**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** Hormonal Contraceptive Patch | |  |
| **Approved by:** |  | **Effective Date:** |
| **Revised Date:** January 2018, 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, 20th Ed; ACOG, 2022 | | |

**POLICY:** This Clinical Practice Standard follows the recommendations of the U.S. MEC, 2016; U.S. SPR, 2016; ACOG; and Contraceptive Technology, 20th Ed.

**PURPOSE:** This Clinical Practice Standard provides direction for reproductive health clinics to assist clients in their use of the hormonal contraceptive patch.

The hormonal contraceptive patchis a weekly adhesive patch worn on the skin of the upper arm, torso, or buttocks. The hormonal contraceptive patch contains both estrogen and progestin and is designed to mimic the 28-day dosing schedule of the contraceptive pill, with 21 days of active hormone and 7 days without. The patch is changed weekly for three weeks, with no patch worn for the fourth week. The patch can also be used for an extended period with infrequent or no patch-free days by replacing patches weekly. Extended and continuous use have only been studied in the 0.75 mg ethinyl estradiol/6.0 mg norelgestromin patch (Xulane®), not in the newer 2.30 mg ethinyl estradiol/2.60 mg LNG patch (Twirla®).

In typical use, 9 out of 100 people who use the hormonal contraceptive patch become pregnant in the first year of use.

The hormonal contraceptive patch does not protect against sexually transmitted infections (STIs).

**STANDARD:**

1. (**insert AGENCY name**) MDs, NPs, PAs, DOs, and NDs may prescribe the hormonal contraceptive patch to any client who requests this method and has no U.S. MEC category 4 risk conditions.
2. (**insert AGENCY name**) RNs may dispense the hormonal contraceptive patch to any client who requests this method and has no U.S. MEC category 3 or 4 risk conditions. RNs may dispense the hormonal contraceptive patch to clients with U.S. MEC category 3 conditions only under a current written or verbal order from a prescribing provider.

**PROCEDURE:**

1. Follow [*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. Follow the [U.S. MEC](https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/appendixd.html) guidelines to determine client eligibility for use of the patch:
3. RNs may initiate the client’s contraceptive method of choice as long as the client has no U.S. MEC category 3 or 4 risk conditions for its use.
4. If client has any MEC category 3 conditions, an NP, PA, DO, ND or MD *may* prescribe the method according to their clinical judgement, if requested by the client. Documentation must show that the client understands the risks of the method and finds other, lower-risk methods unacceptable. RNs may not dispense the method unless under explicit verbal order after discussing the client's case with the prescribing provider.
5. Clients requesting a method for which they have a category 4 risk condition will be offered lower risk methods and referred to an OB/GYN or specialist provider.
6. Each client will receive client instructions regarding warning signs, common side effects, risks, use of method, alternative methods, use of secondary method, and clinic follow-up schedule. Document the client’s education and understanding of the method of choice.

**PLAN:**

* + - 1. Initiating the hormonal contraceptive patch:

The hormonal contraceptive patch can be initiated at any time if it is reasonably certain that the client is not pregnant.

* If started within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
* If the hormonal contraceptive patch is started > 5 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.
  + - 1. RNs may provide up to a 12-month supply of contraception under a standing order/protocol when initiating a method. RNs are allowed to dispense beyond the initial 12 months only if under a current prescription from the clinic’s prescribing provider.

1. When the initial start of the method occurs within a visit with a prescribing provider, the provider will write a prescription for up to 1-year supply and may dispense this amount depending on the client’s preference and anticipated use.
2. Evidence supports that an extended supply of contraception prevents breaks in use and unintended pregnancy. RNs and providers are encouraged to dispense a 12-month supply whenever possible.
   * + 1. Special Considerations:
3. Amenorrhea (not postpartum):

The hormonal contraceptive patch can be started at any time if it is reasonably certain the client is not pregnant.

The client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

1. Postpartum (breastfeeding):

The hormonal contraceptive patch can be started when the client is medically eligible to use the method and if it is reasonably certain that the client is not pregnant.

1. Postpartum clients who are breastfeeding should not use the hormonal contraceptive patch during the first 3 weeks after delivery (Category 4) because of concerns of increased risk for venous thromboembolism and generally should not use the hormonal contraceptive patch during the fourth week postpartum (Category 3) because of concerns about potential effects on breastfeeding.
2. Postpartum breastfeeding clients with other risk factors for venous thromboembolism generally should not use combined hormonal contraceptives 4-6 weeks after delivery (Category 3).

If the client is < 6 months postpartum, amenorrheic, and fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥ 85 %] of feeds are breastfeeds), no additional contraceptive protection is needed.

If the client is ≥ 21 days postpartum and their menstrual cycles have not returned, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

If the client’s menstrual cycle has returned and it has been > 5 days since the menstrual bleeding began, the client will need to abstain from intercourse or use additional contraceptive protection for the next 7 days.

1. Postpartum (not breastfeeding):

The hormonal contraceptive patch can be started when the client is medically eligible and if it is reasonably certain that the client is not pregnant.

1. Postpartum clients should not use the hormonal contraceptive patch during the first 3 weeks after delivery (Category 4) because of concerns of increased risk for venous thromboembolism.
2. Postpartum clients with other risk factors for venous thromboembolism generally should not use the hormonal contraceptive patch 3-6 weeks after delivery (Category 3).

A client who is < 21 days postpartum no additional contraceptive protection is needed.

A client who is ≥ 21 days postpartum and whose menstrual cycles have not returned needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

If a client’s menstrual cycle has returned and it has been > 5 days since it has started, the client will need to abstain from sexual intercourse or use additional contraceptive protection for next 7 days.

1. Post abortion (spontaneous or induced):

The hormonal contraceptive patch can be started within the first 7 days after a first or second trimester abortion, including immediately post abortion (Category 1).

The client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days unless the hormonal contraceptive patch is started at the time of the surgical abortion.

* + - 1. Switching from another contraceptive method:
         1. The hormonal contraceptive patch can be started immediately if it is reasonably certain that the client is not pregnant. Waiting for the next menstrual period is not necessary.

If it has been > 5 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

* + - * 1. Switching from an IUD:

If the client has had sexual intercourse since the start of their current menstrual cycle and it has been > 5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract. A health care provider may consider any of the following options:

1. Advise the client to retain the IUD for at least 7 days after combined hormonal contraceptives are initiated and return for IUD removal;
2. Advise the client to abstain from sexual intercourse or use a barrier contraceptive for 7 days before removing the IUD and switching to the new method, or ;
3. Advise the client to use ECPs at the time of IUD removal. If UPA is used, the Patch should be started no sooner than 5 days later.
   * + - 1. If uncertain whether the client might be pregnant, the benefits of starting a combined hormonal patch likely exceed any risk; therefore, starting the hormonal contraceptive patch should be considered at any time, with a follow-up pregnancy test in 2-4 weeks.

**ROUTINE FOLLOW-UP:**

1. The recommendations listed below address when routine follow-up is recommended for safe and effective continued use of contraception for healthy clients. Although routine follow-up is not necessary for the use of the hormonal contraceptive patch, recommendations might vary for different users and different situations. Specific populations such as adolescents, those with certain medical conditions or characteristics, and those with multiple conditions may benefit from more frequent follow-up visits.
2. Advise the client to return at any time to discuss side effects or other problems, or to change the method being used.
3. At other routine visits, healthcare providers should do the following:

Assess the client’s satisfaction with the contraceptive method and whether the client has any concerns about method use;

Assess any changes in health status that would change the appropriateness of the hormonal contraceptive patch safe and effective use based on U.S. MEC;

Assess blood pressure;

Consider assessing weight changes and counsel clients who are concerned with any weight changes perceived to be due to the contraceptive method; and

Provide up to the maximum number of refills of the contraceptive method under a current prescription from (**insert AGENCY name**)’s prescribing provider.

Late or Missed Doses:

See **Attachment 1** below for client instructions on delayed application or detachment of the patch.

**STOPPING THE HORMONAL PATCH:**

1. The hormonal contraceptive patch may be stopped at any time.
2. Fertility will return rapidly.
3. If the client does not want to be pregnant, advise the client to begin a new contraceptive method immediately.
4. If the client desires pregnancy:
5. Provide the client preconception counseling; and
6. Advise the client to begin taking a daily prenatal vitamin with 0.4 to 0.8 milligrams of folic acid at least 30 days before trying to become pregnant.

**CLIENT EDUCATION:**

1. Provide the client with an instructions sheet on where to place patch, how to apply patch, and when to check the patch.
2. Advise the client that the hormonal contraceptive patch may change their periods; the client may have spotting or irregular bleeding for the first few months.
3. Counsel clients over 198 pounds that the effectiveness of the hormonal patch may be decreased.
4. Advise the client to call the clinic with any questions or concerns regarding the contraceptive method.
5. 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.
6. Advise client of warning signs of ACHES (client should be informed to seek immediate care if any warning signs are noted):
7. Abdominal pain;
8. Chest pain;
9. Headaches;
10. Eye problems; or
11. Severe leg pain.

**REFERENCES:**

Centers for Disease Control and Prevention. 2016. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf>

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Nanda, K. 2011. Contraceptive Patch and Vaginal Contraceptive Ring. In Deborah Kowal (Ed) *Contraceptive Technology*, 20th Ed. Pg. 343-355. Ardent Media: Atlanta, GA

ACOG, 2022. General Approaches to Medical Management of Menstrual Suppression. Clinical Consensus No. 3, September 2022. <https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2022/09/general-approaches-to-medical-management-of-menstrual-suppression>

**ATTACHMENT 1: Recommended Actions after Delayed Application or Detachment with Hormonal Contraceptive Patch**

Delayed application or detachment for ≥48 hours since a patch should have been applied or reattached

Delayed application or detachment for <48 hours since a patch should have been applied or reattached

* Apply a new patch as soon as possible. (if detachment occurred <24 hours since the patch was applied, try to reapply the patch or replace with a new patch.)
* Keep the same patch change day.
* No additional contraceptive protection is needed.
* Emergency contraception is not usually needed but can be considered (with the exception of Ella®) if delayed application or detachment occurred earlier in the cycle or in the last week of the previous cycle.
* Apply a new patch as soon as possible.
* Keep the same patch change day.
* Use back-up contraception (e.g., condoms) or avoid sexual intercourse until a patch has been worn for consecutive days.
* If the delayed application or detachment occurred in the third patch week:
* Omit the hormone-free week by finishing the third week of patch use (keeping the same patch change day) and start a new patch immediately;
* If unable to start a new patch immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until a new patch has been worn for 7 consecutive days.
* Emergency contraception should be considered (with the exception of Ella®) if the delayed application or detachment occurred within the first week of patch use and unprotected sexual intercourse occurred in the previous 5 days.
* Emergency contraception may also be considered (with the exception of Ella®) at other times as appropriate.