



Prescribing Guidelines for Prescription Contraceptives

Contraceptive Pathway

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Prescribing Guidelines for Contraceptives

This document was developed by Nationwide Children's Hospital in conjunction with Partners For Kids using evidence-informed clinical guidelines and drug information resources. It is designed to help primary care practitioners provide timely and effective contraceptives for sexually active adolescent females. This document should not be considered a substitute for sound clinical judgment. Clinicians are encouraged to seek additional information if questions arise.

Teen Pregnancy Prevention and the Role of the Pediatrician

Unlike pregnancies in older women, the vast majority of teen pregnancies are unintended. The current downward trend of teen pregnancy has been linked to decreases in sexual activity and increased use of birth control. The Centers for Disease Control (CDC) has identified teen pregnancy as a “Winnable Battle” and recommends strengthening effective clinical interventions and promoting the use of contraception, including IUDs and contraceptive implants, to reduce teen pregnancy in the United States. Poor access to contraceptive counseling and highly effective contraceptives is a barrier for many teens. Pediatricians are well positioned as trusted health care providers to provide accurate information to patients and their families in a developmentally appropriate matter and to prescribe or provide many contraceptives on site.

Counseling and Provision of Contraception

Clinicians should address an adolescent's sexual activity status at each well visit and initiate pregnancy prevention efforts or preconception care, according to patient interest. The CDC, along with the American Congress of Obstetricians and Gynecologists, recommends assessing pregnancy intention in females of reproductive age. As important as this discussion, is the follow through. Same-day access to method of choice, including IUDs and contraceptive implants, decreases risk of unintended pregnancy. The following elements should be assessed during an encounter for contraceptive counseling:

| | | |
|----------------------|------------------------|-----------------|
| Menstrual history | Sexual history | Body mass index |
| Past medical history | Obstetric history | Weight |
| Problem list | Contraceptive history | Blood pressure |
| Current medications | Family medical history | |

Contraception counseling should be respectful of patients' and families' unique cultural traditions, be non-coercive and utilize shared decision making that prioritizes the patient's values and priorities. Respect for patients' reproductive autonomy includes access to all available methods. Patients should also be counseled that they may choose to switch methods or stop a method. Adolescents who want to discontinue the use of an implant or an IUD should not face undue barriers to removal. Removals, when requested, should be conducted as expeditiously as possible.

Additional Considerations

Conversations around selecting the right contraceptive is a great opportunity to:

- Counsel on the importance of condom use if sexually active
- [Determine the need for a routine sexually transmitted infection \(STI\) screen](#)
- [Consider provision of pre-exposure prophylaxis \(PrEP\) for high risk patients](#)

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Contraceptive Pathway

Assessment

Contraceptives

Education/Follow-up

"Do you want to become pregnant in the next year?"

Yes

[Offer preconception care](#)

No/Unsure/OK either way

"Are you interested in starting a (new) birth control method?"

Yes

No

Continue current birth control method and/or offer [preconception care](#)

Is there enough time to complete the initial contraceptive counseling?

Yes

Pregnancy Test

Positive

[Counseling on pregnancy options](#)

Negative or not done

[Are you reasonably certain the patient is not pregnant?](#)

No

Unprotected sex in previous 5 days?

Yes

Offer emergency contraceptive

Yes

[Assess medical eligibility](#) & provide personalized contraceptive counseling

No

Discuss contraceptive options

Patient accepts

[Emergency Contraceptives](#)

[Patient-focused review of contraceptive methods](#)

[Translating patient preferences into contraceptives](#)

*Bridge contraceptives: If a long acting method is preferred by patient, but cannot be obtained same day

[IUD](#)

[Implant](#)

[Injectable](#)

[Pill](#)

[Patch](#)

[Ring](#)

[Gel](#)

Offer 4-8 week follow-up

No follow-up necessary

Follow-up for next injection in 11-13 weeks

Write prescriptions for 12-months. Include 12-refills for a 28-day supply or 4-refills for an 84-day supply. Patient can be seen annually if doing well.

Is patient experiencing unwanted side effects?

Yes

[Consider adjusting hormone and/or strength](#)

[Guidance on switching between contraceptive methods](#)

- Educate patient to take a home pregnancy test in **2-4 weeks** if no withdrawal bleeding has occurred
- Initiation of a hormonal contraceptive can occur simultaneously with levonorgestrel and 5-days after ulipristal acetate
- Educate patient to abstain from sexual intercourse or use condoms for 7-days after a hormonal contraceptive is initiated

Patient Handouts

[Summary of all methods](#)

[Hormonal IUD](#)

[Non-Hormonal IUD](#)

[Implant](#)

[Injectable](#)

[Pill](#)

[Ring](#)

[Patch](#)

[Condoms](#)

[Emergency Contraception](#)

- Schedule patient for contraceptive counseling
- Start/offer bridge contraceptive*

[Managing breakthrough bleeding](#)

Hormonal Implant and Intrauterine Devices

| | Nexplanon® | Kyleena™ | Liletta® | Mirena® | Skyla® | ParaGard® |
|---|--|--|--|---------|---|---|
| Contraceptive Type/Location | Hormonal Implant (Upper Arm) | Hormonal Intrauterine Device | | | | Copper Intrauterine Device |
| Shape and Size | 4 cm semi-rigid plastic rod | Flexible, plastic, T-shape; 28 mm horizontally and 30 mm vertically | Flexible, plastic, T-shape; 32 mm both horizontally and vertically | | Flexible, plastic, T-shape; 28 mm horizontally and 30 mm vertically | T-shaped, copper wire; 32 mm horizontally and 36 mm vertically |
| Hormone & Dosage | etonogestrel 68 mg | levonorgestrel 19.5 mg | levonorgestrel 52 mg | | levonorgestrel 13.5 mg | None |
| Duration | 3 years | 5 years | 8 years | 8 years | 3 years | 10 years |
| % Efficacy | > 99% | | | | | |
| Potential Adverse Effects Related to Bleeding | May experience unpredictable bleeding patterns. Managing breakthrough bleeding | May cause oligomenorrhea or amenorrhea. Levonorgestrel containing IUDs are preferable for women with history of heavy menstrual bleeding. May also cause prolonged or unscheduled bleeding. | | | | May cause heavy menstrual bleeding and dysmenorrhea. Avoid in women with history of heavy bleeding. |
| Back-up Contraception After Initial Placement | <ul style="list-style-type: none"> Insertion ≤ 5 days of menstruation onset: back-up contraception not needed Insertion > 5 days of menstruation onset: use back-up contraception or abstinence for 7 days post-insertion | <ul style="list-style-type: none"> Insertion ≤ 7 days of menstruation onset: back-up contraception not needed Insertion > 7 days of menstruation onset: use back-up contraception or abstinence for 7 days post-insertion | | | | Back-up contraception is not needed with proper insertion. May also be inserted as an emergency contraceptive up to 5 days after unprotected intercourse. |

[Guidance on switching prescription contraceptive method to or from implant or IUD](#)

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Progestin-only Injectable Contraceptive

The medroxyprogesterone acetate injection is a highly effective contraceptive option (94% effective). It is available as a 150 mg intramuscular dose and 104 mg subcutaneous dose; the subcutaneous product is brand name only, thus availability, cost and coverage for the subcutaneous product can be an issue. Non-contraceptive benefits include treatment for dysmenorrhea, heavy menstrual bleeding, polycystic ovary syndrome and premenstrual tension syndrome.

| Mechanism of Delivery | Drug Name | Dose and Frequency | Delay in administration | Non-contraceptive benefits | Side effects (Incidence > 10%) |
|-----------------------|---|-------------------------------|--|---|--|
| Intramuscular (IM)* | Medroxyprogesterone 150 mg (Depo-Provera®) | 150 mg IM every 11-13 weeks | If > 15 weeks from last injection, pregnancy must be ruled out and back-up contraception is required for 7-days | Treatment for dysmenorrhea and heavy menstrual bleeding | Irregular bleeding Weight gain Headaches Abdominal pain |
| Subcutaneous (SubQ) | Medroxyprogesterone 104 mg (Depo-SubQ Provera® 104) | 104 mg SubQ every 12-14 weeks | | | |

* IM formulation needs to be administered in clinic.

[Click here for guidance on switching prescription contraceptive method to or from injectable medroxyprogesterone](#)

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Oral Contraceptives

Oral contraceptives are 91% effective with typical use. Assess for contraindications to estrogen-containing hormonal contraceptives (e.g., thromboembolic disorder, migraines with aura, severe hypertension) and pregnancy status prior to prescribing.

Hormone activity of COCs:

Most estrogen-containing COCs have ethinyl estradiol (EE) in varying strengths. The progestin within COC products can vary and have distinct hormone effects, contributing to or lessening particular side-effects. Strength and type of hormones may need adjustment depending on patient factors including conditions and side effects listed in Tables 2 and 3 below. Non-contraceptive benefits include treatment for dysmenorrhea, heavy menstrual bleeding, polycystic ovary syndrome and premenstrual tension syndrome.

Starting Regimen:

The recommended starting COC is a monophasic option (i.e., ethinyl estradiol \leq 35 mcg plus levonorgestrel 0.15 mg or norgestimate 0.25 mg) for a good balance of safety and efficacy (options in table 1 below). It is recommended COCs are started on the same day as the contraceptive assessment, if possible. Multiphasic agents have no clinical advantage over monophasic agents and can be confusing to patients due to differing tablet strengths and colors.

Additional oral contraceptive resources:

[Progestin-only oral contraceptives](#)[Extended or continuous cycle](#)[Missed dose guidance](#)[Patient factors and COC switching](#)[Switching between contraceptives](#)

Table 1: Recommended starting combined oral contraceptive

| Interval | Recommended Starting Strengths | Example Product Names |
|---------------------------------------|--|---|
| 21 active tablets; 7 inert tablets | Ethinyl Estradiol 30 mcg / Levonorgestrel 0.15 mg | Levonorgestrel/EE, Kurvelo®, Lillow®, Marlissa®, Portia-28® |
| | Ethinyl Estradiol 35 mcg / Norgestimate 0.25 mg | Norgestimate/EE, Estarylla®, Mili®, Previfem®, Sprintec® |

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Extended Cycle or Continuous Cycle

Extended cycle or continuous cycle regimens may be considered for any patient that prefers an extended cycle. These regimens can be especially helpful for patients with:

- Menstruation-related problems (anemia, menorrhagia, bloating, dysmenorrhea, endometriosis, menstrual headache), premenstrual dysphoric disorder or hyperandrogenism

Prescribing:

- Extended cycle:
 - Brand names: Seasonique®, LoSeasonique®, Jolessa®, Introvale®
 - These have 84 active tablets and 7 inactive tablets, so a patient should expect to have a period every 3-months. Write prescriptions with 3-refills to provide a 1-year supply.
- Continuous cycle:
 - Prescribe extended cycle brands and instruct patient to skip hormone-free pills.
 - Write prescriptions with 4-refills to provide a 1-year supply.

Progestin-only Oral Contraceptives

| Medication | Brand | Half-life | Missed doses |
|--------------------------|--|-----------|---|
| Drospirinone 4mg | Slynd® | 30-hours | Follow missed dose guidance table for COCs If taken ≥ 3 hours late, use back-up contraception for 48-hours. |
| Norethindrone 0.35 mg | Multiple (e.g. Jencycla®, Ortho Micronor®) | 8-hours | |
| Norgestrel 0.075 mg | Opill® | 21-hours | |

Missed Dosing Guidance for Combination Oral Contraceptives (COCs)

When a dose is missed or vomited, many women need guidance on what to do in regards to emergency contraception. COCs need seven days of consistent use to prevent ovulation. This table provides guidance on what steps to take when doses are missed.

| Missed COC Pills | When to Take Missed Doses | Backup Contraception | Emergency Contraception |
|--|---|---|---|
| One pill: Late (< 24 hours) or missed (24 to < 48 hours) | As soon as remembered. Resume taking remaining pills at usual time, even if it means taking two pills in the same day | No | May consider if other doses missed in past month |
| Two or more pills missed consecutively (≥ 48 hours since pill should have been taken) during 1st and 2nd week of hormonal pills | Take the most recent missed pill as soon as remembered. Throw out any other pills that were missed. Resume taking remaining pills at usual time, even if it means taking two pills in the same day. | Yes, until hormonal pills have been taken for 7 consecutive days | Should consider if during the first week of cycle |
| Two or more pills missed consecutively during 3rd week (e.g. day 15-21 for 28-day pill packs) of hormonal pills | Same as two pills above PLUS skip placebo pills and start new pack. Use backup contraception if cannot start new pack immediately. | Yes, until 7 active pills taken IF new pack is not started right away | May consider |

Curtis, K. M et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2024. MMWR. Recommendations and reports : MMWR Recomm Rep. 73(3), 1–77.

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Table 2: Dose-Related Effects of Estrogen and Progestin

| Hormone | Too Much | Too Little |
|-----------|--|--|
| Estrogen | <ul style="list-style-type: none">• Nausea• Breast tenderness• Headache• Increased blood pressure• Melasma (gray-brown patches on face) | <ul style="list-style-type: none">• Spotting• Breakthrough bleeding early/mid-cycle |
| Progestin | <ul style="list-style-type: none">• Weight Gain• Breast tenderness• Acne• Headache• Fatigue• Mood changes• Hirsutism• Increased LDL• Decreased HDL | <ul style="list-style-type: none">• Breakthrough bleeding late cycle |

[Click here for guidance on which oral contraceptive to switch to if patient presents with specific side-effects](#)

Table 3: Recommendations for oral contraceptive hormone or strength change based upon patient factors

| Patient Factor | Recommendation | Products | Example Brand |
|--|--|--|------------------|
| Acne | Switch to higher estrogen dose or progestin with less androgenic activity. | Desogestrel 0.15 mg/EE 30 mcg | Apri® |
| | | Drospirenone 3 mg/EE 20 mcg | Nikki® |
| | | Drospirenone 3 mg/EE 30 mcg | Syeda® |
| | | Norgestimate 0.25 mg/EE 35 mcg | Sprintec® |
| Breast Tenderness | Switch to lower estrogen dose | Drospirenone 3 mg/EE 20 mcg | Nikki® |
| | | Drospirenone 3 mg/EE 30 mcg | Syeda® |
| | | Levonorgestrel 0.1 mg/EE 20 mcg | Vienva® |
| | | Norethindrone acetate 1 mg/EE 20 mcg/75mg ferrous fumarate | Junel® FE 1/20 |
| Breakthrough bleeding (early or mid-cycle) after the first three months of therapy | Switch to higher estrogen dose | Desogestrel 0.15 mg/EE 30 mcg | Apri® |
| | | Drospirenone 3 mg/EE 30 mcg | Syeda® |
| | | Ethinodiol diacetate 1 mg/EE 35 mcg | Kelnor® 1/35 |
| | | Ethinodiol diacetate 1 mg/EE 50 mcg | Kelnor® 1/50 |
| | | Norethindrone acetate 1.5 mg/EE 30 mcg/75mg ferrous fumarate | Junel® FE 1.5/30 |
| | | Norethindrone 0.4 mg/EE 35 mcg | Briellyn® |
| | | Norethindrone 0.5 mg/EE 35 mcg | Nortrel® 0.5/35 |
| | | Norethindrone 1 mg/EE 35 mcg | Alyacen® 1/35 |
| | | Norgestrel 0.3 mg/EE 30 mcg | Low-Ogestrel® |

EE stands for Ethinyl Estradiol

[Patient factors and recommendations continue on the next page](#)

Table 3 cont: Recommendations for oral contraceptive hormone or strength change based upon patient factors

| Patient Factor | Recommendation | Products | Example Brand |
|--|---|--|----------------|
| Breakthrough bleeding (late cycle) after the first three months of therapy | Switch to higher dose progestin or progestin with higher progestin activity | Desogestrel 0.15 mg/EE 30 mcg | Apri® |
| | | Levonorgestrel 0.1 mg/EE 20 mcg | Vienna® |
| | | Levonorgestrel 0.15 mg/EE 30 mcg | Kurvelo® |
| Headache | Switch to lower estrogen dose, progestin with less progestin activity or progestin-only contraceptive* | Drospirenone 3 mg/EE 20 mcg | Nikki® |
| | | Drospirenone 3 mg/EE 30 mcg | Syeda® |
| | | Levonorgestrel 0.1 mg/EE 20 mcg | Vienna® |
| | | Norethindrone acetate 1 mg/EE 20 mcg/75mg ferrous fumarate | Junel® FE 1/20 |
| | | Drospirenone 4 mg | Slynd® |
| | | Norethindrone 0.35 mg | Jencycla® |
| Migraines | If migraines develop or worsen, switch to progestin-only contraceptive* | Drospirenone 4 mg | Slynd® |
| | | Norethindrone 0.35 mg | Jencycla® |
| Nausea | Switch to lower estrogen dose or progestin-only contraceptive* | Levonorgestrel 0.1 mg/EE 20 mcg | Vienna® |
| | | Norethindrone acetate 1 mg/EE 20 mcg/75mg ferrous fumarate | Junel® FE 1/20 |
| | | Drospirenone 4 mg | Slynd® |
| | | Norethindrone 0.35 mg | Jencycla® |
| Weight Gain | Switch to lower estrogen dose, progestin with less androgenic activity or progestin-only contraceptive* | Drospirenone 3 mg/EE 20 mcg | Nikki® |
| | | Drospirenone 3 mg/EE 30 mcg | Syeda® |
| | | Levonorgestrel 0.1 mg/EE 20 mcg | Vienna® |
| | | Norethindrone acetate 1 mg/EE 20 mcg/75mg ferrous fumarate | Junel® FE 1/20 |
| | | Drospirenone 4 mg | Slynd® |
| | | Norethindrone 0.35 mg | Jencycla® |

*May also consider Opill®, injectable progestin, implant or IUD for patient factors

EE stands for Ethinyl Estradiol

Patch or Ring or Gel

The combined hormonal contraceptive skin patch and vaginal ring are 91% effective with typical use. Assess for contraindications to estrogen-containing hormonal contraceptives (e.g., thromboembolic disorder, migraines with aura, severe hypertension) and pregnancy status prior to prescribing.

Combined Hormonal Patch

| Medication (Daily dose) | Brand | Frequency | Clinical Pearls |
|---|--------------------|--|--|
| Ethinyl estradiol (35 mcg) and Norelgestromin (150 mcg) | Zafemy® Xulane® | 1 patch every 7 days for 3 consecutive weeks followed by a patch-free week | Contraindicated in women with a BMI ≥ 30 kg/m ² due to increased VTE* risk |
| Ethinyl estradiol (30 mcg) and Levonorgestrel (120 mcg) | Twirla® | | Efficacy may be reduced in patients that are > 90 kg |

[Guidance for delayed attachment/reattachment of patch or insertion/reinsertion of ring](#)

[Guidance on switching prescription contraceptive method to or from ring/patch](#)

Combined Hormonal Vaginal Ring

| Medication (Daily dose) | Brand | Frequency | Clinical Pearls |
|--|------------------------------------|--|---|
| Ethinyl estradiol (15 mcg) and Etonogestrel (120 mcg) | NuvaRing® EluRyng® Haloette® | 1 ring inserted for 21 days followed by removal for 7 days | |
| Ethinyl estradiol (13 mcg) and Segesterone acetate (150 mcg) | Annovera® | 1 ring inserted every 21 days followed by removal for 7 days | One ring can be used for 13-cycles (1-year) when used 3 weeks in and 1 week out per cycle |

*VTE: venous thromboembolism

Phexxi is 86% effective as an intravaginal gel that reduces vaginal pH and interferes with sperm motility. Phexxi is not included on Ohio Medicaid Unified Preferred Drug List and will require a prior authorization.

Intravaginal Gel

| Medication | Brand | Frequency | Clinical Pearls |
|---|---------|---|--|
| Lactic Acid (1.8%), Citric Acid (1%), and Potassium Bitartrate (0.4%) | Phexxi® | 1 prefilled applicator (5 grams) inserted up to 1 hour before vaginal intercourse | Repeat dose if vaginal intercourse does not occur within 1-hour of administration. |

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Recommendations for delayed application or detachment of patch

| Delayed Application OR Patch Detachment* | When to Apply or Reapply | Patch Change Day | Backup Contraception | Emergency Contraception |
|---|--|--------------------------------|--|--|
| < 48 hours since patch should have been applied or reattached | Apply a new patch as soon as possible (if < 24 hours since original patch was applied, try reapplying same patch or replace with new patch) | Keep the same patch change day | No additional contraceptive protection is needed | Usually not needed but can be considered if delayed application or detachment occurred early in current cycle or in last week or previous cycle |
| ≥ 48 hours since patch should have been applied or reattached | <ul style="list-style-type: none"> - Apply a new patch as soon as possible - If delayed application or detachment occurred in third patch week, omit hormone-free week by finishing the third week of patch use (keep same patch change day) and start a new patch immediately | Keep the same patch change day | Use backup contraception (e.g. condoms) or avoid sexual intercourse until a patch has been worn for 7 consecutive days | <ul style="list-style-type: none"> - Should be considered if delayed application or detachment occurred within first week of patch use and unprotected sexual intercourse occurred in the previous 5 days - May also be considered at other times as appropriate |

Recommendations for delayed insertion or reinsertion of vaginal ring

| Delayed Insertion OR Reinsertion* | When to Apply or Reapply | Patch Change Day | Backup Contraception | Emergency Contraception |
|---|--|---|---|--|
| < 48 hours since ring should have been inserted or reinserted | Insert ring as soon as possible | Keep ring in until scheduled ring removal day | No additional contraceptive protection is needed | Usually not needed but can be considered if delayed insertion or reinsertion occurred early in current cycle or in last week of previous cycle |
| ≥ 48 hours since ring should have been inserted or reinserted | <ul style="list-style-type: none"> - Insert ring as soon as possible - If ring removal occurred in third week of ring use, omit hormone-free week by finishing the third week of ring use and start a new ring immediately | Keep ring in until scheduled ring removal day | Use backup contraception (e.g. condoms) or avoid sexual intercourse until a ring has been worn for 7 consecutive days | <ul style="list-style-type: none"> - Should be considered if delayed insertion or reinsertion occurred within first week of ring use and unprotected sexual intercourse occurred in the previous 5 days - May also be considered at other times as appropriate |

Emergency Contraceptives

Emergency contraception (EC) should be offered to patients who have experienced unprotected sex within the last 5 days (120 hours) who do not desire a pregnancy. These methods are most effective if used as soon as possible after unprotected sex. There are no contraindications to the use of oral EC other than known pregnancy, however, a pregnancy test is NOT required prior to taking an oral EC. A pregnancy test is recommended if a woman has not resumed menses within 3 weeks of EC. Decisions about which EC to use, including potential delay of chosen contraceptive method, should be balanced with the risk of a patient not starting her chosen contraceptive method and the risk of pregnancy. Use the table below to help guide decision-making for what EC is the best option for the patient.

| Medication | Brand | Dosage and Frequency | Timing | Start/resume hormonal contraceptive | Bridging contraception | Weight > 75 kg | Nausea and Vomiting |
|--------------------------------|---|--|--|--------------------------------------|--|--|--|
| Ulipristal acetate (UPA) 30 mg | Ella® | Take 1 tablet (30 mg) as a one-time dose | As soon as possible but within 5-days of unprotected sex | 5-days after dose* | Abstain or use barrier contraception for 7-days after starting/resuming hormonal contraception | Ulipristal acetate may be more effective than levonorgestrel | **If vomiting occurs within 3 hours of taking an oral EC another dose should be taken as soon as possible. |
| Levonorgestrel 1.5 mg | E.g. Plan B One-Step®, My Choice®, others | Take 1 tablet (1.5 mg) as a one-time dose | As soon as possible but within 3-days of unprotected sex | Immediately | | | |
| Copper IUD | Paragard® | As soon as possible but within 5-days of unprotected sex | | Ongoing contraceptive upon placement | Not necessary | Does not impact efficacy | Not relevant for this method |

* Drug interaction with hormonal contraceptives exist. UPA may diminish the effect of hormonal contraceptives and likewise, hormonal contraceptives may reduce efficacy of UPA during the first 5-days.

**Routine pretreatment with an antiemetic is not recommended, but may be effective if patient has a history of vomiting after oral ECs

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Preconception Care

When discussing the risk of pregnancy with an adolescent, consider the following:

1. A dialogue regarding the patient's readiness for pregnancy
2. An evaluation of her overall health and opportunities for improving her health
3. Education about the significant impact that social, environmental, occupational, behavioral, and genetic factors have in pregnancy
4. Identification of women at high risk for an adverse pregnancy outcome

To optimize health and reduce risk prior to conception, focus on the following health factors:

1. Undiagnosed, untreated, or poorly controlled medical conditions
2. Immunization history
3. Medication and radiation exposure in early pregnancy
4. Nutritional issues
5. Family history and genetic risk
6. Tobacco and substance use and other high-risk behaviors
7. Occupational and environmental exposures
8. Social issues
9. Mental health issues

Reference: Committee on Gynecologic Practice. *ACOG Committee Opinion: The Importance of Preconception Care in the Continuum of Women's Health Care*. 313, 2015.

Counseling about pregnancy options

Pregnant adolescents have the right to be informed and counseled on all legal pregnancy options. Pediatricians should take the following steps:

1. Inform the pregnant adolescent of the options, which include carrying the pregnancy to delivery and raising the infant, carrying the pregnancy to delivery and making an adoption or kinship care plan, or terminating the pregnancy.
2. Be prepared to provide a pregnant adolescent with basic, accurate information about each of these options in a developmentally appropriate manner, support her in the decision-making process, and assist in making connections with community resources that will provide her with quality services during and after her pregnancy.
3. Examine their own beliefs and values to determine if they can provide nonjudgmental, factual pregnancy options counseling. If they cannot, they should facilitate a prompt referral for counseling by another knowledgeable professional in their practice setting or community who is willing to have such discussion with adolescent patients.

Reference: AMERICAN ACADEMY OF PEDIATRICS, COMMITTEE ON ADOLESCENCE; Options Counseling for the Pregnant Adolescent Patient. Pediatrics August 2022; 150 (3)

How to be reasonably certain a woman is not pregnant

A contraceptive method may be started at any time in a woman's menstrual cycle as long as a health care provider is reasonably certain she is not pregnant. A provider can be reasonably certain a woman is not pregnant if she meets any of the following criteria:

- Is ≤ 7 days after the start of normal menses,
- Has not had sexual intercourse since the start of last normal menses,
- Has been correctly and consistently using a reliable method of contraception,
- Is ≤ 7 days after spontaneous or induced abortion,
- Is within 4 weeks postpartum, or
- Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority $[\geq 85\%]$ of feeds are breastfeeds), amenorrheic, and < 6 months postpartum.

Curtis, K. M et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2024. MMWR. Recommendations and reports : MMWR Recomm Rep. 73(3), 1–77.

Assessing medical eligibility for contraceptive use

A healthy adolescent female who has normal menstruation, no active or previous medical conditions or congenital anomalies, has never been pregnant, takes no medications or supplements, and does not have a sexually transmitted infection is eligible for any reversible contraceptive method.

| Does the patient have any of the following conditions? | | |
|---|---|--|
| Condition | Category | Consideration |
| Migraine with aura* | Category 4 for CHC | Consider a contraceptive other than CHC |
| Current PID, purulent cervicitis, chlamydial infection, gonorrheal infection | Category 4 for Cu-IUD and LNG-IUD | Consider an option other than IUD |
| Certain anticonvulsants*: phenytoin, carbamazepine, barbiturates, primidone, topiramate and oxcarbazepine | Category 3 for CHC and POP | Consider an option other than CHC and POP |
| Certain anticonvulsants*: lamotrigine | Category 3 for CHC | Consider an option other than CHC |
| History of deep venous thrombosis – High risk for recurrence (i.e. DVT, PE)* | Category 4 for CHC Category 3 for DMPA | Consider an option other than CHC and DMPA |
| History of deep venous thrombosis – Lower risk for recurrence (i.e. DVT, PE)* | Category 3 for CHC | Consider an option other than CHC |
| Current and history of cerebrovascular accident | Category 4 for CHC Category 3^ for DMPA, LNG-IUD and POP | Consider an option other than CHC, DMPA, LNG-IUD, or POP |
| Hypertension*: adequately controlled and systolic 140-159 or diastolic 90-99 | Category 3 for CHC | Consider an option other than CHC |
| Hypertension*: systolic ≥ 160 or diastolic > 100 | Category 4 for CHC Category 3 for DMPA | Consider an option other than CHC and DMPA |
| Hypertension*: vascular disease | Category 4 for CHC Category 3 for DMPA | Consider an option other than CHC and DMPA |
| Thrombophilia (e.g. factor V Leiden; prothrombin mutation, and protein S, protein C and antithrombin deficiencies)* | Category 4* for CHC Category 3 for DMPA | Consider an option other than CHC and DMPA |
| Post-partum < 21 days | Category 4 for CHC | Consider an option other than CHC |
| *Please see complete guideline for a clarification of this classification | | |
| ^These methods are category 3 for continuing DMPA, LNG-IUD and POP. They are category 2 for initiation. | | |

If an adolescent female has a known or suspected medical condition or takes medications other than those listed above, the provider should further assess medical eligibility for contraceptive use prior to initiation.

Reference: U.S. Medical Eligibility Criteria for Contraceptive Use, 2024 MMWR / July 29, 2024 / Vol. 65 / No. 3
<https://www.cdc.gov/contraception/hcp/usmec/index.html>

Abbreviations:

Cu IUD – copper IUD

LNG IUD – Levonorgestrel IUD

DMPA – depot medroxyprogesterone acetate

CHC – combined hormonal contraceptives

POP – progestin only pill

MEC Summary Chart

| Condition Category | Definition for hormonal contraceptives |
|--------------------|---|
| 2 | Advantages generally outweigh theoretical or proven risks. |
| 3 | Theoretical or proven risks usually outweigh the advantages. |
| 4 | Unacceptable health risk if the contraceptive method is used. |

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