Contraceptive Prescribing in Primary Care: A Quick Reference Guide

- History: Take full clinical history (family, sexual, gynaecological - including cervical smears, social, medications, previous contraception)
- Check: BP, weight and body mass index (BMI)
- Exclude: STI, pregnancy if necessary

- Determine patient’s preferences for contraception
- Exclude contra indications to chosen method using the UK Medical Eligibility Criteria (UKMEC 2016)
- Promote barrier methods in addition for protection against STIs

Offer and discuss long-acting reversible methods of contraception (LARCs) as 1st line option - most effective method for preventing pregnancy

If LARC declined or not suitable, consider combined hormonal contraceptives (CHC) or Progestogen-only pill (POP) if appropriate according to UKMEC and patient history

Contraindications or intolerance to CHC?

Progestogen-Only Pill (POP)

1st Line Choice:
- Desogestrel 75 micrograms - prescribe generically Cost: £1.93 (12 hours missed pill window) (equivalent to cerazette® £9.55)
- OR
- Norethisterone 350 micrograms (e.g. Noriday) Cost: £1.80 (3 hours missed pill window)

*Desogestrel should be used if compliance is likely to be a problem due to the longer missed pill window.

Anti-androgen Progestosterone Containing COCs: Restricted Prescribing

Yasmin® (£14.70) & Qlaira® (£25.18): No conclusive evidence to show superiority or reduced side effect profile over other currently available COCs & are significantly more costly.

Use Yasmin® only when symptoms remain uncontrolled following an adequate trial (minimum 3 months) of at least 2 other COCs, including one with progestogen that has minimal androgenic effect.

If prescribing Yasmin®, issue branded generics: Yacella® (£8.30), or Dretine® (£8.30) as more cost-effective alternatives.

Qlaira® - WCCG does not recommend prescribing for new patients.

Dianette® - Should not be used solely for contraception due to risk of VTE. Indicated for treatment of severe acne unresponsive to oral antibiotics. Continued need should be periodically reviewed.

Combined-hormonal contraceptives (CHC)

1st Line Choice (2nd Generation pills):
- Preferred brands: Levest® (£1.80)
- Rigevidon® (£1.89)
- (equivalent to Microgynon® £2.82)
- Contain: 30 micrograms of ethinylestradiol (EE) and 150 micrograms levonorgestrel (LNV)

2nd Line Choice (1st Generation Pills):
- Loestrin 30® (£3.32)
- 30 micrograms EE/1.5mg NE
- Loestrin 20® (£2.30)
- 20 micrograms EE/1mg norethisterone (NE)
- Ovysmen® (£1.89) OR Brevinor® (1.99)
- 35 micrograms EE/500 micrograms NE

If side effects (acne, headache, depression, breast symptoms, breakthrough bleeding) with 2nd generation pills - consider 3rd Line option

3rd Line Choice (3rd Generation Pills):
- Lestramyl 20® (£4.08) (=Mercilon®£8.44)
- Lestramyl 30® (£3.80) (=Marvelon®£7.10)
- 20/30 micrograms EE/desogestrel 150 micrograms
- Millinen® (£3.80) (=Femodette®£8.85)
- Millinen 30® (£4.12) (=Femodene®£6.73)
- 20/30 micrograms EE/gestodene 75 micrograms
- Cilique® (£4.65) (=Cilest®£7.16)
- 35 micrograms EE/Norgestimate 250 micrograms

Long Acting Reversible Contraception (LARC)

Copper IUD (Cu-IUD)
- 1st Line (10-year license): Copper T380 A® or T-Safe® 380 A QL or TT380 Slimline®
- 2nd Line (5-year license): Mini-TT380 Slimline® or Flexi-T 380

Intrauterine progestogen-only device
- 1st Line (5-year license): Mirena® IUS - effective for 5 years*
- 2nd Line (3-year license): Levovista®, Jaydess®

*Mirena is also licensed for menorrhagia and therefore may be preferred for women with heavy periods

Progestogen-only subdermal implant (Etonogestrel)
- Nesplanon® (3 year license)

Progestogen-only injection (Medroxyprogesterone)
- 1st Line (12 weekly INTRAMUSCULAR injection): Depo-Provera®
- 2nd Line (12 weekly SUBCUTANEOUS injection): Sayana Press®

Associated with small loss of BMD, which is usually recovered after discontinuation. Risks and benefits should be re-assessed every 2 years. Subcutaneous route may be preferable for some patients (e.g. those at risk of haematoma).

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WCCG Medicines Management Team. June 2017
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NOT a cost-effective choice: Consider only if compliance issues with oral CHC and LARC unsuitable

Combined Transdermal Patch
- Eva® (£19.51)
- One patch applied on day 1, changed on day 8 and 15 then 7-day patch-free period

Combined Vaginal Ring
- NuvaRing® (£29.70)
- 1 ring inserted on day 1 of cycle and left in for 3 weeks, followed by 7-day ring-free week.

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Risk of Venous Thromboembolism (VTE)

The European Medicines Agency (EMA) review in 2013 concluded that there was good evidence to suggest that the risk of VTE associated with different combined oral contraceptive (COCs) was influenced by progestogen type, with those COCs containing:

- levonorgestrel, norethisterone or norgestimate having the lowest risk
- drospirenone, desogestrel or gestodene having the highest risk

| Non contraceptive users and not pregnant | 2 |
| COC containing ethinylestradiol plus levonorgestrel, norgestimate or norethisterone | 5.7 |
| COC containing etonogestrel (ring) or norelgestromin (patch) | 6.12 |
| COC containing ethinylestradiol plus gestodene, desogestrel or drospirenone | 9.12 |

However, the EMA noted that the benefits of combined hormonal contraceptive use generally outweighed the risk of venous thrombosis, which is low overall and is lower than the VTE risk associated with pregnancy and the postpartum period.

There is no evidence to suggest that the newer, less androgenic progestogens are any safer in terms of arterial thrombosis risk than older progestogens.

Long-term safety data for new formulations containing estradiol valerate, estradiol hemihydrate, Dienogest, and nomegestrol acetate are not yet available. Therefore, the risks and benefits of use must be assumed to be as for other COCs.

**Combined transdermal patch and vaginal ring**
Long-term data on VTE risk with the combined ethinylestradiol and norelgestromin transdermal patch is limited. There is less available data for the vaginal ring which contains ethinylestradiol and etonogestrel.

**Special Groups**

**Young people under 16 years:**

The Fraser Guidelines (Department of Health Guidance - July 2004): Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health, available at [www.tinyurl.com/bpg16](http://www.tinyurl.com/bpg16) should be followed when prescribing contraception for women under 16 years.

**Learning Difficulties:**

Consider any relevant ethical and legal issues if the woman has learning and/or physical difficulties to make their own decisions. For more information, see the reference guide to consent for examination or treatment published by the DoH ([https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition](https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition)).

**Drug Interactions:**

**Short Course (2 months or less) & Long-Term Course (over 2 months) of an enzyme inducing drug**

Contraceptive efficacy reduced by interaction with drugs that **INDUCE** hepatic enzyme activity (e.g. carbamazepine, eslicarbamazepine, oxicarbazepine, phenytoin, phenobarbital, primidone, topiramate, St John’s Wort, rifabutin and rifampicin).

**Patient requires enzyme inducing drug** - Change to an alternative contraceptive method unaffected by liver enzyme-inducing drugs (e.g. one-off progestogen-only injection, intra-uterine device to cover the short-term treatment and for 28 days after stopping).

If change in contraceptive method is not acceptable or possible, take combined oral contraceptive to provide at least 50 micrograms of ethinylestradiol daily (e.g. 20 and 30 micrograms). Use a ‘tricycling’ regimen (i.e. take 3 pill packs continuously without a break followed by a shortened tablet-free interval of 4 days).

Continue, in addition with additional contraceptive precautions (barrier methods – condoms, diaphragm, and caps) for the duration of treatment with the enzyme-inducing drug and for 4 weeks after stopping. If breakthrough bleeding occurs (and all other causes are ruled out) it is recommended that the dose of ethinylestradiol is increased by increments of 10 micrograms up to a maximum of 70 micrograms daily.

**NOTE:** for rifabutin and rifampicin (potent enzyme-inducing drugs) use alternative method of contraception e.g. IUD.

**Antiretroviral** medication (e.g. ritonavir, efavirenz, nevirapine) - seek advice from HIV specialist.

**Lamotrigine** - change to alternative method of contraception. Use of COC may lower seizure control & seek specialist advice if COC preferred choice.

**Antibacterials** - no additional contraceptive precautions are required for both COC & POP, unless diarrhoea or vomiting occur. **This should be discussed with the women,** who should also be advised that guidance in the patient information leaflet may differ.

Check current British National Formulary (BNF) for details on potential individual interactions that may occur with patient’s concurrent medication.
Other comorbidities and conditions which influence contraceptive choice include:

Teratogenic drugs (e.g., lithium, tetracycline’s, warfarin), migraine without aura, breastfeeding, menorrhagia, fibroids, previous ectopic pregnancy, STIs or PID, CVD risk factors, obesity, smoking, hypertension and diabetes mellitus.