



## CLINICAL GUIDELINE

# Contraceptive Prescribing in Primary Care

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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<b>Approval Group:</b>	Primary Care Prescribing Management Group

### Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

# CONTRACEPTIVE PRESCRIBING IN PRIMARY CARE

Patient requests contraception

- ◆ Check smear status (and BP for COC annually)
- ◆ Consider STI screening
- ◆ Consider drug interactions or teratogenicity e.g. sodium valproate, enzyme inducers
- ◆ Discuss contraceptive choices taking into account the above, patient preference and medical/sexual history

Consider long-acting reversible contraception (LARC) as first line option as this is the most effective way to avoid pregnancy

Consider appropriateness of COC or POP taking into account patients age, medical history, risk factors and patient preferences

POP appropriate

COC appropriate

**Desogestrel\*** is the 1st line POP

- ◆ **Levest** is the 1st line COC
- ◆ If patient suffers from acne, consider a third generation combined pill

A traditional POP such as norethisterone (**Noriday** preferred list) or levonorgestrel (**Norgeston** total formulary)

\*For those with nut allergy **Cerelle** or **Cerazette** can be used

Adverse effects, poor cycle control or poor compliance may dictate further options, which may include tailored pill-taking (off-label use)

Condom use should always be promoted in addition to chosen contraceptive to help prevent the spread of STIs

## Long-Acting Reversible Contraception (LARC)

- See [NICE CG30](#) (updated: July 2019)
- Progesterone-only implant (**Nexplanon**) – Lasts 3 years
  - Copper IUD (**TT380 Slimline**) – Lasts 10 years
  - Progestogen-only IUS (useful if menorrhagia present): **Benilexa** 6 years, **Levosert** 6 years, **Kyleena** 5 years, **Mirena** 8 years
- [endometrial protection 5 years, FSRH advice may differ]**
- Progestogen-only injectable (**Depo-Provera** and **Sayana Press**) every 12 weeks and 13 weeks respectively (FSRH off-label every 14 weeks)
  - Effectiveness of LARC preparations containing hormones (such as **Nexplanon**) may be affected by interacting medicines.
- Refer to individual SPC or BNF for guidance**

## CONTRAINDICATIONS AND RISKS FOR COMMENCING COMBINED HORMONAL CONTRACEPTIVES

(List is not exhaustive - see BNF, UKMEC and individual product SPC)

### CONTRAINDICATIONS

(UKMEC Category 4 – unacceptable health risk)

- ◆ Severe or multiple risk factors for arterial disease or venous thromboembolism (VTE)
- ◆ Migraine with aura
- ◆ Smoker  $\geq 15$  CPD and  $\geq 35$  years of age

(UKMEC Category 3 – risks outweigh benefits)

- ◆ 1<sup>st</sup> degree relative <45yrs with history of VTE or arterial disease
- ◆ BMI  $\geq 35$
- ◆ Smoker <15 CPD or stopped in last year and  $\geq 35$  years of age
- ◆ Symptomatic gall bladder disease
- ◆ Adequately controlled hypertension
- ◆ Diabetes without complications and >20 years duration
- ◆ >50 years of age

**RISK FACTORS TO CONSIDER AT INITIATION (UKMEC Category 2 – benefits outweigh risks)**

- ◆ Smoker of <35 years of age
- ◆ BMI  $\geq 30-34$
- ◆ Migraine without aura at any age
- ◆ Asymptomatic gallbladder disease
- ◆ Diabetes without complications
- ◆ Primarily breastfeeding between 6 weeks and 6 months post partum

Patients should be reviewed annually for changes to risk factors which may affect their eligibility (e.g. measure BP, BMI, smoking status, STI and cervical screening as appropriate). Patients on POP may require less monitoring as per FSRH guidance. Please refer to UKMEC if any new medical conditions present whilst the patient is receiving contraception, as this may alter the patient's risk factors.

Be aware of the risk of interactions between hormonal contraceptives (including some LARC methods) and other medicines. The BNF, Stockley's Drug Interactions and Summary of Product Characteristics for each product can be used for advice and information.

# CONTRACEPTIVE PRESCRIBING IN PRIMARY CARE

## NHSGGC PREFERRED LIST CONTRACEPTIVES AND EFFECTIVENESS\*

**NB:** An effectiveness rate of 92% means that if 100 women used this form of contraception for one year, 8 women would fall pregnant. The effectiveness rate should be explained to the patient when considering what form of contraception to use and typical effectiveness rates may be more appropriate.

### COMBINED ORAL CONTRACEPTIVES

*Effectiveness is >99% when used perfectly, but typical use has an associated effectiveness of 92%\**

Monophasic standard-strength: **Levest®**

Monophasic low-strength: **Akizza 20®**

**Bimizza®**

### ORAL PROGESTOGEN-ONLY CONTRACEPTIVES

*Effectiveness when used perfectly is 97.5% for the first year of use and in women under the age of 35 prescribed standard POPs Effectiveness is 99.5% for women >35 years of age when used perfectly. Typical use has an associated effectiveness of approximately 92%\**

**Desogestrel®**

### LONG-ACTING REVERSIBLE CONTRACEPTION

**Depo-Provera® and Sayana Press®**

**(Medroxyprogesterone acetate)**

*Effectiveness with perfect use is >99% and 97% with typical use\**

**Nexplanon®**

*Effectiveness with perfect and typical use is >99%*

**Benilexa®**

**Levosert®**

**Mirena®**

**Kyleena®**

*Effectiveness with perfect and typical use is >99%*

**TT380 Slimline®**

**Nova-T 380®**

*Effectiveness with perfect and typical use is 98-99%\**

### EMERGENCY HORMONAL CONTRACEPTION

**Ulipristal acetate (EllaOne®)** for up to 120 hours post intercourse or **Levonorgestrel** for up to 72 hours post-intercourse. (see [GGC Formulary](#) for full restrictions). Further guidance relating to EHC may be found in the [FSRH Guideline on Emergency Contraception](#) (amended July 2023).

### CONDOMS

*Effectiveness is 98% in the first year when condoms are used perfectly, but typical use has an associated effectiveness of 85%*

\*Typical use effectiveness reference: Trussell J. Contraceptive failure in the United States. Contraception 2004;70:89-96

## Further Advice and Information

- ◆ UKMEC (UK Medical Eligibility Criteria for Contraceptive Use 2016, amended 2019) is available on the Faculty of Sexual and Reproductive Healthcare Website: <https://www.fsrh.org/documents/ukmec-2016/>
- ◆ Advice on all matters of contraception is available from the Sandyford professional email: [ggc.sandyfordprofessionalsupport@nhs.scot](mailto:ggc.sandyfordprofessionalsupport@nhs.scot)
- ◆ NICE Clinical Guideline 30: Long-acting Reversible Contraception: [www.nice.org.uk](http://www.nice.org.uk)
- ◆ NHS Greater Glasgow and Clyde Formulary: [www.ggcmedicines.org.uk](http://www.ggcmedicines.org.uk)
- ◆ For up to date information about medicine shortages and how to manage, contact a member of the central prescribing team: [prescribing@ggc.scot.nhs.uk](mailto:prescribing@ggc.scot.nhs.uk)

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