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 <u>OAR 855-020-0110</u>, 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---

<u>Depo-SQ-Resource-guide---FINAL-FOR-DISTRIBUTION.pdf</u>

Contraception Self-Screening Patient Intake Form

(CONFIDENTIAL-Protected Health Information)

| Date _ | / | Date of Birth// | | | | |
|------------|---|---|-----------------------|--|--|--|
| • | Name | Name | | | | |
| | ssigned at Birth (circle) M / F | Gender Identification (circle) M / | / F / Other | | | |
| | uns (circle) She/Her/Hers, He/Him/His, They/The | | | | | |
| | Address | | | | | |
| Phone | | Email Address | | | | |
| | ncare Provider Name | Phone () Fax () | | | | |
| • | u have health insurance? Yes / No | Insurance Provider Name | | | | |
| - | lergies to medications? Yes / No | If yes, please list | | | | |
| • | lergies to foods (ex. soy, lactose)? Yes / No | If yes, please list | | | | |
| | round Information: | | I | | | |
| 1. | Have you previously had a contraceptive prescrib | | □ Yes □ No | | | |
| | If yes, when was the last time a pharmacist preso | | | | | |
| 2. | What was the date of your last reproductive or so pharmacist? | exual health clinical visit with a non- | / | | | |
| Contra | aception History: | | | | | |
| 3. | Have you ever been told by a healthcare professi | onal not to take hormones? | □ Yes □ No | | | |
| | -If yes, what was the reason? | | | | | |
| 4. | Have you ever taken birth control pills, or used a | | □ Yes □ No | | | |
| 5. | Did you ever experience a bad reaction to using heart of the series of the properties of the series | normonal birth control? | □ 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? | | | | | |
| 7. | Do you have a preferred method of birth control that you would like to use? □ Yes □ No - If yes, please check one: □ Oral pill □ Skin patch □ Vaginal ring □ Injection □ Other (IUD, implant) | | | | | |
| regna | ncy Screen: | | | | | |
| 8. | Did you have a baby less than 6 months ago, are | you fully or nearly-fully breast feeding, AND | □ Yes □ No | | | |
| | have you had no menstrual period since the deli | | | | | |
| 9. | Have you had a baby in the last 4 weeks? | · | □ Yes □ No | | | |
| 10. | Did you have a miscarriage or abortion in the las | t 7 days? | □ Yes □ No | | | |
| 11. | Did your last menstrual period start within the p | ast 7 days? | □ Yes □ No | | | |
| 12. | Have you abstained from sexual intercourse sinc | e your last menstrual period or delivery? | □ Yes □ No | | | |
| 13. | Have you been using a reliable contraceptive me | thod consistently and correctly? | □ Yes □ No | | | |
| Modic | al Health & History: | · | | | | |
| | • | Choic | 1 1 | | | |
| 14. 15. | What was the first day of your last menstrual per | | / | | | |
| 16. | , | | | | | |
| 17. | Have you given birth within the past 21 days? If yes, how long ago? □ Yes □ No Are you currently breastfeeding? □ Yes □ No | | | | | |
| 18. | | | | | | |
| 19. | Do you smoke cigarettes? Do you have diabetes? | | □ Yes □ No | | | |
| | · | | | | | |
| 20. | Do you get migraine headaches? | hat start with warning signs or symptoms | □ Yes □ No □ Yes □ No | | | |
| | If yes, have you ever had the kind of headaches t | | | | | |
| | such as flashes of light, blind spots, or tingling in | your riand or race that comes and goes | □ N/A | | | |
| 24 | completely away before the headache starts? | 20002 | | | | |
| 21. | Are you being treated for inflammatory bowel di | | □ Yes □ No | | | |
| 22/ | Do you have high blood pressure, hypertension, of it is controlled by medication) | or high cholesteror? (Please indicate yes, even | □ Yes □ No | | | |
| 23. | Have you ever had a heart attack or stroke, or be | en told you had any heart disease? | □ Yes □ No | | | |

Contraception Self-Screening Patient Intake Form

(CONFIDENTIAL-Protected Health Information)

| 24. | • | | | |
|----------|---|------------|--|--|
| 25. | , | | | |
| | clot? | | | |
| 26. | Have you had recent major surgery or are you planning to have surgery in the next 4 weeks? | □ Yes □ No | | |
| 27 | Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.) | □ Yes □ No | | |
| 28. | Have you had bariatric surgery or stomach reduction surgery? | □ Yes □ No | | |
| 29. | Do you have or have you ever had breast cancer? | □ Yes □ No | | |
| 30. | Have you had an organ transplant? | □ Yes □ No | | |
| 31. | Do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, | □ Yes □ No | | |
| | or do you have jaundice (yellow skin or eyes)? | | | |
| 32. | Do you have lupus, rheumatoid arthritis, or any blood disorders? | □ Yes □ No | | |
| 33. | Do you take medication for seizures, tuberculosis (TB), fungal infections, or human | □ Yes □ No | | |
| | immunodeficiency virus (HIV)? | | | |
| | - If yes, list them here: | | | |
| 34. | Do you have any other medical problems or take any medications, including herbs or | □ Yes □ No | | |
| | supplements? | | | |
| | - If yes, list them here: | | | |
| | | | | |
| | | | | |
| D | | | | |
| Patier | nt SignatureDate | | | |
| | | | | |
| то ве с | Completed by a Pharmacist: | | | |
| 1. Blo | ood Pressure Reading/ mmHg | | | |
| | | | | |
| 2a. If o | contraception was <u>prescribed/dispensed</u> , please complete the following: | | | |
| Dr | ug: | | | |
| | Directions: | | | |
| | Quantity: | | | |
| | Refills: | | | |
| He | althcare Provider (if known) contacted/notified of therapy Date/ | | | |
| | | | | |
| 2h. If c | ontraception was <u>administered</u> , please complete the following: | | | |
| | ug: | | | |
| | | | | |
| | Directions: | | | |
| D.,, | Quantity: | | | |
| | oduct/Lot: Expiration:// | | | |
| Inj | ection Sites: | | | |
| | Depo-Provera CI - IM \square R deltoid or \square L deltoid | | | |
| | Depo-SubQ Provera- SQ in □ R anterior thigh or □ L anterior thigh or □ abdomen | | | |
| ٨٨ | ministration Time:: AM/PM | | | |
| | | | | |
| | althcare Provider (if known) contacted/notified of therapy Date/ | | | |
| If cont | raception was not prescribed/dispensed/administered, please indicate reason(s) for referral: | | | |
| | | | | |
| | | | | |
| | | | | |
| | gnature Date | | | |
| DDH C! | | | | |

Algorithm A: Oral, Vaginal and Transdermal Contraception with Combined Hormonal Contraceptives (CHC) and Progestin Only Pills (POP). RPH must utilize Summary <u>US MEC</u> (v. 2020) & Full <u>US MEC</u> (v. 2016) to make determinations below. In Full US MEC, Appendix D contains classifications for CHCs and Appendix C contains classifications for POPs.

| | | | = | | |
|---|-----------------|--|--|--|--|
| 1) Background Information – Review Patient Intake Form Q | (uest | ions #1-2. Each patient must complete a new Patient Intake | | | |
| Form a minimum of every twelve months. | | | | | |
| -Never prescribed contraception by RPH -or- | | -Previously prescribed contraception by RPH -and- | | | |
| -Previously prescribed contraception by RPH -and- | | has not had clinical visit with a healthcare provider, other | | | |
| had clinical visit with a healthcare provider, other than a | | than a pharmacist, for reproductive or sexual health in past | | | |
| pharmacist, for reproductive or sexual health in past 3 | | 3 years | | | |
| years | | | ∐ ਹ | | |
| No Exclusion Criteria | | Any Exclusion Criteria | Refer | | |
| 2) Pregnancy Screen- Review Patient Intake Form #8-13 | | | 1 │ ᢡ | | |
| - If YES to AT LEAST ONE <u>and</u> is free of pregnancy | | - If NO to ALL of these questions, pregnancy can NOT be | | | |
| symptoms | | ruled out | | | |
| Patient is not pregnant | | Patient is possibly pregnant | Refer | | |
| 3) Medical and Medication History - Review Patient Intake I | Forn | n #14-34 (and med list in pharmacy record). Evaluate medical |] ° | | |
| health & history utilizing the US MEC. Evaluate medications | | | | | |
| interactions with contraceptives. | | , | | | |
| - If ALL boxes are labeled 1 or 2 (green) on the US MEC for | | -If ANY boxes are labeled 3 or 4 (pink/red) on the US MEC | | | |
| the type of contraception that RPH plans to prescribe (e.g., | | or a significant drug-drug or drug-disease interaction exists | | | |
| CHC, POP) | | for the type of contraception that RPH plans to prescribe | l — | | |
| | | (e.g., CHC, POP) |] " | | |
| No Contraindicated Condition(s) or Medication(s) | | Any Contraindicated Condition(s) or Medication(s) | Refer → | | |
| 4) Blood Pressure Screen: | | <u> </u> | 1 ¬ | | |
| | ent t | he pharmacist's measurement of the patient's current blood | | | |
| pressure. Note: RPH may choose to take a second reading if | | | IIР | | |
| | | | - P | | |
| CHC + BP < 140/90 -or- POP + Any BP | | CHC + BP ≥ 140/90 | ֓֞֟֟֓֓֓֓֓֓֓֓֓֓֓֓֓֟֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓ | | |
| 5) Evaluate patient contraception history, preference, and | | ant thorony for coloction of treatment | POP or DMPA | | |
| | Tuil | • | ┚┃┍ | | |
| Not currently on birth control | | Currently on birth control | 7 | | |
| 6a) Choose Contraception | | 6b) Choose Contraception | | | |
| • <i>Initiate</i> contraception based on patient preferences, | | Continue current form of pills, ring or patch, if no | | | |
| adherence, and history for new therapy | | change is necessary -or - | | | |
| | | Alter therapy based on patient concerns, such as side | | | |
| | | effects patient may be experiencing; or refer, if | | | |
| | | appropriate | | | |
| | | eption product. This must be done as soon as practicable | | | |
| after the pharmacist issues the prescription and must in ORS <u>743A.066</u> requires prescription drug benefit programs to reimbu | | | | | |
| dispensing of the same contraceptive. | <i>x</i> 130 10 | 7 3 Horitis for the first dispersing and 12 Horitis for subsequent | <u> </u> | | |
| 7) Provide Counseling | • | | | | |
| Address any unexplained vaginal bleeding that worries | patie | ent (Patient Intake Form #15) – Refer for further evaluation | | | |
| Address any high blood pressure - Refer for further eva | aluat | ion | | | |
| | | | | | |
| | | eatment (as applicable). For quick start - instruct patient they | | | |
| can begin contraceptive today; use backup method for 7 days | | | | | |
| Discuss adherence and opportunities for follow-up visits | | | | | |
| Encourage routine health screenings and STI prevention | | | | | |
| | | nationt to concult with a primary care practitioner or | أ | | |
| 8) Discuss and provide visit summary to patient and advise women's health care practitioner per ORS (89.689(2)(b)(D). | | patient to consult with a primary care practitioner or | | | |

Algorithm B: Injectable Contraception- Depot Medroxyprogesterone (DMPA). RPH must utilize Summary <u>US MEC</u> (v. 2020) & Full <u>US MEC</u> (v. 2016) 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. Refer No Exclusion Criteria Any Exclusion Criteria 2) Pregnancy Screen- Review questionnaire #8-13 - If YES to AT LEAST ONE and is free of pregnancy - If NO to ALL of these questions, pregnancy can NOT be ruled out symptoms Refer Patient is possibly pregnant Patient is not pregnant 3) Medical and Medication History - Review Patient Intake Form #14-34 (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 -If ANY boxes are labeled 3 or 4 (pink/red) on the US MEC the type of contraception that RPH plans to prescribe (e.g., or a significant drug-drug or drug-disease interaction exists for the type of contraception that RPH plans to prescribe CHC, POP) (e.g., CHC, POP) Refer No Contraindicated Condition(s) or Medication(s) Any Contraindicated Condition(s) or Medication(s) 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. BP < 160/100 BP ≥ 160/100 5) Discuss DMPA therapy and provide counseling Discuss the management and expectations of side effects (bleeding irregularities, etc.) Discuss plans for follow-up visits, particularly for every 3-month administration of DMPA. 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

- Caution with use of DMPA > 2 years (due to loss of bone mineral density). For therapy > 2 years, consultation with healthcare provider is indicated.
- 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) 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 appropriately trained and authorized HCP after providing the patient with educational materials that include step-by-step instructions for self-injection, as well as guidance on the proper disposal of needles. The patient may complete self-administration at home after the initial observation.

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.
 - o 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.

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 <u>743A.066</u> 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).

Oregon Board of Pharmacy- PROPOSED

v. 6/2023

Refer or consider

er ____

| Sta | andardized Assessi | ment and Treatm | ent Care Pathwa | y - Contraception | |
|-----|--------------------|-----------------|-----------------|-------------------|--|
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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 <u>US MEC</u> (v. 2020) & Full <u>US MEC</u> (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 | |
| | | Menarche to <40=1 | Menarche to <18=1 | Menarche to <18=2 | Yes |
| a. Age | | <u>></u> 40=2 | 18-45=1 | 18-45=1 | Yes |
| | | | >45=1 | >45=2 | Yes |
| | a) Age < 35 | 2 | 1 | 1 | Yes |
| b. Smoking | b) Age <u>></u> 35, < 15 cigarettes/day | 3 | 1 | 1 | Yes |
| | c) Age <u>></u> 35, <u>></u> 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 |
| | a) < 21 days | 4 | 1 | 1 | Yes |
| e. Postpartum | b) 21 days to 42 days: | | | | |
| (see also Breastfeeding) | (i) with other risk factors for VTE | 3* | 1 | 1 | Yes |
| (| (ii) without other risk factors for VTE | 2 | 1 | 1 | Yes |
| | c) > 42 days | 1 | 1 | 1 | Yes |
| | a) < 1 month postpartum | 3/4* | 2* | 2* | Yes |
| f. Breastfeeding | b) 30 days to 42 days | | | | |
| (see also Postpartum) | (i) with other risk factors for VTE | 3* | 2* | 2* | Yes |
| (see also i ostpartam) | (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 | | | | |
| | (i) non-insulin dependent | 2 | 2 | 2 | Yes |
| g. Diabetes mellitus (DM) | (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 |
| | a) Non-migrainous | 1* | 1 | 1 | Yes |
| | b) Migraine: | | | | |
| h. Headaches | i) without aura (includes menstrual migraines) | 2* | 1 | 1 | Yes |
| | iii) with aura | 4* | 1 | 1 | Yes |
| : Inflammatory Royal Disease | a) Mild; no risk factors | 2 | 2 | 2 | |
| i. Inflammatory Bowel Disease | b) IBD with increased risk for VTE | 3 | 2 | 2 | |
| | a) Adequately controlled hypertension | 3* | 1* | 2* | Yes |
| | b) Elevated blood pressure levels (properly taken | | | | |
| j. Hypertension | measurements): | | | | |
| j. Hypertension | (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 |
| k. History of high | | | | | |
| blood pressure | | 2 | 1 | 1 | Yes |
| during pregnancy | | | | | |
| | a) Normal or mildly impaired cardiac function: | | | | |
| I. Peripartum | (i) < 6 months | 4 | 1 | 1 | Yes |
| cardiomyopathy‡ | (ii) <u>></u> 6 months | 3 | 1 | 1 | Yes |
| | b) Moderately or severely impaired cardiac function | 4 | 2 | 2 | Yes |
| m. Multiple risk factors for | (such as older age, smoking, diabetes, hypertension, | 3/4* | 2* | | Yes |
| arterial CVD | low HDL, high LDL, or high triglyceride levels) | · · | | 3* | |
| n. Ischemic heart disease‡ | Current and history of | 4 | 2 3 | 3 | Yes |
| o. Valvular heart disease | a) Uncomplicated | 2 | 1 | 1 | Yes |
| | b) Complicated‡ | 4 | 1 | 1 | Yes |
| p. Stroke‡ | History of cerebrovascular accident | 4 | 2 3 | 3 | Yes |
| q. Known Thrombogenic mutations‡ | | 4* | 2* | 2* | Yes |
| * Please see the complete guidance for | C = continuation of contraceptive method; NA = Not applicable a clarification to this classification: Full <u>US MEC</u> (v. 2016) acreased risk as a result of unintended pregnancy. | | | | |

CONTINUES NEXT PAGE →

| Condition | Sub-condition | Combined pill, patch (CHC) | Progestin-only Pill (POP) | DMPA (Inj) | Other Contraception Options Indicated for Patient |
|---|---|----------------------------|------------------------------|----------------------|---|
| | | Initiating Continuing | Initiating Continuing | Initiating Continuin | |
| | 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 |
| r. Deep venous thrombosis | c) DVT/PE and established on anticoagulant therapy for | | | | |
| (DVT) | 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 |
| Pulmonary embolism (PE) | d) Family history (first-degree relatives) | 2 | 1 | 1 | Yes |
| | e) Major surgery | _ | - | - | 163 |
| | (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 | a) Varicose veins | 1 | 1 | 1 | |
| disorders | b) Superficial venous thrombosis (acute or history) | 3* | 1 | 1 | |
| II. Multiple Sclerosis | a) With prolonged immobility | 3 | 1 | 2 | Yes |
| ii. Multiple Scierosis | b)Without prolonged immobility | 1 | 1 | 2 | Yes |
| · · · · · · · · · · · · · · · · · · · | a) Restrictive procedures | 1 | 1 | 1 | Yes |
| surgery‡ | b) Malabsorptive procedures | COCs: 3 P/R: 1 | 3 | 1 | Yes |
| | a) Undiagnosed mass | 2* | 2* | 2* | Yes |
| Busset Disease | b) Benign breast disease | 1 | 1 | 1 | Yes |
| u. Breast Disease & | c) Family history of cancer | 1 | 1 | 1 | Yes |
| & Breast Cancer | d) Breast cancer:‡ | | | | |
| Dicust culled | 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 |
| V. Sona Organ Transplant | 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 |
| | a) Benign: i) Focal nodular hyperplasia | 2 | 2 | 2 | Yes |
| y. Liver tumors | ii) Hepatocellular adenoma‡ | 4 | 3 | 3 | Yes |
| | b) Malignant‡ (hepatoma) | 4 | 3 | 3 | Yes |
| | a) Symptomatic: | 7 | , | , | 103 |
| | (i) treated by cholecystectomy | 2 | 2 | 2 | Yes |
| z. Gallbladder disease | (ii) medically treated | 3 | 2 | 2 | Yes |
| | (iii) current | 3 | 2 | 2 | Yes |
| | b) Asymptomatic | 2 | 2 | 2 | Yes |
| an History of Chalastasis | a) Pregnancy-related | 2 | 1 | 1 | Yes |
| aa. History of Cholestasis | b) Past COC-related | 3 | 2 | 2 | Yes |
| | a) Positive (or unknown) antiphospholipid antibodies | 4* | 3* | 3* 3* | Yes |
| bb. Systemic lupus | b) Severe thrombocytopenia | 2* | 2* | 3* 2* | Yes |
| erythematosus‡ | c) Immunosuppressive treatment | 2* | 2* | 2* 2* | Yes |
| | d) None of the above | 2* | 2* | 2* 2* | Yes |
| | a) On immunosuppressive therapy | 2 | 1 | 2* | Yes |
| cc. Rheumatoid arthritis | (i) Long-term corticosteroid therapy | | | 3 | Yes |
| 11.01.10.10 | b) Not on immunosuppressive therapy | 2 | 1 | 2 | Yes |
| dd. Blood Conditions | a) Thalassemia | 2 | 1 1 | 1 | Yes |
| & Anemias | b) Sickle Cell Disease‡ | 1 | 1 | 1 | Yes |
| ee. Epilepsy‡ | c) Iron-deficiency anemia (see also Drug Interactions) | 1* | 1* | 1 1* | Yes Yes |
| ff. Tuberculosis‡ | a) Non-pelvic | 1* | 1* | 1* | Yes |
| | b) Pelvic | 1* | 1* | 1* | Yes |
| , | a) High risk for HIV | 1 | 1 | 1* | Yes |
| gg. HIV | b) HIV infection | 1* | 1* | 1* | Yes |
| 30 | (i) On ARV therapy | | reatment, see Drug Intera | | Yes |
| hh. Antiretroviral therapy | a) Fosamprenavir (FPV) | 3 | 2 | 2 | Yes |
| All other ARVs are a 1 or 2) | (i) Fosamprenavir + Ritonavir (FPV/r) | 2 | 2 | 1 | Yes |
| | a) Certain anticonvulsants (phenytoin, carbamazepine, | 3* | 3* | 1* | Voc |
| ii. Anticonvulsant therapy | barbiturates, primidone, topiramate, oxcarbazepine) | 3 | 3 | 1 | Yes |
| | b) Lamotrigine | 3* | 1 | 1 | Yes |
| | a) Broad spectrum antibiotics | 1 | 1 | 1 | Yes |
| jj. Antimicrobial | b) Antifungals | 1 | 1 | 1 | Yes |
| jj. Antimicrobial | , | | | | |
| jj. Antimicrobial therapy | c) Antiparasitics | 1 | 1 | 1 | Yes |
| • | c) Antiparasitics d) Rifampin or rifabutin therapy a) St. John's Wort | 1 3* 2 | 3* 2 | 1 1* 1 | Yes Yes Yes |

^{*} 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: | <u>,</u> | |
| City/State/Zip Code: | Phone number: | |
| Rx | | |
| ΓX | | |
| Drug: • Directions: | | |
| Quantity:Refills: | | |
| Written Date: | | |
| Prescriber Name: | Prescriber Signature: | |
| Pharmacy Address: | Pharmacy Phone: | |
| | | |
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Provider Notification Contraception

| Pharmacy Name: | Pharmacist Name: |
|--------------------------------------|--|
| Pharmacy Address: | |
| | Pharmacy Fax: |
| Dear Provider | (name), () (FAX) |
| Your patient | (name)/ (DOB) was: |
| issued and dispense | |
| | |
| _ | Directions: |
| | Quantity: Refills: |
| _ | Nemis |
| issued and adminis O Drug: | Administered contraception at our Pharmacy on/ noted above. The prescription tered consisted of: Directions: Quantity: Refills: dispensed or administered contraception at our Pharmacy noted above, because: |
| □ Pregnancy car | nnot be ruled out. |
| Notes: | |
| ☐ The patient in | dicated they have a health condition than requires further evaluation. |
| Notes: | |
| | dicated they take medication(s) or supplements that may interfere with contraception. |
| Notes: | |
| □ Their blood pr | ressure reading was : |
| □ ≥140/90 | mmHg and I am unable to prescribe any combined hormonal contraceptive (estrogen + |
| progestero | ne) pill, patch, or ring |
| □ ≥160/100 | O mmHg and I am unable to prescribe any injectable (progesterone only) |
| □ The patient di sexual health in | d not have a clinical visit with a healthcare provider, other than a pharmacist, for reproductive or past 3 years. |

The prescription was issued pursuant to the Board of Pharmacy <u>protocol</u> authorized under <u>OAR 855-020-0300</u>.

- 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: | | | |
| | | | | |
| $\hfill\Box$ Today you were prescribed (and $\hfill\Box$ admir | nistered) the following hormonal contraception: | | | |
| | | | | |
| Notes: | | | | |
| If you have a question, my name is | · | | | |
| Please review this information with your | healthcare provider. | | | |
| | or | | | |
| | | | | |
| $\hfill \square$ I am not able to prescribe hormonal conf | raception to you today, because: | | | |
| □ Pregnancy cannot be ruled out. | | | | |
| Notes: | | | | |
| ☐ You have a health condition than requ | ires further evaluation. | | | |
| Notes: | | | | |
| ☐ You take medication(s) or supplement | s that may interfere with contraception. | | | |
| Notes: | | | | |
| ☐ Your blood pressure reading is/ | : | | | |
| □ ≥140/90 mmHg and I am unable t | o 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 additiona | al evaluation by another healthcare provider. Please share this | | | |
| information with your provider. | | | | |
| ☐ You have not had a clinical visit with a sexual health in past 3 years. | healthcare provider, other than a pharmacist, for reproductive or | | | |