

FAQs for Pharmacists Prescribing Hormonal Contraception in Oregon

Common Abbreviations

CHC:	Combined Hormonal Contraceptive
CDC:	Centers for Disease Control
MEC:	Medical Eligibility Criteria for contraceptive use
SPR:	Selected Practice Recommendations for contraceptive use
BP:	Blood Pressure
AHA:	American Heart Association
CVD:	Cardiovascular Disease
ASCVD:	Atherosclerotic Cardiovascular Disease
DMPA:	Depot Medroxyprogesterone Acetate
UPT:	Urine Pregnancy Test
CLIA:	Clinical Laboratory Improvement Amendments

This document is intended to address the most common questions about prescribing hormonal contraception. If there are questions you have that are not addressed in this FAQ, please contact the following:

- For clinical and therapeutic-related questions contact Lorinda Anderson, PharmD, RPh, BCPS at: lorinda.anderson@oregonstate.edu
- For regulatory-related questions contact Fiona Karbowicz, RPh at: fiona.karbowicz@state.or.us

Question: *"If I have a patient whose twice measured BP is either ≥ 140 mmHg systolic OR ≥ 90 mmHg diastolic, BUT they've already been on a CHC, can I continue and prescribe it for them?"*

Answer: NO. You may not continue their CHC if their BP is too high. Currently, rules and regulations in Oregon state that pharmacists cannot prescribe contraception for category 3 and 4 conditions that are identified in the US MEC put out by the CDC.

In this situation, the patient had a doctor prescribe for her in the past. So if the pharmacist doesn't want this patient's contraception to lapse, they can call the doctor to see if they are comfortable with prescribing it and providing a verbal order over the phone.

Question: *"If I have a patient whose systolic BP is less than 140 mmHg, but their diastolic BP is 90 mmHg or more, can I still prescribe a CHC?"*

Answer: NO. Both systolic and diastolic BPs need to be below these thresholds. If the systolic is fine, but the diastolic is elevated, the pharmacist must be referring them.

Question: *"If my patient has an initial high BP reading, according to the standard procedures algorithm I can take another reading. If the second reading is not elevated, can I use this number and prescribe contraception for my patient?" Also related: "If I need to take two BP's, do I need to average these numbers?"*

Answer: Pharmacists are allowed to take two BP's if the initial one is high. They ARE allowed to prescribe contraception if the second reading is within range, and this would be the reading that the pharmacist records. They do NOT need to average the two BP's.

Question: *"Recently the AHA published new guidelines on hypertension that lowered the diagnostic threshold for high BP to 130/80 mmHg. Will this change the BP threshold in the Standard Procedures Algorithm that is currently at 140/90 mmHg?"*

Answer: NO. Not right now. The guidelines pharmacists should follow, and what the standard procedure algorithm is based off of, are those from the CDC in the MEC and the SPR since their recommendations are made based on evidence specific to contraception. The most recent updates to the MEC and SPR were in the summer of 2016, and have not changed yet based on AHA's recommendations. Nor do we foresee that they will make

changes. To explain why, the 2 new recommendations from the AHA that this question is based off of will be broken down below:

1. AHA has a new definition of Stage 1 hypertension that is now lower from 130-139 mmHg systolic OR 80-89 mmHg diastolic.

Table 6. Categories of BP in Adults*

BP Category	SBP		DBP
Normal	<120 mm Hg	and	<80 mm Hg
Elevated	120–129 mm Hg	and	<80 mm Hg
Hypertension			
Stage 1	130–139 mm Hg	or	80–89 mm Hg
Stage 2	≥140 mm Hg	or	≥90 mm Hg

*Individuals with SBP and DBP in 2 categories should be designated to the higher BP category.

BP indicates blood pressure (based on an average of ≥2 careful readings obtained on ≥2 occasions, as detailed in Section 4); DBP, diastolic blood pressure; and SBP systolic blood pressure.

What this means for pharmacists prescribing of contraception:

The MEC has a category for diagnosed “hypertension” (that is not defined) but is given a category 3, meaning that pharmacists are already supposed to refer for anyone with this diagnosis. Yes, this may mean pharmacists could see more patients with this diagnosis on the self-assessment questionnaire, but since they are not the ones making this diagnosis, their practice on what to do should remain the same.

2. AHA has new treatment goals for BP reduction of < 130 mmHg systolic OR < 80 mmHg diastolic in high risk patients who have CVD or multiple risk factors for CVD and a ≥ 10% ASCVD risk score. For patients who are not high risk, the treatment goal remains the same at < 140 mmHg systolic OR < 90 mmHg diastolic.

Recommendations for BP Treatment Threshold and Use of Risk Estimation* to Guide Drug Treatment of Hypertension		
References that support recommendations are summarized in Online Data Supplement 23.		
COR	LOE	Recommendations
I	SBP: A	1. Use of BP-lowering medications is recommended for secondary prevention of recurrent CVD events in patients with clinical CVD and an average SBP of 130 mm Hg or higher or an average DBP of 80 mm Hg or higher, and for primary prevention in adults with an estimated 10-year atherosclerotic cardiovascular disease (ASCVD) risk of 10% or higher and an average SBP 130 mm Hg or higher or an average DBP 80 mm Hg or higher (1-9).
	DBP: C-EO	
I	C-LD	2. Use of BP-lowering medication is recommended for primary prevention of CVD in adults with no history of CVD and with an estimated 10-year ASCVD risk <10% and an SBP of 140 mm Hg or higher or a DBP of 90 mm Hg or higher (3, 10-13).

*ACC/AHA Pooled Cohort Equations (<http://tools.acc.org/ASCVD-Risk-Estimator/>) (13a) to estimate 10-year risk of atherosclerotic CVD. ASCVD was defined as a first CHD death, non-fatal MI or fatal or non-fatal stroke.

What this means for pharmacists prescribing of contraception:

Currently the MEC criteria for “elevated BP levels” are ≥ 140 mmHg systolic or ≥ 90 mmHg diastolic, so if the BP reading that the pharmacist takes falls in the range from 130-139 mmHg systolic or 80-89 mmHg diastolic (and there are no other reasons for referral in the MEC), there would be nothing stopping that pharmacist from prescribing a CHC. The reason that the MEC will likely NOT lower their BP levels for “elevated” is because the AHA isn’t recommending that this group be treated unless they already have CVD or multiple risk factors for CVD. And both these criteria are already addressed in the MEC as categories 4 (for ischemic heart disease) or 3 / 4 (for multiple CVD risk factors) and should be referred by the pharmacist if either of these conditions are met, even without taking a BP.

Question: “Oregon pharmacists are now able to prescribe for the vaginal ring and prescribe/administer the DMPA injection on January 1, 2018. In order to prescribe/administer DMPA we were instructed to take the additional training module specific to this method, however there wasn’t one specific to the ring. Do we need any additional training to prescribe for the vaginal ring?”

Answer: NO. The vaginal ring has the same components, and therefore same prescribing guidelines, as the combined oral pill and the patch that pharmacists have already been prescribing. Therefore, the original training already covered these 3 methods together because of this, and pharmacists do not need additional

training. DMPA is different enough that pharmacists did need additional training for it, and will additionally be following a separate prescribing algorithm.

Question: *“If I go through the pregnancy screen questions that are in the standard procedures algorithm, and I am not able to rule out a possible pregnancy in my patient, should I be recommending to them that they buy and take a urine pregnancy test (UPT)?”*

Also related: *“If my patient tells me that they bought a UPT and that it was negative, can I use this as proof that they are not pregnant?”*

Also related: *“If my pharmacy already has a CLIA waiver and offers point of care testing for things like cholesterol, can we incorporate a UPT into the pregnancy screen?”*

Answer: When the standard procedures algorithm was created, it was decided that UPTs would create a barrier both to pharmacies and to patients. They are therefore not a requirement, and are not even suggested. Instead, the algorithm utilizes a set of rule-out questions that are recommended in the SPR. If a pharmacist is not able to rule out a pregnancy with these questions, then they must be referring that patient. Pharmacists should not be recommending that the patient go buy a home pregnancy test since this can be a cost barrier. If a patient decides to do this on their own and the pharmacist has this information, then it would be ok to factor in these results to rule out a pregnancy. Also keep in mind that if a pharmacist has a patient who is exhibiting symptoms of being pregnant, AND can’t rule out a pregnancy with the questions, they must use their clinical judgement to decide if a UPT would be recommended for their patient.

Ambulatory clinics often utilize UPTs to help in ruling out a pregnancy, but in order for a pharmacy to include this testing as part of their service, they would need to obtain a CLIA waiver. It would be fine if a pharmacy wanted to do this, but should not become a barrier to offering contraception-prescribing as a service. It is advised that any pharmacy who would want to do this follow the recommendations on UPTs in the SPR within their policies and procedures.