

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 855-020-0110](#), 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. (2016). US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2016. Retrieved from <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf>
- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2020). Summary Chart of US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2020. Retrieved from https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria_508tagged.pdf
- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2016). US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2016. Retrieved from <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf>

RESOURCES:

- CDC US MEC & US SPR [App](#)
- 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? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____
2.	What was the date of your last reproductive or sexual health clinical visit with a non-pharmacist? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____

Contraception History:

3.	Have you ever been told by a healthcare professional not to take hormones? -If yes, what was the reason? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you ever taken birth control pills, or used a birth control patch, ring, or shot/injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Did you ever experience a bad reaction to using hormonal birth control? - If yes, what kind of reaction occurred? _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you have a preferred method of birth control that you would like to use? - If yes, please check one: <input type="checkbox"/> Oral pill <input type="checkbox"/> Skin patch <input type="checkbox"/> Vaginal ring <input type="checkbox"/> Injection <input type="checkbox"/> Other (IUD, implant)	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you had a baby in the last 4 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Did you have a miscarriage or abortion in the last 7 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Did your last menstrual period start within the past 7 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Have you abstained from sexual intercourse since your last menstrual period or delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Have you been using a reliable contraceptive method consistently and correctly?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Have you given birth within the past 21 days? If yes, how long ago? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Are you currently breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Do you smoke cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
21.	Are you being treated for inflammatory bowel disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22.	Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)	<input type="checkbox"/> Yes <input type="checkbox"/> No
23.	Have you ever had a heart attack or stroke, or been told you had any heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Contraception Self-Screening Patient Intake Form

(CONFIDENTIAL-Protected Health Information)

24.	Have you ever had a blood clot?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25.	Have you ever been told by a healthcare professional that you are at risk of developing a blood clot?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26.	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
27.	Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
28.	Have you had bariatric surgery or stomach reduction surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
29.	Do you have or have you ever had breast cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
30.	Have you had an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
31.	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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
32.	Do you have lupus, rheumatoid arthritis, or any blood disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
33.	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? - If yes, list them here: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
34.	Do you have any other medical problems or take any medications, including herbs or supplements? - If yes, list them here: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient Signature _____ Date _____

To Be Completed by a Pharmacist:

1. Blood Pressure Reading ____/____ mmHg

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

Drug: _____

Directions: _____

Quantity: _____

Refills: _____

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

2b. If contraception was administered, please complete the following:

Drug: _____

Directions: _____

Quantity: _____

Product/Lot: _____ Expiration: ____/____/____

Injection Sites:

Depo-Provera CI - IM R deltoid or L deltoid

Depo-SubQ Provera- 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

Prescribe and administer up to 3 months **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 question of the Contraception Patient Intake Form. For complete guidance, see: Summary [US MEC](#) (v. 2020) & Full [US MEC](#) (v. 2016)

Note: Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condom 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 (CHC)		Progestin-only Pill (POP)		DMPA (Inj)		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	Initiating	Continuing	
a. 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
b. 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
c. Pregnancy	(Not Eligible for contraception)	NA*		NA*		NA		NA*
d. Vaginal Bleeding	Unexplained or worrisome vaginal bleeding	2		2		3		Yes
e. Postpartum (see also Breastfeeding)	a) < 21 days	4		1		1		Yes
	b) 21 days to 42 days:							
	(i) with other risk factors for VTE	3*		1		1		Yes
	(ii) without other risk factors for VTE	2		1		1		Yes
f. Breastfeeding (see also Postpartum)	c) > 42 days	1		1		1		Yes
	a) < 1 month postpartum	3/4*		2*		2*		Yes
	b) 30 days to 42 days:							
	(i) with other risk factors for VTE	3*		2*		2*		Yes
g. Diabetes mellitus (DM)	(ii) without other risk factors for VTE	2*		1*		1*		Yes
	c) > 42 days postpartum	2*		1*		1*		Yes
	a) History of gestational DM only	1		1		1		Yes
	b) Non-vascular disease:							
h. Headaches	(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
i. Inflammatory Bowel Disease	a) Non-migrainous	1*		1		1		Yes
	b) Migraine:							
	i) without aura (includes menstrual migraines)	2*		1		1		Yes
j. Hypertension	iii) with aura	4*		1		1		Yes
	a) Mild; no risk factors	2		2		2		
	b) Elevated blood pressure levels (properly taken measurements):							
	(i) systolic 140-159 or diastolic 90-99	3*		1*		2*		Yes
k. History of high blood pressure during pregnancy	(ii) systolic ≥160 or diastolic ≥100‡	4*		2*		3*		Yes
	c) Vascular disease	4*		2*		3*		Yes
		2		1		1		Yes
l. Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function:							
	(i) < 6 months	4		1		1		Yes
	(ii) ≥ 6 months	3		1		1		Yes
m. Multiple risk factors for arterial CVD	b) Moderately or severely impaired cardiac function	4		2		2		Yes
	(such as older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	3/4*		2*		3*		Yes
n. Ischemic heart disease‡	Current and history of	4		2	3	3		Yes
	a) Uncomplicated	2		1		1		Yes
o. Valvular heart disease	b) Complicated‡	4		1		1		Yes
	p. Stroke‡	4		2	3	3		Yes
q. Known Thrombogenic mutations‡	History of cerebrovascular accident	4		2	3	3		Yes
		4*		2*		2*		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. 2016)

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

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Standardized Assessment and Treatment Care Pathway - Contraception

Condition	Sub-condition	Combined pill, patch (CHC)		Progestin-only Pill (POP)		DMPA (Inj)		Other Contraception Options Indicated for Patient
		Initiating	Continuing	Initiating	Continuing	Initiating	Continuing	
r. Deep venous thrombosis (DVT) & Pulmonary embolism (PE)	a) History of DVT/PE, not on anticoag therapy							
	i) higher risk for recurrent DVT/PE	4		2		2		Yes
	ii) lower risk for recurrent DVT/PE	3		2		2		Yes
	b) Acute DVT/PE	4		2		2		Yes
	c) DVT/PE and established on anticoagulant therapy for at least 3 months							
	i) higher risk for recurrent DVT/PE	4*		2		2		Yes
	ii) lower risk for recurrent DVT/PE	3*		2		2		Yes
	d) Family history (first-degree relatives)	2		1		1		Yes
	e) Major surgery							
	(i) with prolonged immobilization	4		2		2		Yes
(ii) without prolonged immobilization	2		1		1		Yes	
f) Minor surgery without immobilization	1		1		1		Yes	
s. Superficial venous disorders	a) Varicose veins	1		1		1		
	b) Superficial venous thrombosis (acute or history)	3*		1		1		
II. Multiple Sclerosis	a) With prolonged immobility	3		1		2		Yes
	b) Without prolonged immobility	1		1		2		Yes
t. History of bariatric surgery‡	a) Restrictive procedures	1		1		1		Yes
	b) Malabsorptive procedures	COCs: 3	P/R: 1	3		1		Yes
u. 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	
v. Solid Organ Transplant	a) Complicated – graft failure, rejection, etc.	4		2		2		Yes
	b) Uncomplicated	2*		2		2		Yes
w. Viral hepatitis	a) Acute or flare	3/4*	2 C	1		1		Yes
	b) Carrier/Chronic	1	1	1		1		Yes
x. Cirrhosis	a) Mild (compensated)	1		1		1		Yes
	b) Severe‡ (decompensated)	4		3		3		Yes
y. Liver tumors	a) Benign:							
	i) Focal nodular hyperplasia	2		2		2		Yes
	ii) Hepatocellular adenoma‡	4		3		3		Yes
b) Malignant‡ (hepatoma)	4		3		3		Yes	
z. 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	
aa. History of Cholestasis	a) Pregnancy-related	2		1		1		Yes
	b) Past COC-related	3		2		2		Yes
bb. Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	4*		3*		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
cc. 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	
dd. Blood Conditions & Anemias	a) Thalassemia	1		1		1		Yes
	b) Sickle Cell Disease‡	2		1		1		Yes
	c) Iron-deficiency anemia	1		1		1		Yes
ee. Epilepsy‡	(see also Drug Interactions)	1*		1*		1*		Yes
ff. Tuberculosis‡ (see also Drug Interactions)	a) Non-pelvic	1*		1*		1*		Yes
	b) Pelvic	1*		1*		1*		Yes
gg. HIV	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						
hh. 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
ii. Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3*		3*		1*		Yes
	b) Lamotrigine	3*		1		1		Yes
jj. 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
kk. 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. 2016)

‡ 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 than requires further evaluation.

Notes: _____

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

Notes: _____

Their blood pressure reading was ____/____ :

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

$\geq 160/100$ 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 855-020-0300](#).

- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2016). US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2016. Retrieved from <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf>
- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2020). Summary Chart of US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2020. Retrieved from https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria_508tagged.pdf
- Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2016). US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2016. Retrieved from <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.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 than requires further evaluation.

Notes: _____

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

Notes: _____

Your blood pressure reading is ____/____ :

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

$\geq 160/100$ 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.