias	a) Thalassemia	2	1	1	1	1	1	1	1	1	1	1	1
	b) Sickle cell disease ¹	2	1	1	1	1	1	1	1	1	1	1	2
	c) Iron-deficiency anemia	2	1	1	1	1	1	1	1	1	1	1	1
Benign ovarian tumors	(including cysts)	1	1	1	1	1	1	1	1	1	1	1	1
Breast disease	a) Undiagnosed mass	1	2	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*
	b) Benign breast disease	1	1	1	1	1	1	1	1	1	1	1	1
	c) Family history of cancer	1	1	1	1	1	1	1	1	1	1	1	1
	d) Breast cancer ¹												
Breastfeeding	i) Current	1	4	4	4	4	4	4	4	4	4	4	4
	ii) Past and no evidence of current disease for 5 years	1	3	3	3	3	3	3	3	3	3	3	3
	a) <21 days postpartum				2*	2*	2*	2*	2*	2*	2*	2*	2*
	b) 21 to <30 days postpartum												
Cervical cancer	i) With other risk factors for VTE				2*	2*	2*	2*	2*	2*	2*	2*	3*
	ii) Without other risk factors for VTE				2*	2*	2*	2*	2*	2*	2*	2*	3*
	c) 30-42 days postpartum												
	d) >42 days postpartum												
Cervical ectropion	i) With other risk factors for VTE				1*	1*	1*	1*	1*	1*	1*	1*	3*
	ii) Without other risk factors for VTE				1*	1*	1*	1*	1*	1*	1*	1*	2*
Cervical intraepithelial neoplasia	i) Without other risk factors for VTE				1*	1*	1*	1*	1*	1*	1*	1*	2*
	d) >42 days postpartum				1*	1*	1*	1*	1*	1*	1*	1*	2*
Cirrhosis	a) Mild (compensated)	1	1	1	1	1	1	1	1	1	1	1	1
	b) Severe ¹ (decompensated)	1	3	3	3	3	3	3	3	3	3	3	4
Cystic fibrosis ¹	i) With other risk factors for VTE				1*	1*	1*	1*	1*	1*	1*	1*	3*
	ii) Without other risk factors for VTE				1*	1*	1*	1*	1*	1*	1*	1*	2*
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1	2	2	2	2	2	2	2	2	2	2	4
	ii) Lower risk for recurrent DVT/PE	1	2	2	2	2	2	2	2	2	2	2	3
	b) Acute DVT/PE	2	2	2	2	2	2	2	2	2	2	2	4
History of cholelithiasis	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2	2	2	2	2	2	2	2	2	2	2	4*
	ii) Lower risk for recurrent DVT/PE	2	2	2	2	2	2	2	2	2	2	2	3*
	d) Family history (first-degree relatives)	1	1	1	1	1	1	1	1	1	1	1	2
History of high blood pressure during pregnancy	e) Major surgery												
	i) With prolonged immobilization	1	2	2	2	2	2	2	2	2	2	2	4
	ii) Without prolonged immobilization	1	1	1	1	1	1	1	1	1	1	1	2
History of pelvic surgery	f) Minor surgery without immobilization	1	1	1	1	1	1	1	1	1	1	1	1
		1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes	a) History of gestational disease	1	1	1	1	1	1	1	1	1	1	1	1
	b) Nonvascular disease												
	i) Non-Insulin dependent	1	2	2	2	2	2	2	2	2	2	2	2
	ii) Insulin dependent	1	2	2	2	2	2	2	2	2	2	2	2
Dysmenorrhea	c) Nephropathy/retinopathy/neuropathy ¹	1	2	2	2	2	2	3	2	2	2	3/4*	3/4*
	d) Other vascular disease or diabetes of >20 years' duration ¹	1	2	2	2	2	2	3	2	2	2	3/4*	3/4*
Endometrial cancer ¹	Severe	2	1	1	1	1	1	1	1	1	1	1	1
		4	2	4	2	1	1	1	1	1	1	1	1
Endometrial hyperplasia		1	1	1	1	1	1	1	1	1	1	1	1
		2	1	1	1	1	1	1	1	1	1	1	1
Epilepsy ¹		1	1	1	1	1	1	1	1	1	1	1	1
	(see also Drug Interactions)												
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1	2	2	2	2	2	2	2	2	2	2	2
	ii) Medically treated	1	2	2	2	2	2	2	2	2	2	2	3
	iii) Current	1	2	2	2	2	2	2	2	2	2	2	3
Gestational trophoblastic disease ¹	b) Asymptomatic	1	2	2	2	2	2	2	2	2	2	2	2
	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
	ii) Uterine size second trimester	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*
Headaches	b) Confirmed GTD												
	i) Undetectable/non-pregnant β-hCG levels	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
	ii) Decreasing β-hCG levels	2*	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*
	iii) Persistently elevated β-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*
History of bariatric surgery ¹	iv) Persistently elevated β-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*	1*	1*	1*	1*	1*	1*	1*
	a) Restrictive procedures	1	1	1	1	1	1	1	1	1	1	1	1
History of cholestasis	b) Malabsorptive procedures	1	1	1	1	1	1	1	1	1	1	1	1
		1	1	1	1	1	1	1	1	1	1	1	1
History of high blood pressure during pregnancy	a) Pregnancy related	1	1	1	1	1	1	1	1	1	1	1	1
	b) Past COC related	1	2	2	2	2	2	2	2	2	2	2	3
History of HIV	a) High risk for HIV	2	2	2	2	2	2	2	2	2	2	2	2
	b) HIV infection												
History of pelvic surgery	i) Clinically well receiving ARV therapy	1	1	1	1	1	1	1	1	1	1	1	1
	ii) Not clinically well or not receiving ARV therapy ¹	2	1	2	1								

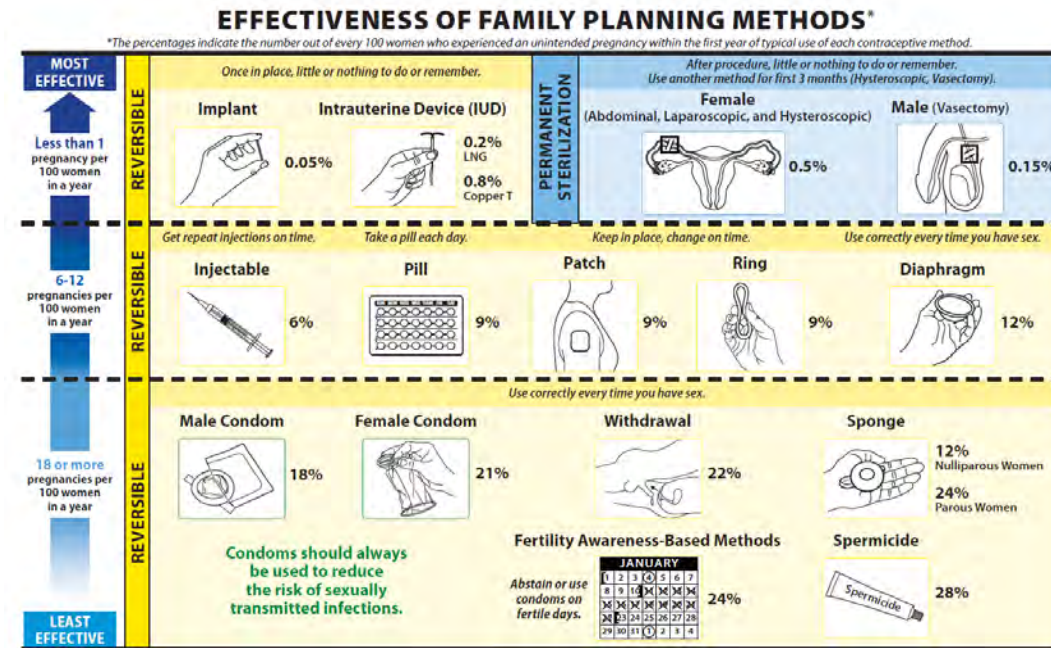
Key:
1 No restriction (method can be used)
2 Advantages generally outweigh theoretical or proven risks
3 Theoretical or proven risks usually outweigh the advantages
4 Unacceptable health risk (method not to be used)

Abbreviations: C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA=depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/B=patch/diaphragm. *Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification. www.cdc.gov/nrproductivehealth/urinaryandpregnancy/USMEC.htm.

CONSIDERATIONS IN SELECTING A CONTRACEPTIVE METHOD

- Safety
- Efficacy
- Past experience
- Ease of access
- Reversibility
- Convenience
- Adherence
- Personal preferences
- Cost
- Privacy

Activity/Condition	Chance of Death in 1 Year (per 100,000)
Oral contraceptives Nonsmoker aged 35-44	3.0
Childbirth	9.1
Pregnancy (beyond 20 weeks)	14.5
Automobile driving	20



PRACTICE TOOL: FURNISHING HORMONAL CONTRACEPTION

- After excluding options using the MEC that are contraindicated, patient preferences are the primary concern when furnishing contraceptives.
 - The most effective method is the one that will be used
- A checklist can be used to help open discussion with women about features desired in their contraceptive method.

	Not sure/ no preference	
Reversible		Permanent
Hormone -free		Contains hormones
Method is used daily		Method is used weekly, monthly or less often
Long duration of effect		Short term duration
Method taken/used daily		Method requires attention every 3-5 years
Method is private		Privacy is not important
Cost is very important		Cost is less important

CURRENT METHODS OF CONTRACEPTION

HORMONAL (PROGESTIN +/- ESTROGEN)

NON-HORMONAL

- Combination E and P
 - Oral tablet
 - Topical Patch
 - Vaginal ring
- Progestin only
 - Injection (SQ/IM)
 - Implant
 - Oral tablet
 - Progestin IUD

- Barrier
- Sponge
- Spermicide
- Cu IUD
- Sterilization
- Fertility awareness
- Abstinence

Self Administered Hormonal Contraceptive Options

- **Type of method desired**
 - pill (oral)
 - vaginal ring
 - patch (transdermal)
 - injection
 - other
- **Regimen options**
 - Type of regimen
 - monophasic
 - triphasic
 - multi-phasic
 - Duration of a cycle
 - 21-day, 28-day
 - Extended cycle (91 day)
- **Formulary issues**
 - What is covered?
 - Cost
- **Hormone options**
 - estrogen/progestin
 - progestin only
- **Hormones available**
 - estrogens: oral, vaginal, transdermal
 - estradiol (mestranol)
 - estradiol valerate
 - 17-Beta estradiol
 - Progestins:
 - 1st generation estranes
 - norethindrone
 - 2nd generation gonanes
 - levonorgestrel
 - 3rd generation
 - desogen
 - norgestimate
 - Other:
 - medroxyprogesterone acetate
 - drospirenone
 - segesterone

NEW ADDITIONS

Hormonal (Estrogen Progestin)

✓ Combination E and P

- ✓ Oral
- ✓ Patch
- ✓ Vaginal ring

• Progestin only

- Injection
- Implants
- ✓ Pills
- ✓ IUD



Annovera®



Slynd®



TWIRLA (ETHINYL ESTRADIOL/LEVONORGESTREL)

- 30 mcg EE + 120mcg LNG
- 3 weeks on, 1 week off
 - Abdomen, upper torso, buttocks
- Expected precautions and CI
- AE: application site reactions, nausea, HA, dysmenorrhea, increased weight

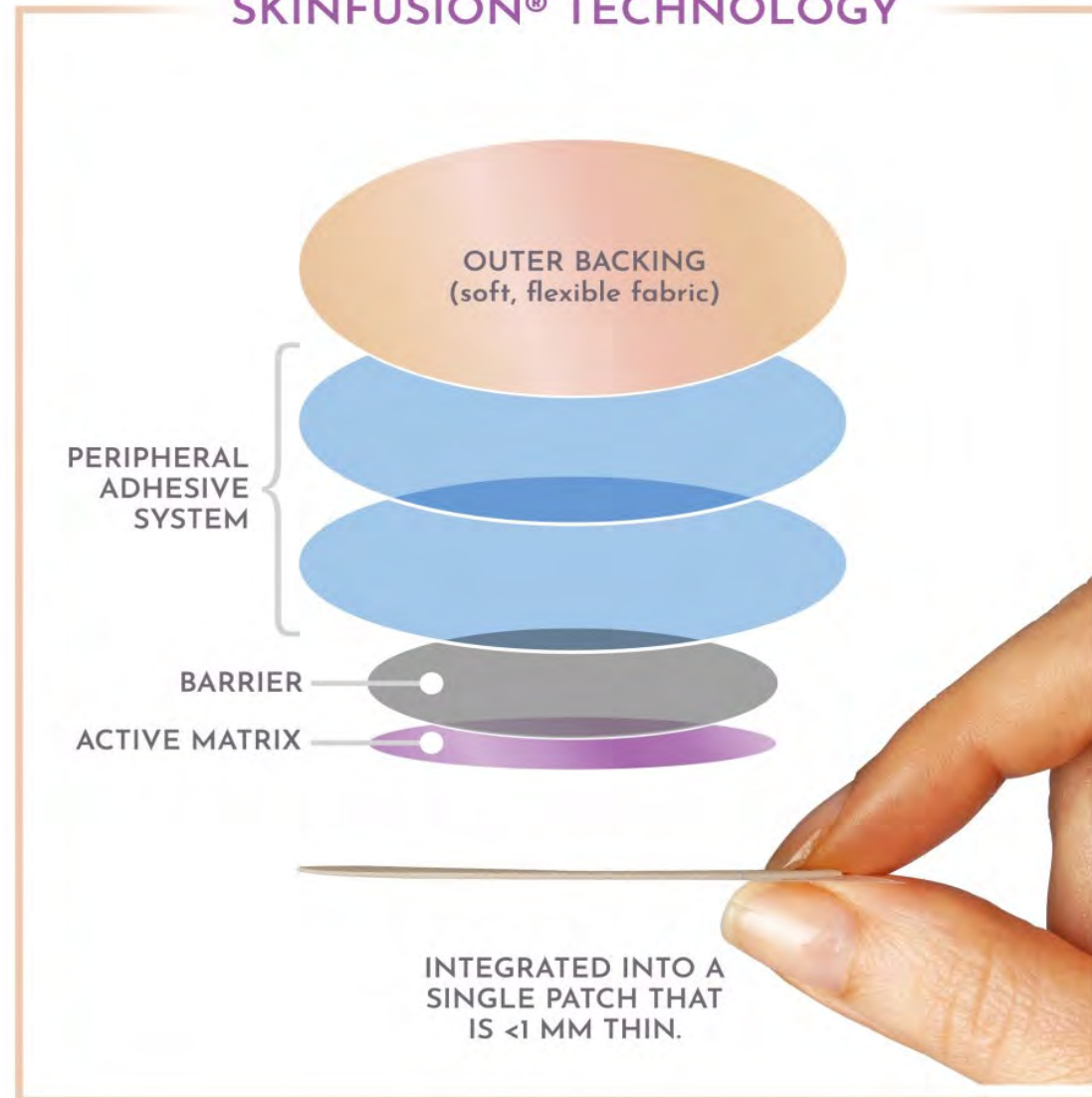


<https://twirla.com/about/> accessed September 17, 2020

TWIRLA

(LEVONORGESTREL/
ETHINYL ESTRADIOL)

SKINFUSION® TECHNOLOGY



CONTRACEPTIVE PATCHES COMPARED



	Ethinyl estradiol and levonorgestrel	Ethinyl estradiol and norelgestromin
Trade name	Twirla®	Xulane®,
Product form	Round transdermal patch, 28 cm ² . Soft, silky, stretchy fabric	Square transdermal patch, 20 cm ² , smooth plastic film
Daily dosing (pK)	EE 30mcg + LNG 120 mcg	EE 35 + norelgestromin 150 mcg/day
Regimen	One patch weekly for 3 weeks followed by 7 days patch-free	One patch weekly for 3 weeks followed by 7 days patch-free
Side effects	Nausea, application site irritation, breast tenderness, headache	Breast symptoms, headache, application site disorders, Nausea
Notes	Boxes of 3 patches	Boxes of 3 patches

TWIRLA – WHAT TO TELL PATIENTS

→ Non-daily option

→ Slightly less estrogen

→ Thinner but larger patch

→ Expect similar AE

CONTRACEPTIVE RINGS COMPARED



	Segesterone acetate and ethinyl estradiol	Etonogestrel and ethinyl estradiol
Ring composition	White, silicone elastomer vaginal system containing 103 mg segesterone acetate and 17.4 mg ethinyl estradiol	Clear, polymeric vaginal ring containing 11.7 mg etonogestrel and 2.7 mg ethinyl estradiol
Trade name	Annovera [®]	Nuvaring [®] / EluRyng [®]
Daily dosing (pK)	0.15mg/0.013mg/24 hours	0.12 mg /0.015 mg/24 hours
Regimen	Insert for 21 days, remove for 7 days then re-insert for a total of 13 cycles	Insert for 21 days, remove for 7 days (discard ring). Insert new ring on Day 28.
Side effects	Headache, N/V, vaginal fungal infections, abdominal pain, dysmenorrhea	vaginitis, headache, mood changes, N/V, increased weight
Notes	Ring is used for one-year. No refrigeration needed. 56 mm x 8.4 mm.	Stable 4 months only without refrigeration. 54 mm x 4 mm

ANNOVERA (ETHINYL ESTRADIOL/SEGESTERONE ACETATE)

- 13 mcg EE + 150mcg segesterone acetate
- Soft, flexible ring
- Inserted for 21 days, removed for 7 days
 - 13 cycles
- Expected precautions and CI
- Vaginal discharge, pruritus, irregular bleeding, device expulsion (25%)



<https://www.annovera.com/> accessed September 17, 2020

Annovera – What to tell patients

→ Non-daily option

→ One ring lasts a year

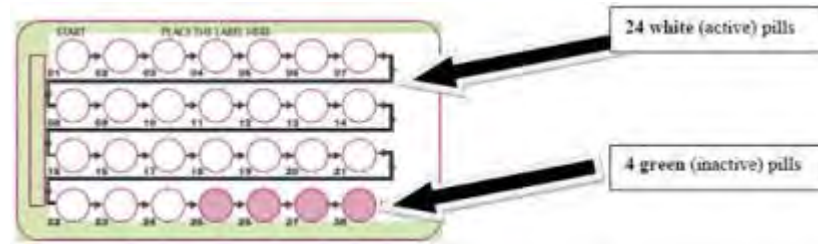
→ Wash and store it

→ Expulsion usually decreases with time

ANNOVERA® WHAT TO DO IF.....

The vaginal system is placed back in:	Then:
Too early , after it had been out for only 5 or 6 days	Keep the vaginal system in for at least 3 weeks (21 days) . You may keep it in up to your normal vaginal system-out day .
Too late , after it had been out for more than 7 days.	Put the vaginal system back in right away. You will now have a new vaginal system-in day . You must use condoms or spermicide as back-up contraception for the next 7 days when you have sexual intercourse.
The vaginal system was removed or taken out:	Then:
Too early , after it had been in for only 19 or 20 days.	Leave the vaginal system out for 1 week. Put it back in after the week is over, as you would normally do. You may then keep it in up to your normal vaginal system-out day , 22 or 23 days after you put the vaginal system in.
Too late , after it had been in for 22 or 23 days.	Remove the vaginal system as soon as you realize this. Then reinsert the vaginal system 7 days later.
For more than 2 hours (collectively) ; the ring was out of the vagina for more than 2 hours total over the 21 days.	Use back-up contraception such as male condoms or spermicide should be used until the vaginal system has been in the vagina for 7 consecutive days.

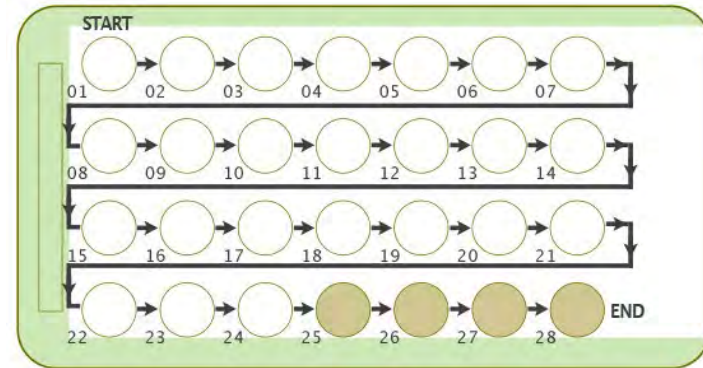
PROGESTIN ONLY PILLS COMPARED



	drospirenone	norethindrone
Active ingredient	Drospirenone	Norethindrone
Trade name	Slynd®	Errin®, Nor-QD®, Camila® and more
Daily dosing	4mg po daily on a 28 day cycle	0.35mg daily
Regimen	4mg po daily for 24 days, inert tablet po daily for 4 days	One tablet (0.35mg) po daily every day- no breaks
Side effects	unscheduled bleeding (40% after 1 year)	spotting and irregular bleeding, breast tenderness, weight gain
Notes	contraindicated in liver or renal impairment	

SLYND (DROSPIRENONE)

- Drospirenone 4 mg
- 24 + 4 dosing regimen
- 24 hour missed dose window
- Expected precautions and CI
- Acne, metrorrhagia, breast pain, HA



<https://slynd.com/> accessed on September 17, 2020

SLYND

4 mg drospirenone

24 + 4 regimen

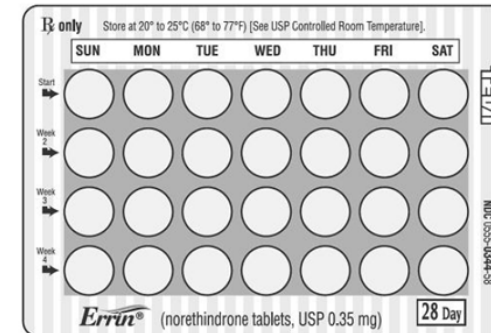
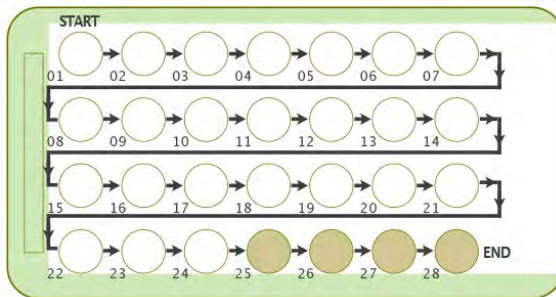
Missed pill – 24 hours

NORETHINDRONE

0.35 mg norethindrone

28 + 0 regimen

Missed pill – 3 hours



SLYND – WHAT TO TELL PATIENTS

→ Different progestin than other POP

→ Good choice if avoiding estrogen

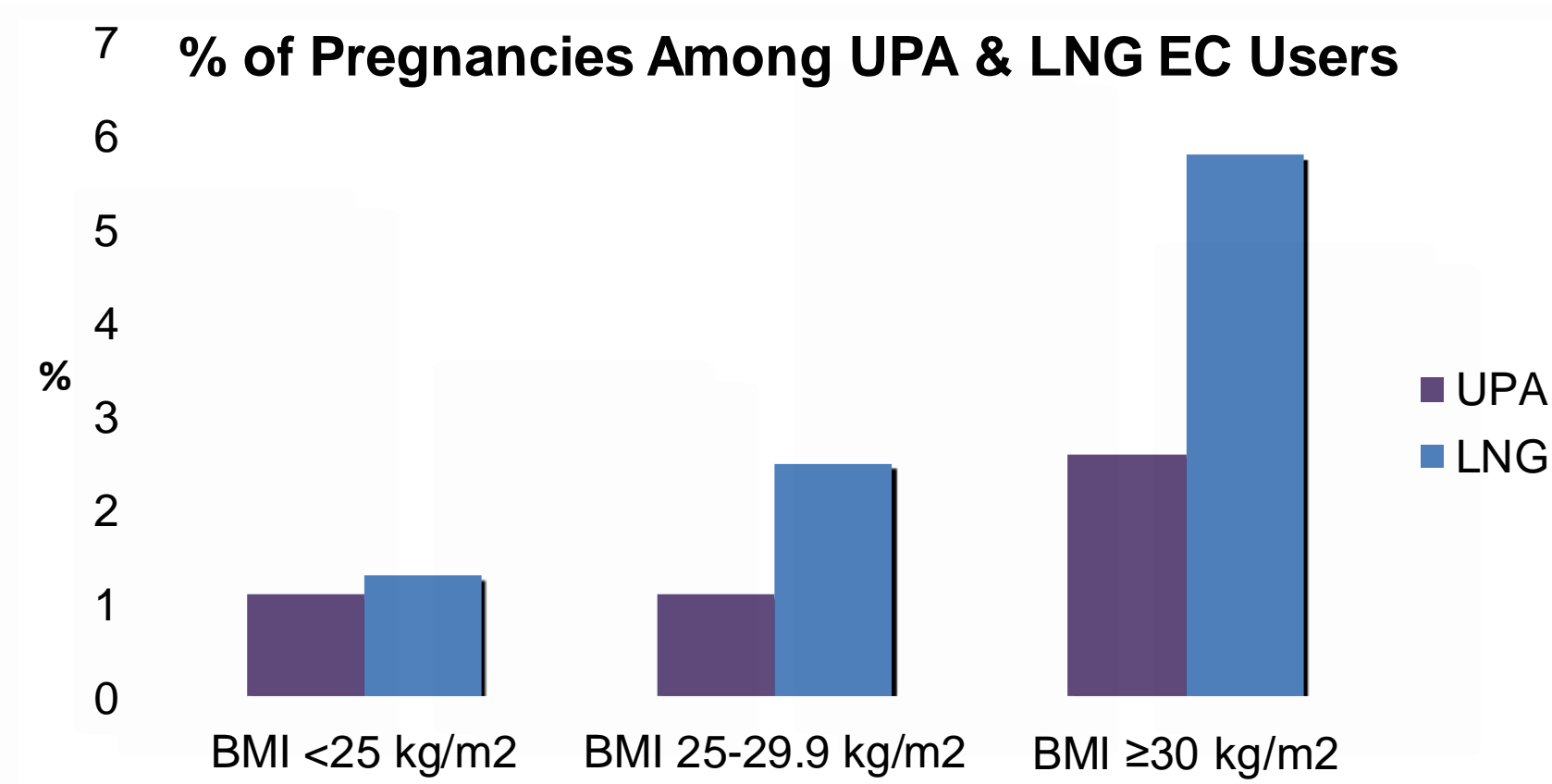
→ Withdrawal bleeding may be more predictable

→ Missed dose can be made up within 24 hours

EC EFFECTIVENESS AND WEIGHT

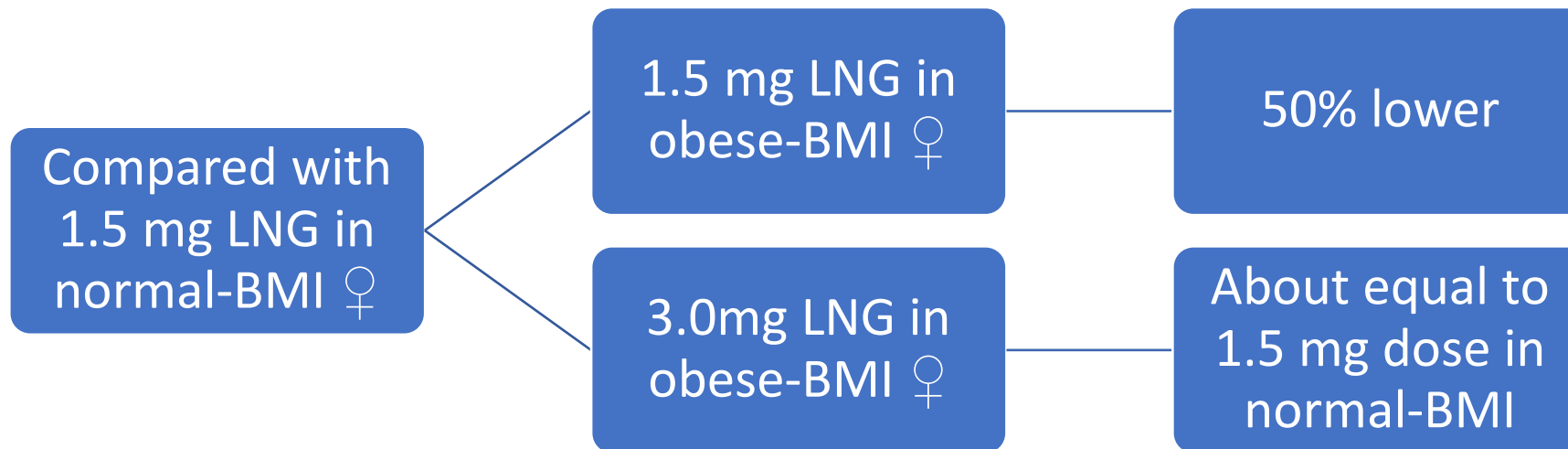


EC EFFICACY & WEIGHT



Glasier, A, Cameron ST, Blithe D, et al. Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel. *Contraception* 2011;84:363-7.

EC EFFICACY & WEIGHT



*No difference in UPA levels between BMI groups

Edelman A, Cherala G, Blue S, Erikson D, Jensen J. Impact of obesity on the pharmacokinetics of levonorgestrel-based emergency contraception: single and double dosing. *Contraception* 2016;94:52-57.

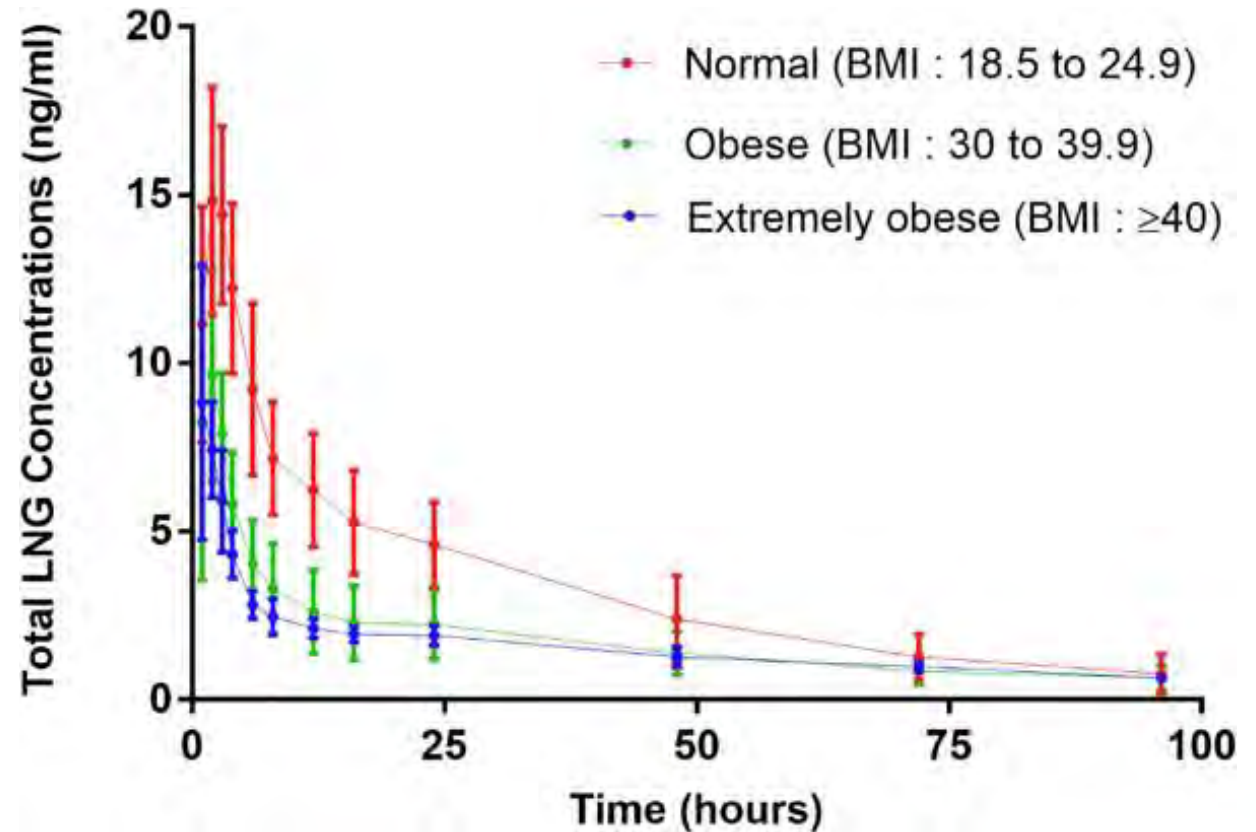
Praditpan P, Hamouie A, Basaraba CN, Nadakumar R, Cremers S, Davis AR, Westhoff CL. Pharmacokinetics of levonorgestrel and ulipristal acetate emergency contraception in women with normal and obese body mass index. *Contraception* 2017;95 :464–469

EC EFFICACY & WEIGHT:

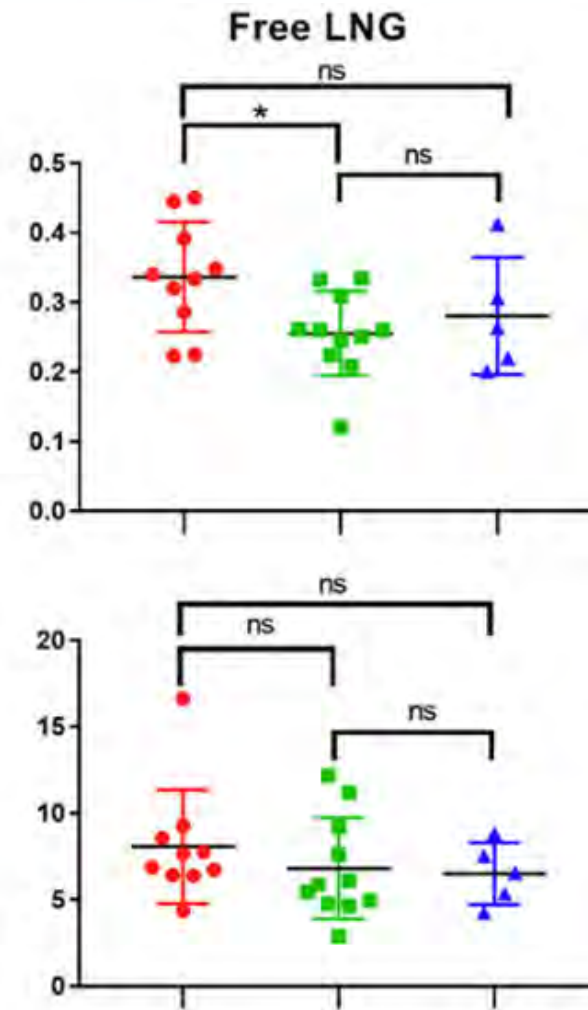
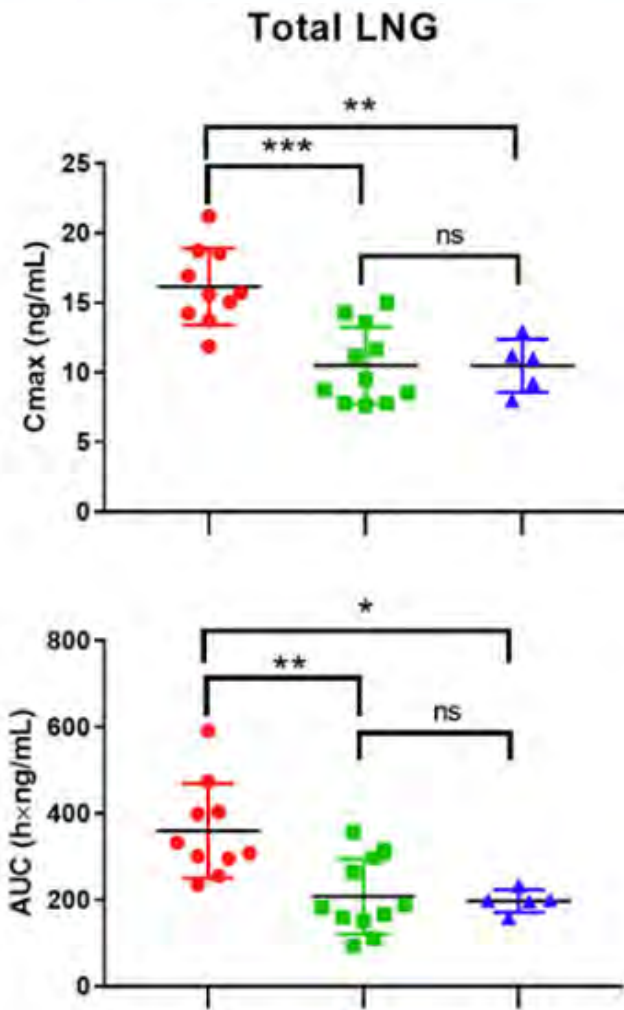
- Small pharmacokinetic study 2016
 - ✓ 5 women, normal-BMI (18.5-24) and 5 women, obese-BMI (35+)
 - Measured serum concentration levels of LNG and compared:
 - ✓ 1.5mg LNG in normal-BMI women (single dose)
 - ✓ 1.5mg LNG and 3.0mg LNG in obese-BMI women
- Second pK study 2017
 - ✓ 16 women with normal BMI and 16 women with obese BMI
 - Measured serum concentration levels of LNG and UPA and compared:
 - ✓ normal-BMI women (single dose UPA and LNG) to obese-BMI women (single dose LNG and UPA)

EC EFFICACY AND WEIGHT

- 26 women age 18 – 34
 - 11 with BMI 18.5–24.9 kg/m²
 - 10 with BMI 30–39.9 kg/m²
 - 5 with BMI ≥ 40 kg/m²
- 1.5 mg LNG



Natavio M, Stanczyk FZ, Molins EAG, Nelson A, Jusko WJ. Pharmacokinetics of the 1.5 mg levonorgestrel emergency contraceptive in women with normal, obese and extremely obese body mass index. *Contraception*. 2019;99(5):306-311.



Natavio M, Stanczyk FZ, Molins EAG, Nelson A, Jusko WJ. Pharmacokinetics of the 1.5 mg levonorgestrel emergency contraceptive in women with normal, obese and extremely obese body mass index. *Contraception*. 2019;99(5):306-311

WEIGHT AND PREGNANCY

- Analysis of 4 WHO studies including 6873 women
 - LNG 1.5 mg as single or divided dose
 - Up to 120 h

	BMI < 25	BMI 25 – 30	BMI > 30
Population	79.1%	16.6%	4.3%
Pregnancy	1.3%	0.6%	2.0%

- Obese patients mainly at 1 study site

EC EFFICACY & WEIGHT: OUTSTANDING ISSUES

- The new research may support the theory that weight may impact EC efficacy
BUT...
- Doubling the dose of LNG may not be financially feasible for many women
- Pharmacokinetic studies don't measure endpoints directly related to efficacy (ovulation, pregnancy)
- One study showed that ½ dose of LNG still disrupted ovulation...are other factors at work besides serum concentrations?

EC EFFICACY & WEIGHT: WHAT TO TELL PATIENTS

→ IUD doesn't lose effectiveness, regardless of weight

→ Women with BMI>35 may consider a double dose of LNG (3.0 mg)

→ Don't deny ECPs due to body weight

→ EC pills should be taken ASAP!

NEW NON-HORMONAL VAGINAL GEL

- Phexxi[®] (lactic acid, citric acid, and potassium bitartrate) vaginal gel (1.8%, 1%, and 0.4%, respectively)
- Prescription only in boxes of 12 units
- Indicated for the prevention of pregnancy only
 - On-demand method
 - Not effective for the prevention of pregnancy when administered after intercourse.

<https://phexxi.com/?msclkid=661c04b51dd717cec3965bd102c416f7&gclid=CJHo7NrX8esCFcuifgodo7MOXg> accessed September 17, 2020

8 Simple Steps

Phexxi™ is a single-use product that is effective immediately, lasts up to 1 hour, and is only effective when used before sex. An additional dose of Phexxi™ must be applied for every act of vaginal sex (similar to using a new condom).

-  Wash your hands.
-  Remove the pre-filled applicator and plunger rod from the foil pouch.
-  Insert the plunger rod into the applicator, and push until the plunger rod connects to the applicator. Use a new pre-filled applicator if gel goes into the pink cap.
-  Remove the pink cap.
PHEXXI™ IS NOW READY FOR USE!
-  In an appropriate position, insert the Phexxi™ pre-filled applicator into your vagina as far as it will comfortably go while you continue to firmly hold it by the grooved area of the applicator.
-  Using your index finger, push the plunger rod until it stops to ensure you receive the entire dose of Phexxi™.
-  Remove the used Phexxi™ pre-filled applicator from your vagina. A small amount of gel may be left in the applicator, however, you will still get the right dose.
-  Throw away (dispose of) the used Phexxi™ pre-filled applicator and cap.

Avoid using Phexxi™ if you or your partner is allergic to any of the ingredients in Phexxi™.

AMPREVENCE

- Potentially the first Multi-Purpose technology product to be approved
- A multipurpose vaginal pH regulator for the prevention of chlamydia and gonorrhea in women

<https://www.biospace.com/article/releases/evofem-biosciences-completes-phase-2b-amprevence-trial-of-amphora-for-prevention-of-chlamydia-and-gonorrhea-in-women/> accessed September 17, 2020

SELF ASSESSMENT QUESTIONS

A new physician resident asks for your help with contraceptive references. She wants to know where she can learn more about safe and effective use of hormonal contraceptives. You direct her to:

- A. The CDC MEC
- B. The CDC SPR
- C. Either document
- D. Her attending

SELF ASSESSMENT QUESTIONS

A 32-year-old woman requests contraception from the pharmacist before she leaves on a 6-month mission trip. There are no pertinent positives on her self-screening questionnaire, and she is open to any method. Which method do you furnish?

- A. Slynd
- B. Twirla
- C. Annovera
- D. Any of the above

SELF ASSESSMENT QUESTIONS

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SELF ASSESSMENT QUESTIONS

A woman comes into the pharmacy the day after unprotected intercourse. She is upset because she doesn't want to become pregnant until after she finishes her PhD next year.

Current medications: None

BMI: 29

What is the best option?

- A. LNG 1.5 mg
- B. LNG 3 mg
- C. UPA 30 mg
- D. Cu IUD

REFERENCE LIST

<https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html> accessed September 17, 2020

https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm accessed September 17, 2020

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Glasier, A, Cameron ST, Blithe D, et al. Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel. *Contraception* 2011;84

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