Update on Contraception: 2017

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Disclosures

- Nexplanon trainer (Merck)
- Bayer Advisory Board
- I will be discussing off-label use of medications
Objectives

• Review evidence-based guidelines for contraceptive care
• Discuss long-acting reversible contraception (LARC)
• Discuss other hot topics:
  – HIV & contraception
  – What’s new in oral contraception
Objectives

• Review evidence-based guidelines for contraceptive care

• Discuss long-acting reversible contraception (LARC)

• Discuss other hot topics:
  – HIV & contraception
  – What’s new in oral contraception
Medical Eligibility Criteria (MEC)

• Based on WHO guidelines, adapted by CDC
• Evidence-based guidance for the use of contraceptive methods by women with certain medical conditions or characteristics
  – Examples: Obesity, hypertension, breastfeeding, history of stroke, breast cancer, HIV
Selected Practice Recommendations (SPR)

- Evidence-based guidance for initiation and use of specific methods of contraception
  - Examples:
    - When can you start a method?
    - How long to use backup?
    - How to manage side effects?
    - What to do about missed pills?
    - What screening tests are needed before starting a method?
US MEC/SPR 2016

• Updates since 2010:
  – Cystic fibrosis, multiple sclerosis
  – Psychotropic drugs, St. John’s Wort
  – Addition of ulipristal acetate (Ella)
  – Revisions: breastfeeding, migraines, HIV, others

• Do it now: Download CDC MEC App!
  – App store: “CDC Contraception”
## MEC Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Interpretation</th>
</tr>
</thead>
</table>
| 1        | No restriction for use  
Use method for any circumstance |
| 2        | Advantages outweigh theoretical/proven risks  
Generally use the method |
| 3        | Theoretical/proven risks outweigh advantages  
Generally not recommended unless no other method available or acceptable |
| 4        | Unacceptable health risk  
Do not use |
History: 38 yo G$_2$P$_1$ woman is seeking contraception. She has a 6 month old child and gained 50 pounds during her pregnancy.

Physical Exam: Wt: 226 lbs, Ht: 5’5” (BMI=37.6) BP:120/79
<table>
<thead>
<tr>
<th>Condition</th>
<th>Symptom</th>
<th>COC/Patch/Ring</th>
<th>POPs</th>
<th>Injection</th>
<th>Implant</th>
<th>LNG-IUD</th>
<th>Cu-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>BMI ≥ 30</td>
<td>2</td>
<td>1</td>
<td>1/2 †</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hx bariatric surgery</td>
<td>Restrictive procedure</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>Malabsorptive proc.</td>
<td></td>
<td>3/1‡</td>
<td>3</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Multiple risk factors for CVD</td>
<td></td>
<td>3/4*</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Hx GDM</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Non-vascular</td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sig. dz, &gt;20 yrs dz</td>
<td></td>
<td>3/4 ∞</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

† ≥18 years/< 18;  * Initiation/continuation; ‡ COC/(P/R); ∞ depends on dz severity
When to start a contraceptive method

<table>
<thead>
<tr>
<th>Method</th>
<th>When to start, if provider is reasonably certain woman is not pregnant</th>
<th>Additional contraception needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copper IUD</td>
<td>Any time</td>
<td>Not needed</td>
</tr>
<tr>
<td>LNG IUD</td>
<td>Any time</td>
<td>If ≤ 7 days since LMP, not needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If &gt; 7 days, use back-up method for 7 days</td>
</tr>
<tr>
<td>Implant</td>
<td>Any time</td>
<td>If ≤ 5 days since LMP, not needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If &gt; 5 days, use back-up method for 7 days</td>
</tr>
<tr>
<td>Injectable</td>
<td>Any time</td>
<td>If ≤ 7 days since LMP, not needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If &gt; 7 days, use back-up method for 7 days</td>
</tr>
<tr>
<td>Combined hormonal</td>
<td>Any time</td>
<td>If ≤ 5 days since LMP, not needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If &gt; 5 days, use back-up method for 7 days</td>
</tr>
<tr>
<td>Progestin-only pill</td>
<td>Any time</td>
<td>If ≤ 5 days since LMP, not needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If &gt; 5 days, use back-up method for 2 days</td>
</tr>
</tbody>
</table>
How to be reasonably certain a woman is not pregnant

- Is ≤ 7 days after start of normal menses
- Has not had sexual intercourse since the start of last normal menses
- Has been correctly and consistently using a reliable method of contraception
- Is ≤ 7 days after spontaneous or induced abortion
- Is within 4 weeks postpartum
- Is fully or nearly fully breastfeeding (≥ 85%), amenorrheic and < 6 months postpartum

Adapted from U.S. Selected Practice Recommendations for Contraceptive Use, 2016 Box 2
Objectives

• Review/discuss evidence-based guidelines for contraceptive care

• Discuss long-acting reversible contraception (LARC)

• Discuss other hot topics:
  – HIV & contraception
  – What’s new in oral contraception
  – Ring & DVT risk
How well do you know our FIVE IUDs?

*Paragard, Mirena, Skyla, Liletta, Kyleena*
But first... Why does it matter?

6.1 million pregnancies per year

- 55% Intended
- 45% UNINTENDED
- 46% Using contraception (5% using consistently)
- 54% No contraception

https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states

Data from the National Survey of Family Growth / Finer et al, NEJM 2016
In 2008, the two-thirds of U.S. women at risk of pregnancy who used contraceptives consistently accounted for only 5% of unintended pregnancies.

**Women at Risk (43 Million)**
- 68% Consistent use
- 18% Inconsistent use
- 14% Nonuse or long gaps in use

**Unintended Pregnancies (3.1 Million)**
- 5% Consistent use
- 41% Inconsistent use
- 54% Nonuse

By consistency of method use all year

By consistency of method use during month of conception

**Notes:** “Nonuse” includes women who were sexually active, but did not use any method of contraception. “Long gaps in use” includes women who did use a contraceptive during the year, but had gaps in use of a month or longer when they were sexually active. “Inconsistent use” includes women who used a method in all months that they were sexually active, but missed taking some pills, or skipped use or incorrectly used their barrier method or condom during some acts of intercourse. “Consistent use” includes women without any gaps in use who used their method consistently and correctly during all months when they were sexually active, including those who used a long-acting or permanent method.
Long-acting Reversible Contraception

Strong evidence:

• Safe
• Effective
• Women like these methods better
• FIRST-LINE methods for teens, nullips, everyone
• Time to adjust your counseling
Contraceptive Failure Rates

- LARC
- DMPA
- PPR

Contraceptive Failure Rates

- Year 1: 12%
- Year 2: 10%
- Year 3: 8%

DMPA = injectable, PPR = pill, patch and ring

Winner et al. NEJM 2012, prospective cohort
5 Year Cumulative Failure Rates

IUD versus Sterilization

- LNG IUS: 0.5
- CuT 380: 1.4
- All Sterilization: 1.3
- Postpartum Salpingectomy: 0.6
## Continuation Rates

<table>
<thead>
<tr>
<th>Method</th>
<th>Continuation at 12 months Age 14-19</th>
<th>Continuation at 12 months Age 26 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>LNG-IUD</td>
<td>80.6%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Copper IUD</td>
<td>75.6%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Implant</td>
<td>82.2%</td>
<td>84.4%</td>
</tr>
<tr>
<td>DMPA</td>
<td>47.3%</td>
<td>53.4%</td>
</tr>
<tr>
<td>OCPs</td>
<td>46.7%</td>
<td>53.9%</td>
</tr>
<tr>
<td>LARC</td>
<td>81.0%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Non-LARC</td>
<td>44.0%</td>
<td>52.6%</td>
</tr>
</tbody>
</table>

Rosenstock et al. 2012. *Obstetrics & Gynecology*
SKYLA (FDA approved 3 years)

- Contains 13.5 mg of LNG
- Provides an initial release rate of approximately 14 mcg/day

MIRENA (FDA approved 5 years*)

- Contains 52 mg of LNG
- Provides an initial release rate of approximately 20 mcg/day

*Effective for 7 years
Soon to be studied up to 8 years!
Kyleena contains 19.5 mg of LNG and provides an initial release rate of approximately 17.5 mcg/day.

LILETTA contains 52 mg of LNG and provides an initial in vivo release rate of 18.6 mcg/day.

*Likely effective for 7 years: clinical trials up to 4+ years, release rates same as Mirena up to 5 years
## IUD Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Size</th>
<th>Inserter Size</th>
<th>Strings</th>
<th>Silver Ring (Ultrasound)</th>
<th>LNG Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liletta</td>
<td>32 x 32 mm</td>
<td>4.75 mm</td>
<td>Blue</td>
<td>No</td>
<td>52 mg</td>
</tr>
<tr>
<td>Mirena</td>
<td>32 x 32 mm</td>
<td>4.4 mm</td>
<td>Silver</td>
<td>No</td>
<td>52 mg</td>
</tr>
<tr>
<td>Kyleena</td>
<td>28 x 30 mm</td>
<td>3.8 mm</td>
<td>Blue</td>
<td>Yes</td>
<td>19.5 mg</td>
</tr>
<tr>
<td>Skyla</td>
<td>28 x 30 mm</td>
<td>3.8 mm</td>
<td>Silver</td>
<td>Yes</td>
<td>13.5 mg</td>
</tr>
<tr>
<td>Paragard</td>
<td>32 x 36 mm</td>
<td>4.4 mm*</td>
<td>White</td>
<td>No</td>
<td>None</td>
</tr>
</tbody>
</table>
Bleeding patterns

• Mirena and Liletta- amenorrhea (NO bleeding in 90 day reference period) ~20% at 1 year
• Increasing amenorrhea with every year of use
• Indicated for women with heavy periods
• Skyla and Kyleena with lower hormone content and lower release rates $\rightarrow$ lower rates of amenorrhea
Should cost be a consideration?

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Outpatient 340b pricing</th>
<th>Monthly cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyleena™ IUS</td>
<td>$558.53</td>
<td>$9.30 (5 years)</td>
</tr>
<tr>
<td>Liletta™ IUS</td>
<td>$48.88</td>
<td>$0.58 (7 years)</td>
</tr>
<tr>
<td>Mirena™ IUS</td>
<td>$260.16</td>
<td>$3.10 (7 years)</td>
</tr>
<tr>
<td>Skyla™ IUS</td>
<td>$390.02</td>
<td>$10.83 (3 years)</td>
</tr>
</tbody>
</table>

• Caveats:

Most women don’t keep IUD for full duration of use
These are costs to UW only, April 2017
This is not what the patient pays
Actual costs depend on many factors (institution, 340b status, bulk ordering, the weather)
Hormonal or non-hormonal?

Hormonal = less bleeding
Liletta, Mirena, Skyla, Kyleena

Do you want lighter periods, but prefer a lower dose of hormones and a smaller IUD?
Choose Kyleena or Skyla
Kyleena: Lasts up to 5 years, lower hormone dose than Mirena/Liletta
Skyla: Lasts up to 3 years, Lowest hormone dose

Would you prefer to stop having periods?
Choose Mirena or Liletta
Mirena: Effective for 7 years. Currently the most popular IUD
Liletta: Newer IUD, developed by nonprofit organization Medicines360 to be identical to Mirena, studies in process, effective for 5-7 years

Non-hormonal
Paragard IUD - no hormones, regular periods that may be heavier
Mechanism of Action

Copper IUD

• Prevents fertilization
  (primary mechanism)
  — ↓ Motility/viability of sperm
  — Disrupts oocyte division
       and fertilization

• Inhibition of implantation
  (secondary mechanism – when
 used for emergency contraception)

Mechanism of Action

**LNG-IUD** *(Kyleena, Liletta, Mirena, Skyla)*

Prevents fertilization:
- Cervical mucus thickened
- Sperm motility/function inhibited
- Ovulation inhibited *(in some cycles)*

*Jonsson, Contraception 1991; Videla-Rivero, Contraception 1987*
Treatment of STI/PID with IUD

• Effective to treat STI with IUD in place — Okay to screen at time of insertion

• Risk of PID increased in first 20 days after insertion

• 1/1,000 risk of PID

• Evidence that treatment of PID effective with IUD in place (with close monitoring)
Fertility Rates

After Discontinuation of IUD

Based on data from Vessey MP, Br Med J. 1983.
Provider insertion concerns: Nulliparity

• “The uterus will be too small”
  – Median sound depth = 7 cm
• “The os looks too small”
  – No correlation with insertion difficulty
  – Prophylactic misoprostol
    • Does not appear to facilitate placement for provider
    • Increases symptoms including pain for the woman
• “Expulsion rates are higher for nullips”
  – Expulsion rates similar for nullips/multips
Provider insertion concerns: Teens

• “The teen won’t tolerate it”
  – 14% No pain, 65% mild to moderate, 21% severe
  – Insertion is not more difficult in teens

• “Teens will be more likely to have it removed”
  – 1 year continuation rates
    — 85% (similar to adults) for LNG-IUD
    — 72% for Copper IUD

• “What about expulsion in teens?”
  – Expulsion slightly higher in teens (5-22%) but still low overall

• “What about infection risk in teens?”
  – Need to screen for GC/CT at insertion but can still do same day insertion per SPR
16 yo G0 presents for pregnancy test
Last sex 3 weeks ago, unprotected
Given Rx for OCPs 3 months ago, took for 2 weeks, then stopped because couldn’t remember to take them
LMP unknown (irregular periods)
Negative pregnancy test today
Interested in Mirena

Good candidate?
Considerations for insertion?
Learning Points

- Screen for GC/CT and make sure you have a reliable, confidential contact number.
- OK to place mid-cycle if “reasonably certain that woman is not pregnant,” but need back up or abstinence x 7 days.
- IUDs are a great option for teens.
Case #3

- 29 yo woman G1P0 presents requesting an IUD
- She has a new partner, so you check for GC/CT before insertion
- 3 days later, test is + for chlamydia
- When you call her to give results, she tells you she has a mild fever

What next?
Effective to treat STI with IUD in place

OK to screen at time of insertion

Treatment of PID is effective with IUD in place: reassess after 48-72 hours and consider removal if no clinical improvement on antibiotics
Contraceptive Implant: Nexplanon

- Single rod, progestin-only subdermal implant
- FDA approved for up to 3 years
- Easy to insert and remove (FDA-mandated clinical training)
Nexplanon Mechanism of Action

- Inhibits ovulation
  - No ovulation observed for 30 months
  - Only 2 out of 31 (6.5%) subjects ovulated in year 3, with no resulting pregnancies

- Increases viscosity of cervical mucus
Implant Bleeding Patterns

- Total amount of bleeding/number of spotting days similar to or slightly better than a normally menstruating woman
- Bleeding irregular and unpredictable
- Hematocrit stable over 3 yrs
Jan 2017

- Nexplanon for 5 years!
- N=291
- 50% of women BMI>30
- NO pregnancies
- Etonogestrel levels above the threshold for ovulation suppression for women in all BMI classes
30 yo G2P2 had Nexplanon inserted 2 months ago and is presenting with unscheduled bleeding.

She had a pelvic ultrasound prior to insertion and no structural abnormalities.

Hematocrit 39
Unscheduled bleeding on Nexplanon unlikely to cause anemia

Preferred management is counseling/expectant

Medical management options (based on scant data) for up to 3 months:

- NSAIDs taken daily x 5-10 days
- OCPs daily x 21 days, then 7-day break
- Investigational: low-dose mifepristone, tranexamic acid 500 mg BID x 5 days
- Data do not support efficacy of estrogen alone

Mansour et al, Contraception, 2011.
Who is an appropriate LARC candidate?

Any fertile woman desiring long-term, effective contraception
Objectives

• Review/discuss evidence-based guidelines for contraceptive care
• Review long-acting reversible contraception (LARC)
• Discuss other hot topics:
  – HIV & contraception
  – What’s new in oral contraception
The New York Times

Contraceptive Used in Africa May Double Risk of H.I.V.

By PAM BELLUCK
Published: October 3, 2011

The most popular contraceptive for women in eastern and southern Africa, a hormone shot given every three months, appears to double the risk the women will become infected with H.I.V., according to a large study published Monday. And when it is used by H.I.V.-positive women, their male partners are twice as likely to become infected than if the women had used no contraception.
HIV & Depo Provera

**FEMALE** seronegative partners

(n = 1,314 couples)

Adjusted Hazard Ratio

1.98 (1.06–3.68) (p=0.03)

**MALE** seronegative partners

(n = 2,476 couples)

Adjusted Hazard Ratio

1.97 (1.12–3.45) (p=0.02)

Heffron, Lancet ID 2012
“Some studies suggest that women using progestin-only injectable contraception may be at increased risk of HIV acquisition; other studies do not show this association...Because of the inconclusive nature of the body of evidence on possible increased risk of HIV acquisition, women using progestin-only injectable contraception should be strongly advised to also always use condoms...and other HIV preventive measures.”
37 year old G₃P₃ who is HIV positive, on antiretroviral therapy.

She is in a new relationship and doesn’t want to get pregnant. She uses condoms for STI prevention, but wants something else for pregnancy prevention.
## Medical Eligibility Criteria: HIV

<table>
<thead>
<tr>
<th>HIV</th>
<th>Combined Pill, P/R</th>
<th>Progestin-only pill</th>
<th>Injection (DMPA)</th>
<th>Implant</th>
<th>LNG-IUD</th>
<th>Copper-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk for HIV</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>I</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HIV infection NOT clinically well or on ARV therapy</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HIV infection Clinically well on ARV therapy</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>If on treatment, see Drug Interactions</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

I = initiation; C = continuation
Note: spermicide and diaphragm are Category 4 for women at high risk for HIV
Medical Eligibility Criteria: Drug Interactions

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticonvulsant therapy</td>
<td>+</td>
</tr>
<tr>
<td>Antimicrobial therapy</td>
<td>+</td>
</tr>
<tr>
<td>Antiretroviral therapy</td>
<td>-</td>
</tr>
<tr>
<td>a. Nucleoside reverse transcriptase inhibitors (NRTIs)</td>
<td>+</td>
</tr>
<tr>
<td>b. Non-nucleoside reverse transcriptase inhibitors (NNRTIs)</td>
<td>+</td>
</tr>
<tr>
<td>c. Ritonavir-boosted protease inhibitors (PIs)</td>
<td>+</td>
</tr>
<tr>
<td>d. Protease inhibitors without ritonavir</td>
<td>+</td>
</tr>
<tr>
<td>e. CCR5 Co-receptor antagonists</td>
<td>+</td>
</tr>
<tr>
<td>f. HIV integrase strand transfer inhibitors</td>
<td>+</td>
</tr>
<tr>
<td>g. Fusion inhibitors</td>
<td>+</td>
</tr>
<tr>
<td>Benign ovarian tumors (including cysts)</td>
<td>&gt;</td>
</tr>
<tr>
<td>Breast disease</td>
<td>+</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>+</td>
</tr>
<tr>
<td>Cervical cancer (awaiting treatment)</td>
<td></td>
</tr>
<tr>
<td>Cervical ectropion</td>
<td></td>
</tr>
</tbody>
</table>
2017: 57 years of the pill

YOU CAN DECIDE HOW MANY CHILDREN YOU WANT
PLANNED PARENTHOOD CAN HELP
...with information on birth control and infertility services
CALL 421-2290

PLANNED PARENTHOOD OF NEW YORK CITY 29 WEST 11 St, NEW YORK, NY
New take on the old standby

No physiologic need for break in hormones!

• Reduce bleeding with shorter pill free interval (24 active/4 placebo or 26 active/2 placebo)

• Suppress menses with extended-cycle/continuous regimen (84 active/7 placebo or NO placebo at all)
  – Higher risk of breakthrough bleeding, but usually improves after first 3 months
Are there benefits to extended cycles?

- Shorter periods
- Less menstrual migraines
- May be more effective!
- For Nuvaring –
  Change ring same day each month, less risk of forgetting to put in new ring

Fig. 4. Life-table estimates of contraceptive failure. Comparison of two 24-day and two 21-day regimens of drospirenone and ethinyl E2 (triangle) and norethisterone acetate and ethinyl E2 (square), respectively.

New take on the old standby

• Low (20 mcg) & very low (5-10 mcg) doses of ethinyl estradiol
• Lower dose formulations → higher risk of breakthrough bleeding
• Progestin is primarily responsible for contraceptive efficacy
Estradiol (E2) based pills

Estradiol OCs

– Dienogest (2-3 mg)
  & Estradiol valerate (3-1 mg)
  26 days (Natazia, Bayer)

FDA-approved for heavy menstrual bleeding

– Nomegestrol Acetate (NOMAC) (2.5 mg)
  Estradiol (1.5 mg)
  21 days (Zoely, Merck)
Emergency contraception updates: Plan B

• Age limits eliminated June 2013, FDA approved Plan B One-Step for use without a prescription for all women of childbearing age
Ulipristal acetate (Ella)

• First selective progesterone receptor modulator approved by FDA (requires Rx)
• Effective in preventing pregnancy up to 5 days after unprotected sex
• Primary mechanism is delayed ovulation
• Compared to LNG EC
  – OR 0.55 (0.32–0.93) if used within 120 hours
  – OR 0.35 (0.11–0.93) if used within 24 hours

Obesity and Emergency Contraception

- Risk of pregnancy 2-4 times greater for obese women who use EC, regardless of type
- Risk 1.5 times greater for overweight women
- Observed pregnancy rate 5.8% among obese women after Plan B – higher than expected pregnancy rate without Plan B

Plan B may be ineffective among obese women!
Copper IUD is best method of EC
Emergency contraception: Copper T IUD

• Most effective emergency contraception (especially for overweight/obese women)
• Can be inserted up to 5 days after unprotected sex
• Use for EC is off-label in the US
• LNG-IUD as EC is under investigation
Contraceptive Counseling

• Review all methods available: emphasize efficacy
• Discuss reproductive life plan and goals
  – Pregnancy intention is not binary! Ambivalence is OK
• Consider adherence behaviors
• Weigh non-contraceptive benefits and bleeding profiles
• Assess need for dual protection (condoms)
• Don’t place barriers to contraceptive initiation
  – Exams, screening tests, multiple appointments
Key Prescribing Tips

- Contraindications? (MEC)
- 1 year supply
- Quick start
- No pelvic exam
- Avoid “hormone breaks”
- Prescribe EC
- Do not hold birth control pill hostage if due for pap smear
- Don’t cause “iatrogenic” pregnancies!
Thank You

Questions

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