

PHARMACIST PROVISION OF HORMONAL CONTRACEPTION: MOVING PA FORWARD

ABSTRACT

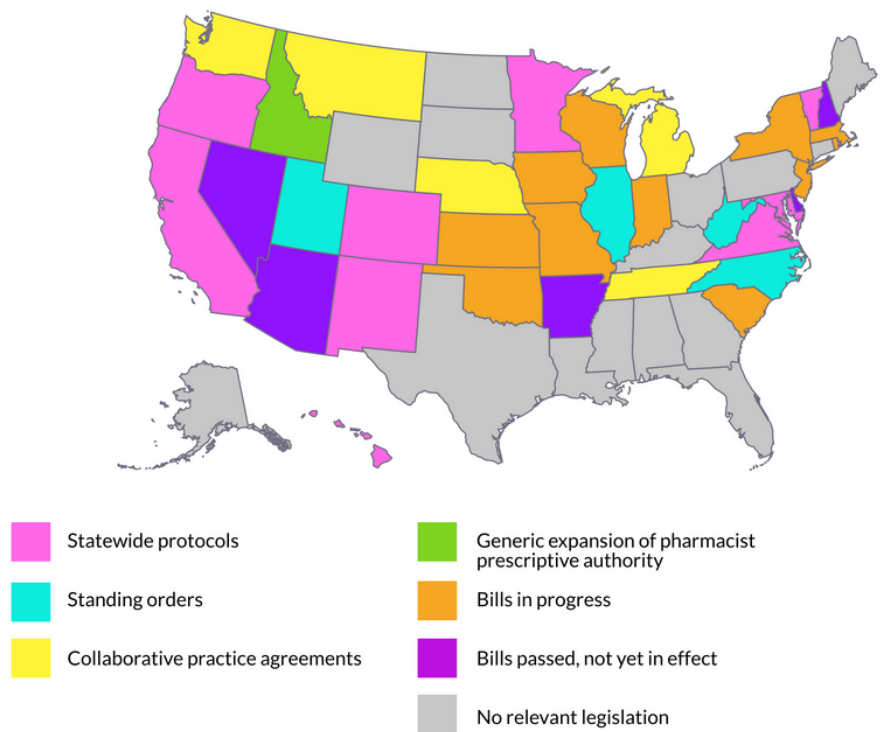
Expanding Pennsylvania pharmacists’ scope of practice to include prescribing of hormonal contraception offers the opportunity to support women’s reproductive autonomy, improve access to essential services, and meaningfully expand clinical pharmacists’ role in women’s health care. Advancing this practice in Pennsylvania also has the potential to advance reproductive health equity for both rural and underserved urban populations.

BACKGROUND

More than 700,000 Pennsylvania women living at or below 250% of the poverty level live in counties without reasonable access to a health center with the full range of contraceptive methods (also known as contraceptive deserts)(1,2). These women may face multiple barriers to getting the contraception they need, including transportation, childcare availability, cost, and time spent away from work and family.

Access to contraception is a critical component of reproductive autonomy (that is, the power to decide whether and when to become pregnant and/or have children). Barriers to access, including the requirement for a prescription from a physician (3,4), contribute to inconsistent or nonuse of contraception which may result in unwanted pregnancies. Prescription of hormonal

Figure 1. Legislation on Pharmacist Prescribing of Hormonal Contraception, by State (as of 9/1/21)



contraception by pharmacists, without a clinic visit, is one strategy to improve access to contraception.

Currently, 24 states and the District of Columbia allow pharmacists to prescribe and dispense self-administered hormonal birth control (e.g., pill, patch, ring, shot; see Figure 1)(5). Ongoing legislation that seeks to reduce abortion access across the US increases the importance of pharmacist prescribing of hormonal contraception to improve patient access to necessary reproductive health services.

States have adopted pharmacist prescribing in different ways. In some states (e.g., Michigan, Montana) collaborative practice agreements (CPAs) allow pharmacists to prescribe on behalf of a supervising physician. Many states (e.g., California, Colorado, Maryland, Oregon) have established statewide protocols for pharmacist-led prescribing of hormonal contraception as well as other drugs; these protocols designate training and practice requirements and enable pharmacists to act as independent prescribers. Other states (e.g., Utah, West Virginia) have implemented 'standing orders', which may act like a CPA or a statewide protocol.

BENEFITS FOR PATIENTS & PROVIDERS

Research in states that have already adopted pharmacist prescribing of hormonal contraception suggests that pharmacist prescribing reduces barriers (including cost for doctor or clinic visits, appointment requirements, and inconvenient clinic hours) and may particularly be of interest among those with historically limited health care access, including women of color and women with low income (6). Evidence from Oregon, California, Colorado, and Hawaii suggests that pharmacist prescribing is filling a gap: Women receiving contraception from a pharmacist are more likely to be younger, uninsured, and have less education than women seeing clinicians (7). The option for pharmacist prescribing is also expanding access by attracting new patients: in the first two years of implementation in Oregon, among Medicaid enrolled women, a majority (73.8%) of patients who received hormonal contraception from a pharmacist were new contraceptive users (8). Pharmacist prescribing may also be associated with improved contraceptive continuation (women are more likely to receive an extended supply when prescribed by a pharmacist) (7) and a reduction in unintended pregnancies (9).

COMMON QUESTIONS/CONCERNS ABOUT PHARMACIST PRESCRIBING OF HORMONAL CONTRACEPTION.

In the following section, we offer evidence-based responses to frequently asked questions about pharmacist prescribing of hormonal contraception (10).

Is pharmacist prescribing of hormonal contraception safe?

Pharmacist prescribing of hormonal contraception is safe for patients. Though basic contraception education is provided in pharmacy schools and as continuing education for pharmacists, completion of a targeted training program is a requirement in all states with current standing orders or statewide protocols for pharmacist-prescribed contraception. Evidence from Oregon suggests that the safety profile of pharmacists prescribing (i.e., adherence to the clinical algorithm for prescribing) is on par with prior findings related to clinicians prescribing contraception (8).

The recommended process for prescribing hormonal contraception involves two main components. First, according to the Center for Disease Control and Prevention's US Selected Practice Recommendations for Contraceptive Use (11), blood pressure assessment is the only clinical examination necessary prior to initiating combined hormonal contraception. Pharmacists are routinely trained to assess patients' blood pressure; in a survey of California pharmacists,

over 98% reported feeling comfortable measuring blood pressure (12).

Second, screening for possible medical or medication contraindications to hormonal contraception using the US Medical Eligibility Criteria for Contraceptive Use (13) is also recommended. Pharmacists are meeting this criterion by having patients complete a simple self-screening questionnaire. Prior research has found that patients' responses on screening questionnaires are accurate, honest, and match when compared with their medical records, suggesting that community pharmacists can effectively screen women for safe use of hormonal contraception (14). The same study also found that prescribing pharmacists can and will refer patients back to a physician if contraindications are identified (14).

What if patients forego routine health screenings because they accessed contraception at the pharmacy instead of at a physician's office?

The American College of Obstetricians and Gynecologists explicitly recommends that lack of

screenings, including pelvic and breast exams, cervical cancer screening, and STI screening, should not be used to deny access to contraception (15). Even so, prior research has shown that other more accessible models of contraceptive care (e.g., over-the-counter availability of hormonal contraception) do not discourage women from obtaining preventive health screenings as needed (16). In addition, recent research from California and Oregon found that most (89%) of patients who accessed hormonal contraception from the pharmacist had seen a primary care provider in the past year (17).

Will pharmacist prescribing deter patients from accessing/using more effective long-acting reversible contraception (LARC)?

Though pharmacists do not currently prescribe LARC methods, they are well-equipped to educate patients about these methods and to refer patients to other providers as necessary (18). Physicians in non-obstetrics/gynecology specialties (including internal medicine and pediatrics) also refer patients to other providers for LARC placement, as do telemedicine providers in any specialty, which suggests that pharmacists can do the same without placing additional burden on interested patients. It is also worth noting that some prior research suggests patients who seek pharmacist provision of hormonal contraception may already have ruled out a LARC method for themselves: the evaluation of a contraceptive prescribing program in community pharmacies in London, UK found that although nearly 90% of clients reported discussing LARC options with the pharmacist, only 1.2% opted for a LARC referral at the end of the consultation (19).

Are pharmacists interested in providing this service?

A national survey of pharmacists found that 85% of respondents were interested in providing hormonal contraception services, and nearly all reported feeling comfortable with steps to prescribing, including assessing a patient's medical history and educating patients on various contraceptive methods (20). Findings from multiple studies in Oregon, New Mexico, and the District of Columbia confirm that pharmacists are interested in and committed to providing contraceptive care (8,17,21,22).

Are patients interested in accessing this service?

Most women in the US believe that hormonal contraception should be available without a prescription (3). They also appreciate the convenience and accessibility of pharmacies: in a survey of patients utilizing contraceptive prescribing services at community pharmacies in California, the most commonly reported reason for seeking this care was the speed of access compared to waiting for a doctor's appointment; patients also noted that pharmacy locations and hours are more convenient than most physicians' clinics (23). Research from Washington also found that women are satisfied with pharmacist prescribing and interested in continuing to see pharmacist prescribers to access hormonal contraception rather than returning to a typical physician-prescribing model of care (14).

Do other healthcare providers support this practice change?

In fact, a national survey found that a majority (76%) of physician respondents were in favor of pharmacist-prescribed hormonal contraception (24), and 70% of advanced practice clinician or midlevel reproductive health providers (e.g., nurse practitioner, certified nurse-midwife, physician assistant, registered nurse) supported pharmacist-initiated access to hormonal contraception (24,25).

Is pharmacist prescribing too expensive?

Since the passing of the Affordable Care Act, federal law requires health insurance coverage for the full range of 'female-controlled' contraceptive methods, including counseling and related services, with no out-of-pocket costs for the patient. However, because pharmacists cannot directly bill for medical services in all states, cost issues remain around insurance coverage for patient visits with pharmacists. California has circumvented this issue by requiring their state Medicaid program to pay for pharmacist contraception services. Other states (e.g., Washington, New Mexico, Virginia, and West Virginia) have passed legislation to require insurers to pay pharmacists for services if the insurer would pay other healthcare providers for the same service (also known as "payment parity legislation").

REFERENCES

1. Power to Decide. Contraceptive Access in Pennsylvania. State Factsheets. https://powertodecide.org/sites/default/files/2021-05/State_Factsheet_Pennsylvania.pdf. Published 2021.
2. Power to Decide. Understanding Contraceptive Deserts. Beyond the Beltway. https://powertodecide.org/sites/default/files/2021-05/Understanding_Contraceptive_Deserts.pdf. Published 2021.
3. Landau SC, Tapias MP, McGhee BT. Birth control within reach: a national survey on women's attitudes toward and interest in pharmacy access to hormonal contraception. *Contraception*. 2006;74(6):463-470. doi:10.1016/j.contraception.2006.07.006
4. Grindlay K, Grossman D. Prescription birth control access among U.S. Women at risk of unintended pregnancy. *J Women's Heal*. 2016;25(3):249-254. doi:10.1089/jwh.2015.5312
5. Power to Decide. Pharmacist Prescribing of Hormonal Contraceptives; 2021. https://powertodecide.org/sites/default/files/2021-01/Pharmacist_Prescribing.pdf.
6. Rafie S, Richards E, Rafie S, Cohen Landau S, Wilkinson TA. Pharmacist Outlooks on Prescribing Hormonal Contraception Following Statewide Scope of Practice Expansion. 2019. doi:10.3390/pharmacy7030096
7. Rodriguez MI, Edelman AB, Skye M, Anderson L, Darney BG. Association of Pharmacist Prescription With Dispensed Duration of Hormonal Contraception. *JAMA Netw Open*. 2020;3(5):e205252. doi:10.1001/jamanetworkopen.2020.5252
8. Anderson L, Hartung DM, Middleton L, Rodriguez MI. Pharmacist Provision of Hormonal Contraception in the Oregon Medicaid Population. *Obstet Gynecol*. 2019;133(6):1231-1237. doi:10.1097/AOG.0000000000003286
9. Rodriguez MI, Hersh A, Anderson LB, Hartung DM, Edelman AB. Association of Pharmacist Prescription of Hormonal Contraception With Unintended Pregnancies and Medicaid Costs. *Obstet Gynecol*. 2019;133(6):1238-1246. doi:10.1097/AOG.0000000000003265
10. Mitchell M, Stauffenberg C, Vernon V, Mospan CM, Shipman AJ, Rafie S. Opposition to Pharmacist Contraception Services: Evidence for Rebuttal. *Pharmacy*. 2020;8(4):176. doi:10.3390/pharmacy8040176
11. Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. Vol 65.; 2016. doi:10.15585/mmwr.rr6504a1
12. Vu K, Rafie S, Grindlay K, Gutierrez H, Grossman D. Pharmacist Intentions to Prescribe Hormonal Contraception Following New Legislative Authority in California. *J Pharm Pract*. 2019;32(1):54-61. doi:10.1177/0897190017737897
13. Curtis KM, Tepper NK, Jatlaoui TC, et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. Vol 65.; 2016. doi:10.3109/14647273.2011.602520
14. Gardner JS, Miller L, Downing DF, Le S, Blough D, Shotorbani S. Pharmacist prescribing of hormonal contraceptives: Results of the Direct Access study. *J Am Pharm Assoc*. 2008;48(2):212-226. doi:10.1331/JAPhA.2008.07138
15. ACOG Committee on Gynecologic Practice. Over-the-Counter Access to Hormonal Contraception. *Obstet Gynecol*. 2019;134(4):886-887. doi:10.1097/aog.0000000000003474
16. Hopkins K, Grossman D, White K, Amastae J, Potter JE. Reproductive health preventive screening among clinic vs. over-the-counter oral contraceptive users. *Contraception*. 2012;86(4):376-382. doi:10.1016/j.contraception.2012.03.003.Reproductive
17. Lu S, Rafie S, Hamper J, Strauss R, Kroon L. Characterizing pharmacist-prescribed hormonal contraception services and users in California and Oregon pharmacies. *Contraception*. 2019;99(4):239-243. doi:10.1016/j.contraception.2018.12.002
18. Rafie S, McIntosh J, Shealy KM, et al. Roles of the pharmacist in the use of safe and highly effective long-acting reversible contraception: An opinion of the women's health practice and research network of the American College of Clinical Pharmacy. *Pharmacotherapy*. 2014;34(9):991-999. doi:10.1002/phar.1457
19. Parsons J, Adams C, Aziz N, Holmes J, Jawad R, Whittlesea C. Evaluation of a community pharmacy delivered oral contraception service. *J Fam Plan Reprod Heal Care*. 2013;39(2):97-101. doi:10.1136/jfprhc-2012-100304
20. Landau S, Besinque K, Chung F, et al. Research pharmacist interest in and attitudes toward direct pharmacy access to hormonal contraception in the United States. *J Am Pharm Assoc*. 2009;49(1):43-50. doi:10.1331/JAPhA.2009.07154
21. Rodriguez MI, Garg B, Williams SM, Souphanavong J, Schrote K, Darney BG. Availability of pharmacist prescription of contraception in rural areas of Oregon and New Mexico. *Contraception*. 2020;101(3):210-212. doi:10.1016/j.contraception.2019.11.005
22. Wollum A, Zuniga C, Katcher T, Daftary M, Grindlay K. Pharmacists' perspectives on prescribing hormonal contraception in Washington, DC, with a focus on young people. *J Am Pharm Assoc*. 2020;60(4):589-597. doi:10.1016/j.japh.2019.12.006
23. Rafie S, Wollum A, Grindlay K, Ibis Reproductive Health, Zora V. Patient Experiences with Pharmacist Prescribing of Hormonal Contraception in California. *J Am Pharm Assoc*. 2019;59(4):e134-e135.
24. Rafie S, Kelly S, Gray EK, Wong M, Gibbs S, Harper CC. Provider Opinions Regarding Expanding Access to Hormonal Contraception in Pharmacies. *Women's Heal Issues*. 2016;26(2):153-160. doi:10.1016/j.whi.2015.09.006
25. Rafie S, Haycock M, Rafie S, Yen S, Harper CC. Direct pharmacy access to hormonal contraception: California physician and advanced practice clinician views. *Contraception*. 2012;86(6):687-693. doi:10.1016/j.contraception.2012.05.010



Center for Innovative Research on Gender Health Equity
230 McKee Place | Pittsburgh PA 15213
412-647-5417 | converge.pitt.edu

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