Family PACT

CLINICAL PRACTICE ALERT
EMERGENCY CONTRACEPTION

Introduction

Emergency contraception (EC) represents a "last chance" after unprotected sexual intercourse to prevent unintended pregnancy. Categories of EC are emergency contraceptive pills (ECPs), including ulipristal acetate (UPA) and levonorgestrel (LNg) and intrauterine devices (IUDs).

Key Recommendations

EC provision is time sensitive and is most effective the sooner it is administered after unprotected sexual intercourse.

UPA and LNg ECPs work equally well up to 72 hours from the time of unprotected sexual intercourse. UPA has a higher efficacy than LNg between 72 and 120 hours after unprotected sexual intercourse.

An individual's body weight affects the efficacy of ECPs. LNg is less effective in individuals who have a body mass index (BMI) of 26-29 kg/m^2 and has little effect in preventing pregnancy in individuals with a BMI ≥ 30 kg/m^2. UPA is effective in individuals with a BMI of 26-29 kg/m^2 but effectiveness decreases in those with a BMI ≥ 30 kg/m^2.

Questions and Answers

In comparing ECP methods, how is UPA different from LNg?

- UPA 30 mg (Ella®) is a progesterone receptor blocker that prevents ovulation of follicles as large as 18-20 mm. It is taken orally in a single dose. It is available by prescription only.
- LNg 1.5 mg is a progestin-only product packaged as a single dose tablet (Plan B One Step® and many generic versions). It is available over the counter and online without a prescription.
- In a comparison of UPA and LNg (0-120 hours after last unprotected sexual intercourse), the failure rate of UPA was 1.3% vs. 2.2% with LNg (a 45% relative difference).[1]

How long after unprotected intercourse are ECPs effective?

- UPA is labeled by the U.S. Food and Drug Administration (FDA) for use up to 120 hours from unprotected sexual intercourse, while LNg products are FDA-labeled for use up to 72 hours. However, studies show that LNg is effective for up to 120 hours after unprotected sexual intercourse.
- Based on published studies, LNg and UPA work equally well up to 72 hours from unprotected sexual intercourse. UPA has a lower failure rate than LNg between 72 and 120 hours, and therefore is preferred for unprotected exposure during this interval.

What are the indications for ECPs in an individual not using contraception?

- When EC is requested by an individual within 5 days of an episode(s) of unprotected sexual intercourse.
- As a component of a "quick start" regimen for off-cycle initiation of a hormonal regimen of contraception, if the individual has had unprotected sexual intercourse in the past 5 days.

When should ECPs be considered by an individual already using contraception?

According to the *U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (U.S. SPR)*[2] from the United States Centers for Disease Control and Prevention (CDC), individuals who used their method incorrectly and who have had sexual intercourse within the past 5 days should use a barrier back-up method for the next 7 days *and* consider the use of ECPs in the following circumstances:

- When oral contraceptives (OCs) used cyclically are missed:
  - One or more days in week 1, or
  - Three or more days in week 2 or 3
- After removal of the contraceptive ring for 3 or more hours in week 1 or longer than 72 hours in week 2 or 3
- When progestin-only pill taking is delayed for longer than 3 hours or after missing 1 or more progestin-only pill(s)

Is a comprehensive history, physical exam, or pregnancy test required before dispensing ECPs?

No. A pregnancy test should be performed only if 10 days or more have elapsed from the

date of unprotected sexual intercourse. Contraceptive counseling should be offered at EC visits and individuals advised that EC is not recommended as a sole method of contraception.

Does the use of ECPs cause abortion?

No. ECPs do not cause an abortion because it works before implantation occurs. If an individual is already pregnant, ECPs will not cause a miscarriage or birth defects. By preventing unintended pregnancy, ECPs reduce the need for abortion.

What follow-up is recommended after the use of ECPs?

- The individual should abstain from sexual intercourse or use barrier contraception for the next 7 days.
- Advise the individual to have a pregnancy test if a withdrawal bleed does not occur within 3 weeks.
- Any contraceptive method can be started immediately after the use of LNg ECPs, but not UPA.

When can an individual start hormonal contraception after the use of UPA?

- Once UPA is taken, the immediate initiation of combined oral contraceptives (COCs) or progestin-only pills (POPs) can reduce its effectiveness, owing to the displacement of UPA from the progesterone receptor. The FDA and U.S. SPR recommend that starting or resuming hormonal contraception occurs no sooner than 5 days after use of UPA.
- Starting a progestin-containing contraceptive method like depot medroxyprogesterone acetate (DMPA, also known as Depo-Provera®), sub-dermal implants, and LNg IUDs at the time of UPA use may be considered; however, the risk that the method might decrease the effectiveness of UPA must be weighed against the risk of not starting a regular hormonal method.

Are there any age restrictions regarding the use of ECPs?

- LNg ECPs can be obtained over-the-counter (without a prescription) by individuals regardless of age.
- UPA requires a prescription at all ages.
- Minors of any age have the legal right to self-consent for pregnancy-related services, including the use of EC. California law does not require parental notification or consent for the provision of contraception (including EC) to minors under the age of 18 years old.

Are there any individuals who should not use ECPs?

- The *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (U.S. MEC)*[3] from the CDC states that the only contraindication to ECPs is a known pregnancy since they will not work after implantation. A history of heart attack, angina, stroke, thromboembolic conditions, migraine, severe liver disease, and obesity are listed as **U.S. MEC Category 2**.

What effect does advance provision of ECP have on clinical outcomes?

Any use of ECPs is 2-7 times greater among individuals who received an advanced supply of ECPs. Although available evidence supports the safety of advance provision of ECPs, the effectiveness of advance provision of ECPs in reducing pregnancy rates has not been

demonstrated.[2] In a large meta-analysis of 15 studies[4], advance provision of ECP does not reduce overall pregnancy rates when compared to conventional (as-needed) ECP provision.

How is an IUD used as emergency contraception?

- A copper IUD (Cu-IUD; Paragard®) is extremely effective (greater than 99%) when used as EC.
- According to the U.S. SPR, it can be inserted within 5 days of the first act of unprotected sexual intercourse as EC. When the day of ovulation can be estimated, the Cu-IUD can be inserted beyond 5 days after sexual intercourse, as long as insertion does not occur more than 5 days after ovulation.
- One study[5] showed that the efficacy of a LNg IUD used as EC is not inferior to the use of a copper IUD; the one-month pregnancy rate for the LNg IUD was 0.3% and there were no pregnancies with the copper IUD. Adverse events in the first month after IUD placement occurred in 5.2% of participants in the LNg IUD group and 4.9% of the copper IUD group. Keep in mind that there is only one study on the topic and that most national organizations have not yet recommended this approach.

Applications of Family PACT Policies

Which ECP products are available in Family PACT?

- The *Medi-Cal Rx Family PACT Pharmacy Formulary* includes UPA and LNg ECP products for both clinic and pharmacy dispensing.
- Bill for clinic dispensed LNg ECPs and UPA with Healthcare Common Procedure Coding System (HCPCS) codes listed in the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual. Billers should also include the National Drug Code (NDC) number of the product used on the claim.
- All products are restricted to one pack per dispensing, with a combined maximum total number of dispensing six packs per recipient, per year, from any provider.

Can an individual receive ECPs without choosing a longer-term method of contraception at the same visit?

- Yes. Use ICD-10-code for "encounter for prescription of emergency contraception" as the primary diagnosis code. If the encounter also includes services for contraceptive management or initiation of a contraceptive method, the family planning ICD-10 Z-code for the method selected by the individual, should be used.
- The only lab test covered with an emergency contraceptive visit is a point-of-care urine pregnancy test as clinically indicated.

Are ECPs a Family PACT benefit for individuals who are unable to become pregnant, if intended for a partner who can become pregnant?

No. ECPs are a Family PACT benefit only when dispensed to an individual who can become pregnant. However, levonorgestrel ECPs can be purchased in a pharmacy or online without a prescription.

Does Family PACT cover ECPs for individuals using other methods of contraception?

» Yes, but only as clinically indicated, not routinely. For example, an individual choosing a contraceptive implant may need an ECP at the time of a "quick start" (off-cycle) implant placement after unprotected sexual intercourse within the prior 5 days.

Does Family PACT cover IUD placement as emergency contraception?

» Yes, but only if the individual intends to use the IUD as their ongoing method of contraception.

Providers should refer to the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual for the complete text of the *Family PACT Standards*, official administrative practices, and billing information.

References

1. Glasier, AF, Cameron ST, et al. Ulipristal acetate versus levonorgestrel for emergency contraception: a randomised non-inferiority trial and meta-analysis. *Lancet*. 2010; 375(9714):555-562. https://www.sciencedirect.com/science/article/pii/S0140673610601018?via%3Dihub.
2. Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. *MMWR Recomm Rep*. 2016 Jul 29;65(4):1-66. https://www.cdc.gov/mmwr/volumes/65/rr/rr6504a1.htm.
3. Curtis KM, Tepper NK, Jatlaoui TC, et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. *MMWR Recomm Rep*. 2016 Jul 29;65(3):1-104. https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm.
4. Polis CB, Schaffer K, Blanchard K, et al. Advance provision of emergency contraception for pregnancy prevention. *Cochrane Database Syst Rev*. 2007 Apr;(2):CD005497. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD005497.pub2/full.
5. Turok DK, Gero A, et al. Levonorgestrel vs. Copper Intrauterine Devices for Emergency Contraception. *N Eng J Med*. 2021 Jan 28;384(4):335-344. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7983017/.

Additional Resources

1. American College of Obstetricians and Gynecologists. Emergency contraception. Practice Bulletin No. 152. *Obstet Gynecol*. 2015 Sep;126(3):e1-11. https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2015/09/emergency-contraception.
2. American Society for Emergency Contraception. https://www.americansocietyforec.org/.
3. Salcedo J, Cleland K, et al. Society of Family Planning Clinical Recommendations: Emergency Contraception. *Contraception*. 2023 May;121:109958. https://www.sciencedirect.com/science/article/pii/S0010782423000112?via%3Dihub.