The New York City Department of Health and Mental Hygiene

2012 EDITION

Quick Guide to Contraception

For Clinicians in Any Specialty

Start Contraception at Today's Visit – Safely and Easily

Featuring New Section on Post-Abortion Contraception!

NYC Health

How to Use This Quick Guide

Contraception is safe and easy to provide. It carries fewer health risks than pregnancy, *and nearly all women can use most methods*.

Helping patients choose an appropriate method is not complicated. Most women, including adolescents, need only a focused history, a blood pressure check and minimal follow-up to begin contraception.

Contraception can start today. "Quick Start" is the preferred, simple way to start contraception at today's office visit. Pelvic exams and Pap tests are not required.

This Quick Guide provides simple, state-of-the-art guidelines for busy clinicians in ANY specialty on how to:

1. **Routinely assess the reproductive health needs of all patients — including adolescents.**
2. **Prescribe appropriate contraception, including emergency contraception, to all women— including adolescents.**
3. **Provide appropriate contraception immediately after an induced or spontaneous abortion.**

For more information on contraception, see Information and Resources on page 13, call 311 or visit nyc.gov/health.

First Printing: May 2008
Revised/Reprinted: June 2012

Contents

Abbreviations

CDC	Centers for Disease Control and Prevention
CHCs	Combined Hormonal Contraceptives (including combined oral contraceptive pills, patch, ring)
COCs	Combined Oral Contraceptives
DMPA	Depot medroxyprogesterone acetate (Depo-Provera)
EC	Emergency Contraception
IUD	Intrauterine Device
LNG	Levonorgestrel
POPs	Progestin-Only Pills
STI(s)	Sexually Transmitted Infection(s)
VTE	Venous Thromboembolism
WHO	World Health Organization

Overview

1. **Routinely discuss contraception** with all women of reproductive age, including adolescents.
   - **Take a brief sexual health history.** Ask about sexual activity, HIV status, STIs, and condom and contraceptive use. *(See page 3.)*
   - **Explain the importance** of contraception and a planned pregnancy to good health.
   - **Dispel myths** about the safety of contraceptive methods.
   - **Help your patient choose an appropriate method.** Consider age, weight, sexual risk behaviors, smoking status, general (including mental) health status, reproductive life goals and socioeconomic factors. *(See page 10.)*
   - **Discuss potential side effects,** explaining that many are temporary. Explain how to seek emergency care if serious adverse effects arise.
2. **Discuss emergency contraception (EC)** and offer an advance prescription or pill pack. *(See page 12.)* Health Department STD Clinics provide EC at no cost. Patients can call 311 for a referral for EC.
3. **Offer contraception** after a negative pregnancy test to women who do not desire pregnancy, immediately following EC and abortion, and at annual preventive health visits.
4. **Use "Quick Start."** Start contraception TODAY, at any point in the menstrual cycle. *(See page 6.)*
5. **Urge all patients to use latex or polyurethane condoms** to reduce risk of HIV and other STIs — no matter what kind of contraception they use.
6. **Provide patient education materials.** *(See page 13.)*

Take a Brief Sexual Health History

General Approach

- Be matter-of-fact, non-judgmental and sensitive.
- Ensure confidentiality. Specifically, make sure adolescents know you will NOT share information with parents without the adolescent's knowledge and consent. *(See* "Minors' Rights" *on page 13.)*

Sample Questions

1. When was the last time you had sex (*vaginal, anal, oral*)?
2. Do you have sex with men, women or both?
3. Are you using condoms to protect against HIV and other STIs?
4. Are there times when a condom is not used or has broken?
5. When did you last get tested for HIV? (*If >1 year ago or has had a new partner—or other new risk factor—since last tested, offer HIV testing.*)
6. Have you ever had an STI?
7. Are you trying to become pregnant?

   If *yes,* provide preconception counseling, prescribe vitamins containing folic acid 400 mcg daily, and/or refer to a reproductive health care provider. *(see: cdc.gov/ncbddd/preconception)*

   If *no,* assess eligibility for hormonal contraceptives. *(See page 4.)*

8. Are you using something to prevent pregnancy? Have you ever had problems or concerns with birth control methods in the past?

Assess Eligibility for Hormonal Contraception

1. Do you have, or have you ever had, any of the following?

- High blood pressure (uncontrolled)
- Migraine headache with aura
- Any migraine and ≥35 years old
- Active smoker ≥ 35 years old
- Symptomatic gallbladder disease
- Liver disease
- Breast cancer
- Recent surgery with current prolonged immobilization
- Other cancer—active or <6 mos. from remission
- Diabetes for > 20 years
- Diabetes with vascular disease
- Blood clot
- Stroke or heart attack
- Known thrombophilia
- Postpartum and/or breastfeeding—see "Help Patients Make the Best Choice" on page 10

- **If "YES," do not prescribe CHCs.**
- **Instead, consider non-hormonal methods such as the copper IUD.**
- **Consult CDC Medical Eligibility Criteria for use of progestin-only methods.** ***(See back cover.)***

If "NO," continue

2. Are you taking any of these medications?

Rifampin, Rifabutin, Griseofulvin, Phenobarbitol/barbituates (Lumina, Barbital, Solfoton), primidone (Mysoline), phenytoin (Dilantin), carbamazepine (Tegretol), felbamate (Felbatol), topiramate (Topamax), vigabitrin (Sabril)

**If taking anti-retroviral medication, consult with their Infectious Diseases specialist or a Family Planning specialist for specific drug-drug interactions with hormonal contraceptives.*

- **If "YES," do not prescribe any hormonal contraceptives.**
- **Instead, consider non-hormonal methods such as the copper IUD.**

If "NO," continue

3. Check blood pressure.

If BP < 140/90, continue

- **If BP ≥ 140/90, do not prescribe CHCs.**
- **Instead, consider progestin-only or non-hormonal methods, such as the copper IUD.**

4. Have you recently had vaginal bleeding between periods that is unusual for you?

If "NO," continue

- **If "YES," do a urine pregnancy test and screen for STIs.**
- **Consider further workup, and reassess for hormonal contraception based on results.**

5. Check weight only for the contraceptive patch.

- **If weight is ≥198 lbs, the patch may be less effective.**
- **Consider other methods first.** ***(See page 8.)***

6. Use Quick Start to initiate contraception today.

With the Quick Start approach, a contraceptive method may be started any time during the menstrual cycle when pregnancy has been ruled out.

Women are more likely to start—and continue—contraception when providers use Quick Start. *(See page 6.)*

Use Quick Start to Initiate Contraception Today

Quick Start can be used for any contraceptive method.

It does NOT require a pelvic exam, Pap test, complete physical exam or lab tests.

First day of LMP < 5 days ago?

YES

Initiate contraception today.

NO

Do a urine pregnancy test. If result is negative:

1. **Initiate contraception today.**
2. **Advise condom use for one week as back-up.**
3. **Provide EC if patient has had unprotected sex in the past 5 days.** ***(See page 12.)***

- **Urge condom use to protect against HIV and other STIs.**
- **Provide at least a 3-month supply of pills, rings, or patches.**
- **Patient should return for pregnancy test:**
  - **3 weeks after starting DMPA**
  - **3 weeks after starting an extended cycle pill**
  - **If no period at the end of first pill, patch, or ring cycle**

Oral Contraceptive Pills

Here is a sampling of lower-dose, 20-35 mcg estrogen and progestin-only pills.

PILL	Progestin	Ethinyl Estradiol (mcg)
Monophasic		
Loestrin 21 1/20, Junel 1/20	NE	20
Loestrin Fe 1/20, Loestrin Fe 24	NE	20
Lutera, Lessina, Aviane	LNG	20
Yaz, Beyaz	DR	20
Loestrin 21-day 1.5/30, Microgestin 1.5/30, Junel 1.5/30	NE	30
Nordette -28, Levlen 28, Portia, Sofia	LNG	30
Lo/Ovral, Low-Ogestrel, Cryselle	N	30
Desogen, Ortho-Cept, Apri	D	30
Yasmin	DR	30
Ortho Cyclen, Sprintec-28	NG	35
Necon 1/35, Ortho Novum 1/35	NE	35
Multiphasic		
Cyclessa	D	25
Ortho Tri Cyclen Lo	N	25
Estrostep Fe	NE	20/30/35
Enpresse, Trivora-28	LNG	30/40/30
Ortho Tri Cyclen, Trinessa, Tri-Sprintec	NG	35
Extended Cycle CHCs		
LoSeasonique 91 days active pills	L	20
Seasonale 84 days active pills	L	30
Seasonique 91 days active pills	L	30/10
Progestin-Only		
Micronor 28,	NE	–
Nor-QD, Camilla, Errin	NE	–

All pills contain EE = ethinyl estradiol
NE = norethindrone, **LNG =** levonorgestrel, **N =** norgestrel, **D =** desogestrel, **DR =** drosperinone, **NG =** norgestimate

Other Combined Hormonal Methods	
Contraceptive Patch (Ortho Evra®)	• EE 20 mcg/day + norelgestromin 150 mcg/day is released transdermally. • Apply one patch/week for 3 weeks to upper outer arm, lower abdomen, upper outer thigh or upper buttock. • Rotate application site each week. • No patch is applied during 4th week (withdrawal bleed). • Not labeled for women ≥ 198 lbs based on prospective trials demonstrating a slightly higher risk of pregnancy compared to women <198 lbs. However, weight is *not* an absolute contraindication: Use clinical judgment and counseling if optimal choice.
Contraceptive Ring (NuvaRing®)	• EE 15 mcg/day + etonogestrel 120 mcg/day is released through ring. • Ring placed in vagina for 3 weeks consecutively, then removed for 1 week (withdrawal bleed).
Other Progestin-Only Methods	
Contraceptive Implant (Nexplanon®)	• A single rod etonogestrel subdermal implant releases hormone over time. • Biologically equivalent to Implanon® and radiopaque • Effective for up to 3 years. • Obtain required training in implant insertion/removal from the manufacturer *(see Information and Resources, page 13)*, or refer to a trained clinician.
Hormonal IUD (Mirena®)	• Levonorgestrel 20 mcg/day is released. • Effective for up to 5 years. • Obtain training in insertion/removal or refer to an experienced clinician.
Contraceptive Injection (Depo-Provera®)	• Depot medroxyprogesterone acetate (DMPA) 150 mg injected intramuscularly or 104 mg injected subcutaneously every 3 months. • *See Important Prescribing Practices on page 9.*
Progestin-only Pills	• 0.35 Norethindrone pills. • Half-life 24 hours. • If pill >3 hours late, need to use emergency contraception. • No hormone-free pills.
Non-Hormonal Methods	
Copper IUD (ParaGard®)	• Copper is active agent. • Effective up to 10 years. • Obtain training in insertion/removal or refer to an experienced clinician.

Important Prescribing Practices

Combined Oral Contraceptive Pills (COCs)

- Pills containing ≤ 35 mcg of ethinyl estradiol are preferred.
- Pills containing the progestins norethindrone, levonorgestrel or norgestrel are preferred. Desogestrel and norgestimate may slightly increase the risk of VTE compared to other progestins. **However, VTE risk with any COC is less than VTE risk with pregnancy**.
- CHC danger signs—**ACHES: A**bdominal pain, **C**hest pain, **H**eadaches (severe), **E**ye problems, and **S**evere leg pain.

Depot Medroxyprogesterone Acetate (Depo-Provera® or DMPA)

- DMPA is a highly effective contraceptive. While the FDA warned in 2004 that use of Depo-Provera® may result in significant loss of bone mineral density (BMD), further studies demonstrated recovery of BMD after discontinuation of DMPA.
- There are no data to suggest that use of DMPA reduces ultimate bone mass or increases risk for fractures later in life. For more information, see: Cromer BA, Scholes D, Berenson A, et al. *J Adolesc Health*. 2006; 39(2):296-301.
- Women whose last injection was 12-17 weeks ago can be given the next injection without need for back-up protection (WHO 2008 Update). If it has been more than 17 weeks and 0 days, a pregnancy test is indicated.

Long-Acting Reversible Contraception (LARC): IUDs and Implant

- IUDs are acceptable choices for adolescents and nulliparous women. IUD insertion and removal are low-risk office-based procedures. The WHO and CDC support their use in these populations (off-label for hormonal IUD).
- IUDs are not contraindicated in women with HIV, history of ectopic pregnancy or PID (WHO and CDC). Defer insertion if PID within past 3 months. If high risk for STIs, may insert with close monitoring. Counsel women to obtain prompt health care if unusual pain, bleeding, vaginal discharge or missed menses while using IUD; not all conditions require removal. For more information, consult CDC Medical Eligibility Criteria. *(See back cover.)*
- Implant insertion and removal require training from the manufacturer but are low-risk, office-based procedures. *(For training, see back cover.)*

Help Patients Make the Best Choice
Base Your Guidance on Lifestyle and Health History

PATIENT	OPTIONS
Adolescent **Any woman through menopause without medical contraindications**	**CHCs, DMPA, IUD, Implant** • Least dependent on user adherence: IUD, Implant, DMPA. • Longest duration: Copper IUD > Hormonal IUD > Implant.
Smoker *younger than 35*	**CHCs, DMPA, IUD, Implant** • Advise and assist with smoking cessation.
Smoker *35 or older*	**DMPA, POPs, IUD, Implant** • Do not prescribe CHCs. • Advise and assist with smoking cessation.
Postpartum (non-breastfeeding woman)	**DMPA, POPs, IUD, Implant** • For lowest IUD expulsion risk, insert <10 minutes following placental delivery or ≥4 weeks postpartum. **CHCs** • Defer until ≥21 days postpartum if no additional risk factors for VTE and ≥42 days postpartum if additional VTE risk factors are present. • **VTE risk factors include age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥30, postpartum hemorrhage, post-cesarean delivery, preeclampsia or smoking.**
Postpartum (breastfeeding woman)	**Copper IUD** • For lowest expulsion risk, insert <10 minutes following placental delivery or ≥4 weeks postpartum. **POPs, Hormonal IUD, Implant, DMPA, CHCs** • Hormonal contraceptives may depress milk supply, but they will not harm the infant. • May defer all hormonal methods until milk supply well-established. • POPs have a short half-life so can stop them if breast milk seems to be affected—counsel on alternative methods or abstinence. • Hormonal IUD: For lowest expulsion risk, insert <10 minutes following placental delivery or >4 weeks postpartum. • Defer CHCs until ≥30 days postpartum if no additional VTE risk and ≥42 days postpartum if patient has additional VTE risk.
Migraine without aura, *younger than 35*	**CHCs, POPs, DMPA, IUD, Implant**
Any type of migraine, *35 or older*	**DMPA, POPs, IUD, Implant** • Do not prescribe CHCs.
Migraine with aura or known vascular complication, *any age*	**DMPA, POPs, IUD, Implant** • Do not prescribe CHCs.

See CDC Medical Eligibility Criteria for more information, www.cdc.gov.

For more detailed information on contraception methods (including the cervical cap, diaphragm, male and female condoms), see www.managingcontraception.com (Contraceptive Technology website).

Post-Abortion Contraception

Contraception can be initiated immediately after an induced or spontaneous abortion; it does not require an additional visit. This practice is safe and effective and is an important way to help women and teens prevent unintended pregnancy.

1. Routinely discuss contraception with all women seeking an induced abortion.
2. Assess sexual history and contraception eligibility, as described on pages 2-5.
3. Urge dual protection with *a highly effective method AND condoms* to protect against unintended pregnancy and HIV/STIs.
4. Follow-up after initiating post-abortion contraception is the same as for initiating contraception unrelated to abortion.

METHOD	NOTES
IUDs	• Can be inserted on the same day immediately after an abortion • Expulsion risk—5% after first trimester abortion (as compared to an expulsion risk of 2-5% when inserted at other times) • Greater risk of expulsion when inserted immediately after a 2nd trimester abortion • Should ***never*** be inserted in the setting of acute cervicitis, pelvic infection or septic abortion • If patient is at high risk for cervicitis but there are no signs of acute infection on exam, may test for gonorrhea and chlamydia and insert IUD at the same time. Must have contact information to follow-up with treatment if patient tests positive. Treatment does not require IUD removal. • Follow-up for the IUD should be as with other IUD insertions—4-8 weeks later
Implant	• Can be inserted on the same day immediately after an abortion
Injection	• Can be initiated on the same day immediately after an abortion
Ring, Patch, Pill	• Can be initiated on the same day immediately after an abortion

For more information and references

1. CDC Medical Eligibility Criteria www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm
2. PH Bednarek, et al. Immediate versus Delayed IUD Insertion after Uterine Aspiration. *N Engl J Med* 2011; 364:2208-17.
3. Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 121. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2011; 118:184–96.

Emergency Contraception: Hormonal Methods and Copper IUD

- Plan B, Plan B One-Step®, Next Choice® and ella™ are FDA-approved products taken by mouth and marketed exclusively for emergency contraception. They are more effective and have fewer side effects than CHCs previously used for EC.
- Plan B, Plan B One-Step® and Next Choice® contain levonorgestrel; ella™ contains ulipristal acetate, a progesterone agonist/antagonist.
- ella™ works equally well up to 120 hours (5 days) after unprotected sex. Levonorgestrel EC is *most* effective when taken as soon as possible within 72 hours after unprotected sex and remains moderately effective for up to 120 hours.
- Dosage
  - Two-dose regimen (Plan B, Next Choice®): Each dose contains 0.75 mg of levonorgestrel. First dose is taken as soon as possible after unprotected sex. The second dose can be taken together with the first dose or 12 hours later.
  - One-dose regimen (Plan B One-Step®, ella™): Plan B One-Step®, a single 1.5 mg tablet of levonorgestrel, or ella™, a single 30 mg tablet of ulipristal acetate, is each taken as soon as possible after unprotected sex within the timeframes indicated above.
- Levonorgestrel EC is available behind the counter to anyone 17 or older (male or female); patients younger than 17 need a prescription. ella™ is available by prescription only.
- EC costs $35-$60. Eligible patients can use Medicaid or their commercial prescription drug plan to help pay for EC if they have a prescription.
- Provide EC in advance. Give a pill-pack or an advance Rx with a list of pharmacies that stock it.
- The copper IUD can be used as a highly effective method of EC if placed within 120 hours of unprotected sex. It has the added advantage of functioning as long-term contraception.
- Levonorgestrel EC reduces the risk of pregnancy by 52-94%; ulipristal acetate reduces the risk by 62-85%, with greater effectiveness in the 72-120 hour window than levonorgestrel. The IUD reduces the risk of pregnancy by 99%.

Emergency Contraception Counseling

Data show that women are more likely to use EC if counseled by their provider about how to use it and/or given an advance Rx.

- EC is safe and is neither an abortifacient nor a teratogen.
- EC does *not* pose harm to a developing pregnancy; it is *not* effective if already pregnant.
- Pregnancy testing is *not* required before initiation. Perform a pregnancy test based on clinical judgment if prior menses was unusual, missed or not recalled.

- Expect menses within 3 weeks of EC use; if not, the patient should return to the office for a pregnancy test.
- Mild nausea, spotting and cramping occur rarely.
- EC does not change the risk of STIs from unprotected sex.
- Use Quick Start to initiate ongoing contraception on the same day. Offer the IUD as the most effective method of emergency contraception, plus a safe and effective option for ongoing contraception.

Sexual Assault Victims and Emergency Contraception

NYS Public Health Law and NYC Local Law 26 (2003) require that emergency departments offer EC to rape victims.

Information and Resources

Financial Support

Cost can be a barrier to dispensing contraception onsite. Providers may be eligible for discounts through the federal 340b contraception funding plan — see www.nycrx.org/providers for more information.

Minors' Rights to Confidential Reproductive Health Care

Both federal and New York State law gives adolescents 17 and younger the right to consent to certain health services without parental permission or knowledge.*

These services include:

- Contraception, including emergency contraception
- Pregnancy testing
- Abortion
- Testing for HIV
- Testing and treatment for STIs
- Prenatal care

For more information:
http://www.nyclu.org/rrp_minorsrights.html

* While no minimum age is specified, and each situation should be considered individually, a child younger than 12 would generally be considered NOT to have the capacity for informed consent.

New York State Public Health Law Sections 2305, 2504 and 2781; see also Alfonso v. Fernandez, 195 A.D.2d 46, 606 N.Y.S.2d 259, 264 (1993).

Continued on back cover.

New York City Health Department

For the Public

Call 311 for sexual and reproductive health information and referrals, including:

- Brochures and Health Bulletins (ask for Health Bulletin #90 How to Prevent Pregnancy and Sexually Transmitted Infections)
- Neighborhood health care providers
- Free or low-cost health insurance
- Emergency contraception (or call (888) 668-2528 or visit www.not-2-late.com)
- Abortion services
- Where to get free, confidential or anonymous HIV counseling and testing, and free testing and care for other sexually transmitted infections (or visit nyc.gov/std)

For Providers

Providers may call the Health Department Call Center at 1-866-692-3641 for sexual and reproductive health resources, or visit the Health Care Provider Information page: www.nyc.gov/html/doh/html/ms/ms-hcp.shtml

Other Resources

Medical Eligibility Criteria for Contraceptive Use

CDC: www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm

WHO: www.who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html

Managing Contraception
www.managingcontraception.com

Copper IUD (ParaGard®) Support
(877) 727-2427 or www.paragard.com

Hormonal IUD (Mirena) Support
(888) 842-2937 or www.mirena-us.com

Implant (Nexplanon®) Support
(877) 467-5266 or www.nexplanon-usa.com

NYC Health

HPD592135 - 5.12