

## **Utah Guidance for Self-Administered Hormonal Contraceptives**

### **Approved xx,x, 2021**

This guidance authorizes qualified Utah-licensed pharmacists ("Pharmacists") to perform the pertinent assessments and prescribe hormonal contraceptives under the conditions of this guidance and according to and in compliance with all applicable state and federal laws and rules.

#### **Training Program**

Only a Utah-licensed pharmacist, who has completed an Accreditation Council for Pharmacy Education (ACPE) accredited educational training program related to the prescribing of contraceptives by a pharmacist, may dispense hormonal contraceptive patches, a hormonal vaginal ring, and oral hormonal contraceptives to a patient. In addition, pharmacists shall comply with the most current United States Medical Eligibility Criteria (USMEC) for Contraceptive Use as adopted by the U.S. Centers for Disease Control and Prevention (CDC).

#### **Age Requirements**

A pharmacist may prescribe hormonal contraceptive patches, a hormonal vaginal ring, and self-administered oral hormonal contraceptives to a person who is at least 18 years of age.

#### **Further Conditions**

(1) For each new patient requesting a contraceptive service and, at a minimum of every twelve months for each returning patient, a participating pharmacist must:

- (a) Obtain a completed Utah Hormonal Contraceptive Self-Screening Questionnaire;
- (b) Utilize and follow the Standard Procedures Algorithm for Prescribing of Contraceptives to perform the patient assessment;
- (c) Prescribe, if clinically appropriate, the hormonal contraceptive patch, self-administered oral hormonal contraceptive, hormonal vaginal ring, or refer to a healthcare practitioner;
- (d) Provide the patient with a Visit Summary;
- (e) Advise the patient to consult with a primary care practitioner or women's health care practitioner;
- (f) Refer any patient that may be subject to abuse to an appropriate social services agency; and
- (g) Ensure that the pharmacy provides appropriate space to prevent the spread of infection and ensure confidentiality.

(2) If the hormonal contraceptive patch, hormonal vaginal ring, or self-administered oral hormonal contraceptive is dispensed, it must be done as soon as practicable after the pharmacist issues the prescription and shall include any relevant educational materials.

(3) A pharmacist must not:

- (a) Continue to prescribe and dispense a hormonal contraceptive to a patient beyond three years from the initial prescription without evidence of a clinical visit; or

(b) Prescribe in instances that the Standard Procedures Algorithm requires referral to a provider.

(4) Records:

(a) Pursuant to Utah Admin Code [R156-17b-627](#), a process shall be in place for the pharmacist to communicate with the patient's primary care provider and document changes to the patient's medical record. If the patient does not have a primary care provider, or is unable to provide contact information for his or her primary care provider, the pharmacist shall provide the patient with a written record of the drugs or devices furnished and advise the patient to consult an appropriate health care professional of the patient's choice.

(b) Pharmacists shall comply Utah Code 58-17b-611 with respect to the maintenance of proper records.

DRAFT

**STANDARD PROCEDURES ALGORITHM FOR PRESCRIBING OF CONTRACEPTIVES (excluding DMPA)**

**1) Health and History Screen**

Review Hormonal Contraceptive Self-Screening Questionnaire.  
To evaluate health and history, refer to USMEC or Utah MEC.

**1 or 2 (green boxes) - Hormonal contraception is indicated, proceed to next step.**  
**3 or 4 (red boxes) - Hormonal contraception is contraindicated → Refer**

Contraindicating Condition(s)

Refer

No Contraindicating Conditions

**2) Pregnancy Screen**

- a. 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?
- b. Have you had a baby in the last 4 weeks?
- c. Did you have a miscarriage or abortion in the last 7 days?
- d. Did your last menstrual period start within the past 7 days?
- e. Have you abstained from sexual intercourse since your last menstrual period or delivery?
- f. Have you been using a reliable contraceptive method consistently and correctly?

**If YES to AT LEAST ONE and is free of pregnancy symptoms, proceed to next step.**

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

Possible Pregnancy

Refer

Patient is not pregnant

**3) Medication Screen (Questionnaire #24 + med list) (Corticosteroids - refer to DMPA algorithm)**

Caution: anticonvulsants, antiretroviral, antimicrobials, barbiturates, herbs & supplements, including:  
 carbamazepine    lamivudine/lamivudine    primidone    (\*PLEASE ALWAYS REFER TO CURRENT MEC\*)  
 felbamate            oxcarbazepine            rifampin / rifabutin  
 griseofulvin        phenobarbital            topiramate  
 lamotrigine         phenytoin                fosamprenavir (when not combined with ritonavir)

Contraindicating Medications

Refer

No Contraindicating Medications

**4) Blood Pressure Screen:**

Take and document patient's current blood pressure. Is BP <140/90?  
Note: RPH may choose to take a second reading, if initial is high.

BP ≥ 140/90

Refer or consider PCP

BP < 140/90

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

Not currently on birth control

Patient is currently on birth control

**5a) Choose Contraception**

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

-Prescribe up to 12 months of desired contraception and dispense product (quantity based on professional judgment and patient preference)

**5b) Choose Contraception**

**Continue** current form of pills 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 up to 12 months of desired contraception and dispense product. (quantity based on professional judgment and patient preference)

**6) Discuss Initiation Strategy for Initial Treatment/Change in Treatment (as applicable)**

- a) Counseling - Quick start - Instruct patient she can begin contraceptive today; use backup method for 7 days.
- b) Counseling - Discuss the management and expectations of side effects (bleeding irregularities, etc.)
- c) Counseling - Discuss adherence and expectations for follow-up visits

**7) Discuss and Provide Referral / Visit Summary to patient**

Encourage: Routine health screenings, STD prevention, and notification to care provider

## Utah Hormonal Contraceptive Self-Screening Questionnaire

Name \_\_\_\_\_ Health Care Provider's Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ (must be 18) Weight \_\_\_\_\_ Do you have health insurance? Yes / No

What was the date of your last women's health clinical visit? \_\_\_\_\_

Any allergies to Medications? Yes / No If yes, list them here \_\_\_\_\_

**Do you have a preferred method of birth control that you would like to use?**

A daily pill  A weekly patch  A monthly vaginal ring  Injectable (every 3 mo.)  Other (IUD, implant)

**Background Information:**

1	Do you think you might be pregnant now?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	What was the first day of your last menstrual period?	___/___/___
3	Have you ever taken birth control pills, or used a birth control patch, ring, or injection?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Have you previously received contraceptives?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Did you ever experience a bad reaction to using hormonal birth control?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	- If yes, what kind of reaction occurred?	_____
	Are you currently using any method of birth control including pills, or a birth control patch, ring or shot/injection?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	- If yes, which one do you use?	_____
4	Have you ever been told by a medical professional not to take hormones?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Do you smoke cigarettes?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Medical History:**

6	Have you had a recent change in vaginal bleeding that worries you?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7	Have you given birth within the past 21 days? If yes, how long ago?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8	Are you currently breastfeeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9	Do you have diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10	Have you ever had a migraine headaches?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11	Are you being treated for inflammatory bowel disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
12	Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)	Yes <input type="checkbox"/> No <input type="checkbox"/>
13	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14	Have you ever had a blood clot?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15	Have you ever been told by a medical professional you are at risk of developing a blood clot?	Yes <input type="checkbox"/> No <input type="checkbox"/>
16	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
17	Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
18	Have you had bariatric surgery or stomach reduction surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
19	Do you have or have you ever had breast cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
20	Have you had a solid organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
21	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 <input type="checkbox"/> No <input type="checkbox"/>
22	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>
23	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	- If yes, list them here:	_____
24	Do you have any other medical problems or take any medications, including herbs or supplements?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	- If yes, list them here:	_____

Signature \_\_\_\_\_ Date \_\_\_\_\_

Optional Side – May be used by pharmacy

This side of form may be customized by pharmacy –Do not make edits to the Questionnaire (front side)

Pregnancy Screen		
a. 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 <input type="checkbox"/>	No <input type="checkbox"/>
b. Have you had a baby in the last 4 weeks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c. Did you have a miscarriage or abortion in the last 7 days?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d. Did your last menstrual period start within the past 7 days?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e. Have you abstained from sexual intercourse since your last menstrual period or delivery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f. Have you been using a reliable contraceptive method consistently and correctly?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Verified DOB with valid photo ID     BP Reading \_\_\_\_\_ / \_\_\_\_\_

*Note: Must refer patient if either systolic or diastolic reading is out of range, per algorithm*

**Rx** Drug Prescribed \_\_\_\_\_ Rx \_\_\_\_\_  
Directions for Use \_\_\_\_\_  
Pharmacist Name \_\_\_\_\_ Pharmacist Signature \_\_\_\_\_  
Pharmacy Address \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Patient Referred

-or-

Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





## Hormonal Contraception Information for DOPL's Website

1. This guidance
2. Utah Hormonal Contraceptive Self Screening Questionnaire  
[https://dopl.utah.gov/pharm/hormonal\\_contraception\\_questionnaire.pdf](https://dopl.utah.gov/pharm/hormonal_contraception_questionnaire.pdf)
3. Utah Hormonal Contraceptive Self Screening Questionnaire-Spanish  
[https://dopl.utah.gov/pharm/hormonal\\_contraceptive\\_Questionnaire\\_Spanish.pdf](https://dopl.utah.gov/pharm/hormonal_contraceptive_Questionnaire_Spanish.pdf)
4. Standard Procedures Algorithm for Prescribing of Contraceptives  
[https://dopl.utah.gov/pharm/standard\\_procedures\\_algorithm\\_contraceptive.pdf](https://dopl.utah.gov/pharm/standard_procedures_algorithm_contraceptive.pdf)
5. Summary Chart of U.S Medical Eligibility Criteria For Contraceptive Use  
[https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria\\_508tagged.pdf](https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria_508tagged.pdf)
6. Women's Health Resources <https://mihp.utah.gov/wp-content/uploads/Womens-Health-Resources.pdf>
7. Utah Maternal and Infant Health Program <https://mihp.utah.gov/>
8. ACOG Well-Woman Recommendations [https://www.acog.org/topics/well-woman-health-care?utm\\_source=redirect&utm\\_medium=web&utm\\_campaign=otn](https://www.acog.org/topics/well-woman-health-care?utm_source=redirect&utm_medium=web&utm_campaign=otn)
9. JCCP Pharmacist Patient Care Process <https://jcpp.net/patient-care-process/>