





Title	Contraception and gynaecological conditions formulary		
Persons/Bodies consulted during preparation.	Senior Medicines Management Team, NEL Norfolk and Waveney Prescribing Reference Group,		
Other relevant resources	NICE Guidance,		
Consultation on Documents	Norfolk and Waveney Prescribing Reference Group		
	NEL CSU Medicine Management Team		
	Relevant NHS Anglia Programme Commissioning Boards		
	Formulary Pharmacists at Norfolk & Norwich University Hospitals Trust, Queen Elizabeth Hospital Kings Lynn NHS Trust, James Paget University Hospital Trust and Norfolk & Waveney Mental Health Care Partnership Trust.		
Training Implications	Promotion to Primary Care prescribers via Medicine Management Team		
Monitoring and Audit	Evaluation and maintenance managed by the NEL N&WPRG		
Dissemination	To be prepared by the NEL CSU Medicines Management Team, Approved by the N&WPRG, and signed off by the PRG- added to NHS Knowledge Anglia, Disseminated to the Norfolk and Waveney CCGs for adoption as a working document to advise the Primary Care Prescribers within their CCG.		
Approved by	Norfolk Prescribing Reference Group, 08-14		
Authorised by	Drugs and Therapeutics Committee		
Review date and by whom	September 2018 - N&WPRG		
Date of Issue	01 September 2016		

BNF Chapter 7.3 Contraceptives and Gynaecological Conditions

Formulary Key

1st line formulary choice		Encouraged
Alternative formulary choice		On Formulary
2nd line formulary choice		2nd Line
Shared Care (TAG Amber)		Shared Care Agreement

Drug	Formulations	Strength	Dose	Notes
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NICE guidance (PH51) recommends providing information and advice on all types of contraception in order to allow an individual to choose a contraceptive method that suits their needs and lifestyle, making it more likely that they will use contraception and use it effectively. The information should comprise verbal advice and printed material giving details about the:

- full range of contraceptive methods available, but with a focus on the most effective and appropriate choice for the individual concerned
- benefits and risks of each method and how to manage any side effects

Combined Hormonal Contraceptives


Standard Strength (containing 30–35 micrograms of ethinylestradiol)

First line choice

RIGEVIDON (Standard Strength)	 Tablets	Ethinylestradiol 30micrograms Levonorgestrel 150micrograms	21 day cycle	
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Second line choice


Combined oral contraceptives containing third generation progesterones such as desogestrel, maybe considered for women who have side effects (acne, headache, depression, breast symptoms and breakthrough bleeding),but maybe associated with higher risk of venous thromboembolism

GEDAREL 30/150 (Standard Strength)	 Tablets	Ethinylestradiol 30micrograms Desogestrel 150 micrograms	21 day cycle	
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Low Strength (containing 20 micrograms of ethinylestradiol)

Low strength may be appropriate for women with risk factors for circulatory disease.


First line choice

LOESTRIN 20 (Low Strength)	 Tablets	Ethinylestradiol 20micrograms Norkhisterone acetate 1mg	21 day cycle	
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Second line choice

GEDAREL 20/150 (Low Strength)	 Tablets	Ethinylestradiol 20micrograms Desogestrel 150 micrograms	21 day cycle	Contains third generation progesterone - may be considered for women who have side effects (acne, headache, depression, breast symptoms and breakthrough bleeding)
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Vaginal

NUVARING		Ethinylestradiol 15micrograms, etonogestrel120micrograms / 24hours	1 ring inserted in to vagina, removed on day 22; subsequent courses repeated after 7-day ring free interval.	Recommended on specialist advice from Sexual Health and Contraception services. Specialist responsible for first script. Patients should be taught to self-administer. TAG Green
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Oral Progesterone Only Contraceptives

Progesterone only conceptives may be an alternative when oestrogens are contraindicated but may have a higher failure rate than combined preparations. Suitable for older women, smokers and those with hypertension, valvular heart disease, diabetes mellitus and migraine.


First line choice

MICRONOR	 Tablets	Norethisterone 350micrograms	1 tablet daily	3 hour missed dose window. Less suitable for patients with erratic lifestyles.
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Second line choice - Low Strength

DESOGESTREL	 Tablets	Desogestrel 75micrograms	1 tablet daily	Suitable for those with erratic lifestyles as 12 hour missed dose window.
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Parenteral Progesterone Only Contraceptives

DEPO-PROVERA	 Injection (aqueous) 1ml vial or 1ml PFS	Medroxyprogesterone acetate 150mg/ml	150micrograms by intramuscular injection within first 5 days of cycle or parturition, every 12 weeks.	Reduction in bone mineral density has been reported. For women with risk factors for osteoporosis a method of contraception other than Medroxy-progesterone acetate should be used.
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SAYANA PRESS		Injection (suspension) in 0.65-mL prefilled injector device	Medroxyprogesterone acetate 104mg/0.65ml	104 mg by subcutaneous injection into anterior thigh or abdomen, within first 5 days of cycle or within 5 days postpartum, repeated every 13 weeks .	May be administered by a healthcare professional (HCP) or when considered appropriate, self-injected by the patient , with medical follow up as necessary ¹ .
NEXPLANON		Implant in radiopaque flexible rod	Etonogestrel 68mg	1 implant by subdermal implantation during first 5 days of cycle; postpartum, 21-28 days after delivery.	Remove implant 3 years after insertion.
Intra-Uterine Progesterone Only System					
JAYDESS		IUS	Levonorgestrel 13.5 mg	Insert within 7 days of onset of menstruation, or anytime if replacement. .	Effective for 3 years . Jaydess should only be inserted by healthcare professionals who are experienced in IUS insertions and/ or have undergone training on the Jaydess insertion procedure.
MIRENA		IUS	Levonorgestrel 20micrograms/ 24 hours	Insert within 7 days of onset of menstruation, or anytime if replacement.	Effective for 5 years . Mirena should only be inserted by healthcare professionals who are experienced in Mirena insertions and/or have undergone sufficient training for Mirena insertion.
Contraceptive Devices - Intra-Uterine Devices					
T-SAFE 380A QuickLoad		IUD	Copper 380mm ²	Replacement every 10 years.	
Emergency Contraception					
Women who are given emergency contraception should be encouraged to consider and choose a suitable form of contraception for their future needs and offered immediate referral for an intrauterine device, if they choose this method (NICE PH51).					
LEVONELLE 1500		Tablet	Levonorgestrel 1.5mg	1.5mg as single dose as soon as possible after coitus, preferably within 12 hours but no later than 72 hours	Women who have used cytochrome P450 3A4 (CYP3A4) enzyme inducers within the last 4 weeks, should: preferably use a non-hormonal emergency contraceptive—ie, a copper intrauterine device, or double the usual dose of levonorgestrel from 1.5 milligrams to 3 milligrams (ie, 2 packs). See MHRA warning on Levonorgestrel-containing emergency hormonal contraception
ELLAONE		Tablet	Ulipristal Acetate 30mg	30mg as single dose as soon as possible after coitus but no later than 120 hours	EllaOne can be offered as a second line option from 72 to 120 hours post USI for patients who are unable to accept use of an IUD. Not recommended in women who are using enzyme-inducing drugs or who have stopped them in the last 4 weeks. TAG Double Green
7.6 Treatment of Vaginal and Vulval Conditions					
Bacterial Vaginal and Vulval Infections					
First line choice					
METRONIDAZOLE		Tablets	400mg 500mg	400mg BD 7 days 2g stat	See antibiotic formulary Not for use in pregnancy
Second line choice					
CLINDAMYCIN		Cream	2% 40-g pack with 7 applicators	insert 5-g applicatorful at night for 3–7 nights	
Fungal Vaginal and Vulval Infections					
CLOTRIMAZOLE		Cream	1%, 2%	Apply to anogenital area 2-3 times a day	Preparations available to purchase from pharmacies.
		Intravaginal Cream	10%	Insert 5g at night	
		Pessary	500mg	Insert 1 pessary at night as single dose	
FLUCONAZOLE		Capsules	150mg	stat	Do not use oral antifungals in pregnancy See antibiotic formulary
Vaginal Atrophy					
First line choice					
ESTRIOL		Cream	0.1%	1 applicatorful daily for 2-3 weeks, reducing to twice a week. Discontinue every 2-3 months for 4 weeks to assess need to continue.	Topical oestrogens should be applied on short-term basis to improve the vaginal epithelium in menopausal atrophic vaginitis. The smallest effective quantity should be used to minimise systemic effects. Attempts to reduce / discontinue should be made at 3-6 monthly intervals with re-examination. Endometrial safety of long-term or repeated use of topical vaginal oestrogens is uncertain; treatment should be reviewed at least annually ² .
ESTRADIOL (Vagifem)		Vaginal Tablets	10 micrograms	1 vaginal tablet daily for 2 weeks reducing to 1 tablet twice weekly	

References:

- Summary of Product Characteristics SAYANA PRESS 104 mg/0.65 ml suspension for injection Aug 2018 <http://www.medicines.org.uk/emc/medicine/27798>
- BNF Aug 2016 <https://www.medicinescomplete.com/mc/bnf/current/PHP4807-topical-hrt-for-vaginal-atrophy.htm>

