TO: Title X Sub-recipients and CCare Providers

FROM: Reproductive Health Program, Center for Prevention and Health Promotion, Oregon Health Authority

RE: Efficacy of Emergency Contraception

Recently the effectiveness of emergency contraception (EC) has received attention in the news media. Several published studies have indicated both ulipristal acetate and levonorgestrel formulations of EC are associated with decreased effectiveness for individuals at either higher weight or body mass index (BMI). The purpose of this letter is to summarize these findings and to reinforce best practice for the provision of EC. For the purposes of this discussion, unprotected intercourse (UPI) is defined as any act of vaginal-penile sex occurring without the use of a condom; with condom slippage or breakage; and/or in which a known or suspected contraceptive failure has occurred.

The most commonly prescribed forms of EC are the levonorgestrel-based emergency contraception formulas (Plan B One-Step® or Next Choice®). Levonorgestrel EC is available over the counter for males and females of any age. It is recommended that women take levonorgestrel EC as soon as possible as its efficacy decreases over a period of 120 hours after UPI and is ineffective beyond that time period. It has been shown to be 89% effective when used within 72 hours and decreases to approximately 81% when used 72 - 120 hours after UPI. There are no contraindications for the use of levonorgestrel EC and no indication that it has negative impacts on an existing pregnancy. The 340b price per dose is $5.00. Recent studies have demonstrated that the efficacy of levonorgestrel EC decreases as the woman’s weight or BMI increases. Levonorgestrel EC appears to be completely ineffective at preventing pregnancy in women whose BMI is greater than 25 or for women who weigh over 154 pounds regardless of BMI (pregnancy rates among these women were equal to that of women who did not take EC after UPI).

Ulipristal acetate (ella®), a selective progesterone receptor modulator, is a more recently approved option for EC. ella® was found to be embryotoxic in animal studies and pregnancy must be excluded prior to administration. Its use is not recommended for breastfeeding women as is it not known if any active metabolites are excreted into the breast milk. ella® is available by prescription only and the 340b price is $14.85 per dose. ella® should be administered as soon as possible and within 120 hours of UPI. ella® does appear to maintain the same level of effectiveness (approximately 85%) over the 120 hour period as opposed to levonorgestrel EC. In these same studies, ella® was found to be more effective than levonorgestrel EC for women with a BMI over 25. However, it reaches its efficacy limit for women with a BMI over 35 (regardless of actual weight) or at a weight over 193 pounds (regardless of BMI). Repeated use of ella® within the same menstrual cycle is not recommended, as safety and efficacy of repeat use within the same cycle has not been evaluated. Due to the modulation of progesterone receptors and possible reduced efficacy of hormonal
contraception, it is recommended that women currently using or initiating hormonal contraception at the time of the administration of ella® use a barrier method in addition to their contraceptive method for the remainder of the cycle.

An alternative option for EC is the copper IUD (Paragard®). Paragard® provides up to 10 years of contraception and is also used for EC. The Paragard® is an effective EC method if inserted within 5 days of UPI and the 340b price is $245.00. Data indicate that this is the most effective form of EC, regardless of weight.

Though not addressed in these studies, the off-label use of combined hormonal contraceptive pills (COCP), called the Yuzpe method, for EC has been in place since the mid 1970’s but has been rarely used since the advent of levonorgestrel and ulipristal formulations. The standard dosage consists of ethinyl estradiol, 100 μg, and levonorgestrel, 0.5 mg, to be taken within 72 hours of UPI and repeated 12 hours later. The Yuzpe method of EC has been shown to be about 75% effective; requires a prescription; and the 340b price is roughly $7. Follow the link below for a chart of commonly used COCP EC dosages. At this point there are no documented studies that evaluate the impact of weight or BMI on the effectiveness of this method.

In addition to the association between effectiveness and weight/BMI, these studies also suggest that women most at risk for EC failure are those who have had UPI at the most fertile time of the cycle and those who have additional acts of UPI within the same cycle. Given that the average weight of US women over the age of 20 is 166.2 pounds, the potential link between weight/BMI and EC effectiveness impacts a large number of women. Ideally, the goal should be to match women with a birth control method that they can use perfectly, thereby substantially reducing the need for EC.

When counseling and providing EC for immediate use, it is important to consider the population your agency serves, the ability to insert IUDs and accommodate insertion within 5 days of UPI, and the cost impact of providing ella® and Paragard®. In general, the following recommendations reflect EC best practice:

- Offer the Paragard® IUD as a first line strategy
- If the agency is unable or the client is unwilling to have a Paragard® placed, consider ella® in place of levonorgestrel EC for women with a BMI between 26 and 35 or for those with a weight between 154 and 193 pounds
- Counsel women on the affects of weight/BMI on efficacy of EC
- Emphasize the importance of not having further UPI
- Offer same-day start of birth control methods to reduce future need for EC
- Keep in mind that there is no harm to offering EC to women who fall outside of the range of effectiveness; it just might not prevent a pregnancy.
- Counsel women who choose less effective EC formulations regarding the increased risk of pregnancy
- Rule out an existing pregnancy as indicated by client history and presentation
- Offer breastfeeding women the options of either levonorgestrel-based EC formulations or Paragard®
- Offer future use EC and condoms at all reproductive health (RH) visits
- Incorporate the assessment of weight and BMI into all RH office visits and offer weight reduction counseling to all women with a BMI over 25 (see the link below)
- Assess for and counsel women on the correct use of their birth control method at every opportunity
- Encourage those who have misused their method of birth control to switch to a method that is easier to use
- When presenting information on birth control methods, begin the discussion with the most effective methods
Please contact Linda McCaulley or Connie Clark, Nurse Consultants, with any questions regarding the above information.

Resources:

Healthy Weight Management:
http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Pages/HealthyWeightManagementToolkit.aspx

Yuzpe Method:

References:

CDC Anthropometric Reference Data for Children and Adults: United States, 2007–2010:


POLICY: This policy provides direction for Nurse Practitioners (NP), Physician Assistants (PA) and Registered Nurses (RN) in the provision of emergency contraception (EC) for the prevention of unintended pregnancy.

DEFINITION: Emergency contraception consists of several different formulations which can be used by women to prevent pregnancy after unprotected sexual intercourse or a known or suspected contraceptive failure. EC prevents pregnancy primarily by delaying or inhibiting ovulation and inhibiting fertilization, and it may also inhibit implantation by altering the endometrial lining. EC does not cause abortion or harm an established pregnancy. EC should be used as soon as possible within 120 hours of unprotected sexual intercourse.

Formulations: There are four options of EC available in the United States including:

1. **Cu-IUD (Paragard®)** for immediate use
2. **Levonorgestrel or Plan B one step®** for immediate and future use and is available in a 1.5 mg single dose tablet
3. **Ulipristal acetate (ella®)** for both immediate and future use and is available in a 30 mg single dose tablet.
4. Combined estrogen and progestin or the **Yuzpe formulation** (for immediate use) is available in a two dose regimen. (Yuzpe regimen includes one dose of 100 µg of ethinyl estradiol plus 0.5 mg of levonorgestrel followed by a second dose of 100 µg of ethinyl estradiol plus 0.5 mg of levonorgestrel 12 hours later)

1) **Cu-IUD (Paragard®)**

Intrauterine contraceptives are among the safest and most effective methods of contraception available today. The Cu-IUD can be inserted for use as EC within 5 days of unprotected sexual intercourse; if 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 >5 days after ovulation.

Effectiveness of the Paragard® is not affected by weight or body mass index (BMI).

a) **Contraindications:**

i) Absolute contraindications to Paragard® - US MEC Category 4 risks:

- Distorted uterine cavity
- Current cervical cancer (initiation)
• Endometrial cancer (initiation)
• Gestational trophoblastic disease with persistently elevated β-hCG levels or malignant disease
• Current PID (initiation)
• Immediately post septic abortion
• Puerperal sepsis
• Current pregnancy
• Current purulent cervicitis, Chlamydia infection or Gonorrhea (initiation)
• Pelvic- tuberculosis (initiation)
• Unexplained vaginal bleeding suspicious for serious condition before evaluation (initiation)

ii) Relative contraindications to Paragard® - US MEC Category 3 risks: the prescribing provider must determine if benefit of use outweighs risks for the following Category 3 US MEC risks:
• Gestational trophoblastic disease with decreasing or undetectable β-hCG levels
• AIDS – (initiation- monitor closely for pelvic infection)
• Solid organ transplantation-complicated (initiation)
• Systemic lupus erythematosus with severe thrombocytopenia (initiation)
• Pelvic tuberculosis (continuation)
• Antiretroviral (ARV) therapy: NRTIs; NNRTs; and Ritonavir-boosted protease inhibitors ( 2/3 for initiation – if woman is clinically well on ARV therapy, would be category 2 for initiation and continuation)

2) Levonorgestrel EC (Plan B One Step®)
Levonorgestrel EC is available over the counter for males and females of any age. It is recommended that women take levonorgestrel EC as soon as possible as its efficacy decreases over a period of 120 hours after UPI and is ineffective beyond that time period. It has been shown to be 89% effective when used within 72 hours and decreases to approximately 81% when used 72 - 120 hours after UPI. Recent studies have demonstrated that the efficacy of levonorgestrel EC decreases as the woman’s weight or BMI increases. Levonorgestrel EC appears to be completely ineffective at preventing pregnancy in women whose BMI is greater than 25 or for women who weigh over 154 pounds regardless of BMI (pregnancy rates among these women were equal to that of women who did not take EC after UPI).

a) Contraindications:
• Pregnancy: Use of Plan B One Step® once a pregnancy has been established is not harmful to the pregnancy but simply provides no benefit

3) Ulipristal acetate (Ella®)
Ulipristal acetate (ella®), a selective progesterone receptor modulator, is a more recently approved option for EC. ella® was found to be embryotoxic in animal studies and pregnancy must be excluded prior to administration. Its use is not recommended for breastfeeding women as is it not known if any active metabolites are excreted into the breast
milk. ella® is available by prescription only and the 340b price is $14.85 per dose. ella® should be administered as soon as possible and within 120 hours of UPI. ella® does appear to maintain the same level of effectiveness (approximately 85%) over the 120 hour period as opposed to levonorgestrel EC. In these same studies, ella® was found to be more effective than levonorgestrel EC for women with a BMI over 25. However, it reaches its efficacy limit for women with a BMI over 35 (regardless of actual weight) or at a weight over 193 pounds (regardless of BMI). Repeated use of ella® within the same menstrual cycle is not recommended, as safety and efficacy of repeat use within the same cycle has not been evaluated. Due to the modulation of progesterone receptors and possible reduced efficacy of hormonal contraception, it is recommended that women currently using or initiating hormonal contraception at the time of the administration of ella® use a barrier method in addition to their contraceptive method for the remainder of the cycle.

a) Contraindications
- Pregnancy
- Ella® is not recommended for use by breastfeeding women

4) **Yuzpe – ECP containing ethinyl estradiol and levonorgestrel**
The Yuzpe method for EC has been in place since the mid 1970’s but has been rarely used since the advent of levonorgestrel and ulipristal formulations. The standard dosage consists of ethinyl estradiol, 100 μg, and levonorgestrel, 0.5 mg, to be taken within 72 hours of UPI and repeated 12 hours later. The Yuzpe method of EC has been shown to be about 75% effective; requires a prescription, and the 340b price is roughly $7. Follow the link below for a chart of commonly used COCP EC dosages. **At this point there are no documented studies that evaluate the impact of weight or BMI on the effectiveness of this method.**

a) **Absolute contraindications** (US MEC category 4 risks):
- Age ≥ 35, smoking ≥ 15 cigarettes/day
- Multiple risk factors for arterial CVD: older age; smoking; diabetes; hypertension
- Elevated BP (≥ 160 / ≥ 100)
- Vascular disease
- History of deep vein thrombosis (DVT) or pulmonary embolism (PE), not on anticoagulant therapy
- Higher risk for recurrent DVT/PE - history and ≥1 additional risk factor:
  - History of estrogen-associated DVT/PE
  - Pregnancy-associated DVT/PE
  - Idiopathic DVT/PE
  - Known thrombophilia, including antiphospholipid syndrome
  - Active cancer (metastatic, on therapy, or within 6 months after clinical remission, exclude non-melanoma skin cancer)
- Active DVT/PE
- DVT/PE and established on anticoagulant therapy for 3 months and ≥ additional risk factor:
  1. Known thrombophilia, including antiphospholipid syndrome
  2. Active cancer (metastatic, on therapy, or within 6 months after clinical remission, exclude non-melanoma skin cancer
  3. History of recurrent DVT/PE
• Major surgery with prolonged immobilization
• Known thrombogenic mutations:
  1. Factor V Leiden
  2. Prothrombin mutation; protein S, protein C
  3. Antithrombin deficiencies
• Current or history of ischemic heart disease
• Stroke
• Complicated valvular heart disease:
  1. Pulmonary hypertension
  2. Risk for atrial fibrillation
  3. History of sub acute bacterial endocarditis
• Peripartum cardiomyopathy < 6 months
• Moderately or severely impaired cardiac function
• Lupus erythematosus with positive or unknown antiphospholipid antibodies
• Migraine without aura ≥ 35 years
• Migraine with aura, any age
• Current breast cancer
• Diabetes with nephropathy/retinopathy/neuropathy (could be “3” depending on severity)
• Diabetes with other vascular disease of diabetes of >20 yrs duration (could be “3”)
• Severe cirrhosis
• Liver tumor, malignant or hepatic adenoma
• Viral hepatitis with acute or flare stage (could also be a “3” based on severity) – for initiation
  1. A category “2” for continuation
• Complicated solid organ transplantation (graft failure; rejection; cardiac allograft vasculopathy)
• Postpartum < 21 days and breastfeeding and non-breastfeeding

b) Relative contraindications (provider to determine if benefit outweighs risks) Category 3 US MEC risks:
• Age > 35, smoking, <15 cigarettes/day
• HX bariatric surgery with malabsorptive procedure (COC only, R/P =1)
• Cardiovascular disease (as in category “4”, could be a “3” based on risk factors)
• Adequately controlled hypertension
• Elevated BP 140-159/90-99
• HX of DVT/PE not on anticoagulant therapy, but lower risk for recurrent DVT/PE and no risk factors
• HX of DVT/PE, established on anticoagulant therapy for at least 3 months, no risk factors (Category 4)
• Known hyperlipidemias (could be category “2”, based on type, severity, and other CVA risk factors)
• Peripartum cardiomyopathy >6 months
• Migraines without aura age <35
• Past breast cancer and no evidence of current disease for 5 years
• Diabetes with nephropathy/retinopathy/neuropathy (could be category “4” based on severity)
- Diabetes with other vascular disease or diabetes of >20 years (could be “4” based on severity)
- Inflammatory bowel disease (ulcerative colitis/Crohn's disease) (could be a “2” or “3”) Consider:
  1. Active/extensive disease
  2. Surgery
  3. Immobilization
  4. Corticosteroid use
  5. Vitamin deficiencies
  6. Fluid depletion
- Current gallbladder disease or current medical TX for gallbladder disease
- Past HX of cholestasis that was COC-related
- Viral hepatitis in acute or flare stage (could also be a category 4, depending on severity) for initiation
  1. Category “2” for continuation

**Anticonvulsant therapy:**
  1. phenytoin;
  2. carbamazepine;
  3. barbiturates;
  4. primidone;
  5. topiramate;
  6. oxcarbazepine
  7. Lamotrigine if used as monotherapy

- Rifampicin or rifabutin therapy

- Postpartum 21 to <30 days and breastfeeding and without other risk factors for VTE:
  1. ≥35 years
  2. Previous VTE
  3. Thrombophilia
  4. Immobility
  5. Transfusion at delivery
  6. BMI ≥ 30
  7. Postpartum hemorrhage
  8. Preeclampsia
  9. smoking

- Postpartum 30-42 days and breastfeeding with and without other risk factors for VTE
- Postpartum 21-42 days, non breastfeeding with other risk factors for VTE (as above)

**PROCEDURE:**

1. Screen client for appropriateness to receive EC
   a) LNMP
   b) Date and time of unprotected intercourse
   c) Current contraceptive method
   d) Ensure that client is not wanting to be pregnant
   e) Assess need for future use EC
   f) R/O contraindications per U.S. MEC category 3 and 4 risk conditions
   g) Obtain weight/BMI
2. Perform pregnancy test to rule out an existing pregnancy if indicated by medical history of prior acts of UPI or contraceptive failure/mis-use since LNMP or within the past month
3. Discuss EC options available for the individual client incorporating information regarding affects of weight/BMI on efficacy of EC of formulation. Lead the discussion with the most effective options, ending with least effective.
4. If client requests an EC formulation in which they have a US MEC category 3 or 4 risk condition, the RN will refer the client to the NP/PA/MD
5. Administer/provide selected EC formulation (see below)

A) Cu-IUD (Paragard®)
   1. Scheduling:
      a) RN will schedule client with NP/PA/MD for insertion the same day if possible, and within 120 hours of unprotected intercourse

2. Insertion:
   b) NP/PA/MD will follow the Paragard® policy and procedure for insertion of the device

3. Client Education:
   c) Follow the client education steps outlined in the Paragard® policy and procedure
d) Client will be instructed to return to the clinic for a pregnancy test if no menses occurs within the next 3 weeks

B) Levonorgestrel EC (Plan B One Step®):
   1. Administration:
      a) Administer Plan B One Step® tablet ASAP while client is in the office; otherwise instruct the client to take the pill as soon as possible within 120 hours after UPI
      b) If a two pill formulation of Levonorgestrel is used, administer both pills together as a single dose
c) Advise the client to eat or drink something, if possible, prior to administration to prevent nausea.
d) If vomiting occurs within one hour of taking the dose, the client should repeat the dose. May use OTC anti-nausea drugs:
   ✔ Dramamine 50 mg tabs  1-2 p.o. q 4-6 hours
   ✔ Benadryl 25 mg tabs  1-2 p.o. q 4-6 hours

2. Dispensing for future use:
   a) Offer/dispense additional packs of Plan B One Step® for future use

3. Client education:
   a) Give client copy of EC information/fact sheet
b) Counsel client on the affects of weight on efficacy of EC
c) Instruct client to abstain or to use barrier or hormonal contraception until next menses, as this EC formulation will not provide pregnancy protection for future acts of UPI
d) Any contraceptive method may be started immediately after the use of Levonorgestrel EC
e) Discuss and facilitate plans for future contraception, highlight the benefits of using a highly effective method such as an IUD or implant
f) Discuss and offer STD counseling and testing
g) Encourage client to contact the clinic whenever she has questions about EC
h) Provide counseling on contraceptive method currently used or initiated at this visit
i) Recommend use of condoms for protection from STI’s/HIV – offer/dispense condoms
j) Recommend contraceptive start visit, periodic well-women visits, Pap tests, when indicated and testing for STI’s, if indicated
k) Keep in mind that Levonorgestrel EC is not contraindicated for those weighing over 154 pounds or with a BMI over 25; it just might not be effective
l) When a two pill formulation is used, instruct the client to take both pills together as a single dose

C) Ulipristal acetate (Ella®)

1. Administration:
   a) Administer ella® tablet ASAP while client is in the office; otherwise instruct the client to take the pill as soon as possible within 120 hours after UPI
   b) Prescription may be called into a local pharmacy for established client
   c) Advise the client to eat or drink something, if possible, prior to administration to prevent nausea
d) If vomiting occurs within one hour of taking the dose, the client should repeat the dose. May use OTC anti-nausea drugs:
   - Dramamine 50 mg tabs 1-2 p.o. q 4-6 hours
   - Benadryl 25 mg tabs 1-2 p.o. q 4-6 hours

2. Dispensing for future use:
   a) Offer/dispense additional packs of ella® for future use

3. Client education:
   a) Give client copy of EC information/fact sheet
   b) Counsel client on the affects of weight on efficacy of EC
   c) Instruct client to abstain or to use barrier or hormonal contraception to prevent pregnancy. If using a hormonal method, instruct client to use condoms as a back-up method next menses, as this formulation may interfere with the progesterone component of the method and render it less effective
d) Discuss and facilitate plans for future contraception, highlight the benefits of using a highly effective method such as an IUD or implant  
e) Discuss and offer STD counseling and testing  
f) Encourage client to contact the clinic whenever she has questions about EC  
g) Provide counseling on contraceptive method currently used or initiated at this visit  
h) Recommend use of condoms for protection from STI’s/HIV – offer/dispense condoms  
i) Recommend contraceptive start visit, periodic well-women visits, Pap tests and testing for STI’s, if indicated  
j) Keep in mind that ella® is not contraindicated for those weighing over 193 pounds or with a BMI over 35; it just might not be effective  

D) **Yuzpe**

1. **Administration:**
   a) When administering EC to clients presenting to the clinic for care, other formulations are preferable to the Yuzpe method, simply because they are better tolerated by the client. Therefore, most often the Yuzpe method will be utilized for clients in need of EC; who have no future use EC at hand or are unable to obtain this from a pharmacy; are unable to return to the clinic; and have combined oral contraceptive pills (COCP) on hand  
b) Determine the type of COCP on hand refer to the Yuzpe chart for number and color of pills needed for each dose  
c) Consult with the NP/PA/MD for written or verbal orders for EC dosage  
d) Advise the client to eat or drink something, if possible, prior to administration to prevent nausea  
e) May use OTC anti-nausea drugs:  
   - Dramamine 50 mg tabs  1-2 p.o. q 4-6 hours  
   - Benadryl 25 mg tabs  1-2 p.o. q 4-6 hours  

2. **Client education:**
   a) Instruct client to abstain or to use barrier or hormonal contraception to prevent pregnancy. If using a hormonal method, instruct client to use condoms as a back-up method next menses, as this formulation may interfere with the progesterone component of the method and render it less effective  
b) Discuss and facilitate plans for future contraception, highlight the benefits of using a highly effective method such as an IUD or implant  
c) Discuss and offer STD counseling and testing  
d) Encourage client to contact the clinic whenever she has questions about EC  
e) Provide counseling on contraceptive method currently used or other more effective methods  
f) Recommend use of condoms for protection from STI’s/HIV  
g) Recommend contraceptive start visit, periodic well-women visits, Pap tests,
when indicated and testing for STI’s, if indicated

Resources:
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<th>Brand</th>
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<th>Ethinyl Estradiol per Dose (mcg)</th>
<th>Levonorgestrel per Dose (mg)</th>
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Benefits:
- Safe.
- Can be used after sex.
- Effective for preventing pregnancy if no birth control method is used or is not used the right way, if a condom breaks or slips, or in cases of rape.

Effectiveness:
- Works best if taken as soon as possible after sex.
- If taken within 72 hours (3 days) after sex, the risk of pregnancy is reduced by 89%.
- If taken between 72–120 hours, the risk of pregnancy is reduced by 72-87%.
- Ulipristal acetate is a better choice if you weigh more than 156 pounds and less than 194 pounds.

Risks:
- No known risks.
- Levonorgestrel does not cause harm if already pregnant.
- If breastfeeding, pump and throw out milk for 36 hours after taking ulipristal acetate.

Potential Side Effects or Disadvantages:
- Nausea, fatigue, breast tenderness, headache, abdominal pain and dizziness are rare.
- May change the amount, timing, and how long the next period lasts.
- Does not work as well as other birth control methods that you use all the time.
- No protection against HIV(AIDS) or sexually transmitted diseases (STDs).

Potential Complications:
- None.

Stopping This Method:
- Emergency contraception (EC) is taken in 1 dose. If you don’t have a period within 3 weeks, call the clinic for a pregnancy test. If you don’t wish to become pregnant after taking emergency contraception, start a birth control method the day after taking EC pills.

Danger Signs:
- None.

I have been counseled, have written information and have had my questions answered about my birth control method. I release XXX agency and its staff from responsibility for any condition that may result from my choice.

Client Signature: ______________________________ Date: ____________________________
Witness: ______________________________ Date: ____________________________
Interpreter: ______________________________ Date: ____________________________

12/2013  Client Name: ______________________________  Chart Number: ______________
Versión inicial del consentimiento para el método anticonceptivo de emergencia

Beneficios:
- Es seguro.
- Puede usarse después de tener relaciones sexuales.
- Ayuda a prevenir el embarazo si no se usó ningún método anticonceptivo antes de tener relaciones sexuales, si un método falla o no se lo usa correctamente o en los casos de violación o abuso sexual.

Riesgos:
- No se conocen riesgos.
- No causa daño si ya está embarazada.
- Si está dando el pecho no puede tomar Ulipristal acetate.

Eficacia:
- Es más eficaz si se toma la píldora inmediatamente y dentro de las 24 horas siguientes a haber tenido relaciones sexuales sin protección, pero puede tomarse dentro de los cinco días siguientes.
- Si se la toma dentro de las 72 horas siguientes a haber tenido relaciones sexuales, el riesgo de embarazo se reduce en un 89%.
- Si se la toma entre las 72 y 120 horas siguientes, el riesgo de embarazo se reduce en un 72 a 87%.
- Ulipristal acetate es una elección mejor si su peso es más de 156 libras y menos a 194.

Efectos secundarios o desventajas posibles:
- Se informan muy pocos efectos secundarios: las nauseas, la fatiga, la sensibilidad al tacto en los senos, los dolores de cabeza, el dolor abdominal y los mareos son inusuales.
- Puede cambiar la cantidad, la fecha y la duración de la siguiente menstruación.
- No es tan eficaz como un método anticonceptivo regular (la píldora, el anillo, el parche, la inyección Depo-Provera) para prevenir el embarazo.
- No ofrece protección contra el VIH (SIDA) ni contra las enfermedades de transmisión sexual.

Complicaciones posibles:
- No presenta.

Cómo dejar de usar este método:
- El método anticonceptivo de emergencia se administra en una dosis. Si no tiene menstruación dentro de las tres semanas siguientes al uso de este método, comuníquese con la clínica para pedir una consulta para un examen de embarazo. Si no desea quedar embarazada, inicie un método anticonceptivo el día siguiente a la toma de las pastillas de emergencia.

Señales de peligro:
- No hay.

Me aconsejaron y proporcionaron material informativo, comprendo lo que he recibido y respondieron satisfactoriamente mis preguntas sobre el método anticonceptivo que escogí. Eximo al condado XXX y a sus empleados de toda responsabilidad por cualquier problema de salud que pudiera surgir como consecuencia de mi decisión.

Firma del cliente: ___________________________ Fecha: ______________________
Testigo: ___________________________ Fecha: ______________________
Intérprete: ___________________________ Fecha: ______________________

9/2012 Nombre del cliente: _________________ Nº de historia clínica: __________