Policy

Maternal and Family Health Services, Inc. shall make available either directly or through referral, all of the DHHS approved methods of contraception including the dedicated emergency contraception product Plan B.

Standards

1. Routine method counseling for enrolled family planning clients will include information on the availability and use of emergency contraception. To facilitate access, MFHS clinicians may provide an advance supply of or prescription for emergency contraception pills to clients at the time of a routine family planning visit.
   - Method specific consent form must include sign off of “emergency contraception pills” when provided in advance of need.
   - Method specific consent form should include sign off of “emergency contraception pills” in addition to the long term contraceptive method of choice if the client considers future use.

2. Emergency contraception will be offered or made available to women who request it (enrolled client or initial visit request) at any time prior to or up to 72 to 120 hours (3-5 days) after unprotected or inadequately protected sexual intercourse. No clinician examination or pregnancy testing is necessary before provision or prescription of emergency contraception. Treatment should be initiated as soon as possible after unprotected or inadequately protected intercourse to maximize efficacy.
   - No evidence demonstrates that emergency contraception is unsafe for women with specific contraindications to oral contraceptives or for those with any particular medical condition.
   - Although existing pregnancy is not a contraindication for emergency contraception in terms of risk of adverse effects, emergency contraception is not indicated in women with confirmed pregnancy because it will have no effect.

3. Initial visit emergency contraception request service process must include signed “Consent for Provision of Services and/or Supplies” with signed method specific election of “emergency contraception pills” and completion of the “Request for Emergency Contraception Pills” visit form.

   Clients who present to the clinic for emergency contraception pills as an initial visit must also be counseled about STD/HIV risks, and should be offered urine based STD screening for Chlamydia and gonorrhea at the same visit (see “Request for ECP” visit form).

4. Progestin-only pills and combination pills may be used if the woman has used it before, even within the same menstrual cycle. Ulipristal should be taken only once during a menstrual cycle.
5. Method counseling will include instruction that:

**Progestin-only pills:**
- The 1.5mg levonorgestrel-only regimen, can be taken as a single dose.
- Levonorgestrel-only EC is less effective for women with a BMI ≥ 26.
- Because the incidence of nausea and vomiting is low with the levonorgestrel-only regimen, prophylactic antiemetics are not necessary, but that the dose of emergency contraception should be repeated if vomiting does occur within two hours of taking a dose.
- There is pregnancy risk later in the same menstrual cycle with subsequent coital acts, and effective contraceptive methods for immediate and long term use should be used post emergency contraception (i.e. emergency contraception should not be used as long-term contraception).
  - All women should begin using barrier contraception to prevent pregnancy (e.g. condoms, diaphragm, or spermicides) immediately after taking emergency contraception
  - Short term hormonal contraceptives (e.g. pills, patches and rings) may be started either immediately (with a backup barrier method) or after the next menstrual period
  - Long term hormonal methods should be started after the next menstrual period when it is clear that the client is not pregnant
- No scheduled follow up is required after use of emergency contraception, however, clinical evaluation is indicated for women who have used emergency contraception if:
  1. Menses are delayed by a week or more after the expected time, or
  2. Lower abdominal pain develops, or
  3. Persistent irregular bleeding develops

**Combination pills:**
- Combined estrogen-progestin treatment involves two doses taken 12 hours apart.
- The number of pills needed for emergency contraception is different for each brand of pill.
- There is a higher risk of nausea and vomiting than the progestin-only method.

**Ulipristal pills:**
- A single dose of ella (30 mg Ulipristal pill)
- ella may decrease the effectiveness of hormonal birth control methods, therefore a non-hormonal method (condom) should be used until the next menstrual period starts.

**BMI / EC effectiveness:**
- Clinical trials have shown that any EC pill loses its effectiveness in women with a BMI > 35.

**Procedure**

1. Include information on emergency contraception pills (ECPs) – indications, availability, use –when counseling enrolled clients about birth control methods. Obtain method specific consent for ECPs if provided in advance of need or if client considers future use.

2. For initial visit ECP requests, obtain client consent for services/supplies with ECP method selection and complete the "Request for Emergency Contraception Pills" visit form; prescribe or provide the method per eligibility determination with method counsel as outlined in standards (#5); counsel about STD/HIV risks and offer urine based STD screening for Chlamydia and gonorrhea; provide condoms for immediate post ECP method use/STD protection. Provide and review "Instructions for using Emergency Contraception Plan B" to include discussion of ongoing contraception needs and information regarding effective contraceptive methods. Schedule return family planning services visit as indicated.
3. For enrolled clients with ECP request at any visit, provide/prescribe ECPs to those who request it at any time prior to or up to 72 to 120 hours (3-5 days) after unprotected or inadequately protected sexual intercourse after eligibility determination, confirming/obtaining method consent and counseling re use, side effects, resuming contraceptive method of choice, and reasons for follow up evaluation after ECP use.

Resources
- ACOG FAQ 114
- Contraceptive Technology (Hatcher et al…) 20th Edition Chapter 6

Document History
- Revised August 2013
- April 2010
- September 2007
- September 2003