Contraception in the time of COVID-19

In order to keep everyone safe, at home, and protected from more than just a virus, here are some guiding principles. These are scenarios that you can play out on Telehealth visits.

1. LARC Duration, for women who are worried that they need a new device
    a. Nexplanon: FDA approved for 3 years; evidence based for 5 years[1]
    b. Liletta: **FDA approved for 6 years**; evidence based for 7 years
    c. Mirena (same dose of levonorgestrel as Liletta): FDA approved for 5 years; evidence based for 7 years
    d. Skyla: FDA approved, and evidence based for 3 years
    e. Kyleena: FDA and evidence based for 5 years
    f. Paragard: FDA approved for 10 years; evidence based for 12 (not a hard stop)

2. LARC truly has "expired" even by science
    a. Advise condoms unless patient is over 35, in which case IUD likely still works
    b. Consider prescribing and CHC (combined hormonal contraception) see below

3. Patient wants a LARC, but we are not offering visits, or they would like CHC
    a. Assess for interest in other methods by phone
    b. If OCPs, patch, ring are appropriate
        i. Look at their medical conditions, refer to the CDC contraception app prn
        ii. Look to see if we have a non-hypertensive Blood pressure on file
            1. Hypertension is a contraindication to estrogen
            2. Women with hypertension generally can have Progestin only pills
        iii. Ask about a history of migraines with aura
            1. Migraines with aura are a contraindication to estrogen
            2. Progestin only pills are safe
        iv. Patch (Xulane) change weekly (estrogen and progesterone)
        v. Vaginal ring (EluRyng is the new generic), change after 3 or 4 weeks, contains estrogen and progesterone
    c. For CHC, refills should be given for one year

4. How will I know if they are pregnant?
    a. Ask about timing of LMP and unprotected intercourse
    b. Perhaps they did a home pregnancy test
    c. Remember OCPs and Emergency contraception will not disrupt an implanted pregnancy, nor will they harm a pregnancy

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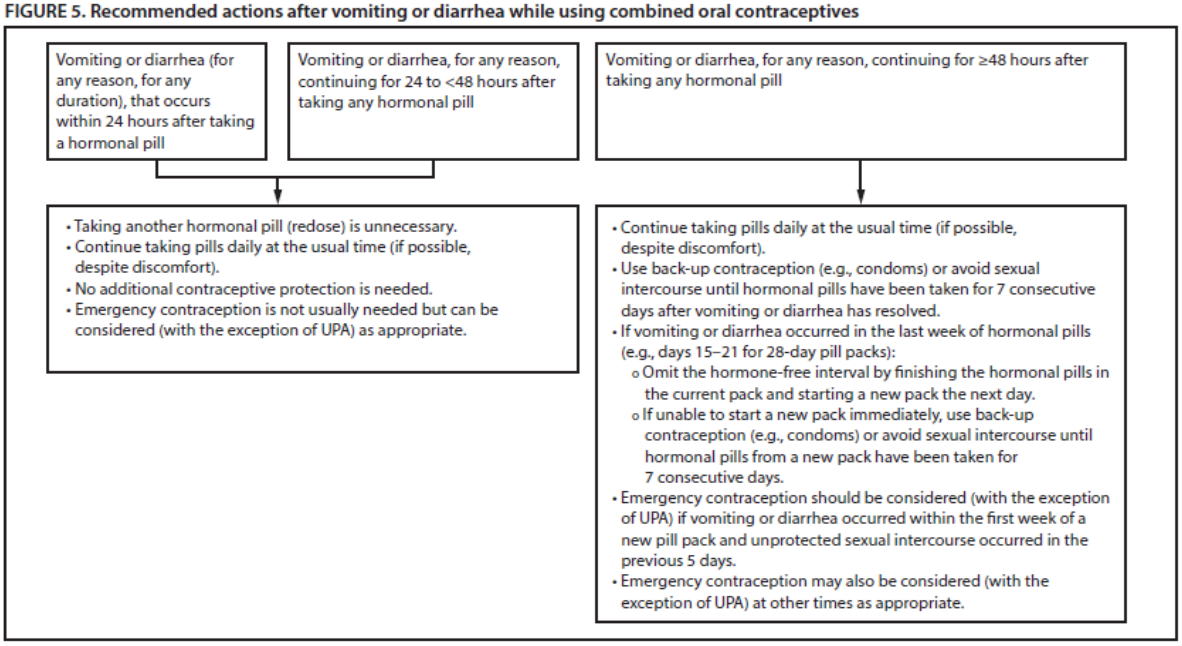
[1] McNicholas, C., Swor, E., Wan, L., Peipert, JF. Prolonged use of the etonogestrel implant and levonorgestrel intrauterine device: 2 years beyond Food and Drug Administration-approved duration. Am J Obstet Gynecol. 2017 Jun;216(6):586.e1-586.e6.

5. <u>They need a repeat Depo shot</u>
    a. Depo lasts for 15 weeks (even though we tell people to come in at 13 weeks)[2]
    b. See above re: OCPs
    c. They could be offered a subcutaneous depo shot that can be dispensed from the pharmacy and administered from home

6. <u>Patient calls for a refill or new script for emergency contraception</u>
    a. Paragard is the most effective EC form, but prefer to have no visits in highly endemic areas
    b. Ella is the next best option, decreasing effectiveness after BMI 35
        i. Main contraindication is breastfeeding
    c. <u>Plan B, no more effective than water alone for BMI>26</u> (less effective overall as well.)[3]

7. <u>They have missed pills, or been vomiting/having diarrhea</u>
    a. Pull up your CDC Contraception app (free) and follow the algorithms
        i. Late or missed doses
        ii. Vomiting or Severe Diarrhea

FIGURE 5. Recommended actions after vomiting or diarrhea while using combined oral contraceptives



Abbreviation: UPA = ulipristal acetate.

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[2] Center for Disease Control and Prevention Morbidity and Mortality Weekly Report. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. Recommendation and Reports. Vol. 65, No. 4. July 19, 2016.

[3] Glasier A, Cameron ST, Blithe D, et al. Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel. Feb 2011, 84(2011): 363-367.