Government of **Western Australia**
Department of **Health**

Enhanced Access Community Pharmacy Pilot
Hormonal contraception

Clinical practice guideline

Service restricted to patients assigned female at birth aged 16 years or over.

Ineligibility for treatment as part of a prescribing service does not preclude a patient from accessing services provided as part of usual pharmacy care.

The information and content in this clinical practice guideline do not constitute medical advice, diagnosis, or treatment recommendations for individual patients. Pharmacists must exercise professional discretion and judgement consistent with their qualifications and legislative authority. This guideline does not override the responsibility of the pharmacist to undertake clinical assessments and to make decisions appropriate to the circumstances of the individual and the relevant standards of care, in consultation with the patient and/or their parent/caregiver. This clinical practice guideline may only be used by pharmacists who have been approved by the Department of Health to participate in the Enhanced Access Community Pharmacy Pilot (EACPP) and are authorised to prescribe under the *Medicines and Poisons Regulations 2016* (WA). This document alone does not provide an authorisation for a pharmacist to prescribe.

Contents

Guideline overview

Meet service and professional obligations

- Initial patient eligibility and suitability for management within the scope of the service
- Patient informed consent (including consent for communication with other health practitioners if relevant)

Patient history and assessment

- Patient history:
  - sexual (and social) history
- Sexual and reproductive health counselling
- Examination:
  - body mass index (BMI)
  - blood pressure measurement

Contraceptive and sexual health plan

- Select appropriate contraceptive option:
  - combined oral contraceptive pill
  - combined hormonal vaginal ring
  - progestogen-only contraceptive pill
  - depot medroxyprogesterone acetate (DMPA)

Confirm contraception plan is appropriate

- Contraindications, precautions, and interactions
- Pregnancy and lactation
- UK Medical Eligibility Criteria for Contraceptive Use (UKMEC)

Communicate agreed contraceptive plan

- Medication counselling
- General advice and patient information
- Communication with other health practitioners

Clinical review

- Measure BP
- Adverse effects
- Continue, change, or stop contraception
- Communication with other health practitioners

Refer when

- The patient is aged below 16 years (does not preclude a patient from accessing usual pharmacy care)
- The patient requests or requires a method of contraception that is not available in the Hormonal Contraception Service
- The patient has unexplained vaginal bleeding, severe or painful menstrual bleeding, irregular periods, amenorrhea, or pain/discomfort with sexual intercourse
- The patient may be pregnant
- The patient has signs and symptoms of PMOS (polyendocrine metabolic ovarian syndrome, previously referred to as polycystic ovarian syndrome - PCOS) that have not been assessed by an appropriate healthcare provider
- The patient has undiagnosed hypertension, is hypertensive, or has poorly managed hypertension
- The preferred contraceptive type is contraindicated or not appropriate.

Provide contraception and concurrently refer

- The patient has been, or suspected to have been, subject to reproductive coercion, sexual abuse, or sexual violence
- The patient has a BMI > 35 kg/m^2
- Patient has symptoms of or risk factors for sexually transmitted infection (STI) or requests STI screening.

Key points

- The Hormonal Contraception Service allows for the prescription of 4 types of hormonal contraception:
  - the combined oral contraceptive pill (COC)
  - the progestogen-only pill (POP)
  - depot medroxyprogesterone acetate (DMPA) injection (including administration of the injection)
  - the combined hormonal contraceptive vaginal ring.
- Patients are required to have a pharmacist consultation, including blood pressure measurement and BMI calculation, before a hormonal contraceptive method may be prescribed, regardless of whether the patient is currently using the type of contraception requested.
- Before prescribing hormonal contraception, pharmacists should discuss the use of LARCs with women seeking contraception, as per the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommendations.
- Individuals accessing the service should be provided with appropriate resources regarding STIs and be advised to be tested if at risk.

Refer when

Refer the patient to an appropriate healthcare provider (including sexual health service or emergency services, if required) in the following situations:

- the patient is aged below 16 years (does not preclude a patient from accessing usual pharmacy care)
- the patient requests or requires a method of contraception that is not available in the Hormonal Contraception Service e.g. long-acting reversible contraception (LARCs), combined oral contraceptives containing ≥ 50 micrograms ethinylestradiol, or preparations containing mestranol
- the patient has unexplained vaginal bleeding, severe or painful menstrual bleeding, irregular periods, amenorrhea, or pain/discomfort with sexual intercourse
- the patient may be pregnant (refer to Exclude pregnancy)
- the patient has signs and symptoms of PMOS (polyendocrine metabolic ovarian syndrome, previously referred to as polycystic ovarian syndrome - PCOS) that have not been assessed by an appropriate healthcare provider
- the patient has undiagnosed hypertension, is hypertensive, or has poorly managed hypertension
- the preferred contraceptive type is contraindicated or not appropriate (UKMEC 3 or 4).

Provide contraception and concurrently refer

Provide contraception and concurrently refer to an appropriate healthcare provider (including sexual health service or emergency services, if required) in the following situations:

- patient has been, or suspected to have been, subject to reproductive coercion, sexual abuse or sexual violence (refer to Reproductive coercion, sexual and domestic violence and abuse)
- patient has a body mass index (BMI) > 35 kg/m^2
- patient has symptoms of or risk factors for sexually transmitted infection (STI) or requests STI screening.

Patient history and assessment

Undertaking a comprehensive assessment of the patient's needs is essential to determine the most appropriate contraception method.

Initial consultation

- An individualised assessment of contraceptive and sexual health needs, and suitability for hormonal contraception and management within the service should consider:
  - patient history including sexual history
  - discussion of all available contraceptive options (including options not available in the service that may be suitable)
  - assessment of medical eligibility and contraindications
  - BP measurement and BMI
  - risk assessment for STIs.
- Selection of an appropriate hormonal method and formulation should consider:
  - factors that could affect contraceptive effectiveness (including product efficacy)

- how long the patient thinks they will be using contraception (e.g. < 1 year, < 3 years, > 3 years)
- non-contraceptive benefits
- common side effects and risk of adverse effects
- health risks and individualised advice.

- Comprehensive counselling and advice may include:
  - the use of tailored regimens
  - avoiding contraceptive failure, including instructions on missed pills or DMPA injections.

For detailed information on each contraceptive option, including contraindications and precautions, pharmacists should consult the Therapeutic Guidelines: Sexual and Reproductive Health, current guidance from The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), and the Royal College of Obstetricians and Gynaecologists (RCOG) College of Sexual and Reproductive Healthcare (CoSRH) including:

- UK Medical Eligibility Criteria for Contraceptive Use (UKMEC)[1]
- FSRH Clinical guideline – Progestogen-only Pills[2]
- FSRH Clinical guideline – Combined Hormonal Contraception[3]
- FSRH Clinical guideline – Progestogen-only injectable contraception[4]
- RANZCOG Contraception Clinical Guideline[5]

The Faculty of Sexual and Reproductive Healthcare (FSRH) has changed its name to the College of Sexual and Reproductive Healthcare (CoSRH). Some pages and documents will continue to display the FSRH name. Where you see FSRH, this refers to CoSRH.

Sexual and reproductive health counselling

WA's Sexual Health Quarters (SHQ) delivers courses designed to build competency in this area – see Pharmacist Resources.

Working with Aboriginal and Torres Strait Islander people

Sexual health is not openly discussed in Aboriginal and Torres Strait Islander cultures and 'shame' a deeply internalised feeling of inadequacy, self-doubt, or ostracism) may be a strong barrier to seeking sexual health care or contraception, especially in smaller communities[6, 7].

All healthcare providers should be cognisant of causing additional 'shame' to Aboriginal and Torres Strait Islander people while providing reproductive counselling[6].

Pharmacists should consult the Pharmaceutical Society of Australia's Guideline for Pharmacists supporting Aboriginal and Torres Strait Islander peoples with Medicines Management for guidance on understanding culture, building relationships, and communication[7].

Where appropriate, Aboriginal and Torres Strait Islander health workers or health practitioners may be involved to support clients with contraception self-management and facilitate the provision of a culturally safe service by the pharmacist[7].

Working with young people

People younger than 16 should be confidentially referred to an appropriate healthcare provider or sexual health clinic for hormonal contraception. For the purposes of this guideline, people aged 16 and 17 years seeking contraceptive advice and treatment without parental knowledge or consent must be assessed to determine whether or not they are a 'mature minor' capable of understanding the nature, risks, and benefits of the contraception (and the seriousness of the risks of using hormonal contraception and not using contraception). Where the individual is assessed as being a 'mature minor', the additional consent of the minor's parent or guardian is not required before contraceptive advice and treatment can be given (however, it is considered good practice for the parent/caregiver to be involved in decision making around health care).

If a 'mature minor' does not wish to involve an adult, this should be respected. Concerns about confidentiality can stop young people from accessing health care. They are more likely to seek health care and return for review if they know that their health concerns will not be revealed to other third parties, including their parents[8]. Parental consent is required where the minor is assessed as not being a 'mature minor' (i.e. not being competent to consent to treatment), except in the case of an emergency[9].

Pharmacists should consider whether there may be child protection concerns relating to a request for contraception and report to the Department of Communities accordingly. More information is available on the Department of Communities Child Protection website.

Assessments of capacity to consent for minors (or adults where competency may be in doubt, for example people with an intellectual disability) must be documented in the patient record.

If the pharmacist cannot determine the minor's capacity, they should refer the patient to an appropriate healthcare provider for further assessment.

Reproductive coercion, sexual, and domestic violence and abuse

Pharmacists should be aware of the possibility that a person seeking contraception may be and/or may have been subjected to reproductive coercion, sexual violence, or abuse (assault or sexual coercion), either within a relationship or outside of a relationship (e.g. from a family or community member)[10].

If the pharmacist becomes aware of this during the consultation, they should provide appropriate support and assistance, including referral to support options depending on the patient circumstances.

Referral options include to the local hospital, sexual health clinic, and/or community-based sexual violence support services. A list of services, including sexual assault and domestic violence helplines and local services is provided on the Government of Western Australia Family and domestic violence helplines and support services webpage.

If emergency contraception (EC) is required, oral EC may be supplied as per usual pharmacy care, refer to the Australian Pharmaceutical Formulary and Handbook (APF): Treatment guidelines for pharmacists (Emergency contraception). Insertion of a copper intrauterine device (IUD) is the most effective form of EC[5]. The patient will require referral to an appropriate medical practitioner or health service for IUD insertion. Contact the Sexual Health Helpline for further information.

Contraceptive options for transgender and non-binary people

Transgender (trans) and non-binary people may benefit from referral to specialist sexual health services for comprehensive and culturally safe sexual health care that is tailored to their individual needs.

Sexual health clinics and outreach services are located across WA. For more information, see https://www.wa.gov.au/service/health-care/public-health-services/find-sexual-health-clinic.

Current gender identity for trans or non-binary people assigned female at birth does not impose any restrictions on methods of contraception that may be used. The same considerations apply for choosing safe and effective contraception, including personal characteristics, existing medical conditions, and current drug therapies[11, 12].

Information on cervical screening should be provided to people who have a uterus[13].

People over 50 years

Using a hormonal form of contraception (particularly COCs) may mask the onset of menopause[14].

The choice of contraceptive should be reconsidered at the age of 50 years and at menopause[12]. Switching from an oestrogen-containing method or DPMA to an alternative progestogen only or non-hormonal method is advised[15].

Caution is required when considering stopping contraception. Contraception is required for 12 months after the final menstrual period if it occurs after the age of 50. If the final menstrual period occurs before the age of 50, 24 months of contraception is required before cessation[15]. If it is unclear when contraception can be ceased, refer to a medical practitioner.

The CoSRH has published Contraception for Women Aged Over 40 Years, which provides more detailed information. Some methods of contraception are not suitable for certain age groups. More information is provided below.

Patient history

Obtain sufficient information from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- gender assigned at birth and fertility status (for transgender and non-binary patients)
- plans to become pregnant, current pregnancy status (and how this has been determined)
- recent pregnancies and lactation status
- underlying medical conditions including mental health conditions, which may:
  - be a contraindication to hormonal contraception e.g. migraine with aura, liver disease
  - impact on contraceptive effectiveness and choice
- current and recently ceased treatments (including prescribed medicines, vitamins, herbs, other supplements, and over-the-counter medicines)
- drug allergies/adverse reactions
- prior use of contraceptives, tolerability and adverse effects including mood-related symptoms
- smoking status
- BMI
- other factors such as, usual menstrual cycle, heavy periods, period pain or changes in menstrual cycle, irregular or post-coital bleeding, symptoms that may suggest endometriosis (e.g. pelvic pain, severe pain with menstruation and/or sexual intercourse), symptoms that may suggest PMOS (e.g. oligomenorrhea, hirsutism, acne, weight gain)
- signs or symptoms of menopause or perimenopause
- last STI screen and Cervical Screening Test (CST) (see Sexually Transmitted Infections)
- presence of genitourinary symptoms that may suggest an STI:
  - changes in vaginal or urethral discharge
  - vulval, genital skin problems or symptoms
  - lower abdominal pain
  - dysuria
- Human Papillomavirus (HPV) vaccination status.

Sexual (and social) history

In addition to a standard patient history, pharmacists should also take a social and sexual history from the patient to inform shared decision making.

When taking a sexual history:

- start by asking open questions about the patient's social background (to enable the patient to relax and provide the appropriate context for decision-making)[15]
- more specific questions can then be asked about risk behaviours, followed by questions around sexual practices if required[16].

The following issues should be considered to determine if the patient is at risk of an STI, or if STI testing is indicated, but may not be relevant to all people[16]:

- previous use and experiences with contraception
- current relationship status
- number of recent partners and their gender
- risky behaviours including illicit and/or intravenous drug use, alcohol use
- potential for reproductive coercion, sexual and domestic abuse (refer to Reproductive coercion, sexual and domestic violence and abuse)
- previous STIs and risk factors for STIs (including STI history of current and/or recent partner if applicable).

The following issues should be considered to determine if the patient is at risk of an STI, or if STI testing is indicated, but may not be relevant to all people[16]:

- previous use and experiences with contraception
- current relationship status
- number of recent partners and their gender
- risky behaviours including illicit and/or intravenous drug use, alcohol use
- potential for reproductive coercion, sexual and domestic abuse (refer to Reproductive coercion, sexual and domestic violence and abuse)
- previous STIs and risk factors for STIs (including STI history of current and/or recent partner if applicable).

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies, and current medical conditions.

Examination

The pharmacist should measure the patient's height and weight, and calculate BMI as part of the consultation, as self-reported height and weight may be inaccurate.

The pharmacist should measure BP to determine the patient's suitability for their preferred contraceptive type, and to monitor potential impacts of contraception, including hypertension:

- BP should be measured in accordance with the National Heart Foundation of Australia Guideline for the diagnosis and management of hypertension in adults[17]
- a single elevated BP reading is not enough to classify a patient as hypertensive, and a second BP reading should be taken at the end of the consultation[17, 18].

Exclude pregnancy

Pregnancy should be reasonably excluded before commencing any hormonal contraception[19-21].

A patient can be reasonably assumed not to be pregnant if:

- there are no symptoms or signs of pregnancy

AND any of the following criteria are met:

- they have not had intercourse since the start of the last normal (natural) menstrual period, or since childbirth, abortion, or miscarriage
- they have been correctly and consistently using a reliable method of contraception (barrier methods can be assumed to be reliable if used correctly in this context)
- they are within the first 5 days of the onset of a normal (natural) menstrual period or within the first 5 days after abortion or miscarriage
- they are less than 21 days postpartum
- they have not had intercourse for > 21 days and have a negative urine pregnancy test[4, 12].

If there is any doubt regarding whether the patient may be pregnant, even if a negative urine test is returned, hormonal contraception should NOT be prescribed and the patient referred to an appropriate healthcare provider.

Contraceptive and sexual health plan

Selecting the most appropriate hormonal contraceptive option

Pharmacists must ensure that they are prescribing medicines according to the specified sections of the current online version of the Therapeutic Guidelines: Sexual and Reproductive Health (Contraception).

The choice of hormonal contraception will depend on:

- **the patient's history**
- **the patient's preference:**
  - cost (short and long term)
  - ease of use
  - management of other conditions including medication history
  - potential side effects and potential benefits
- **contraceptive efficacy:**
  - when used correctly, the hormonal methods available in the Hormonal Contraception Service have similar failure rates. However, the consistency of user adherence required is variable, and this may impact on effectiveness[23]. LARC methods (IUDs and implants) are the most reliable and cost-effective reversible methods of contraception[22]
  - pharmacists should not assume effectiveness is the only factor in an individual's choice of contraception but they should explain relative efficacy to patients[10].

Patient resources

- Sexual Health Quarters: Brochures, Posters & Information Sheets[24]
- Jean Hailes for Women's Health: Contraception fact sheets[25]
- Family Planning New South Wales website[26]
- SPHERE Centre of Research Excellence: Which contraceptive method is right for you?[27]
- The College of Sexual and Reproductive Healthcare: Medical Eligibility Criteria for Contraceptive Use (UKMEC)[1]

Combined oral contraceptive pill

Refer to: RANZCOG & FSRH Contraception Clinical Guideline and FSRH Clinical guideline: Combined Hormonal Contraception[3, 5].

COCs containing 50 micrograms or more ethinylestradiol, or preparations containing mestranol, are NOT permitted for use in the Hormonal Contraception Service.

Choice of COC

- Comparative information about COCs to assist with COC choice is available in the Australian Medicines Handbook: Combined oral contraceptive[23].
- The COC with the lowest effective dose of estrogen and progestogen that is well tolerated and able to provide acceptable menstrual cycle control for the patient should be chosen as first-line[10, 28].
- Other guiding principles for COC pill selection are: safety profile, affordability, and additional non-contraceptive benefits if desired[28].
- There have been limited head-to-head trials to guide COC selection. Some pills have specific indications and non-contraceptive benefits that may assist with selection[19].
- Newer progestogens reduce the potential for androgenic, estrogenic, and glucocorticoid effects, but increase the VTE risk[3, 28].
- The quadriphasic pill is indicated for heavy menstrual bleeding as well as contraception, but it has complex instructions for managing a missed pill[19].
- Triphasic pills are no longer commonly used because of a lack of benefits over other types[19].
- The COCs available in Australia and for use in the Hormonal Contraception Service are listed in the Therapeutic Guidelines: Formulations of combined hormonal contraception table[19].
- COCs with a high estrogen dose (50 micrograms of ethinylestradiol or containing mestranol) are not routinely recommended for contraception because of the unacceptable risk of venous thromboembolism (VTE)[19]. These formulations are not permitted for use in the Hormonal Contraception Service.

Combined hormonal vaginal ring

Refer to: RANZCOG & FSRH Contraception Clinical Guideline and FSRH Clinical guideline: Combined Hormonal Contraception[3, 5].

Patients that require assistance with insertion of a vaginal ring should be referred to an appropriate healthcare provider.

Progestogen-only contraceptive pill

Refer to: RANZCOG & FSRH Contraception Clinical Guideline and FSRH Clinical guideline: Progestogen-only Pills[2, 5].

Choice of POP

For patients who have a contraindication to estrogen in COC pills or prefer estrogen-free contraception, POPs can be considered[2]. Drospirenone provides more consistent suppression of ovulation than levonorgestrel or norethisterone, and may provide better bleeding control[5, 21].

DMPA injection

Refer to: RANZCOG & FSRH Contraception Clinical Guideline and FSRH Clinical guideline: Progestogen-only injectables[4, 5].

DMPA may be the contraceptive of choice for individuals with contraindications to estrogen, those taking drugs that induce the CYP3A4 liver enzyme (refer to the *Australian Medicines Handbook*) if a discreet method of contraception is preferred or less user input required.

DMPA is not a first-line option for people with higher risk of VTE, as well as adolescents or perimenopausal people because of the theoretical propensity to cause bone mineral density (BMD) loss and/or limit peak BMD[12]:

- during each annual consultation, pharmacists should assess the user's risk factors for VTE, low BMD, and cardiovascular disease[20]
- people who wish to continue using DMPA should be reviewed by an appropriate healthcare provider every 2 years to assess any changes in benefits and potential risks of use[4].

People should be informed that there can be a delay of up to one year in the return of fertility after discontinuation of DPMA[4].

Confirm contraceptive plan is appropriate

Consult the current editions of the *Therapeutic Guidelines*, the *Australian Medicines Handbook*, and the *UKMEC* to confirm contraceptive management is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

A hormonal contraception that is classified as UKMEC category of 3 or 4 for a patient cannot be prescribed as part of the Hormonal Contraception Service.

Communicate agreed contraceptive plan

Comprehensive advice and counselling (including supporting written information when required) should be provided to the patient regarding:

- individual product and medicine use:
  - instructions for commencing
  - deviation from schedule (e.g. a pill is missed, a DMPA injection is not administered between 10 to 14 weeks post previous dose, or a new vaginal ring is inserted too late or removed before the 3-week interval)
  - how long a secondary method of contraception must be used to avoid unplanned pregnancy
  - instructions on tailored regimens
  - advice on when fertility can be expected to return after ceasing the contraceptive
- emergency contraceptive options that are available in instances of contraceptive failure
- how to manage adverse effects
- when to seek further care and/or treatment:
  - signs of VTE and what to do if it is suspected
  - the importance of reporting new or worsening mood-related symptoms
  - before ceasing the contraceptive
- review with an appropriate healthcare provider at least every 2 years
- when to return for follow-up.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

Other considerations

Where appropriate, individuals may be provided with additional resources to support sexual health.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients (and parent/caregiver if applicable), and to ensure compliance with all copyright conditions.

Venous Thromboembolism

- There may be a small increased risk of VTE with the use of DMPA. Other progestogen-only contraceptives are not associated with a clinically significant risk of VTE[12].
- There is approximately a 3 times increase in the risk of VTE in people using COC, however, this increased risk is still smaller than the risk of VTE during pregnancy and immediately post-partum[28].
- The risk is highest in the first year of use, and still remains higher than for non-users after the first year, however the absolute risk is still very low[12].
- COCs containing levonorgestrel or norethisterone have a slightly lower risk of VTE[12].
- People should be reassured of the overall safety of the contraceptive pill. Studies show that compared to non-users of the COC, users have significantly lower death rates from cancer, cardiovascular disease and other disease, and have generally lower rates of death from any cause[28].

Contraception and cancer risks

- Users of COC have a slightly increased relative risk of breast cancer (risk returns to normal 10 years after cessation of the OCP) and cervical cancer (non-causal), however, the risk of endometrial and ovarian cancers is slightly decreased[12, 19].

Sexually Transmitted Infections (STIs)

- Individuals who may be at risk of STIs should be informed of the risk factors, the availability of screening and treatment, and strategies on how to prevent STIs.
- Pharmacists should recommend STI testing for individuals who may be at risk, even if the individual does not report any symptoms.
- Individuals should be advised of the link between HPV and cervical cancer, and advised of strategies that reduce the risk, including HPV vaccination and cervical screening, as per the current national guidelines[20, 34-36].
- Aboriginal and Torres Strait Islander People are disproportionally affected by STIs. Consider the Australian STI Management Guidelines for use in primary care - Aboriginal and Torres Strait Islander People for priority populations testing and frequency for recommendations on STI screening[37].
- Flyers and information suitable for patients on STIs include:
  - the WA Department of Health HealthySexual and Get The Facts webpage[30, 31]
  - Sexually Transmissible Infections (STIs) - Sexual Health Quarters[32]
  - STI factsheets and other resources designed to promote sexual health for Aboriginal and Torres Strait Islander young people are available as part of the Young Deadly Free campaign (permission for use is requested)[33].
- The WA Department of Health HealthySexual webpage includes an online STI quiz that indicates eligibility for a free STI test through PathWest Clinics without a Medicare card or appointment[30]:
  - the free STI test is not a substitute for comprehensive STI testing and is not intended to replace existing testing and treatment processes, however it provides a pathway for people who may be unlikely or unable to attend a GP or sexual health clinic
  - Sexual Health Quarters also offers Click-and-Collect STI Testing, fees apply.
- The Sexual Health Helpline can assist in finding a GP or sexual health clinic, an Aboriginal Medical Service, or a community-based testing site:
  - (08) 9227 6178 for metropolitan callers
  - 1800 198 205 for country callers.

National Cervical Screening Program

- A cervical screening test (CST) for HPV is recommended every 5 years for women and people with a cervix aged 25 to 74 years who have had sexual contact[34, 36, 38]

Clinical review

Clinical review with the pharmacist (or the patient's chosen healthcare provider) should occur in line with recommendations in the *Therapeutic Guidelines*:

- patients should return for a follow up consultation 3 to 4 months after initiation of a new contraceptive method (i.e. the patient has no recent experience of taking that type of contraception) to screen for adverse effects including hypertension
- clinical review, including measurement of the patient's BP and BMI is recommended at 12 monthly intervals for all patients on regular hormonal contraception[5]
- for patients continuing therapy, follow-up should be individualised to the patient's clinical presentation, response to treatment, and therapeutic goals.

Pharmacists should prescribe a quantity of medicine (including repeats) that aligns with the expected duration of therapy, ensuring sufficient supply until the patient's next review. The total quantity prescribed should not exceed 12 months' supply (including repeats).

Pharmacist resources

- Therapeutic Guidelines: Sexual and Reproductive Health
- Australian Medicines Handbook: Drugs for contraception
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG): Contraception clinical guideline
- The College of Sexual and Reproductive Healthcare (CoSRH):
  - UK Medical Eligibility Criteria for Contraceptive Use
  - UKMEC Calculator
  - Standards and guidance
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM):
  - Decision Making in Contraception
  - Australian STI Management Guidelines
  - Australian STI Management Guidelines - Aboriginal and Torres Strait Islander People
- Sphere resources
  - For consumers
  - News and media
- Pharmaceutical Society of Australia Essential CPE: Women's sexual and reproductive health
- World Health Organisation: Family Planning: A Global Handbook for Providers (2018)
- Australian Pharmaceutical Formulary and Handbook (APF): Treatment guidelines for pharmacists (Emergency contraception)
- Healthy WA: Contraception
- Clinician Assist WA: Clinician Assist WA » Contraception
- King Edward Memorial Hospital Obstetrics and Gynaecology Clinical Practice Guideline
  - Contraception
- WA Department of Health:
  - Healthysexual - Sexual Health resources and STI testing: Healthysexual
  - Get the Facts STI Resources and local sexual health clinics: Get The Facts | Get the Facts
- Sexual Health Quarters:
  - Sexual health and relationship wellbeing for all - Sexual Health Quarters
  - Clinical information for professionals - Sexual Health Quarters
  - Brochures, Posters & Information Sheets - Sexual Health Quarters
  - Education - Sexual Health Quarters
- Cancer Council: Cervical screening for LGBTIQ people
- TransHUB: Contraception
- Australian Menopause Society: Contraception

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To provide feedback on this clinical practice guideline, please email DOH.EACPP@health.wa.gov.au

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