PREVENTIVE CARE

CONTRACEPTION – Oral, Transdermal Patch, Vaginal Ring and Injectable

STATEWIDE DRUG THERAPY MANAGEMENT PROTOCOL for the OREGON PHARMACIST

AUTHORITY and PURPOSE:

- Per ORS 689.689, a pharmacist may prescribe and administer injectable hormonal contraceptives and prescribe and dispense self-administered hormonal contraceptives.
- Per ORS 689.645, a pharmacist may provide patient care services pursuant to a statewide drug therapy management protocol.

- Following all elements outlined in OAR 855-115-0330, a pharmacist licensed and located in Oregon may prescribe oral, vaginal ring, transdermal patch or injectable hormonal contraceptives for the prevention of pregnancy.

STANDARDIZED PATIENT ASSESSMENT PROCESS ELEMENTS:

- Utilize the standardized Contraception Patient Intake Form (pg. 2-3)
- Utilize the standardized Contraception Assessment and Treatment Care Pathway Form (pg. 4-8)
- Utilize the standardized Contraception Prescription Template *optional* (pg. 9)
- Utilize the standardized Contraception Provider Notification Form (pg. 10)
- Utilize the standardized Contraception Patient Visit Summary Form (pg. 11)

PHARMACIST TRAINING/EDUCATION:

- Completed a Board-approved and Accreditation Council for Pharmacy Education (ACPE) accredited educational training program related to the prescribing of contraceptives by a pharmacist.

REFERENCES:

- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2024). US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2024. Retrieved from https://www.cdc.gov/mmwr/volumes/73/rr/pdfs/rr7304a1-H.pdf
- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2024). Summary Chart of US Medical Eligibility Criteria for Contraceptive Use (US MEC), 2024. Retrieved from https://www.cdc.gov/contraception/media/pdfs/2024/07/us-mec-summary-chart-color-508.pdf
- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2024). US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2024. Retrieved from https://www.cdc.gov/mmwr/volumes/73/rr/pdfs/rr7303a1-H.pdf

RESOURCES:

- CDC US MEC & US SPR Application - Available for Apple™ and Android™ devices.
- National Family Planning and Reproductive Health Association. (2020). Self-Administration of Injectable Contraception Retrieved from https://www.nationalfamilyplanning.org/file/documents---service-delivery-tools/NFPRHA---Depo-SQ-Resource-guide---FINAL-FOR-DISTRIBUTION.pdf

Contraception Self-Screening Patient Intake Form

(CONFIDENTIAL-Protected Health Information)

Date _____/_____/_____ Date of Birth _____/_____/_____ Age_____
Legal Name_____ Name _____
Sex Assigned at Birth (circle) M / F Gender Identification (circle) M / F / Other____
Pronouns (circle) She/Her/Hers, He/Him/His, They/Them/Their, Ze/Hir/Hirs, Other_____
Street Address _____
Phone ( ) _____ Email Address _____
Healthcare Provider Name _____ Phone ( ) _____ Fax ( ) _____
Do you have health insurance? Yes / No Insurance Provider Name _____
Any allergies to medications? Yes / No If yes, please list _____
Any allergies to foods (ex. soy, lactose)? Yes / No If yes, please list _____

Background Information:

1.	Have you previously had a contraceptive prescribed to you by a pharmacist? If yes, when was the last time a pharmacist prescribed a contraceptive to you?	□ Yes □ No ___/___/___
2.	What was the date of your last reproductive or sexual health clinical visit with a non-pharmacist?	___/___/___

Contraception History:

3.	Have you ever been told by a healthcare professional not to take hormones? -If yes, what was the reason? _____	□ Yes □ No
4.	Have you ever taken birth control pills, or used a birth control patch, ring, or shot/injection?	□ Yes □ No
5.	Did you ever experience a bad reaction to using hormonal birth control? - If yes, what kind of reaction occurred? _____	□ Yes □ No
6.	Are you currently using any method of birth control including pills, patch, ring or shot/injection? - If yes, which one do you use? _____	□ Yes □ No
7.	Do you have a preferred method of birth control that you would like to use? - If yes, please check one: □ Oral pill □ Skin patch □ Vaginal ring □ Injection □ Other (IUD, implant)	□ Yes □ No

Pregnancy Screen:

8.	Did you have a baby less than 6 months ago, are you fully or nearly-fully breast feeding, AND have you had no menstrual period since the delivery?	□ Yes □ No
9.	Have you had a baby in the last 4 weeks?	□ Yes □ No
10.	Did you have a miscarriage or abortion in the last 7 days?	□ Yes □ No
11.	Did your last menstrual period start within the past 7 days?	□ Yes □ No
12.	Have you abstained from sexual intercourse since your last menstrual period or delivery?	□ Yes □ No
13.	Have you been using a reliable contraceptive method consistently and correctly?	□ Yes □ No

Medical Health & History:

14.	What was the first day of your last menstrual period?	___/___/___
15.	Have you had a recent change in vaginal bleeding that worries you?	□ Yes □ No
16.	Have you given birth within the past 21 days? If yes, how long ago? _____	□ Yes □ No
17.	Are you currently breastfeeding?	□ Yes □ No
18.	Do you smoke cigarettes?	□ Yes □ No
19.	Do you have diabetes?	□ Yes □ No
20.	Do you have chronic kidney disease?	□ Yes □ No
21.	Do you get migraine headaches? If yes, have you ever had the kind of headaches that start with warning signs or symptoms, such as flashes of light, blind spots, or tingling in your hand or face that comes and goes completely away before the headache starts?	□ Yes □ No □ Yes □ No □ N/A
22.	Are you being treated for inflammatory bowel disease?	□ Yes □ No
23	Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)	□ Yes □ No

Contraception Self-Screening Patient Intake Form

(CONFIDENTIAL-Protected Health Information)

24.	Have you ever had a heart attack or stroke, or been told you had any heart disease?	□ Yes □ No
25.	Have you ever had a blood clot?	□ Yes □ No
26.	Have you ever been told by a healthcare professional that you are at risk of developing a blood clot?	□ Yes □ No
27.	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	□ Yes □ No
28.	Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)	□ Yes □ No
29.	Have you had bariatric surgery or stomach reduction surgery?	□ Yes □ No
30.	Do you have or have you ever had breast cancer?	□ Yes □ No
31.	Have you had an organ transplant?	□ Yes □ No
32.	Do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, or do you have jaundice (yellow skin or eyes)?	□ Yes □ No
33.	Do you have lupus, rheumatoid arthritis, or sickle cell disease.	□ Yes □ No
34.	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? - If yes, list them here: _____	□ Yes □ No
35.	Do you have any other medical problems or take any medications, including herbs or supplements? - If yes, list them here: _____ _____ _____	□ Yes □ No

Patient Signature_____Date_____

To Be Completed by a Pharmacist:

1. Blood Pressure Reading _____/_____ mmHg

2a. If contraception was <u>prescribed/dispensed</u>, please complete the following:

Drug: _____

Directions: _____

Quantity: _____

Refills:_____

Healthcare Provider (if known) contacted/notified of therapy Date _____/_____/_____

2b. If contraception was <u>administered</u>, please complete the following:

Drug: _____

Directions: _____

Quantity: _____

Product/Lot: _____ Expiration: ___/___/_____

Injection Sites:

□ Depot Medroxyprogesterone Acetate (DMPA) - **IM** in □ R deltoid or □ L deltoid

□ Depot Medroxyprogesterone Acetate (DMPA) - **SQ** in □ R anterior thigh or □ L anterior thigh or □ abdomen

Administration Time: ____:_____ AM/PM

3. Healthcare Provider (if known) contacted/notified of therapy Date _____/_____/_____

If contraception was not prescribed/dispensed/administered, please indicate reason(s) for referral:

_____

_____

_____

RPH Signature_____Date_____

Standardized Assessment and Treatment Care Pathway - Contraception

Algorithm A: Oral, Vaginal and Transdermal Contraception with Combined Hormonal Contraceptives (CHC) and Progestin Only Pills (POP). RPH must utilize Summary US MEC (v. 2024) & Full US MEC (v. 2024) to make determinations below. In Full US MEC, Appendix D contains classifications for CHCs and Appendix C contains classifications for POPs.

1) Background Information –Each patient must complete a new Patient Intake Form a minimum of every twelve months. Review Patient Intake Form Questions #1-2 and use the answers to determine:

Exclusion Criteria:

-Previously prescribed contraception by RPh **-and-**
-Has not had a clinical visit with a healthcare provider, other than a pharmacist, for reproductive or sexual health within the 3 years immediately following the initial contraceptive prescription by RPh.

Does NOT meet Exclusion Criteria

Meets Exclusion Criteria → Refer

2) Pregnancy Screen- Review Patient Intake Form #8-13

- If YES to AT LEAST ONE question and is free of pregnancy symptoms

- If NO to ALL of these questions, pregnancy can NOT be ruled out

Patient is not pregnant

Patient is possibly pregnant → Refer

3) Medical and Medication History - Review Patient Intake Form #15-35 (and med list in pharmacy record). Evaluate medical health & history utilizing the US MEC. Evaluate medications utilizing the US MEC and any current references for drug-drug interactions with contraceptives.

- If ALL boxes are labeled 1 or 2 (green) on the US MEC for the type of contraception that RPH plans to prescribe

-If ANY boxes are labeled 3 or 4 (pink/red) on the US MEC or a significant drug-drug or drug-disease interaction exists for the type of contraception that RPH plans to prescribe

No Contraindicated Condition(s) or Medication(s)

Any Contraindicated Condition(s) or Medication(s) → Refer

4) Blood Pressure Screen:
Assess the patient's self-reported blood pressure or document the pharmacist's measurement of the patient's current blood pressure. Note: RPH may choose to take a second reading if initial report or measurement is **≥** 140/90 mmHg

CHC + BP < 140/90 mmHg **-or-** POP + Any BP

CHC + BP **≥** 140/90 mmHg → Refer or consider POP or DMPA

5) Evaluate patient contraception history, preference, and current therapy for selection of treatment

Not currently on birth control

Currently on birth control

6a) Choose Contraception

- ***Initiate*** contraception based on patient preferences, adherence, and history for new therapy

6b) Choose Contraception

- ***Continue*** current form of pills, ring or patch, if no change is necessary **-or-**
- ***Alter*** therapy based on patient concerns, such as side effects patient may be experiencing; or refer, if appropriate

- ***Prescribe and dispense*** up to 12 months of desired contraception product. This must be done as soon as practicable after the pharmacist issues the prescription and must include any relevant educational materials.
  ORS 743A.066 requires prescription drug benefit programs to reimburse for 3 months for the first dispensing and 12 months for subsequent dispensing of the same contraceptive.

7) Provide Counseling

- Address any unexplained vaginal bleeding that worries patient (Patient Intake Form #15) – Refer for further evaluation
- Address any high blood pressure - Refer for further evaluation
- Discuss the management and expectations of side effects (bleeding irregularities, etc.)
- Discuss initiation strategy for initial treatment/change in treatment (as applicable).
  - For quick start - instruct patient they can begin contraceptive today; use backup method for 7 days unless patient is within 5 days of last menstrual period (Patient Intake Form #14)
- Discuss adherence and opportunities for follow-up visits
- Encourage routine health screenings and STI prevention

8) Discuss and provide visit summary to patient and advise the patient to consult with a primary care practitioner or women's health care practitioner per ORS 689.689(2)(b)(D).

Standardized Assessment and Treatment Care Pathway - Contraception

Algorithm B: Injectable Contraception- Depot Medroxyprogesterone Acetate (DMPA). RPh must utilize Summary US MEC (v. 2024) & Full US MEC (v. 2024) to make determinations below. In Full US MEC, Appendix C contains classifications for DMPA.

1) Background Information – Review Patient Intake Form (Questionnaire) #1-2. Each patient must complete a new Patient Intake Form a minimum of every twelve months.

Exclusion Criteria:

-Previously prescribed contraception by RPh **-and-**

-Has not had a clinical visit with a healthcare provider, other than a pharmacist, for reproductive or sexual health within the 3 years immediately following the initial contraceptive prescription by RPh.

Does NOT meet Exclusion Criteria

Meets Exclusion Criteria → Refer

2) Pregnancy Screen- Review questionnaire #8-13

- If YES to AT LEAST ONE and is free of pregnancy symptoms

- If NO to ALL of these questions, pregnancy can NOT be ruled out → Refer

Patient is not pregnant

Patient is possibly pregnant → Refer

3) Medical and Medication History - Review Patient Intake Form #15-35 (and med list in pharmacy record). Evaluate medical health & history utilizing the US MEC. ***Any unexplained vaginal bleeding that worries patient (Patient Intake Form #15) – requires a referral*.** Evaluate medications utilizing the US MEC and any current references for drug-drug interactions with contraceptives.

- If ALL boxes are labeled 1 or 2 (green) on the US MEC for the type of contraception that RPh plans to prescribe and administer (e.g., DMPA).

-If ANY boxes are labeled 3 or 4 (pink/red) on the US MEC or a significant drug-drug or drug-disease interaction exists for the type of contraception that RPh plans to prescribe (e.g., DMPA).

No Contraindicated Condition(s) or Medication(s)

Any Contraindicated Condition(s) or Medication(s) → Refer

4) Blood Pressure Screen: Assess the patient's self-reported blood pressure or document the pharmacist's measurement of the patient's current blood pressure. Note: RPh may choose to take a second reading if initial report or measurement is ≥ 160/100 mmHg.

BP < 160/100 mmHg

BP ≥ 160/100 mmHg → Refer or consider POP

5) Discuss DMPA therapy and provide counseling

- Discuss the management and expectations of side effects (bleeding irregularities, etc.)
- Discuss plans for follow-up injections of DMPA that should happen every 3-months.
  - If getting IM: stress importance of returning for next injection within 11-13 weeks of previous injection.
  - Provide patient with specific calendar date range for next injection.
- Caution with use of DMPA > 2 years (due to loss of bone mineral density). For therapy > 2 years, consultation with healthcare provider is advised.
- Encourage routine health screenings and STI prevention.

Initial dose of DMPA IM or SQ

Follow-up (every) 3-month dose of DMPA IM or SQ

6a) *Prescribe* and *administer (IM or SQ) DMPA or dispense (SQ)* DMPA to the patient.

- Instruct patient that if this injection is not within 7 days of start of their period, then abstain or use backup method for 7 days.
- If *administering* DMPA IM or SQ, observe, monitor, report, and otherwise take appropriate action regarding desired effect, side effect, interaction, and contraindication associated with administering the drug or device. **-or-**
- If *dispensing* DMPA SQ for self-administration, the first self-administration must be observed by RPh or by an appropriately trained and authorized HCP after providing the patient with educational materials that include step-by-step instructions for self-injection, as

6b) *Continue* current form of contraception, DMPA, if no change is necessary.

- Confirm that date of last injection or dispensing was within 11-15 weeks.
  - If > 15 weeks ago, then pharmacist must rule out pregnancy (repeat Step 2, and document), and instruct patient to abstain or use backup method for 7 days.
  - If between 11-15 weeks ago, administer or dispense the medication.
  - Do not administer or dispense if < 11 weeks ago.

-or-

***Alter* therapy based on patient concerns (see Algorithm A), such as side effects patient may be experiencing; or refer, if appropriate.**

well as guidance on the proper disposal of needles.
The patient may complete subsequent self-administration doses at home after the initial observation. **SEE NEXT PAGE ->**

SEE NEXT PAGE ->

Prescribe and administer a 3 month dose ***and/or dispense*** up to 12 months of desired contraception product. This must be done as soon as practicable after the pharmacist issues the prescription and must include any relevant educational materials.

ORS 743A.066 requires prescription drug benefit programs to reimburse for 3 months for the first dispensing and 12 months for subsequent dispensing of the same contraceptive.

7) *Discuss* and *provide* visit summary to patient and *refer* the patient to the patient's primary care practitioner or women's health care practitioner per ORS 689.689(2)(b)(C).

Standardized Assessment and Treatment Care Pathway - Contraception

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

This summary sheet only contains a subset of the recommendations from the USMEC. It is color coded in the left column to match the corresponding questions of the Contraception Patient Intake Form
For complete guidance, see: Summary US MEC (v. 2024) & Full US MEC (v. 2024)
Note: Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of male and female latex condoms reduces the risk of STDs and HIV.

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)	

Corresponding to the Contraception Patient Intake Form:

Condition	Sub-condition	Combined pill, patch or ring (CHC)		Progestin-Only Pill (POP)		DMPA (Inj)		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	Initiating	Continuing	
Age		Menarche to <40=1		Menarche to <18=1		Menarche to <18=2		Yes
		≥40=2		18-45=1		18-45=1		Yes
				>45=1		>45=2		Yes
Smoking	a) Age < 35	2		1		1		Yes
	b) Age ≥ 35, < 15 cigarettes/day	3		1		1		Yes
	c) Age ≥ 35, ≥15 cigarettes/day	4		1		1		Yes
Pregnancy	(Not Eligible for contraception)	NA*		NA*		NA		NA*
Vaginal Bleeding	Unexplained or worrisome vaginal bleeding	2		2		3		Yes
Postpartum/ Non-breastfeeding (see also Breastfeeding)	a) < 21 days	4		1		2		Yes
	b) 21 days to 42 days:							
	(i) with other risk factors for VTE	3*		1		2		Yes
	(ii) without other risk factors for VTE	2		1		1		Yes
	c) > 42 days	1		1		1		Yes
Breastfeeding (see also Postpartum)	a) < 21 days postpartum	4*		2*		2*		Yes
	b) 21 to 30 days postpartum							
	(i) with other risk factors for VTE	3*		2*		2*		Yes
	(ii) without other risk factors for VTE	3*		2*		2*		Yes
	c) 30 to 42 days postpartum							
	(i) with other risk factors for VTE	3*		1*		2*		Yes
	(ii) without other risk factors for VTE	2*		1*		1*		Yes
	c)> 42 days postpartum	2*		1*		1*		Yes
Diabetes mellitus (DM)	a) History of gestational DM only	1		1		1		Yes
	b) Non-vascular disease							
	(i) non-insulin dependent	2		2		2		Yes
	(ii) insulin dependent‡	2		2		2		Yes
	c) Nephropathy/ retinopathy/ neuropathy‡	3/4*		2		3		Yes
	d) Other vascular disease or diabetes of >20 years' duration‡	3/4*		2		3		Yes
Chronic Kidney disease‡	a) Current nephrotic syndrome	4		2/4*		3		Yes
	b) Hemodialysis	4		2/4*		3		Yes
	c) Peritoneal dialysis	4		2/4*		3		Yes
Headaches	a) Non-migraine	1*		1		1		Yes
	b) Migraine:							
	i) without aura (includes menstrual migraines)	2*		1		1		Yes
	iii) with aura	4*		1		1		Yes
Inflammatory Bowel Disease	a) Mild; no risk factors	2		2		2		Yes
	b) IBD with increased risk for VTE	3						
Hypertension	a) Adequately controlled hypertension	3*		1*		2*		Yes
	b) Elevated blood pressure levels (properly taken measurements):							
	(i) systolic 140-159 or diastolic 90-99	3*		1*		2*		Yes
	(ii) systolic ≥160 or diastolic ≥100‡	4*		2*		3*		Yes
	c) Vascular disease	4*		2*		3*		Yes
History of high blood pressure during pregnancy		2		1		1		Yes
Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function:							
	(i) < 6 months	4		1		2		Yes
	(ii) ≥ 6 months	3		1		2		Yes
	b) Moderately or severely impaired cardiac function	4		2		3		Yes
Multiple risk factors for ASCVD	(e.g. older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	3/4*		2*		3*		Yes
Ischemic heart disease‡	Current and history of	4		2	3	3		Yes
Valvular heart disease	a) Uncomplicated	2		1		1		Yes
	b) Complicated‡	4		1		2		Yes
Stroke‡	History of cerebrovascular accident	4		2	3	3		Yes
Thrombophilia‡		4*		2*		3*		Yes

I = initiation of contraceptive method; C = continuation of contraceptive method; NA = Not applicable
* Please see the complete guidance for a clarification to this classification: Full US MEC (v. 2024)
‡ Condition that exposes a woman to increased risk as a result of unintended pregnancy.

CONTINUES NEXT PAGE →

Standardized Assessment and Treatment Care Pathway - Contraception

Condition	Sub-condition	Combined pill, patch or ring (CHC)		Progestin-Only Pill (POP)		DMPA (Inj)		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	Initiating	Continuing	
Deep venous thrombosis (DVT) & Pulmonary embolism (PE)	a) Current or history of DVT/PE, receiving anticoagulant therapy (*therapeutic dose)*	3*		2*		2*		Yes
	b) History of DVT/PE, receiving anticoagulant therapy (*prophylactic dose)*							
	i) higher risk for recurrent DVT/PE	4*		2*		3*		Yes
	ii) lower risk for recurrent DVT/PE	3*		2*		2*		Yes
	c) History of DVT/PE, not on anticoag therapy							
	i) higher risk for recurrent DVT/PE	4		2		3		Yes
	ii) lower risk for recurrent DVT/PE	3		2		2		Yes
	d) Family history (first-degree relatives)	2		1		1		Yes
Surgery	a) Minor surgery without immobilization	1		1		1		Yes
	b) Major surgery							
	(i) without prolonged immobilization	2		1		1		Yes
	(ii) with prolonged immobilization	4		1		2		Yes
Superficial venous disorders	a) Varicose veins	1		1		1		Yes
	b) Superficial venous thrombosis (acute or history)	3*		1		2		Yes
Multiple Sclerosis	a) With prolonged immobility	3		1		2		Yes
	b)Without prolonged immobility	1		1		2		Yes
History of bariatric surgery‡	a) Restrictive procedures	1		1		1		Yes
	b) Malabsorptive procedures	COCs: 3	P/R: 1	3		1		Yes
Breast Disease & Breast Cancer	a) Undiagnosed mass	2*		2*		2*		Yes
	b) Benign breast disease	1		1		1		Yes
	c) Family history of cancer	1		1		1		Yes
	d) Breast cancer:‡							
	i) current	4		4		4		Yes
	ii) past/no evidence current disease x 5yr	3		3		3		Yes
Solid Organ Transplant‡	a) No graft failure	2*		2		2/3*		Yes
	b) Graft failure	4		2		2/3*		Yes
Viral hepatitis	a) Acute or flare	3/4*	2 C	1		1		Yes
	b) Carrier/Chronic	1	1	1		1		Yes
Cirrhosis	a) Compensated (*normal liver function)*	1		1		1		Yes
	b) Decompensated‡ (*impaired liver function*)	4		2		3		Yes
Liver tumors	a) Benign:							
	i) Focal nodular hyperplasia	2		2		2		Yes
	ii) Hepatocellular adenoma‡	4		2		3		Yes
	b) Malignant‡ (hepatoma)	4		3		3		Yes
Gallbladder disease	a) Symptomatic:							
	(i) treated by cholecystectomy	2		2		2		Yes
	(ii) medically treated	3		2		2		Yes
	(iii) current	3		2		2		Yes
	b) Asymptomatic	2		2		2		Yes
History of Cholestasis	a) Pregnancy-related	2		1		1		Yes
	b) Past COC-related	3		2		2		Yes
Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	4*		2*		3*	3*	Yes
	b) Severe thrombocytopenia	2*		2*		3*	2*	Yes
	c) Immunosuppressive treatment	2*		2*		2*	2*	Yes
	d) None of the above	2*		2*		2*	2*	Yes
Rheumatoid arthritis	a) On immunosuppressive therapy	2		1		2*		Yes
	(i) Long-term corticosteroid therapy					3		Yes
	b) Not on immunosuppressive therapy	2		1		2		Yes
Sickle Cell Disease‡		4		1		2/3*		Yes
Epilepsy‡	(see also Drug Interactions)	1*		1*		1*		Yes
Tuberculosis‡ (see also Drug Interactions)	a) Non-pelvic	1*		1*		1*		Yes
	b) Pelvic	1*		1*		1*		Yes
HIV (see also Drug Interactions)	a) High risk for HIV	1		1		1*		Yes
	b) HIV infection	1*		1*		1*		Yes
	(i) On ARV therapy	If on treatment, see Drug Interactions						Yes
Antiretroviral therapy (All other ARVs are a 1 or 2)	a) Fosamprenavir (FPV)	3		2		2		Yes
	(i) Fosamprenavir + Ritonavir (FPV/r)	2		2		1		Yes
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3*		3*		1*		Yes
	b) Lamotrigine	3*		1		1		Yes
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		1		Yes
	b) Antifungals	1		1		1		Yes
	c) Antiparasitics	1		1		1		Yes
	d) Rifampin or rifabutin therapy	3*		3*		1*		Yes
Supplements	a) St. John's Wort	2		2		1		Yes

I = initiation of contraceptive method; C = continuation of contraceptive method; NA = Not applicable

* Please see the complete guidance for a clarification to this classification: Full US MEC (v. 2024)

‡ Condition that exposes a woman to increased risk as a result of unintended pregnancy.

Contraception Prescription

Optional-May be used by pharmacy if desired

Patient Name:	Date of birth:
Address:	
City/State/Zip Code:	Phone number:

Rx

☐ **Drug:** _____

- Directions: _____
- Quantity: _____
- Refills:_____

Written Date: _____

Prescriber Name:_____Prescriber Signature: _____

Pharmacy Address:_____Pharmacy Phone: _____

Provider Notification
Contraception

Pharmacy Name:_____ Pharmacist Name: _____
Pharmacy Address:_____
Pharmacy Phone:_____ Pharmacy Fax: _____

Dear Provider_____ (name), (____) _____ -_____ (FAX)

Your patient _____(name) _____/_____/_____ (DOB) was:

☐ **Prescribed and dispensed** contraception at our Pharmacy on ____/_____/_____ noted above. The prescription issued and dispensed consisted of:

- Drug: _____
  - Directions: _____
  - Quantity: _____
  - Refills:_____

☐ **Prescribed and administered** contraception at our Pharmacy on ____/_____/_____ noted above. The prescription issued and administered consisted of:

- Drug: _____
  - Directions: _____
  - Quantity: _____
  - Refills:_____

☐ **NOT prescribed, dispensed or administered** contraception at our Pharmacy noted above, because:

□ Pregnancy cannot be ruled out.

Notes: _____

□ The patient indicated they have a health condition that requires further evaluation.

Notes: _____

□ The patient indicated they take medication(s) or supplements that may interfere with contraception.

Notes: _____

□ Their blood pressure reading was _____/_____ :

□ ≥140/90 mmHg and I am unable to prescribe any combined hormonal contraceptive (estrogen + progesterone) pill, patch, or ring

□ ≥160/100 mmHg and I am unable to prescribe any injectable (progesterone only)

□ The patient did not have a clinical visit with a healthcare provider, other than a pharmacist, for reproductive or sexual health in past 3 years.

The prescription was issued pursuant to the Board of Pharmacy protocol authorized under OAR 855-115-0330.

- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2024). US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2024. Retrieved from https://www.cdc.gov/mmwr/volumes/73/rr/pdfs/rr7304a1-H.pdf
- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2024). Summary Chart of US Medical Eligibility Criteria for Contraceptive Use (US MEC), 2024. Retrieved from https://www.cdc.gov/contraception/media/pdfs/2024/07/us-mec-summary-chart-color-508.pdf
- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2024). US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2024. Retrieved from https://www.cdc.gov/mmwr/volumes/73/rr/pdfs/rr7303a1-H.pdf

Pharmacist Referral and Visit Summary

CONTRACEPTION – Oral, Transdermal Patch, Vaginal Ring or Injectable

Pharmacy Name:_____ Pharmacist Name:_____

Pharmacy Address:_____

Pharmacy Phone: _____ Pharmacy Fax: _____

☐ Today you were prescribed (and ☐ administered) the following hormonal contraception:

_____

Notes: _____

If you have a question, my name is _____.

Please review this information with your healthcare provider.

-- or --

☐ I am not able to prescribe hormonal contraception to you today, because:

□ Pregnancy cannot be ruled out.

Notes: _____

□ You have a health condition that requires further evaluation.

Notes: _____

□ You take medication(s) or supplements that may interfere with contraception.

Notes: _____

□ Your blood pressure reading is _____/_____ :

□ ≥140/90 mmHg and I am unable to prescribe any combined hormonal contraceptive (estrogen + progesterone) pill, patch, or ring

□ ≥160/100 mmHg and I am unable to prescribe any injectable (progesterone only)

Each checked box requires additional evaluation by another healthcare provider. Please share this information with your provider.

□ You have not had a clinical visit with a healthcare provider, other than a pharmacist, for reproductive or sexual health in past 3 years.