

# State of Utah Department of Commerce

Division of Occupational and Professional Licensing

MARGARET W. BUSSE Executive Director

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# <u>Utah Guidance for Self-Administered Hormonal Contraceptives</u> Approved September 28, 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**

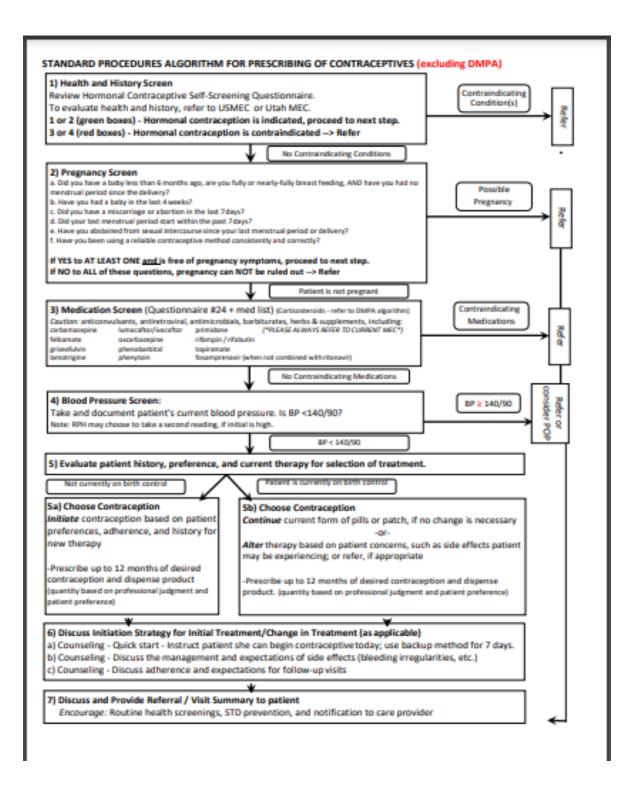
Only a Utah-licensed pharmacist, who has completed an Accreditation Council for Pharmacy Education (ACPE) accredited educational training program related to the prescribing of contraceptives by a pharmacist, may dispense hormonal contraceptive patches, a hormonal vaginal ring, and oral hormonal contraceptives 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.



Name		Utah Hormonal Contraceptive Self-Screening Questionnaire		
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 III weekly patch III Am monthly vaginal ring III plectable (every 3 mo.) III Do you think you might be pregnant now?  What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  Wes III Note III was the period of pirth control patch, ring, or injection?  Wes III Note III was well and of reaction occurred?  Are you currently using any method of birth control including pills, or a birth control patch, ring or shot/injection?  If yes, which one do you use?  Have you ever been told by a medical professional not to take hormones?  Yes III Note III Have you were been told by a medical professional not to take hormones?  Wes III Note III Have you given birth within the past 21 days? If yes, how long ago?  Wes III Note III Have you being treated for inflammatory bowel disease?  Yes III Note III Have you being treated for inflammatory bowel disease?  Yes III Note III Have you being treated for inflammatory bowel disease?  Yes III Note III Have you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  Are you ever had a migraine headaches?  Wes III Note III Have you had a recent major surgery or are you planning to have surgery in the next 4 weeks?  Yes III Note III Have you had a present major surgery or stomach reduction surgery?  Wes III Note III Have you had a solid organ transplant?  Wes III Note III Have you had a solid organ transplant?  Yes III Note III Have you had beart attack or stroke, or been told you have surgery in the next 4 weeks?  Yes III Note III Have you	Name		Date	
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 alnjectable (every 3 mo.) all other (IUD, implant)  Bockground Information:  1 Do you think you might be pregnant now?  Yes a Noa What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  I Have you ever taken birth control pills, or used a birth control patch, ring, or injection?  Have you previously received contraceptives?  Did you ever experience a bad reaction to using hormonal birth control?  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?  If yes, which one do you use?  Have you ever been told by a medical professional not to take hormones?  Yes a Noa Medical History:  Begin this open with within the past 21 days? If yes, how long ago?  Have you given birth within the past 21 days? If yes, how long ago?  Yes a Noa Are you currently breastfeeding?  Do you have diabetes?  Yes a Noa Are you currently breastfeeding?  Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  Have you ever had a heart attack or stroke, or been told you had any heart disease?  Yes a Noa Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Have you ever been told by a medical professional you are at risk of developing a blood clot?  Yes a Noa Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Yes a Noa Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Yes a Noa Have you had bariatric surgery or stomach reduction surgery?  Yes a Noa Have you had bariatric surgery or stomach reduction surgery?  Yes a Noa Have you had bariatric surgery or stomach reduction su	_		rance? Yes	/N
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)  Bockground Information:  1 Do you think you might be pregnant now?  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 □ No□  1 Did you ever experience a bad reaction to using hormonal birth control?  • If yes, what kind of reaction occurred?  • If yes, what kind of reaction occurred?  • If yes, what was the first day of your last menstrual period?  • If yes, what kind of reaction occurred?  • If yes, what was the first day of your last menstrual period?  • If yes, what was the first day of your last menstrual period?  • If yes, what kind of reaction occurred?  • If yes, what was the first day of your last menstrual period?  • If yes, what how occurred?  • If yes, what how of occurred?  • If yes, what how one do you use?  • If yes, which one do you use?  • Have you ever been told by a medical professional not to take hormones?  • Yes □ No□  Do you smoke cigarettes?  • Wes □ No□  • Have you given birth within the past 21 days? If yes, how long ago?  • Yes □ No□  • Have you given birth within the past 21 days? If yes, how long ago?  • Yes □ No□  10 Have you ever had a migraine headaches?  10 Have you ever had a migraine headaches?  11 Are you being treated for inflammatory bowel disease?  12 Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  13 Have you ever had a hart attack or stroke, or been told you had any heart disease?  • Yes □ No□  14 Have you ever had a blood clot?  15 Have you ever had a blood clot?  16 Have you have might hold blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  17 Have you have bigh blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if i	What w	as the date of your last women's health clinical visit?		
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Do you think you might be pregnant now?  What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  What was the first day of your last menstrual period?  Have you ever taken birth control pills, or used a birth control patch, ring, or injection?  Have you previously received contraceptives?  Did you ever experience a bad reaction to using hormonal birth control?  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?  If yes, which one do you use?  Have you ever been told by a medical professional not to take hormones?  Wes Do you smoke cigarettes?  Medical History:  Have you given birth within the past 21 days? If yes, how long ago?  Have you given birth within the past 21 days? If yes, how long ago?  Have you given birth within the past 21 days? If yes, how long ago?  Have you ever had a migraine headaches?  Have you ever had a migraine headaches?  Are you being treated for inflammatory bowel disease?  Yes Do you have diabetes?  Wes Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  Have you ever had a heart attack or stroke, or been told you had any heart disease?  Yes Do you have been told by a medical professional you are at risk of developing a blood clot?  Have you ever had a heart attack or stroke, or lean told you had any heart disease?  Wes Do you have ever had a blood clot?  Have you had a cecent major surgery or are you planning to have surgery in the next 4 weeks?  Wes Do you have ever had a blood clot?  Have you had a solid organ transplant?  Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Yes Do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, or do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bl	Doy	ou have a preferred method of birth control that you would like to use?		
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Have you ever been told by a medical professional not to take hormones?  Do you smoke cigarettes?  Have you had a recent change in vaginal bleeding that worries you?  Have you given birth within the past 21 days? If yes, how long ago?  Are you currently breastfeeding?  Do you have diabetes?  Yes DO you have diabetes?  Have you ever had a migraine headaches?  Are you being treated for inflammatory bowel disease?  Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  Have you ever had a heart attack or stroke, or been told you had any heart disease?  Yes DO you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  Have you ever had a blood clot?  Have you ever had a blood clot?  Have you ever had a blood clot?  Have you ever been told by a medical professional you are at risk of developing a blood clot? Yes DO you have been told by a medical professional you are at risk of developing a blood clot? Yes DO you have on a heart attack or stroke, or been told you have surgery in the next 4 weeks? Yes DO you have you ever been told by a medical professional you are at risk of developing a blood clot? Yes DO you have you ever been told by a medical professional you are at risk of developing a blood clot? Yes DO you have you had a cold organ transplant? Yes DO you have you had baristric surgery or stomach reduction surgery? Yes DO you have you had baristric surgery or stomach reduction surgery? Yes DO you have you have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, Yes DO you have any other medical problems or take any medications, or human immunodeficiency virus (HIV)?  If yes, list them here:  Do you have any other medical problems or take any medications, including herbs or supplements?			Yes 🗆 No	0 🗆
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9 Do you have diabetes? Yes No 10 Have you ever had a migraine headaches? Yes No 11 Are you being treated for inflammatory bowel disease? Yes No 12 Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication) 13 Have you ever had a heart attack or stroke, or been told you had any heart disease? Yes No 14 Have you ever had a blood clot? Yes No 15 Have you ever been told by a medical professional you are at risk of developing a blood clot? Yes No 16 Have you had recent major surgery or are you planning to have surgery in the next 4 weeks? Yes No 17 Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.) Yes No 18 Have you had bariatric surgery or stomach reduction surgery? Yes No 19 Do you have or have you ever had breast cancer? Yes No 19 Do you have or have you ever had breast cancer? Yes No 20 Have you had a solid organ transplant? Yes No 21 Do you have jaundice (yellow skin or eyes)? 22 Do you have lupus, rheumatoid arthritis, or any blood disorders? Yes No 23 Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? 24 Do you have any other medical problems or take any medications, including herbs or supplements?	8		Yes D No	0 0
Have you ever had a migraine headaches?  Are you being treated for inflammatory bowel disease?  Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  Have you ever had a heart attack or stroke, or been told you had any heart disease?  Yes	9		Yes D No	0 0
Are you being treated for inflammatory bowel disease?  Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  Have you ever had a heart attack or stroke, or been told you had any heart disease?  Yes No Have you ever had a blood clot?  Have you ever been told by a medical professional you are at risk of developing a blood clot? Yes No Have you had recent major surgery or are you planning to have surgery in the next 4 weeks? Yes No Have you had bariatric surgery or stomach reduction surgery? Yes No Have you had bariatric surgery or stomach reduction surgery? Yes No Have you had a solid organ transplant? Yes No Have you had a solid organ transplant? Yes No Ordo 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)?  Do you have lupus, rheumatoid arthritis, or any blood disorders? Yes No Do you have medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  If yes, list them here:  Do you have any other medical problems or take any medications, including herbs or supplements?	10		Yes D No	0.0
Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)  Have you ever had a heart attack or stroke, or been told you had any heart disease?  Yes No Have you ever had a blood clot?  Have you ever been told by a medical professional you are at risk of developing a blood clot?  Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?  Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Have you had bariatric surgery or stomach reduction surgery?  Yes No Have you had a solid organ transplant?  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)?  Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes No No Do you have medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  If yes, list them here:	11	-		
if it is controlled by medication)  Have you ever had a heart attack or stroke, or been told you had any heart disease?  Yes No Have you ever had a blood clot?  Have you ever been told by a medical professional you are at risk of developing a blood clot?  Yes No Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?  Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Have you had bariatric surgery or stomach reduction surgery?  Yes No Do you have or have you ever had breast cancer?  Yes No Have you had a solid organ transplant?  Yes No 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)?  Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes No Do you have any other medical problems or take any medications, including herbs or supplements?				
Have you ever had a blood clot?  Have you ever been told by a medical professional you are at risk of developing a blood clot?  Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?  Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Have you had bariatric surgery or stomach reduction surgery?  Yes □ No □  Do you have or have you ever had breast cancer?  Have you had a solid organ transplant?  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)?  Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes □ No □  Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  If yes, list them here:	<u> </u>	if it is controlled by medication)	Test: III	
Have you ever been told by a medical professional you are at risk of developing a blood clot?  Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?  Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Have you had bariatric surgery or stomach reduction surgery?  Pes No Do you have or have you ever had breast cancer?  Have you had a solid organ transplant?  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)?  Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes No Do you have medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  If yes, list them here:	13	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes □ No	0 🗆
Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?  Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Have you had bariatric surgery or stomach reduction surgery?  Do you have or have you ever had breast cancer?  Have you had a solid organ transplant?  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)?  Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  If yes, list them here:  No Do you have any other medical problems or take any medications, including herbs or supplements?	14	Have you ever had a blood clot?	Yes □ No	0 🗆
Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)  Have you had bariatric surgery or stomach reduction surgery?  Yes No Do you have or have you ever had breast cancer?  Have you had a solid organ transplant?  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)?  Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes No Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes No No Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  If yes, list them here:	15		Yes □ No	0 🗆
Have you had bariatric surgery or stomach reduction surgery?  19 Do you have or have you ever had breast cancer?  19 Have you had a solid organ transplant?  20 Have you had a solid organ transplant?  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)?  22 Do you have lupus, rheumatoid arthritis, or any blood disorders?  23 Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  24 Do you have any other medical problems or take any medications, including herbs or supplements?	16		Yes □ No	0 🗆
Do you have or have you ever had breast cancer?  Have you had a solid organ transplant?  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)?  Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes No Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  If yes, list them here:  Do you have any other medical problems or take any medications, including herbs or supplements?		Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)	Yes 🗆 No	0 🗆
Have you had a solid organ transplant?  Per No 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)?  Do you have lupus, rheumatoid arthritis, or any blood disorders?  Per No Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  If yes, list them here:  Do you have any other medical problems or take any medications, including herbs or supplements?			Yes □ No	0 🗆
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or do you have jaundice (yellow skin or eyes)?  Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes □ No □  Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  - If yes, list them here:  24 Do you have any other medical problems or take any medications, including herbs or supplements?	20		Yes □ No	0 🗆
Do you have lupus, rheumatoid arthritis, or any blood disorders?  Yes  No  No  Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?  - If yes, list them here:  24 Do you have any other medical problems or take any medications, including herbs or supplements?	21		Yes 🗆 No	0 🗆
immunodeficiency virus (HIV)?  - If yes, list them here:  24 Do you have any other medical problems or take any medications, including herbs or supplements?  Yes  No  Supplements?	22	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes□ No	0 🗆
immunodeficiency virus (HIV)?  - If yes, list them here:  24 Do you have any other medical problems or take any medications, including herbs or supplements?	23	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human	Yes D No	0 🗆
- If yes, list them here:  24 Do you have any other medical problems or take any medications, including herbs or supplements?  Yes Do No D				
supplements?				
	24	_	Yes 🗆 No	
- If yes, list them here:				
		- If yes, list them here:		
	Signa	Date 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	Yes 🗆	No 🗆
you had no menstrual period since the delivery?		
b. Have you had a baby in the last 4 weeks?	Yes 🗆	No 🗆
c. Did you have a miscarriage or abortion in the last 7 days?	Yes 🗆	No 🗆
d. Did your last menstrual period start within the past 7 days?	Yes 🗆	No 🗆
e. Have you abstained from sexual intercourse since your last menstrual period or delivery?	Yes 🗆	No 🗆
f. Have you been using a reliable contraceptive method consistently and correctly?	Yes 🗆	No 🗆

Drug Prescribed	Rx	
Directions for Use		
Pharmacist Name	Pharmacist Signature	
Pharmacy Address	Pharmacy Phone	
_	-or-	
Patient Referred		
otes:		

# **Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use**

CDC Contact for City Co

Condition	Sub-Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
		I C	1 C	I C	1 C	I C	1 0
Age		Menarche	Menarche	Menarche	Menarche	Menarche	Menarch
		to	to	to	to	to	to
		<20 yrs:2	<20 yrs:2	<18 yrs:1	<18 yrs:2	<18 yrs:1	<40 yrs:
		≥20 yrs:1	≥20 yrs:1	18-45 vrs:1	18-45 vrs:1	18-45 yrs:1	≥40 yrs:
					>45 yrs:2		
Anatomical	a) Distorted uterine cavity	4	4				
abnormalities	b) Other abnormalities	2	2				
Anemias	a) Thalassemia	2	1	1	1	1	1
	b) Sickle cell disease <sup>2</sup>	2	1	1	1	1	2
	c) Iron-deficiency anemia	2	1	1	1	1	1
Benign ovarian tumors	(including cysts)	1	1	1	1	1	1
Breast disease	a) Undiagnosed mass	1	2	2*	2*	2"	2*
	b) Benign breast disease	1	ī	ī	1	1	1
	c) Family history of cancer	1	1	i	-	1	1
	d) Breast cancer <sup>a</sup>						_
	i) Current	1	4	4	4	4	4
	ii) Past and no evidence of current	_	_	_			_
	disease for 5 years	1	3	3	3	3	3
Breastfeeding	a) <21 days postpartum			2*	2*	2*	4*
_	b) 21 to <30 days postpartum					-	
Ì	i) With other risk factors for VTE			2*	2*	2*	3*
	ii) Without other risk factors for VTE			2*	2*	2*	3*
	c) 30-42 days postpartum						
	i) With other risk factors for VTE	-	-	1*	1*	1*	3*
	ii) Without other risk factors for VTE	-	-	1*	10	1*	2*
	d) >42 days postpartum			1*	1*	1*	2*
Cervical cancer	Awaiting treatment	4 2	4 2	2	2	1	2
Cervical ectropion	The state of the s	1	1	î	1	-	î
Cervical intraepithelial							_
neoplasia		1	2	2	2	1	2
Cirrhosis	a) Mild (compensated)	1	1	1	1	1	1
	b) Severe <sup>‡</sup> (decompensated)	1	3	3	3	3	- 4
Cystic fibrosis <sup>1</sup>		1*	1*	1"	2*	1*	1*
Deep venous thrombosis	a) History of DVT/PE, not receiving						
(DVT)/Pulmonary	anticoagulant therapy	_					
embolism (PE)	i) Higher risk for recurrent DVT/PE	1	2	2	2	2	4
	ii) Lower risk for recurrent DVT/PE	1	2	2	2	2	3
	b) Acute DVT/PE	2	2	2	2	2	4
	<ul> <li>c) DVT/PE and established anticoagulant therapy for at least 3 months</li> </ul>						
	i) Higher risk for recurrent DVT/PE	2	2	2	2	2	4*
	ii) Lower risk for recurrent DVT/PE ii) Lower risk for recurrent DVT/PE						_
	d) Family history (first-degree relatives)	2	2	2	2	2	31
		1	1	_1_	1	1	2
	e) Major surgery	_		2	2	2	_
							- 4
	i) With prolonged immobilization	1	2				-
	i) With prolonged immobilization ii) Without prolonged immobilization f) Minor surgery without immobilization	1	1	1	1	1	2

Condition	Sub-Condition	Cu-	IUD	LNG	-IUD	Implant	DMPA	POP	CHC
		1	C	1	C	I C	I C	1 C	I C
Diabetes	a) History of gestational disease					1	1	1	1
	b) Nonvascular disease								
	i) Non-insulin dependent		1	- 2	2	2	2	2	2
	ii) Insulin dependent		1		1	2	2	2	2
	c) Nephropathy/retinopathy/neuropathy <sup>2</sup>		_	- 7		2	3	2	3/4*
	d) Other vascular disease or diabetes of >20 years' duration <sup>2</sup>		1	- 2	2	2	3	2	3/4*
Dysmenorrhea	Severe		,	-	_	1	1	1	- 1
Endometrial cancer <sup>1</sup>	Jereite .	4	2	4	2		<u> </u>	-	-
Endometrial hyperplasia		-	-	-	-	-	<del>- i -</del>	<del>- i -</del>	-
Endometriosis			2		=	-	<del>- i -</del>	<u> </u>	-
Epilepsy <sup>2</sup>	(see also Drug Interactions)		1			11	1*	1.	1*
Gallbladder disease					_	- 1"	12	- 1-	-
Gallbladder disease	a) Symptomatic	_	_	_	_	_	_	_	_
	i) Treated by cholecystectomy			-		2	2	2	2
	ii) Medically treated			_ 2		2	2	2	3
	iii) Current			- 2		2	2	2	3
	b) Asymptomatic			- 2	2	2	2	2	2
Gestational trophoblastic disease <sup>t</sup>	a) Suspected GTD (immediate postevacuation)								
	i) Uterine size first trimester			1		1*	1*	1*	1*
	ii) Uterine size second trimester		2*			1*	1*	1*	1*
	b) Confirmed GTD								
	i) Undetectable/non-pregnant B-hCG levels	1*	1*	1*	1*	1*	1*	1*	1*
	ii) Decreasing 8-hCG levels	2*	1.	2*	1*	1*	1*	1*	1*
	iii) Persistently elevated B-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*	1*	11	11
	<ul> <li>iv) Persistently elevated B-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease</li> </ul>	4*	2*	4*	2*	14	1*	11	1*
Headaches	a) Nonmigraine (mild or severe)					1	1	1	1*
	b) Migraine								
	i) Without aura (includes menstrual migraine)	•	1	1		1	1	1	2"
	ii) With aura		_	1		1	1	1	4"
History of bariatric	a) Restrictive procedures					-i	Ti-	i	1
surgery <sup>‡</sup>	b) Malabsorptive procedures		1	1		1	1	3	COCs:
History of cholestasis	a) Pregnancy related		_	,		1	1	1	2
, a. a.o.a.a.a.a	b) Past COC related					2	2	2	3
History of high blood pressure during	b) Past COC related			1		1	1	1	2
pregnancy									
History of Pelvic surgery			_	1		1	1	1	_1_
HIV	a) High risk for HIV	1*	1*	1*	1*	1	1	1	1
	b) HIV infection			_	_	1*	1*	1*	1*
	i) Clinically well receiving ARV therapy	1	1	1	1	If on tr	eatment, se	e Drug Inter	ctions
	ii) Not clinically well or not receiving ARV therapy <sup>4</sup>	2	1	2	1	If on tr	eatment, se	e Drug Inter	ections

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# **Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use**



Condition	Sub-Condition	Cur	-IUD	LNG	-IUD	lm	plant	DMPA	POP	CHC
		1	C	1	C	1	C	I C	1   0	
Hypertension	a) Adequately controlled hypertension		1*		1*		1*	2*	1*	3*
,,	b) Elevated blood pressure levels	-	_	-	_	-	•			_
	(properly taken measurements)			1 1						
	i) Systolic 140-159 or diastolic 90-99		1*		1*		1*	2*	1*	31
	ii) Systolic ≥160 or diastolic ≥1001		1*		2*		2*	3*	2*	4
Inflammation beyond		1*		2*		2*	3*	21	41	
Inflammatory bowel disease	(Ulcerative colitis, Crohn's disease)			_		_	1	2	2	2/3
Ischemic heart disease <sup>2</sup>	Current and history of		1	2	3	2	3	3	2 3	4
Known thrombogenic mutations <sup>‡</sup>			1*		2*		2*	2*	2*	4
Livertumors	a) Benign			$\overline{}$		$\overline{}$				
	i) Focal nodular hyperplasia		1		2		2	2	2	2
							3	3		4
							3	3		4
Malaria	symmetry and the patternal						1	1		1
Multiple risk factors for atherosclerotic	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high						2"	3*	2*	3/4
							1	2		3
multiple scierosis		_	_	_	_	_	_		_	_
							1	2		
Obesity		1			1	_	<u> 1                                   </u>		1	2
	b) Menarche to <18 years and BMI ≥ 30 1 1 1 2	2	1	2						
A	kg/m²							_	-	-
	-111.00						<del>! -</del>	1		-
Parity										
	b) Parous						1	1		_1
					1	_	1	1	2	1
		_	_	_	_	_				_
disease					1		1	1		1
					2		1	1		1
		4	2*	4	2*		1	1	1	1
						ı			l .	
cardiomyopathy*		_	_	_	_	_				_
							1	1		4
			2	2		_	1	1	1	3
	function	_	_	_	_	_	2	2	2	4
Postabortion					1*		1*	1*		- 1
				2*			1*	1*		1
			4	,	4		1*	1*		- 1
Postpartum							1	1	1	4
womeny	i) With other risk factors for VTE						1	1	1   C   1   C   1   C   1   C   1   C   1   C   1   C   1   C   1   C   C	3
	ii) Without other risk factors for VTE						1	1	1	2
Inflammatory bowel disease  (Vascular disease)  (User turner)  (Us			1	1	1	- 1				
Postpartum	a) <10 minutes after delivery of the placenta									
(in breastfeeding or non-	i) Breastfeeding		1*		2*					
breastfeeding women,	ii) Nonbreastfeeding		1*		1*	-				
including cesarean	b) 10 minutes after delivery of the placenta	_		_				-		
delivery)	to <4 weeks		2*		2*	l				
	c) ≥4 weeks		1*		1*			$\overline{}$		

Condition	Sub-Condition	Cu-	IUD	LNG	HUD	Implant	DMPA	POP	CHC
			С		С	I C	1 C	1 C	1 (
Pregnancy		4		4		NA*	NA*	NA*	NA*
Rheumatoid	a) On immunosuppressive therapy	2	1	2	1	1	2/3*	1	2
arthritis	b) Not on immunosuppressive therapy	-	-	-	_		2	i	2
Schistosomiasis	a) Uncomplicated		-		-		1	<u> </u>	1
SCHISTOSOMIASIS	b) Fibrosis of the liver <sup>1</sup>		_		-		-	<del>- i -</del>	<del></del>
Sexually transmitted diseases (STDs)	Current purulent cervicitis or chlamydial infection or gonococcal infection	4	2*	4	2*	1	1	1	1
diseases (STDs)	b) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	2	2	2	2	1	1	1	1
	c) Other factors relating to STDs	2*	2	2*	2	1	1	1	1
Smoking	a) Age <35		-		-		- i	-i	2
amoung	b) Age ≥35. <15 cigarettes/day	_	_		_				3
	c) Age ≥35, ≥15 cigarettes/day		<u>.                                    </u>		_		-		
E-II-I			-		-				4
Solid organ transplantation <sup>2</sup>	a) Complicated	3	<u>_2</u>	3	2	2	2	2	4
	b) Uncomplicated		2		2	2	2	2	2*
Stroke <sup>1</sup>	History of cerebrovascular accident				2	2 3	3	2 3	4
Superficial venous	a) Varicose veins						1	_1_	1
disorders	<ul> <li>b) Superficial venous thrombosis (acute or history)</li> </ul>	1	_		1	1	1	1	3*
Systemic lupus erythematosus <sup>1</sup>	<ul> <li>a) Positive (or unknown) antiphospholipid antibodies</li> </ul>	1*	1*		3*	3*	3* 3*	3*	4*
	b) Severe thrombocytopenia	3*	2*		2*	2*	3* 2*	2*	2*
	c) Immunosuppressive therapy	2*	1*		2*	2*	2" 2"	2*	2*
	d) None of the above	-1*	1*		2*	2*	2" 2"	2*	2*
Thyroid disorders	Simple goiter/ hyperthyroid/hypothyroid				1	1	1	1	1
Tuberculosis <sup>2</sup>	a) Nonpelvic	1	1	1	1	1*	1*	1*	1*
(see also Drug Interactions)	b) Pelvic	4	3	4	3	1*	1*	1*	1*
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	4*	2*	4*	2*	3*	3*	2*	2*
Uterine fibroids					2	-1	1	1	1
Valvular heart	a) Uncomplicated				1	1	1	1	2
disease	b) Complicated <sup>2</sup>				1	1	1	1	4
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding			1	1	2	2	2	1
	b) Heavy or prolonged bleeding		2*	1*	2*	2*	2*	2*	1*
Viral hepatitis	a) Acute or flare			_	-	1	1	1	3/4" 2
	b) Carrier/Chronic		_		_				1 1
Drug Interactions	b) Carrier, Criticine							_	
Antiretrovirals used for	Fosamprenavir (FPV)								
prevention (PrEP) or treatment of HIV	All other ARVs are 1 or 2 for all methods.	1/2*	1*	1/2*	1*	2*	2*	2*	3*
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone,	,	_			2*	1*	3*	3*
	topiramate, oxcarbazepine)								
	b) Lamotrigine	1			_	1	1	1	3*
Antimicrobial	a) Broad spectrum antibiotics				1	1	1	1	1
therapy	b) Antifungals				1	1	1	1	1
	c) Antiparasitics				1	1	1	- 1	1
	d) Rifampin or rifabutin therapy		_		1	2*	1*	3*	3*
SSRIs					1	1	1	1	- 1

pdated in 2020. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see <a href="https://www.chr.com/security/

### **Self-Administered Hormonal Contraception Resources**

- Utah Hormonal Contraceptive Self Screening Questionnaire
   https://dopl.utah.gov/pharm/hormonal contraception questionnaire.pdf
- 2. Utah Hormonal Contraceptive Self Screening Questionnaire-Spanish https://dopl.utah.gov/pharm/hormonal contraceptive Questionnaire Spanish.pdf
- 3. Standard Procedures Algorithm for Prescribing of Contraceptives https://dopl.utah.gov/pharm/standard\_procedures\_algorithm\_contraceptive.pdf
- 4. Summary Chart of U.S Medical Eligibility Criteria For Contraceptive Use <a href="https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria">https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria</a> 508tagged.pdf
- 5. Women's Health Resources <a href="https://mihp.utah.gov/wp-content/uploads/Womens-Health-Resources.pdf">https://mihp.utah.gov/wp-content/uploads/Womens-Health-Resources.pdf</a>
- 6. Utah Maternal and Infant Health Program https://mihp.utah.gov/
- 7. ACOG Well-Woman Recommendations <a href="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</a>
- 8. JCCP Pharmacist Patient Care Process <a href="https://jcpp.net/patient-care-process/">https://jcpp.net/patient-care-process/</a>