Contraception prescribing guidelines

Methods of Contraception

Intrauterine Contraception (IUC)

- Copper-Bearing Intrauterine Device (Cu-IUD)
- Levonorgestrel Intrauterine System (LNG-IUS)

Combined Hormonal Contraception (CHC)

- Combined oral contraception (COC)
- Combined transdermal patches (CTP)
- Combined Vaginal rings (CVR)

Progestogen-only Contraception (POC)

- Progestogen only implant (IMP)
- Progestogen only injectable (POI)
- Progestogen only pill (POP)

Summary of key messages

This guideline should be read in conjunction with the individual Summaries of Product Characteristics (SmPCs), the BNF and the FSRH UK Medical Eligibility criteria for contraceptive use (UKMEC):

- Women should be made aware that no method of contraception is 100% effective.
- Women requiring contraception should be given information about and offered a choice of all methods, including LARC methods.
- All currently available LARC methods (intrauterine devices, the intrauterine system, injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use. They are also the most reliable method of contraception and should be used **1st Line where possible**.
- IUDs, the IUS, and implants are more cost effective than injectable contraceptives.
- Combined Oral Contraceptives (COC): choose a preparation with the oestrogen and progestogen combination which gives lowest associated VTE risk, good cycle control and reduced risk of side effects.
- If a younger women aged 16 years of age or under requests contraception without parental consent, she should be assessed for her capacity to give informed consent to treatment. It should be documented in the clinical record whether or not Fraser criteria is met. (NB this may have been documented previously).
- A traditional progesterone only pill (POP) is the recommended **1st line** when a POP is chosen unless compliance is known to be a problem.
- Emergency contraception: the copper coil is the most effective method, it should be offered to all women seeking emergency contraception. Please refer to the NICE CKS Emergency Contraception guidance for further information.
- **Nut and / or soya allergy**: Some formulations of both COC and POPs contain ingredients not suitable for women with nut and /or soya allergies - If applicable, refer to individuals SmPCs for excipient content – select a suitable preparation and continue to prescribe by **brand name.**

- **History:** Take full clinical history (medical, medication use including OTC and non-prescribed, family, sexual, cervical smears, social, previous contraception use, lifestyle)
- **Check:** BP, Weight, and BMI
- **Exclude:** STI, pregnancy if appropriate

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- Determine patient's preferences for contraception.
- Exclude contraindications to chosen method using UKMEC 2019.
- Promote barrier methods in addition for protection against STI. If appropriate, discuss vasectomy as a potential method of contraception.

The UKMEC Categories

For each of the personal characteristics or medical conditions considered by the UKMEC a Category 1, 2, 3 or 4 is given. The definitions of the categories are given in Table 1.

Table 1: Definition of UKMEC categories

UKMEC	DEFINITION OF CATEGORY
Category 1	A condition for which there is no restriction for the use of the method
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable
Category 4	A condition which represents an unacceptable health risk if the method is used

Offer and discuss Long-Acting Reversible Contraception (LARC) as 1st Line option → If LARCS declined, contraindicated/ intolerance → Consider Combined Hormonal Contraceptives (CHC) → Contraindications /Intolerance/ Poor compliance to CHC → Progestogen Only Pill

Contraception for women using a known teratogenic drugs or drugs with potential teratogenic effects

NB This advice also applies to women whose partner is using a known teratogenic drugs or drugs with potential teratogenic effects.

- **FSRH guidance advises that women of reproductive age who are taking known teratogenic drugs or drugs with potential teratogenic effects should always be advised to use highly effective contraception both during treatment and for the recommended timeframe after discontinuation to avoid unintended pregnancy.**
- Women should be made aware that no method of contraception is 100% effective.
- Women should seek advice from a specialist, who will carry out a pregnancy risk assessment and provide evidence-based advice on the most suitable method for them.
- **MHRA** have published advice on teratogenic drugs including pregnancy testing requirements – click here

If using a method of contraception which is considered 'highly effective'

- E.g. long-acting reversible contraceptives (LARC) copper intrauterine device (Cu-IUD), levonorgestrel intrauterine device (LNG-IUD) , progestogen-only implant and male and female sterilisation, additional contraceptive precautions (e.g. condoms or a second effective contraceptive method) are not required.
- Use of condoms should be advised for protection against sexually transmitted infections.
- **NB women using progestogen only implant must not take any interacting drugs that could reduce contraceptive effectiveness**.

If using Combined hormonal Contraception (CHC) or Progestogen-only pill (POP) or Progestogen-only Injections

The typical use failure rate of combined hormonal contraception (CHC) and the progestogen-only pill (POP) is 9%; for progestogen-only injectables eg depot medroxyprogesterone acetate (DMPA) it is 6%).

- If pills, patches, vaginal rings or injectables are used then **an additional barrier contraception, such as condoms, are advised and regular pregnancy testing considered.**
- **NB women using CHC or POP must not take any interacting drugs that could reduce contraceptive effectiveness.**
- **Use of barrier methods, withdrawal and fertility awareness methods alone is not recommended.**
  Click here for the full FSRH Clinical Effectiveness unit Statement on this subject.

1st line choice contraception – Long- Acting Reversible Contraception

IUD/IUS	Progestogen only implant (IMP) and injection (POI)
Copper-Bearing Intrauterine Device **1st line (10-year license):** Copper T380 A®, T-Safe 380A® QL or TT380 Slimline® **2nd line (5-year license):** Load® 375, Ancora® 375 Cu, Multi-Safe® 375	**Progestogen-only subdermal implant (IMP) (Etonogestrel):** **Nexplanon®** 68mg (3-year license)
Levonorgestrel Intrauterine System (LNG-IUS) **1st line (8-year license for patients <45 years of age):** Mirena® 20mcg/Levosert® 20mcg/Benilexa One Handed® 20mcg **2nd line (3-year license)**: Kyleena® 19.5mg **3rd line (3-year license)**: Jaydess® 13.5mg: To be used if progestogenic side effects unacceptable from other IUS.	**Progestogen Only Injections (POI) (Medroxyprogesterone acetate):** **1st line: Depo-Provera** (12 Weekly intramuscular injection) **2nd line: Sayana Press** (13 Weekly Subcutaneous Injection) Associated with small loss of BMD, which is usually recovered after discontinuation. Risks and benefits should be re-assessed every 2 years.

Combined Hormonal Contraception (CHC) - If LARC is declined or contraindicated

Flow chart 1 – UKMEC1: A condition for which there is no restriction for the use of combined oral contraception (COC). Refer to UKMEC summary sheet

Individual preference (if ≥6 weeks postpartum and non-breast feeding or ≥ 6 months & breast feeding)

No special considerations

Irregular lifestyle e.g., forgetfulness → Consider other non-oral methods

Table on the following page indicates contraception formulary choices

As requested according to formulary → If ok give initial 3 months, then 6-12 months Rx

1st line Standard strength 30mcg EE + LNG

Key
- Situation/symptom
- Action/ advice
- Prescribe
- COC/POP not appropriate

Side effects

Breast tenderness
Encourage perseverance
Suggest better bra support
Suggest evening primrose oil (buy OTC)

If symptoms continue after further 3 months, consider LARC method or reduce oestrogen component

20mcg EE + DSG or GSD

Nausea
Check pill taking timing: Recommend take at night, or with or soon after food

20mcg EE + DSG or GSD
OR
POP

Headache

Classical migraine (no aura)
During pill active weeks

Consider LARC method or reduce oestrogen component

During pill free week only

Recommend extended taking regimens or reduced hormone free interval from 7 to 4-days

Refer to section on tailored regimens

Tension headache
Reassure - Lifestyle advice e.g., reduce caffeine intake, reduce stress, increase water intake

Recommend OTC analgesia

Migraine with aura
STOP COC immediately
Give advice on alternative methods of contraception which do not contain oestrogen

Unscheduled bleeding
Consider STI/ gynaecological reason

Encourage to persevere for up to 3 months
Check compliance
Check drug interactions, Chlamydia/SHS/vaginal Infection screen,
Absorption issues (D&V)
Gynae & C/S history,
Cervical examination

Consider LARC method or change progestogen component or increase oestrogen component

30mcg EE + DSG or GSD
35mcg EE + NGM or NE

If continues after further 3 months, consider Gynaecology Specialist advice

Mood change
Reassure & encourage perseverance
Explore lifestyle issues, Social & relationship history

Loss of libido
Explore social & relationship issues
Explore Self-esteem issues
Explore lifestyle issues

Acne/spots
Lifestyle advice
Diet
Skincare advice
Referral for topical treatment if moderate/ severe

If continues after 3 months, consider LARCs or change progestogen component

30mcg EE + DSG or GSD or DRSP

30mcg EE + DSG or GSD or DRSP

If no improvement, consider Co-CYPRINDIOL & regular review (max 2 years)

Weight gain/bloating
Reassure & encourage perseverance
Explore lifestyle/ Healthy eating plan

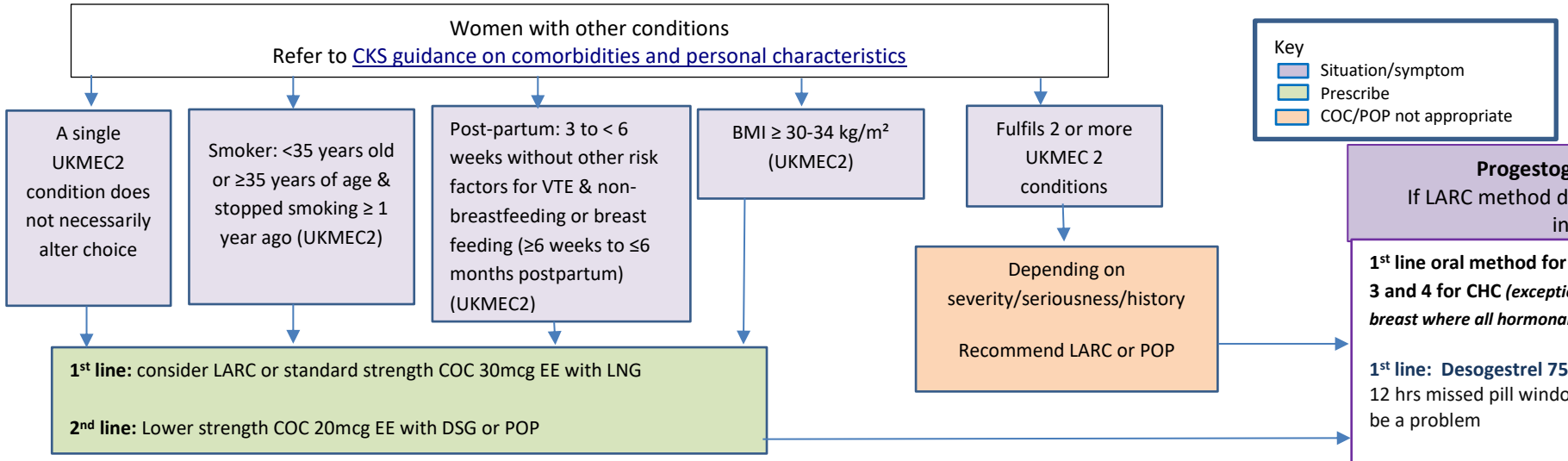
Do not switch to an alternative COC. If a change is requested, consider alternative methods of contraception

Abbreviations

EE –	Ethinylestradiol
LNG –	Levonorgestrel
DSG –	Desogestrel
NE –	Norethisterone
CPA –	Cyproterone acetate
DRSP –	Drospirenone
GSD –	Gestodene
NGM -	Norgestimate

Combined Hormonal Contraception (CHC) continued

Flow chart 2 - UKMEC2: A condition where the advantages of using combined oral contraception generally outweigh the theoretical or proven risks



Abbreviations

DRSP – Drospirenone
DSG – Desogestrel
EE – Ethinylestradiol
GSD – Gestodene
LNG – Levonorgestrel

Progestogen Only Pill (POP)

If LARC method declined, contraindicated/ intolerance

1st line oral method for women with conditions UKMEC 3 and 4 for CHC ***(exception: current or past history of Ca breast where all hormonal methods are unsuitable)***

1st line: Desogestrel 75mcg
12 hrs missed pill window, use if compliance is likely to be a problem

2nd line: Noriday (Norethisterone 350 mcg)
3 hrs missed pill window

Formulary choices of COC		
Standard strength preparations	**Formulary choice brands**	**Additional information**
30mcg Ethinylestradiol with 150mcg Levonorgestrel	Levest®, Maexeni®, Rigevidon®	1st line choice - Lower VTE risk
Lower oestrogen with alternative progestogen preparations		**May benefit those with oestrogenic side effects e.g. bloating, breast tenderness, nausea, headache**
20mcg Ethinylestradiol with 150mcg Desogestrel	Bimizza®, Gedarel®	1st line choice
20mcg Ethinylestradiol with 75mcg Gestodene	Millinette 20®	May be beneficial for those with mild acne concerns whilst using EE/LNG
Standard strength oestrogen with alternative progestogen preparations		**May benefit those with progestogenic side effects e.g. breast tenderness, headache, mood swings, abdominal pain, acne**
30mcg Ethinylestradiol with 150mcg Desogestrel	Cimizt®	3rd line choice
30mcg Ethinylestradiol with 75mcg Gestodene	Katya®	3rd line choice - May be beneficial for those with mild acne concerns whilst using EE/LNG
30mcg Ethinylestradiol with 3mg Drospirenone	Yacella®, Dretine®	
Higher strength oestrogen		**May benefit those with progestogenic side effects e.g. breast tenderness, headache, mood swings, abdominal pain, acne**
35mcg Ethinylestradiol with 500mcg Norethisterone	Brevinor®	2nd line choice - Lower VTE risk – good for breakthrough bleeding with COC use
35mcg Ethinylestradiol with 250 Norgestimate	Cilique®	3rd line choice - Lower VTE risk
35mcg Ethinylestradiol with 2mg Cyproterone acetate (co-cyprindiol)	Clairette®	Licensed for use in women with severe acne which has not responded to oral antibacterials and for moderately severe hirsutism

Non-Oral CHC

Not a cost-effective option, consider only where alternative contraception has been tried, LARC is unsuitable and compliance issues with oral contraception

Note: Limited evidence to suggest risk of VTE may be higher compared to COCs.

Combined Transdermal patch: Evra®
(203 micrograms/24 hours + 33.9 micrograms/24 hours transdermal patch Norelgestromin/ Ethinylestradiol)

One patch applied on day 1, changed on day 8 and 15 then 7-day- patch free period

Combined Vaginal Ring
1st line - NuvaRing®
2nd line - SyreniRing®
(0.120 mg/0.015 mg per 24 hours ethinylestradiol + etonogestrel)

1 ring inserted on day 1 of cycle and left in for 21 days, remove it for 7-day ring free break.

Missed pills
Missed pill advice from CKS – COC
Missed pill advice from CKS – POP

Drug interactions
Liver enzyme inducing drugs (e.g., antibiotics, antiepileptics, antiretrovirals, St John's Wort) and tirzepatide may reduce the efficacy of the COC and POP. Refer to the relevant drug's SPC for advice on managing the interaction or if alternative contraception methods should be used.

Tailored CHC Regimens

• Tailored regimens are as safe as and may be more effective for contraception than the standard 21/7 regimen and therefore should be actively promoted (NICE, FSRH guidance, off-label use). See FSRH CHC guidance

• Consider tailored regimens to broaden contraception choice and support compliance.

• Details of tailored regimens are available on CKS website - CKS advice on tailored regimens

• Traditional use of combined hormonal contraceptives (CHCs) is 21 days of active pills or one ring, or three patches, followed by a 7-day hormone free interval (HFI).

Tailored (non-standard) CHC regimens:

➢ Reduce the frequency of the Hormone free interval (HFI) (extended regimens), abolish the HFI (continuous regimens) and/or shorten the HFI

➢ May reduce or avoid HFI-associated symptoms.

➢ There is potentially a reduced risk of escape ovulation and resulting contraceptive failure with tailored regimens compared to traditional 21/7 regimens.

Non-contraceptive benefits can influence the choice of contraceptive:

Method	Health Benefits
Cu-IUS	May be associated with reduced risk of endometrial and cervical cancer
LNG-IUS	Reduced bleeding and pain associated with primary dysmenorrhoea, endometriosis and adenomyosis, management of HMB
Progestogen injection	Reduced bleeding or amenorrhoea is common May reduce pain associated with endometriosis
Progestogen implant	Improvement in dysmenorrhoea and endometriosis-associated pain
CHC	May increase BMD (depot medroxyprogesterone can reduce BMD) Improved bleeding – regular, lighter, less painful Significant reduction in risk of endometrial and ovarian cancer Reduced risk of colorectal cancer Improve acne, hirsutism and PCOS symptoms, reduce PMS symptoms
POP	Reduced menstrual pain

Follow-up and review of oral combined hormonal contraception:

- Arrange a follow up review 10–12 weeks after starting oral contraception.
- Re-check blood pressure and body mass index.
- Assess the woman for any new risk factors that means her current method is no longer suitable (UKMEC guidance).
- If the woman is experiencing troublesome side effects, give advice for managing side effects using **Flow chart 1** or change contraceptive method.
- Offer advice and information on considering LARCs, where there are no contraindications to use.
- Check compliance: Ensure the pill is being taken consistently and correctly and that the women understands the missed or late pill taking and drug interaction advice.
- Review annually thereafter (or sooner if anything changes).

In the older woman (aged over 40 years) ≤50 years of age, all intrauterine and hormonal methods of contraception can be considered provided there are no contraindications. (see UKMEC, FSRH guidance)

- **Advise that hormone replacement therapy (HRT) does not provide contraception.**
- Advise that a woman is potentially fertile for 2 years after her last menstrual period if she is under 50 years of age, and for 1 year after her last period if she is 50 years of age or over.
- Advise that, in general, women require contraception until the age of 55 years. From 55 years of age natural loss of fertility can be assumed for most women.
- All progestogen-only methods of contraception are safe to use alongside sequential HRT.
- The FSRH IUD guideline supports the use of any 52 mg LNG-IUS for up to 5 years for endometrial protection in individuals using oestrogen as part of HRT. **(FSRH recommendation, off label use)** (See FSRH IUD guidance)
- CHC can be used in eligible women ≤ 50 years of age as an alternative to HRT for relief of menopausal symptoms and prevention of loss of BMD provided there are no contraindications.
- COC with 30mcg EE should be considered 1st COC for women over 40 years due to risks of VTE, cardiovascular disease and stroke.
- When aged 50 or over advise women using CHC to stop and use a safer contraception method e.g. IUD/IUS, IMP, POP

Risk of Venous Thromboembolism

Evidence from observational studies suggest that current use of CHC is associated with a 3- to 3.5-fold increase in VTE risk compared with non-use of CHC.

Despite this increased risk, the number of VTE events in women using CHC remains very small. See figures below.

VTE risk is lower when taking CHC than during pregnancy and the postpartum period.

VTE risk is highest in the months immediately after initiation of CHC or when restarting after a break of at least 1 month. The risk then reduces over the first year of use and remains stable thereafter. The frequent stopping and restarting of CHC is discouraged.

- The European Medicines Agency (EMA) review published estimated figures for absolute risk of VTE in users of CHC evidence to suggest that the risk of VTE associated with different CHC was influenced by progestogen type. Risk of VTE per 10,000 healthy women over one year:
    - Not using CHC and not pregnant: ~2
    - CHC with levonorgestrel, norgestimate or norethisterone: ~5-7
    - CHC with etonogestrel or norelgestromin: ~6-12
    - CHC with gestodene, desogestrel or drospirenone and co-pyrindiol: ~9-12
- Due to limited evidence; it is difficult to compare the effect of EE dose on VTE risk.
- Safety data for new formulations containing estradiol valerate, estradiol hemihydrate, dienogest, and nomegestrol acetate is limited. Preparations containing these formulations are non-formulary.
- Combined transdermal patch and vaginal ring: Long-term data on VTE risk with the patch or ring are limited and conflicting.
- The benefits of any CHC far outweigh the risk of serious side effects - prescribers and women should be aware of the major risk factors for thromboembolism, and of the key signs and symptoms.

Access to Hertfordshire Sexual Health Service: https://www.sexualhealthhertfordshire.clch.nhs.uk/ Helpline: **0300 008 5522.**

Access to Essex Sexual Health Service: https://essexsexualhealthservice.org.uk/ Helpline: **0300 003 1212**

National Pharmacy Contraception Service: Find a pharmacy that offers the contraceptive pill without a prescription - NHS

References	• UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) 2016 – updated 2019 – link to summary page https://www.fsrh.org/standards-and-guidance/documents/ukmec-2016-summary-sheets/ • NICE guidance CG30 Long-acting reversible contraception Clinical guideline [CG30] Published: 26 October 2005 Last updated: 02 July 2019 https://www.nice.org.uk/guidance/cg30/chapter/1-Recommendations • Faculty of Sexual and Reproductive Healthcare clinical guidance: Intrauterine Contraception, April 2015, amended September 2019. https://www.fsrh.org/standards-and-guidance/documents/ceuguidanceintrauterinecontraception/ • Faculty of Sexual and Reproductive Healthcare clinical guidance: Progesterone-only implants, February 2014, amended February 2021 https://www.fsrh.org/documents/cec-ceu-guidance-implants-feb-2014/2fsrh-guideline-progestogen-only-implant-feb-2021.pdf • Faculty of Sexual and Reproductive Healthcare clinical guidance: Combined Hormonal Contraception, November 2020. https://www.fsrh.org/standards-and-guidance/documents/combined-hormonal-contraception/ • Faculty of Sexual and Reproductive Healthcare clinical guidance: Progesterone-only pills, April 2019. https://www.fsrh.org/standards-and-guidance/fsrh-guidelines-and-statements/method-specific/progestogen-only-pills/ • Faculty of Sexual and Reproductive Healthcare clinical guidance: Progesterone-only injectable contraception, December 2014, amended October 2020. https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-injectables-dec-2014/ • Faculty of Sexual and Reproductive Healthcare clinical guidance: Contraception for Women Aged over 40 Years (August 2017, amended September 2019) https://www.fsrh.org/documents/fsrh-guidance-contraception-for-women-aged-over-40-years-2017/ • Faculty of Sexual and Reproductive Healthcare: Member's Evidence Request response - UPA and breastfeeding (April 2022) https://www.fsrh.org/documents/members-evidence-request-response-upa-and-breastfeeding/ • NICE Clinical Knowledge Summaries Contraception – assessment. Last revised in October 2021 https://cks.nice.org.uk/topics/contraception-assessment/ • NICE Clinical Knowledge Summaries Contraception - IUS/IUD. Last Revised in February 2021 https://cks.nice.org.uk/topics/contraception-ius-iud/ • NICE Clinical Knowledge Summaries Contraception - Combined hormonal methods. Last revised in April 2022 https://cks.nice.org.uk/topics/contraception-combined-hormonal-methods/ • NICE Clinical Knowledge Summaries Contraception – progestogen-only methods. Last revised in March 2021 https://cks.nice.org.uk/topics/contraception-progestogen-only-methods/ • FSRH CEU Statement: Contraception for women using known teratogenic drugs or drugs with potential teratogenic effects 14 February 2018 https://www.fsrh.org/standards-and-guidance/documents/fsrh-ceu-statement-contraception-for-women-using-known/ • MHRA: Combined hormonal contraceptives and venous thromboembolism. December 2014, https://www.gov.uk/drug-safety-update/combined-hormonal-contraceptives-and-venous-thromboembolism-review-confirms-risk-is-small • Monthly Index of Medical Specialties https://www.mims.co.uk/ • British National Formulary online https://bnf.nice.org.uk/
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