**STANDARD NURSE PROTOCOL FOR EMERGENCY CONTRACEPTIVE PILLS (ECPs)**

**DEFINITION** Emergency Contraception (EC) is a contraceptive method used to prevent pregnancy. ECPs are ineffective if a woman is already pregnant.

Progestin-only ECPs are increased doses of levonorgestrel taken after sexual intercourse to prevent pregnancy by inhibiting ovulation.

Ulipristal acetate is the newest branded ECP. It is a selective progestin receptor modulator. It also works to delay ovulation. It is only available by prescription, but has superior efficacy in preventing pregnancy compared to progestin-only ECP between 72-120 hours after sex and also in women who are obese.

The copper IUD is the most effective method of EC and should be offered to women who need EC as well as desire contraception going forward. It can be placed up to 5 days after unprotected sex and left in place up to at least 10 years, with studies suggesting up to 12 years efficacy. See Copper IUD protocol for details on placement.

As of April 2013, a court ruling indicated levonorgestrel based ECP must be made available over-the-counter, with no age or gender restrictions. They are still available by prescription, and this may be an important clinical practice to continue because of cost concerns. Ulipristal acetate and the Copper IUD are available only by prescription.

**ETIOLOGY** ECP work by delaying or preventing ovulation. ECP are most effective if given within 72 hours of unprotected intercourse, but are effective up to 120 hours. The sooner ECP are initiated, the more effective the treatment. ECP will not disrupt a pregnancy once implantation has occurred. There is no evidence that ECP will harm a pregnancy once implantation has occurred. The effectiveness of treatment depends on when in the woman’s menstrual cycle the emergency contraception is used and how soon after sex it is taken.

There are no medical contraindications to the use of ECP except known pregnancy and allergy to the medicine. The duration of use of ECP is less than that of regular use of combined oral contraceptives and progestin only pills and thus would be expected to have less clinical impact.

**SUBJECTIVE** 1. Patient provides history of unprotected sexual intercourse within the last 120 hours (5 days) andrequests post-coital contraception as an emergency measure only (not as ongoing routine contraception).

For women who are interested in ongoing contraception, the copper IUD provides the most effective EC and highly effective long acting reversible contraception. It should be discussed with all women requesting emergency contraception (See Copper IUD Protocol).

**NOTE:** Progestin only EC is most effective if given within 72 hours of unprotected intercourse. The sooner ECP are initiated, the more effective the treatment. If the patient is more than 72 hours from unprotected intercourse, educate the woman that the copper IUD and ulipristal acetate are superior to levonorgestrel for pregnancy prevention in this window.

1. Due to the time-sensitive nature of use of ECPs, patients may request and/or providers can recommend or provide EC in advance for use as needed. This may be particularly valuable for women who elect short term or coitally-dependent contraception (contraceptive pills, condoms, contraceptive patch, contraceptive rings, etc.) or for any woman who has a medical condition that puts her at increased risk if she experiences an unintended pregnancy (See Box 2 CDC Medical Eligibility Criteria).

3. Precautions:

When providing Plan B® One-Step, Plan B® Two-Step, Next Choice, generic levonorgestrel, or ulipristal acetate, Ella®:

a. History of hypersensitivity to any component of ECPs.

1. Known or suspected pregnancy.

**OBJECTIVE** 1. A pregnancy test is not needed before providing ECP, but may be performed if the patient reports more than one act of unprotected intercourse since last menstrual period (LMP).

2. Pelvic exam, if indicated.

3. Current and local availability of Plan B® One-Step, Plan B® Two-Step, Next Choice, generic levonorgestrel, or ulipristal acetate.

**ASSESSMENT** Patient requests EC; no contraindications or allergies to any component of the emergency contraceptive.

**PLAN THERAPEUTIC**

**NOTE:** Hazardous agent; use appropriate precautions for handling and disposal which can be found at:<https://www.cdc.gov/niosh/docs/2016-161/default.html>

**PHARMACOLOGIC**

* + - 1. Levonorgestrel 1.5 mg (e.g. Plan B® One-Step, My Way®, React®, EContra EZ®, Aftera®): one single dose of 1.5mg levonorgestrel PO as soon as possible within 120 hours after unprotected intercourse.

OR

* + - 1. Levonorgestrel 0.75mg (e.g.Plan B® Two-Step, Next Choice®) packaged as two doses of 0.75mg with package instructions to take each dose 12 hours apart. However, it works better and is easier for the patient to take both pills PO at once as soon as possible.

**NOTE:** Antiemetics not needed with progestin only ECP.

OR

* + - 1. If the patient is a candidate for ulipristal acetate, one tablet of 30mg ulipristal acetate PO as soon as possible. Ulipristal acetate works better than levonorgestrel-only ECP between 72-120 hours and for women who have BMI greater than 30. For women in these situations, clinicians should preferentially offer Ulipristal acetate or Paragard if available due to their higher efficacy.
      2. If patient wants to initiate an ongoing method, ParaGard should be considered as it provides the most effective EC and provides highly effective long acting contraception.
         1. For those who use ulipristal acetate as ECP, a back-up barrier method is encouraged until her next menses. Patient may initiate a hormonal contraceptive method according to manufacturer’s directions at the next menstrual cycle or she may initiate hormonal contraceptives 5 days after taking the ulipristal acetate for ECP. She should beprovided contraceptive supplies and instructions about when to begin. Women who are interested in DMPA or a subdermal implant should return in 5 days for the injection or at the time of next menses.
         2. For those who use levonorgestrel-only ECP**,** initiate the method according to manufacturer’s directions at the next menstrual cycle or begin the method the day after ECP treatment is complete. DMPA and a subdermal implant can be initiated on the same day as this ECP. Encourage use of a back-up method for 7 days and repeat urine pregnancy testing in 2-3 weeks.
      3. ECPs (Ella (ulipristal acetate) or Levonorgestrel only) are not indicated for use in children or adolescents prior to menarche. Adolescents (postmenarchal) who need ECPs should follow adult dosing schedule. If there is any situation in which a clinician feels that a minor’s request for EC is a result of a sexual act that was not consensual, the clinician should report the concern according to clinical guidelines regarding Mandatory Reporting Laws.
      4. Offer STD screening if sexual encounter also placed patient at risk of contracting STDs. If patient has been raped, refer to local authorities and clinical setting where an exam can be performed for collecting evidence (if your clinic does not do this). Provision of the ECP should not be delayed for this referral.
      5. Refer patient to NP for copper IUD placement if she is interested in copper IUD as emergency contraception.

**PATIENT EDUCATION/COUNSELING**

1. Provide the patient with exact directions for taking medication. This will include taking one dose (combining doses if necessary, for those that suggest separating progestin only ECP over 12 hours) of the levonorgestrel based ECP or ulipristal acetate as soon as possible.
2. Strongly encourage patient to choose an acceptable, ongoing method of birth control**.** ECP is not intended for routine contraception. Repeated use within the same menstrual cycle is not recommended. For women who initiate a hormonal method and use levonorgestrel-only ECP, encourage use of a back-up method for 7 days. For those who use ulipristal acetate as ECP a back-up method is encouraged until her next menses. Emergency contraception does not protect from pregnancy going forward (except for use of Paragard as EC) and future acts of sex require additional contraception.
3. Inform patient that next menstrual period may start a few days earlier or later than usual. The next menstrual period should begin within the next 2 or 3 weeks. If no menses in 3 weeks advise patient to return to clinic for pregnancy test.
4. If patient initiates an ongoing method immediately after ECP, her next cycle may also be delayed. In this setting, offer a urine pregnancy test in 2-4 weeks. **(This can be done by a home pregnancy test if the patient desires).**
5. Women who use ulipristal acetate for EC and who begin a hormonal contraception should use a back-up method **until her next menses**.

1. Provide counseling on preconception health counseling and future fertility. (Refer to Preconception Health Toolkit)

[http://www.fpm.emory.edu/preventive/research/project s/](http://www.fpm.emory.edu/preventive/research/project%09s/)

1. Advise patient that ECP does not protect against STD/HIV. Counsel on the use of condoms to reduce the risk of STD/HIV.
2. Provide information **for** the Emergency Contraception Hotline (1-888-NOT-2-LATE). The Hotline is an automated, toll free confidential service available 24 hours a day in English and Spanish. In addition to basic information, each caller hears a recording of the names and telephone numbers of the five closest ECP providers.

**FOLLOW-UP**

1. Return to clinic if menses has not started in 3 weeks or if next menses is unusually light or painful.
2. Return to clinic for ongoing birth control method if not provided at visit.

**CONSULTATION/REFERRAL**

1. Refer patient to physician immediately for symptoms concerning for an ectopic pregnancy.

**REFERENCES**

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2. Joellen Hawkins et al., *Protocols for Nurse Practitioners in Gynecologic Settings,* 11th ed., Springer Publishing Co., New York, 2015.

3. M. Zieman, R.A. Hatcher. *Managing Contraception, 13th ed., Ardent Media Inc.,* New York, 2015

4. CDC, U.S. Medical Eligibility Criteria for Contraceptive Use, 2016, MMWR 2016; 65: 3 <http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf>

5. CDC, U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR 2016; 65:4 <http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf>

6. Association of Reproductive Health Professionals, Emergency Contraception: Clinical Update < <https://www.arhp.org/Publications-and-Resources/Clinical-Proceedings/EC/Methods>> (Accessed April 12, 2013)

7. US Department of Health and Human Services; Centers for Disease Control and Prevention; National Institute for Occupational Safety and Health. NIOSH list of antineoplastic and other hazardous drugs in healthcare settings, 2016. Available at https://www.cdc.gov/niosh/docs/2016-161/default.html. Updated September 2016. Accessed November 8, 2016.

8. Wolters Kluwer; *Lexicomp Online*, 2017; http://online.lexi.com/lco/action/doc/retrieve/docid/patch\_f/5245 >accessed June 4, 2017