**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** Emergency Contraception | **No.** |
| **Approved by:**  |  | **Effective Date:**  |
| **Revised Date:** January 2019, January 2021, **October 2022** |
| **References:** U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), 2016; U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR), 2016; Contraceptive Technology, 21st Ed |

**POLICY:** This Clinical Practice Standard follows the recommendations of the U.S. MEC, 2016; U.S. SPR, 2016 and Contraceptive Technology, 21st Ed

**PURPOSE:** This Clinical Practice Standard provides direction for reproductive health clinics to assist clients in the use of emergency contraception.

Emergency contraception (EC) consists of several different formulations which can be used by clients to prevent pregnancy after unprotected sexual intercourse, or a known or suspected contraceptive failure.

Emergency contraceptive pills (ECPs):

ECPs prevent pregnancy primarily by delaying or inhibiting ovulation and inhibiting fertilization. They do not cause abortion or harm an established pregnancy. ECPs may be provided for immediate use or provided in advance for future use.

There are three options for ECPs in the United States, including:

* **Levonorgestrel formulations** for immediate and future use–available in a 1.5 mg single dose tablet**.**
* **Ulipristal acetate (UPA)** for both immediate and future use–available in a 30-mg single dose tablet.
* Combined estrogen and progestin or the **Yuzpe formulation** (for immediate use) is available in a two-dose regimen. (Yuzpe regimen includes one dose of 100 µg of ethinyl estradiol plus 0.5 mg of levonorgestrel followed by a second dose of 100 µg of ethinyl estradiol plus 0.5 mg of levonorgestrel 12 hours later.) Clients can use the Yuzpe regimen when no other type of EC is immediately accessible.

Emergency Contraceptive IUDs:

IUDs are the most effective form of emergency contraception. They are not FDA-approved for use as EC at this time. IUDs act primarily to prevent fertilization. The copper IUD causes an inflammatory reaction within the intrauterine environment that is toxic to sperm and ova. This impairs sperm function and prevents fertilization. The hormonal IUD thickens cervical mucus, thins the lining of the uterus, inhibits sperm movement, and reduces sperm survival.

The IUDs that may be used for emergency contraception are:

* The **copper T380A IUD** (Paragard®) for immediate use
* The **52mg levonorgestrel IUD** (Mirena®, Liletta®) for immediate use.

**STANDARD:**

(**insert AGENCY name**) MDs, NPs, PAs, DOs, NDs, and RNs may provide ECPs for immediate or future use to any client who requests this method. There are no U.S. MEC category 3 or 4 risk conditions for any of the ECP formulations. MDs, NPs, PAs, DOs, and NDs trained in IUD insertion may provide IUDs as EC to any client who requests this method and has no U.S. MEC category 4 risk conditions.

**METHOD SELECTION:**

1. **IUD**: Intrauterine contraceptives are among the safest and most effective methods of contraception available today. The copper IUD is highly effective for up to 7 days from unprotected intercourse and data are available to support its use through 10 days from unprotected intercourse. Although most guidelines recommend placing a copper IUD for EC within 5 days of unprotected intercourse, evidence suggests that a copper IUD is highly effective if placed at any time in the menstrual cycle. There is strong evidence that the 52mg LNG IUD is just as effective as the copper IUD if placed within 5 days after unprotected intercourse. The 19.5mg and 13.5 mg LNG IUDs are NOT to be used for emergency contraception.

Effectiveness of the IUD is not affected by weight or body mass index (BMI).

See [*Intrauterine Contraception CPS*](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-IUC.docx) for further information. Use the [U.S. MEC](https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/appendixk.html) to determine if a client has any category 3 or 4 risk conditions for IUD use.

1. **Levonorgestrel EC**:Progestin-only ECPs (Plan B One Step® and its generic forms Take Action, Next Choice one dose and My Way) are available over-the-counter for clients of any age or gender. It is recommended that clients who can become pregnant take levonorgestrel EC as soon as possible but within 72 hours of unprotected intercourse (UPI). Levonorgestrel may be taken up to 120 hours after UPI; however, recent evidence suggests that it is ineffective if taken more than 96 hours after UPI. Clients weighing more than 154 pounds should be informed that the effectiveness of levonorgestrel may be decreased. According to the U.S. MEC, there are no category 3 or 4 risk conditions for the use of progestin-only EC given that the duration of use is less than that of regular use and would be expected to have less clinical impact. Recurrent EC use may indicate that the client would benefit from counseling about other contraceptive options. Recurrent use may be harmful for clients with U.S. MEC conditions classified as 2, 3, or 4 for progestin-only pills.
	* Contraindications (There are no U.S. MEC category 3 or 4 risks conditions):
2. Pregnancy: Use of levonorgestrel EC once a pregnancy has been established is not harmful to the pregnancy but simply provides no benefit.
3. **Ulipristal acetate (Ella**®**)**: Ulipristal acetate is a selective progesterone receptor modulator and is available by prescription only. UPAshould be administered as soon as possible and within 120 hours of UPI. Studies have shown no significant reduction in effectiveness with increasing time between UPI and taking UPA (up to 120 hours). Some limited data suggest UPA could be less effective for people with a BMI over 35. The CDC recommends that breastfeeding clients discard milk for 24 hours after taking UPA; however, this is no longer a requirement according to current FDA-approved labeling as the amount of UPA in breastmilk is low. Recent studies looking at repeated use of UPA within the same menstrual cycle showed no safety concerns, indicating UPA can safely be used more than once per cycle. Recurrent EC use may indicate that the client would benefit from counseling about other contraceptive options.
	* Contraindications (There are no U.S. MEC category 3 or 4 conditions):
4. Pregnancy: Use of UPA once a pregnancy has been established is not harmful to the pregnancy but simply provides no benefit.
	* Warnings and Precautions
5. Because UPA and the progestin component of hormonal contraceptives both bind to the progesterone receptor, using them together could reduce their contraceptive effect. If a client wishes to start or resume hormonal contraception, they should be advised to do so no sooner than 5 days after using UPA. For methods requiring a visit to a health care provider, such as DMPA, implants, and IUDs, starting the method at the time of UPA use may be considered; the risk that the regular contraceptive method might decrease the effectiveness of UPA must be weighed against the risk of not starting a regular hormonal contraceptive method.
6. Clients should use a reliable barrier method of contraception with subsequent acts of intercourse that occur within the next 7 days.
7. **Yuzpe – ECP containing ethinyl estradiol and levonorgestrel**: The Yuzpe method for EC has been in place since the mid 1970’s but has been rarely used since the advent of levonorgestrel and ulipristal formulations. The standard dosage consists of ethinyl estradiol, 100 μg, and levonorgestrel, 0.5 mg, to be taken within 72 hours of UPI and repeated 12 hours later. The Yuzpe method of EC has been shown to be about 75% effective and requires a prescription. See **Attachment 1** for a chart of commonly used combined oral contraceptive pill (COCP) EC dosages. **At this point, there are no documented studies that evaluate the impact of weight or BMI on the effectiveness of this method.**

According to the U.S. MEC, there are no category 3 or 4 risk conditions for the use of combined oral contraceptives as EC given that the duration of use is less than that of regular use and would be expected to have less clinical impact. Recurrent EC use may indicate that the client would benefit from counseling about other contraceptive options. options. Recurrent use may be harmful for clients with U.S. MEC conditions classified as 2, 3, or 4 for COCP.

* + Contraindications:
1. Pregnancy: Use of COCP once a pregnancy has been established is not harmful to the pregnancy but simply provides no benefit.

**PROCEDURE:**

1. Follow the [*Core Reproductive Health Services* *Clinical Practice Standard*.](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-Core_RH.docx)
2. Screen client for appropriateness to receive EC:
3. Last normal menstrual period;
4. Date and time of unprotected intercourse;
5. Current contraceptive method;
6. Ensure that client is not wanting to be pregnant;
7. Assess need for future-use EC;
8. Obtain weight/BMI in order to offer the most effective EC formulation.
9. Discuss EC options available for the individual client, incorporating information regarding possible effects of weight/BMI on efficacy of EC of formulation. No one should be denied or discouraged from using ECPs based on weight.

**PLAN:**

1. Administer/provide selected EC formulation (see below).
2. **IUDs:**
* Scheduling:
1. RN will schedule client with NP/PA/MD/DO/ND for insertion the same day if possible, and within 120 hours of unprotected intercourse.
* Insertion:
1. NP/PA/MD/DO will follow the [*Intrauterine Contraception CPS*](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-IUC.docx)for insertion of the device.
* Client education:
1. Follow the client education steps outlined in the [*Intrauterine Contraception CPS*.](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-IUC.docx)
2. **Levonorgestrel EC:**
* Administration:
1. Administer levonorgestrel EC tablet as soon as possible (ASAP) while the client is in the office; otherwise instruct the client to take the pill ASAP within 120 hours after UPI.
2. If a two-pill formulation of levonorgestrel is used, administer both pills together as a single dose.
3. Advise the client to eat or drink something, if possible, prior to administration to prevent nausea.
4. If vomiting occurs within one hour of taking the dose, the client should repeat the dose. May use over-the-counter anti-nausea drugs:
* Dramamine® 50 mg 1-2 tablets by mouth every 4-6 hours;
* Benadryl® 25 mg 1-2 tablets by mouth every 4-6 hours.
* Dispensing for future use: An advance supply of ECPs may be provided so that ECPs will be available when needed and can be taken as soon as possible after unprotected sexual intercourse.
1. **Ulipristal acetate (Ella)**
* Administration:
1. Administer Ella tablet ASAP while client is in the office; otherwise instruct the client to take the pill ASAP within 120 hours after UPI.
2. The prescription may be called into a local pharmacy for an established client.
3. Advise the client to eat or drink something, if possible, prior to administration to prevent nausea.
4. If vomiting occurs within one hour of taking the dose, the client should repeat the dose. May use over-the-counter anti-nausea drugs:
* Dramamine 50 mg, 1-2 tablets by mouth every 4-6 hours;
* Benadryl 25 mg, 1-2 tablets by mouth every 4-6 hours.
* Dispensing for future use: An advance supply of ECPs may be provided so that ECPs will be available when needed and can be taken as soon as possible after unprotected sexual intercourse.
1. **Yuzpe**
* Administration:
1. When administering EC to clients presenting to the clinic for care, other formulations are preferable to the yuzpe method, simply because they are better tolerated by the client. Therefore, most often the yuzpe method will be utilized by clients in need of EC who have no future-use EC at hand or are unable to obtain EC from a pharmacy, are unable to return to the clinic, and have combined oral contraceptive pills (COCP) on hand.
2. Determine the type of COCP on hand by referring to the yuzpe chart for the number and color of pills needed for each dose. (see **Attachment 1**)
3. Consult with the prescribing provider for written or verbal orders for EC dosage.
4. Advise the client to eat or drink something, if possible, prior to administration to prevent nausea.
5. May use over-the-counter anti-nausea drugs:
* Dramamine 50 mg 1-2 tabs by mouth every 4-6 hours;
* Benadryl 25 mg 1-2 tabs by mouth every 4-6 hours.

**CLIENT EDUCATION:**

1. Give client copy of EC information/fact sheet.
2. If ECPs were administered, instruct the client to abstain or to use a barrier or hormonal contraception until their next menses, as this EC formulation will not provide pregnancy protection for future acts of UPI.
3. Instruct the client to return to the clinic for a pregnancy test if no menses occurs within the next 3 weeks.
4. Discuss and facilitate plans for future contraception, if desired.
5. Advise the client to call the clinic with any questions or concerns regarding this method.
6. Inform the client that any signs or symptoms of complications should be reported to the clinic; if the clinic is not open, the client should call 911 or go to the emergency room.
7. Over-the-counter EC formulations may be made available to clients as a supply pick-up when the client previously received complete counseling and written information on the particular EC formulation. Refer to 340B Eligible Patient definition in the *Pharmacy – Dispensing Medications Clinical Practice Standard.*

**REFERENCES:**

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**ATTACHMENT 1: Emergency Contraceptive Dosages**

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| Brand | Manufacturer  | Pills per Dose  | Ethinyl Estradiol per Dose (mcg)  | Levonorgestrel per Dose (mg) |
| Dedicated emergency contraception (take one dose) |
| Plan B One Step | Teva  | 1 white pill  | 0  | 1.5  |
| Next Choice™ | Watson  | 2 peach pills  | 0  | 1.5  |
| Ella | Watson  | 1 white pill  | 0  | 0 |
| Combined progestin and estrogen pills (take two does 12 hours apart)  |
| Aviane®  | Teva  | 5 orange pills  | 100  | 0.50  |
| Cryselle®  | Teva  | 4 white pills  | 120  | 0.60  |
| Enpresse®  | Teva  | 4 orange pills  | 120  | 0.50  |
| Jolessa®  | Teva  | 4 pink pills  | 120  | 0.60  |
| Lessina® | Teva  | 5 pink pills  | 100  | 0.50  |
| Levora® | Watson  | 4 white pills  | 120  | 0.60  |
| Lo/Ovral® | Akrimax  | 4 white pills  | 120  | 0.60  |
| LoSeasonique® | Teva  | 5 orange pills  | 100  | 0.50  |
| Low-Ogestrel® | Watson  | 4 white pills  | 120  | 0.60  |
| Lutera® | Watson  | 5 white pills  | 100  | 0.50  |
| Lybrel® | Wyeth  | 6 yellow pills  | 120  | 0.54  |
| Nordette® | Teva  | 4 light-orange pills  | 120  | 0.60  |
| Ogestrel® | Watcon  | 2 white pills  | 100  | 0.50  |
| Portia® | Teva  | 4 pink pills  | 120  | 0.60  |
| Quasense® | Watson  | 4 white pills  | 120  | 0.60  |
| Seasonale® | Teva  | 4 pink pills  | 120  | 0.60  |
| Seasonique® | Teva  | 4 light-blue-green pills  | 120  | 0.60  |
| Sronyx®  | Watson  | 5 white pills  | 100  | 0.50  |
| Trivora® | Watson  | 4 pink pills  | 120  | 0.50  |