7.1 Contraceptives
The Fraser Guidelines should be followed when prescribing contraception for women less than 16 years. The faculty of sexual and reproductive healthcare provides this and other useful information and guidance www.fsrh.org

Review patients on hormonal contraceptives at least annually for changes in risk factors, personal and family medical history.

Full counselling, backed by the appropriate FPA leaflet, should be provided.
NICE Clinical Guideline 30 recommends:
- women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods;
- contraceptive service providers should
  - be aware that:
    - All currently available LARC methods (intrauterine devices [IUDs], the intrauterine system [IUS], injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use.
    - IUDs, the IUS and implants are more cost effective than the injectable contraceptives
    - increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies

For advice on interactions between hormonal contraception and other drugs see FSRH guidance.

7.1.1 Combined hormonal contraceptives (CHC)

<table>
<thead>
<tr>
<th>1st line option Ethinyloestradiol 30 micrograms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand Name</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>rigevidon</td>
</tr>
<tr>
<td>Loestrin 30</td>
</tr>
<tr>
<td>Millinette 30/75</td>
</tr>
<tr>
<td>Gedarel 30/150</td>
</tr>
</tbody>
</table>

If suffering progestogenic effects of products above try products below:

<table>
<thead>
<tr>
<th>2nd line option- Ethinyloestradiol 20 micrograms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand Name</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>Gedarel 20/150</td>
</tr>
</tbody>
</table>
1. Ethinylestradiol 20mcg/kg
   Gestodene 75mcg
   2nd line option in this class
   Same formulation as Femodette/Sunya

2. Ethinylestradiol 20mcg/kg
   Norethisterone Acetate 1mg
   Existing patients only
   NO new initiations due to breakthrough bleeding sexual health team are phasing out

3. Ethinylestradiol 35micrograms
   Norinon
   Ethinylestradiol 35mcg
   Norethisterone 1mg

N.B. products are selected by both cost-effectiveness but also based on keeping a consistent product choice to enable easier ordering for local pharmacies.
*New brands of oral contraceptives are constantly being launched and prescribers may find this information helpful in selecting formulary equivalents

1. Appropriate for women up to 50 years of age if no risk factors for CVD, provided a CHC is otherwise suitable. Caution re: risk of VTE with BMI >30 (contraindicated with BMI ≥35). Avoid in women aged over 50. Avoid in smokers aged 35 years and over.

2. There is an increased risk of venous thromboembolic disease in users of combined hormonal contraceptives particularly during the first year and possibly after restarting combined hormonal contraceptives following a break of four weeks or more. This risk is considerably smaller than that associated with pregnancy (about 60 cases of venous thromboembolic disease per 100,000 pregnancies). (BNF online). The MHRA in February 2014 confirmed the small VTE risk of CHCs and recommended that prescribers consider risk factors and remain vigilant for signs and symptoms. A prescribing checklist is available in the annex of the CAS letter sent to prescribers.

3. The MHRA in March 2014 advised St John’s Wort interacts with hormonal contraceptives including implants. This interaction reduces the effectiveness of these contraceptives and increases the risk of unplanned pregnancy

4. CHCs containing both oestrogen and progestogen are the most effective. A low hormone content pill should be tried initially and the patient maintained on a preparation with the lowest oestrogen and progestogen content consistent with good cycle control and minimal side effects. Preparations containing the older progestogens levonorgestrel and norethisterone are to be preferred.

5. Phased preparations are available but they are more complicated to use. They may help to improve cycle control with a lower dose increase in some women, where this is inadequate with a recommended (monophasic) preparation above. These are reserved for women who either do not have withdrawal bleeding or who have breakthrough bleeding with monophasic. As these are extremely expensive this should be used on specialist recommendation only so are classified as amber 1. The formulary preparation lognon ED.

6. Ethinylestradiol 30mcg/drospirenone 3mg e.g. Lucette (preferred choice), Dretine and Yasmin is a 3rd line choice. However the patient should have already tried at least two other CHC’s including a third generation one —i.e. containing either Gestodene or Desogestrel e.g Gedrael or Femodette.

7. Evra patch is 2nd line to oral formulary CHC. Reserved for women who have demonstrated or are deemed to be at substantial risk of poor compliance with oral CHC. It is significantly more expensive than oral CHC.
8. NuvaRing is not used frequently but is green for Gp initaiton though it is a last line contraception.

### 7.1.2 Progestogen only contraceptives:

#### Oral progestogen only contraceptives

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Progestogen</th>
<th>Use</th>
<th>Comments and alternative equivalent brands* for information</th>
</tr>
</thead>
<tbody>
<tr>
<td>cerelle</td>
<td>75mcg</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; line</td>
<td>Prescribe generically as caused some confusion due to supply availability. Brands include Aizea/Cerzette/Cerelle/Desomono/Desorex/Nacre/Zelleta</td>
</tr>
</tbody>
</table>

#### Levonorgestrel

<table>
<thead>
<tr>
<th>Norgeston</th>
<th>30mcg</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; line</th>
<th></th>
</tr>
</thead>
</table>

#### Norethisterone

<table>
<thead>
<tr>
<th>Noriday</th>
<th>350mcg</th>
<th></th>
</tr>
</thead>
</table>

#### Parenteral progestogen only contraceptives

<table>
<thead>
<tr>
<th>Etonogestrel</th>
<th>Nexplanon</th>
<th>68mg</th>
<th>Subdermal implant</th>
</tr>
</thead>
</table>

### Norethisterone

<table>
<thead>
<tr>
<th>Noristerat</th>
<th>200mg</th>
<th>Deep intramuscular injection</th>
<th></th>
</tr>
</thead>
</table>

### Medroxyprogesterone acetate

<table>
<thead>
<tr>
<th>Depo-Provera</th>
<th>150mg/ml</th>
<th>Deep intramuscular injection</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sayana Press</th>
<th>104mg/0.65ml</th>
<th>Subcutaneous injection whereby patients may self-administered by the patent at 13 week intervals after appropriate training.</th>
</tr>
</thead>
</table>

### Intra-uterine progestogen only system

**N.b. the health professional should be fully trained in the technique and should provide full counselling backed by the patient information leaflet**
Levonorgestrel
These should always be prescribed by brand name because products have different indication, duration of use and introducers. MHRA Jan 2016

<table>
<thead>
<tr>
<th>Mirena</th>
<th>20mcg/24hours</th>
<th>Duration 5 years and licensed for menorrhagia</th>
<th>• Not to be prescribed to be purchased and used as per the SLA agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jaydess</td>
<td>13.5mg</td>
<td>Duration 3 years, not licensed for menorrhagia</td>
<td>• Not to be prescribed to be purchased and used as per the SLA agreement</td>
</tr>
</tbody>
</table>

*New brands of oral contraceptives are constantly being launched and prescribers may find this information helpful in selecting formulary equivalents

1. Levosert (levonorgestrel 20micrograms/24 hours) is currently non formulary.

Medroxyprogesterone acetate
Full counselling, backed by manufacturer’s approved leaflet, required before administration.
1. In women aged under 18 years progestogen-only injectable contraception can be used after consideration of alternative methods.
2. Women using DMPA who wish to continue use should be reviewed every 2 years to assess individual situations, and to discuss the benefits and potential risks.
3. In women with risk factors for osteoporosis, a method of contraception other than medroxyprogesterone acetate should be considered.

7.1.3 Spermicidal contraceptives
No recommendations for this section

7.1.4 Contraceptive devices
The most effective intra-uterine devices have at least 380mm² of copper and have banded copper on the arms. On the formulary are the TT-380 slim line and the Nova-T 380.

Levonorgestrel 52mg (Mirena Coil) Levonorgestrel 13.5mg (Jaydess Coil) are progestone only coils on the formulary. For menorrhagia only the mirena coil is licensed.

Please note: These devices should be purchased and supplied as part of the SLA with public health. They should not be prescribed on FP10.

7.1.5 Emergency contraception- See decision aid
All women seeking emergency contraception should be advised that a copper IUD is more effective than EHC. “A copper IUD (or advice on how to obtain one) should be offered to all women attending for emergency contraception, even if they present within 72 hours of unprotected sexual intercourse” (FSRH 2017).

Women should be advised that if they have already ovulated there is no evidence that hormonal emergency contraception has any effect.

Levonorgestrel 1.5mg (Upostelle)
Ulipristal acetate 30mg (EllaOne) – second line when patient presents more then 72 hours after coitus but less then 120 hours, also more effective in those of higher weight (see point 3)

1. Do not prescribe as ‘Levonelle One Step’ as this is the OTC preparation and more expensive.
2. Women using liver enzyme-inducing drugs should be advised that an IUD is the preferred option for Emergency Contraception (Grade A). Women who are using liver enzyme-inducing drugs who are given. 1.5 mg tablets of levonorgestrel should be advised to take a total of 3 mg (two tablets) as a single dose, as soon as possible and within 72 hours of unprotected sexual intercourse. This use is outside the product license.

3. Women who are over 70 kg or have a BMI of 26 or more should also receive a higher off label dose of 3 mg (two tablets of levonorgestrel or take the second line option ulipristal (EllaOne®))

4. MHRA September 2016. For missed pills levonorgestrel is the preferred option.

**Quick starting contraception includes:**
- Starting contraception at a time other than the beginning of the menstrual cycle, but it is reasonably certain that there is no risk of pregnancy.
- Starting contraception at a time other than the beginning of the menstrual cycle and there is a potential risk of very early pregnancy from recent UPSI (but it is too early to exclude pregnancy using a high-sensitivity pregnancy test). Quick starting in this situation is appropriate if a woman considers it likely that she will continue to be at risk of pregnancy or if she wishes to avoid delaying commencement of contraception.

After oral emergency contraception, further episodes of unprotected intercourse in the same cycle put women at risk of pregnancy therefore quick starting method is advised.
- After levonorgestrel EC administration, CHC, POP, IMP (and DMPA) can be quick started immediately.
- After ulipristal acetate EC administration, they should wait 5 days before quick starting suitable hormonal contraception.

**Number of days for abstinence or barrier methods after oral emergency contraception dose:**

<table>
<thead>
<tr>
<th>Type of HC</th>
<th>Quick start after ulipristal after 5 day delay</th>
<th>Quick start after levonorgestrel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined oral contraceptive pill (except Qlaira®)</td>
<td>5 day delay+7 days</td>
<td>+7 days</td>
</tr>
<tr>
<td>Qlaira® - combined oral contraceptive pill</td>
<td>5 day delay +9 days</td>
<td>+9 days</td>
</tr>
<tr>
<td>Combined vaginal ring/ transdermal</td>
<td>5 day delay +7 days</td>
<td>+7 days</td>
</tr>
<tr>
<td>Progestogen-only pill</td>
<td>5 day delay +2 days</td>
<td>+2 days</td>
</tr>
<tr>
<td>Progestogen-only implant or injectable</td>
<td>5 day delay +7 days</td>
<td>+7 days</td>
</tr>
</tbody>
</table>
Decision-making Algorithms for Emergency Contraception

Algorithm 1: Decision-making Algorithm for Emergency Contraception (EC): Copper Intrauterine Device (Cu-IUD) vs Oral EC

Currently <120 hours since last UPSI?

- Yes
  - Additional UPSI this cycle, >120 hours ago?
    - Yes or unknown
      - Currently ≤5 days after earliest likely date of ovulation?
        - Yes
          - Offer Cu-IUD
            - If not acceptable, offer oral EC* and suitable ongoing contraception
          - Oral EC unlikely to be effective
          - Offer suitable quick start contraception
          - Consider pregnancy test if UPSI this cycle, more than 21 days ago
          - Offer oral EC* and suitable ongoing contraception
        - No or unknown
          - Offer Cu-IUD
          - Oral EC unlikely to be effective
          - Offer suitable quick start contraception
      - No
        - Offer oral EC* and suitable ongoing contraception
      - No or unknown
        - Offer oral EC* and suitable ongoing contraception
  - No
    - Currently ≤5 days after earliest likely date of ovulation?
      - Yes
        - Offer Cu-IUD
        - Oral EC unlikely to be effective
        - Offer suitable quick start contraception
      - No or unknown
        - Offer Cu-IUD
          - If not acceptable, offer oral EC* and suitable ongoing contraception
        - Offer oral EC* and suitable ongoing contraception
      - Unknown
        - Offer oral EC* and suitable ongoing contraception

*For choice of oral EC see Algorithm 2.

Note that there is no evidence that oral EC is effective if ovulation has already occurred.

Cu-IUD - copper intrauterine device
EC - emergency contraception
UPS - unprotected sexual intercourse
Algorithm 2: Decision-making Algorithm for Oral Emergency Contraception (EC): Levonorgestrel EC (LNG-EC) vs Ulipristal Acetate EC (UPA-EC)

The Cu-UID is the most effective form of EC. If criteria for insertion of a Cu-UID are not met or a Cu-UID is not acceptable to a woman, consider oral EC:

1. Last UPSI < 24 hours ago?
   - Yes
   - UPSI likely to have taken place 24 hours prior to the estimated day of ovulation?
     - Yes or unknown
       - BMI > 30 kg/m² or weight > 70 kg
         - Yes
         - Oral EC unlikely to be effective.
         - Reconsider Cu-UID if currently within 5 days after likely ovulation.
         - **Consider double-dose (3 mg LNG if BMI > 25 kg/m² or weight > 70 kg) or if taking an enzyme inducer (Section 10.1)**
       - No
         - Oral EC unlikely to be effective.
         - Reconsider Cu-UID if currently within 5 days after likely ovulation.
     - No
       - Oral EC unlikely to be effective.
       - Reconsider Cu-UID if currently within 5 days after likely ovulation.

2. Last UPSI < 120 hours ago?
   - No
     - Oral EC unlikely to be effective.
     - Reconsider Cu-UID if currently within 5 days after likely ovulation.
   - Yes or unknown
     - BMI > 30 kg/m² or weight > 70 kg
       - Yes
       - Oral EC unlikely to be effective.
       - Reconsider Cu-UID if currently within 5 days after likely ovulation.
       - Immediate GS only
     - No
       - Oral EC unlikely to be effective.
       - Reconsider Cu-UID if currently within 5 days after likely ovulation.

**NOTE THAT ORAL EC IS UNLIKELY TO BE EFFECTIVE IF TAKEN AFTER OVULATION**

- **UPA-EC**: + start contraception after 5 days
  - Reconsider Cu-UID if not UPSI within 120 hours or if currently within 5 days after likely ovulation
  - If UPSI not suitable: LNG-EC
    - Immediate GS

- **LNG-EC**: + start contraception after 5 days
  - Reconsider Cu-UID if not UPSI within 120 hours or if currently within 5 days after likely ovulation
  - Immediate GS

- **UPA-EC**: + start contraception after 5 days
  - **Consider double-dose (3 mg LNG if BMI > 25 kg/m² or weight > 70 kg) or if taking an enzyme inducer (Section 10.1)**

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