Queensland Health

Queensland Community Pharmacy Scope of Practice Pilot

Hormonal Contraception - Clinical Practice Guideline

Guideline Overview

Pilot and professional obligations

- Initial patient eligibility and suitability for management within the scope of the pilot
- Patient informed consent
  - Pilot participation
  - Financial
  - Pharmacist communication with other health practitioners
- Professional standards
- Privacy
- Documentation and record keeping
- Interprofessional communication

Gather information and assess patient's needs

- Sexual and reproductive health counselling
- Patient history
  - Sexual (and social) history
- Examination
  - Body mass index (BMI)
  - Blood pressure measurement

Contraceptive and sexual health plan

- Selecting the most appropriate hormonal contraceptive option
  - Resources
  - Combined oral contraceptive pill
  - Combined hormonal vaginal ring
  - Progestogen-only contraceptive pill
  - Depot medroxyprogesterone acetate (DMPA)

Confirm contraception plan is appropriate

- Contraindications and precautions
- Drug interactions
- Pregnancy and lactation
- Excluding pregnancy

Communicate agreed contraceptive plan

- General advice
- Patient resources/ information
- How to use
- Adverse effects
- Communication with other health practitioners

Refer when

Refer to a medical practitioner if:

- The patient is younger than 16 years of age
- The patient has been, or suspected to have been, subject to sexual abuse or sexual violence (refer to sexual and domestic abuse)
- The patient requests or requires a method of contraception that is not available in the pilot e.g., a LARC
- The patient has a BMI > 35
- The patient has hypertension
- The patient has (or is suspected to have) PCOS
- The preferred contraceptive type is contraindicated or not appropriate (UKMEC 3 or 4)
- The patient has unexplained and un-investigated vaginal bleeding or acute, severe menstrual bleeding
- The patient may be pregnant (refer to excluding pregnancy)

Clinical review

- Measure BP
- Adverse effects
- Continue, change or stop contraception
- Communication with other health practitioners

Key points

- The Pilot enables the prescription of four types of hormonal contraception – the combined oral contraceptive pill (COC), the progestogen-only Pill (POP), depot medroxyprogesterone acetate (DMPA) injection (including administration of the injection) and the combined hormonal contraceptive vaginal ring.
- Patients are required to have a pharmacist consultation, including blood pressure monitoring, before a hormonal contraceptive method may be prescribed, regardless of whether the patient is currently using the type of contraception requested.
- Before prescribing hormonal contraception, pharmacists should discuss the use of long-acting reversible contraception (LARCs) with women seeking contraception, as per the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommendations. Referral to a medical practitioner is required if the patient requests a form of contraception not available in the Pilot.
- Individuals accessing the service should be provided with appropriate resources regarding sexually transmitted infections (STIs) and be advised to be tested if at risk.

When applying the information contained within this clinical practice guideline, pharmacists are advised to exercise professional discretion and judgement. The clinical practice guideline does not override the responsibility of the pharmacist to make decisions appropriate to the circumstances of the individual, in consultation with the patient and/or their carer.

Refer when

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- The patient has a BMI > 35
- The patient has hypertension
- The patient has (or is suspected to have) PCOS
- The preferred contraceptive type is contraindicated or not appropriate (UKMEC 3 or 4)
- The patient has unexplained and un-investigated vaginal bleeding or acute, severe menstrual bleeding
- The patient may be pregnant (refer to excluding pregnancy).

Gather information and assess patient's needs

Undertaking a comprehensive assessment of the patient's needs is essential to determine the most appropriate contraception method for each individual.

Initial comprehensive consultation

- An individualised assessment of contraceptive and sexual health needs and suitability for hormonal contraception and management within the Pilot should consider:
  - patient history including sexual history
  - discussion of all available contraceptive options (including options not available in the Pilot that may be suitable)
  - assessment of medical eligibility and contraindications
  - blood pressure (BP) measurement and body mass index (BMI)
  - risk assessment for sexually transmitted infections.
- Selection of an appropriate hormonal method and formulation should consider:
  - factors that could affect contraceptive effectiveness
  - non-contraceptive benefits
  - common side effects and risk of adverse effects
  - health risks and individualised advice.
- Comprehensive counselling and advice may include:
  - the use of tailored regimens
  - avoiding contraceptive failure, including instructions on missed pills or DMPA injections.

For detailed information on each contraceptive option, including contraindications and precautions, pharmacists should consult the Therapeutic Guidelines and the current versions of the Royal College of Obstetricians and Gynaecologists (RCOG) Faculty of Sexual and Reproductive Healthcare (FSRH) documentation, including:

- UK Medical Eligibility Criteria for Contraceptive Use 2016 (UKMEC) [1]
- Clinical guidance – Progestogen-only Pills [2]
- Clinical guidance – Combined Hormonal Contraception [3]
- Clinical guidance – Progestogen-only injectable contraception [4].

Sexual and reproductive health counselling

Working with Aboriginal and Torres Strait Islander people

Sexual health is not openly discussed in Aboriginal and Torres Strait Islander cultures and 'shame' (a deeply internalised feeling of inadequacy, self-doubt or ostracism) may be a strong barrier to First Nations people seeking sexual health care or contraception, especially in the community pharmacy setting in smaller communities [5, 6].

All health care providers should be cognisant of causing additional 'shame' to Aboriginal and Torres Strait Islander people while providing reproductive counselling [5].

Pharmacists should consult the Pharmaceutical Society of Australia's Guide to providing pharmacy services to Aboriginal and Torres Strait Islander people for guidance on understanding culture, building relationships and communication [6].

It may be both necessary and beneficial to refer Aboriginal and Torres Strait Islander people seeking contraception to a medical practitioner or health service/clinic where the patient has an existing relationship (if the patient consents).

Where appropriate, Aboriginal and Torres Strait Islander health workers or health practitioners may be involved to support clients with self-management with contraception and facilitate the provision of a culturally safe service by the pharmacist [6].

Working with young people

Patients younger than 16 are to be confidentially referred to a sexual health clinic or medical practitioner.

People aged 16 and 17 years are generally assumed to have the capacity to consent to medical treatment (known as Gillick Competency), including for contraception, and consent from a parent or guardian is not required (however, it is considered good practice for the parent/guardian to be involved in decision making around health care) [7, 8].

If the minor has the capacity to consent and does not wish to involve an adult, this should be respected [8].

Pharmacists should consider whether there may be child protection concerns relating to a request for contraception and report to Child Safety accordingly. More information is available on the Queensland Government Child Abuse website.

To assess the minor's capacity to consent to treatment, health care providers must consider the minor's:

- maturity (including physical and emotional development)
- intelligence and education
- attitude
- social circumstances and history
- capacity to understand the risks and benefits of the contraception (and the seriousness of the risks of using hormonal contraception and not using contraception) to make an informed decision [7, 8].

Assessments of capacity to consent for minors (or adults where competency may be in doubt, for example people with an intellectual disability) must be documented in the patient record.

If the pharmacist cannot determine the minor's capacity, they should refer the patient to a medical practitioner for further assessment.

Sexual and domestic abuse

Pharmacists should be aware of the possibility that a woman seeking contraception may be and/or may have been subjected to sexual violence or abuse (assault or sexual coercion), either within a relationship or outside of a relationship [9].

If the pharmacist becomes aware of this during the consultation, they should provide appropriate support and assistance, including referral to support options depending on the patient circumstances.

Referral options include to the local hospital, sexual health clinic and/or community-based sexual violence support services. A list of services, including sexual assault and domestic violence helplines and local services is provided on the Queensland Government webpage.

If required, emergency contraception may be supplied as per standard pharmacy care, or the patient may be referred to an appropriate medical practitioner or health service for another method of emergency contraception e.g., insertion of a copper intrauterine device.

Contraceptive options for transgender and non-binary people

Pharmacists are strongly advised to refer transgender (trans) and non-binary people to specialist sexual health services to ensure they receive comprehensive and culturally safe sexual health care that is tailored to their individual needs.

Queensland Health sexual health clinics and outreach services are located across Queensland. For more information, see www.health.qld.gov.au/clinical-practice/guidelines-procedures/sex-health/services.

Current gender identity for trans or non-binary people assigned female at birth does not impose any restrictions on methods of contraception that may be used; the same considerations apply for choosing safe and effective contraception, including personal characteristics, existing medical conditions and current drug therapies [10, 11].

Information on cervical screening should also be provided to trans men and non-binary people who have a uterus [10].

Women over 50 years of age

The choice of contraceptive should be reconsidered at age 50 and at menopause [11].

Contraceptive use may be discontinued when the patient reaches 55 years of age, or earlier if menopause has occurred [12].

Menopause may be assumed after one year of amenorrhoea and contraception can be ceased at this time for women over 50

For women aged between 40-50, it is recommended that contraception be continued for an additional year (2 years of amenorrhoea) [12].

Some methods of contraception are not suitable for certain age groups; more information is provided below.

Patient history

Sufficient information should be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- gender assigned at birth and fertility status (for transgender and non-binary patients)
- plans to become pregnant, recent pregnancies and lactation status
- underlying medical conditions including mental health conditions, which may:
    - be a contraindication to hormonal contraception e.g., migraine with aura
    - impact on contraceptive effectiveness and choice.

- current medications
- drug allergies/adverse effects
- prior use of contraceptives, tolerability and adverse effects including mood-related symptoms
- smoking status
- BMI
- other factors such as age of menarche, usual menstrual cycle, heavy periods, period pain or changes in menstrual cycle, irregular or post-coital bleeding, symptoms that may suggest polycystic ovarian syndrome (PCOS) e.g., oligomenorrhea, hirsutism, acne, weight gain
- last STI screen and Cervical Screening Test (CST) (refer to Sexually Transmitted Infections section)
- presence of genitourinary symptoms that may suggest STI:
    - changes in vaginal or urethral discharge
    - vulval, genital skin problems or symptoms
    - lower abdominal pain
    - dysuria.
- HPV vaccination status.

Sexual (and social) history

In addition to a standard patient history, pharmacists should also take a social and sexual history from the patient to inform shared decision making.

When taking a sexual history:

- Start by asking open questions about the patient's social background (to enable patient to relax and provide the appropriate context for decision-making) [13].
- More specific questions can then be asked about risk behaviours, followed by questions around sexual practices if required [13].

The following issues should be considered to determine if the patient is at risk of an STI, or if STI testing is indicated, but may not be relevant to all people (apply professional judgement) [13]:

- previous use and experiences with contraception
- current relationship status
- number of recent partners and their gender
- risk behaviours including illicit and/or intravenous drug use, alcohol use
- potential for sexual and domestic abuse (see Sexual and domestic abuse)
- previous STIs and risk factors for STIs (incl. STI history of current and/or recent partner if applicable).

Examination

The pharmacist should measure BP to determine the patient's suitability for their preferred contraceptive type, and to monitor potential impacts of contraception, including hypertension.

- BP should be measured in accordance with the National Heart Foundation of Australia Guideline for the diagnosis and management of hypertension in adults [14].
- A single elevated BP reading is not enough to classify a woman as hypertensive and a second BP reading should be taken at the end of the consultation. If BP remains elevated, the patient should be referred to a medical practitioner for further assessment and selection of an appropriate contraceptive method [14, 15].

Contraceptive and sexual health plan

Selecting the most appropriate hormonal contraceptive option

Hormonal contraception must be prescribed in accordance with Therapeutic Guidelines: Sexual and Reproductive Health: Contraception [16].

The choice of hormonal contraception will depend on:

- **the patient's history:**
  - underlying medical conditions and comorbidities
  - safety profile and contraindications
  - medication history
  - potential for drug interactions
  - age/reproductive stage of life
  - need for immediate start
  - reversibility
  - need for protection against STIs (including HPV vaccination status).
- **the patient's preference:**
  - cost (short and long term)
  - ease of use
  - potential side effects.
- **contraceptive efficacy:**
  - When used correctly, the hormonal methods available in the Pilot have similar failure rates; however, the amount of user input required is variable, and this may impact on effectiveness [17].
  - Pharmacists should not assume effectiveness is the only factor in an individual's choice of contraception [9].

Patient resources to assist with contraceptive selection

- True relationships and reproductive health: Contraception Factsheets [18]
- Jean Hailes: Contraception fact sheets [19]
- Family Planning New South Wales website [20].

Pharmacist resources

- Therapeutic Guidelines: Sexual and Reproductive Health
- Australian Medicines Handbook: Drugs for contraception
- Faculty of Sexual and Reproductive Health, Royal College of Obstetricians and Gynaecologists
    - UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) 2016
    - UKMEC Summary Table Hormonal and Intrauterine Contraception
    - Contraceptive Choices and Sexual Health for Transgender and Non-Binary People
- Pharmaceutical Society of Australia – Women's sexual and reproductive health

Combined oral contraceptive pill

Refer to: FSRH Clinical guidance – Combined Hormonal Contraception [3].

Choice of COC

- Comparative information about COCs to assist with COC choice is available in the Australian Medicines Handbook: Combined oral contraceptives.
- The COC with the lowest effective dose of estrogen and progestogen that is well tolerated and able to provide acceptable menstrual cycle control for each patient should be chosen as first-line [9, 21].
    - Low-dose estrogen pills (ethinylestradiol 35 micrograms or less) with levonorgestrel or norethisterone are considered the 'gold standard' [21].
    - Newer COCs such as estradiol/nomegestrol acetate (Zoely®) and ethinylestradiol/drospirenone (Yaz®) are significantly more expensive than other types of COCs and have limited evidence to support any additional benefits over cheaper versions [21, 22].
- Other guiding principles for COC pill selection are safety profile, affordability and additional non-contraceptive benefits if desired [21].
- There have been limited head-to-head trials to guide COC selection; some pills have specific indications and non-contraceptive benefits that may assist with selection use e.g. acne [22]
- Newer progestogens (gestodene and desogestrel) reduce the potential for androgenic, estrogenic and glucocorticoid effects; drospirenone has a mild diuretic effect and cyproterone has anti-androgenic effects which may be beneficial in women with severe acne [21]
- The quadriphasic dienogest/estradiol pill (Qlaira®) is indicated for heavy menstrual bleeding as well as contraception but it has complex instructions for managing a missed pill [22].
- Triphasic pills are no longer commonly used because of a lack of benefits over other types [22].
- COCs with a high estrogen dose (50 micrograms of ethinylestradiol or mestranol) are not routinely recommended for contraception because of the unacceptable risk of venous thromboembolism (VTE) [22]. These formulations are not permitted for use in the Pilot.

- The COCs available in Australia and indicated for contraception (and use in the Pilot) are presented in Table 1.

Table 1. Combined oral contraceptive pills (10,21-23)

Table 1. Combined oral contraceptive pills [9, 21-23]		
Estrogen dose (micrograms)	**Progestogen dose (micrograms)**	**Example brand names (not exhaustive)**
COC: Monophasic – low dose estrogen		
estradiol 1500	nomegestrol 2500	Zoely (24 active pills and 4 inactive pills)
ethinylestradiol 20	levonorgestrel 100	Femme-Tab ED 20/100#, Lenest 20 ED, Microgynon 20 ED
	drospirenone 3000	Yaz (24 active pills and 4 inactive pills)
COC: Monophasic – standard dose estrogen		
ethinylestradiol 30	desogestrel 150	Madeline, Marvelon
	dienogest 2000	Valette
	drospirenone 3000	Petibelle, Yasmin
	gestodene 75	Minulet
	levonorgestrel 150	Eleanor 150/30 ED#, Evelyn 150/30 ED#, Femme-Tab ED 30/150#, Lenest 30 ED#, Levlen ED#, Microgynon 30 ED, Micronelle 30 ED, Monofeme#, Nordette, Seasonique*
ethinylestradiol 35	cyproterone 2000	Diane-35 ED, Estelle-35 ED, Juliet-35 ED, Brenda-35 ED
	norethisterone 500	Brevinor, Norimin#
	norethisterone 1000	Brevinor-1#, Norimin-1#, Pirmella#
COC: Triphasic – low or standard dose estrogen		
phase 1 (6 pills): ethinylestradiol 30 + levonorgestrel 50 phase 2 (5 pills): ethinylestradiol 30 + levonorgestrel 75 phase 3 (10 pills): ethinylestradiol 40 + levonorgestrel 125		Logynon ED#, Trifeme#, Triphasil#, Triquilar ED#
COC: Quadriphasic – low or standard-dose estrogen		
phase 1 (2 pills): estradiol valerate 3000 alone phase 2 (5 pills): estradiol valerate 2000 + dienogest 2000 phase 3 (17 pills): estradiol valerate 2000 + dienogest 3000 phase 4 (2 pills): estradiol valerate 1000 alone		Qlaira
# Available on the PBS –patient should be advised of the price difference between a private prescription and PBS eligible prescription (concessional/non-concessional). * Seasonique® is specifically packaged to enable a tailored regimen of extended use (84 active pills and 7 inactive pills).		

Combined hormonal vaginal ring

Refer to: FSRH Clinical guidance – Combined Hormonal Contraception [3].

Patients that require assistance with insertion of a vaginal ring must be referred to a medical practitioner.

Progestogen-only contraceptive pill

Refer to: FSRH Clinical guidance – Progestogen-only Pills [2].

Choice of PoP

A new POP containing 4 micrograms of drospirenone (Slinda®) was approved for use in Australia in July 2021 [24]. It is not listed on the PBS and significantly more expensive than the older POPs (Microlut® and Noriday®).

DMPA injection

Refer to: FSRH Clinical guidance – Progestogen-only injectable contraception [4]

DMPA may be the contraceptive of choice for individuals with contraindications to estrogen, those taking drugs that induce the CYP3A4 liver enzyme (refer to the Australian Medicines Handbook) or if a discrete method of contraception is preferred with less user input required

DMPA is not a first-line option for adolescents or in perimenopausal women because of the theoretical propensity to cause bone mineral density (BMD) loss and/or limit peak BMD [11].

- During each annual consultation, pharmacists should assess the user's risk factors for low BMD and cardiovascular disease [25].
- Women who wish to continue using DMPA should be reviewed by a medical practitioner every 2 years to assess any changes in benefits and potential risks of use [4].

Confirm management is appropriate

Pharmacists must consult the Therapeutic Guidelines, Australian Medicines Handbook, the UKMEC 2016, and other relevant references to confirm the contraceptive recommendation is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

For the purposes of the Pilot, a UKMEC category of 3 or 4 is considered an absolute contraindication and that contraceptive type must not be supplied as part of the Pilot.

Excluding pregnancy

Pregnancy should be reasonably excluded before commencing any hormonal contraception [22, 25, 26].

A patient can be reasonably assumed not to be pregnant if:

- there are no symptoms or signs of pregnancy

and any of the following criteria are met:

- they have not had intercourse since the start of the last normal (natural) menstrual period, or since childbirth, abortion or miscarriage
- they have been correctly and consistently using a reliable method of contraception (barrier methods can be assumed to be reliable if used correctly in this context)
- they are within the first 5 days of the onset of a normal (natural) menstrual period, within the first 5 days after abortion or miscarriage
- they are less than 21 days postpartum (non-lactating women)
- they have not had intercourse for >21 days and have a negative urine pregnancy test [4, 11].

Use of an appropriate pregnancy test is recommended – this may include referral to a medical practitioner for a blood test for serum human Chorionic Gonadotropin (hCG) levels which may detect pregnancy from approximately 1 week after conception, and up to a week earlier than a urine pregnancy test.

If there is any doubt regarding whether the patient may be pregnant, even if a negative urine test is returned, hormonal contraception should NOT be supplied and the patient referred to a medical practitioner.

Communicate agreed management plan

Comprehensive counselling that covers adverse effects, instructions for use and patient expectations assists to promote effective and ongoing contraceptive use [27].

Comprehensive advice and counselling (including supporting written information when required) as per the Therapeutic Guidelines, Australian Medicines Handbook, UKMEC 2016, and other relevant references, should be provided to the patient regarding:

- individual product and medicine use
    - instructions for commencing
    - deviation from schedule (a pill is missed, a DMPA injection is not administered at 12 weeks, or a new vaginal ring is inserted too late or removed before the 3-week interval).
    - how long a secondary method of contraception must be used to avoid an unplanned pregnancy
    - instructions on tailored regimens.
- emergency contraceptive options that are available in instances of contraceptive failure
- how to manage adverse effects
- when to seek further care and/or treatment
    - the signs of VTE and what to do if it is suspected
    - the importance of reporting new or worsening mood-related symptoms to the pharmacist and usual medical practitioner.
- when to return to the pharmacist for clinical review.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

General advice

Patient resources

Where appropriate, individuals may be provided with additional resources to support sexual health. It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients (and parent/caregivers if applicable), and to ensure compliance with all copyright conditions.

- Flyers and information suitable for patients on STIs include:
  - the Queensland Government's Stop the Rise of STIs webpage [28]
  - STI factsheets and other resources designed to promote sexual health for Aboriginal and Torres Strait Islander young people are available as part of the Young Deadly Free campaign (permission for use is requested) [29].
- 13 HEALTH Webtest service:
  - The 13 HEALTH Webtest service is a free and confidential urine test for chlamydia and gonorrhoea that is available to Queenslanders aged 16 years and over, without a Medicare card, ordered by the individual via 13 HEALTH Webtest (www.qld.gov.au/health/staying-healthy/sexual-health/chlamydia-test/order).
  - Individuals are able to order a Webtest online, take a home sample using the supplied kit and return it using pre-paid post, or take the downloadable pathology request form provided to a collection centre.
  - The 13 HEALTH Webtest is not a substitute for comprehensive STI testing and is not intended to replace existing testing and treatment processes, however it provides a pathway for people who may be unlikely or unable to attend a GP or sexual health clinic.
- 13 HEALTH (13 43 25 84) service to find a GP or sexual health clinic, an Aboriginal Medical Service or a community-based testing site.

Venous Thromboembolism

- DMPA and other progestogen-only contraceptives are not associated with a clinically significant risk of VTE [11].
- There is approximately a three times increase in the risk of VTE in women using CHC, however, this increased risk is still smaller than the risk of VTE during pregnancy and immediately post-partum [21].
- The risk is highest in the first year of use, and still remains higher than for non-users after the first year, however, the absolute risk is still very low [11].
- CHCs containing levonorgestrel or norethisterone have a slightly lower risk of VTE [11].
- Women should be reassured of the overall safety of the contraceptive pill; studies show that compared to non-users of the COC, users have significantly lower death rates from cancer, cardiovascular disease and other disease, and have generally lower rates of death from any cause [21].

Contraception and cancer risks

- Users of CHC have a slightly increased relative risk of breast cancer (risk returns to normal 10 years after cessation of the OCP) and cervical cancer (non-causal), however, the risk of endometrial and ovarian cancers is slightly decreased [11, 22].

Sexually Transmitted Infections (STI)

- Individuals who may be at risk of STIs should be informed of the risk factors, the availability of screening and treatment, and strategies on how to prevent STIs.
- Pharmacists should recommend STI testing for individuals who may be at risk, even if the individual does not report any symptoms. They are still eligible for the service in the Pilot.
- Individuals should be advised of the link between Human Papillomavirus (HPV) and cervical cancer and advised of strategies that reduce the risk, including HPV vaccination and primary HPV screening, as per the current national guidelines (25, 30-32).
- Aboriginal and Torres Strait Islander People are disproportionally affected by STIs. Consider the Australian Consensus STI Testing Guideline for Aboriginal and Torres Strait Islander People for priority populations testing and frequency for recommendations on STI screening [33].

National Cervical Screening Program

- A new cervical cancer screening program was introduced in 2017, replacing the need for Pap smears every 2 years with a cervical screening test (CST) for HPV, recommended every 5 years for women and people with a cervix aged 25 to 74 years of age who have ever had any sexual contact [30, 32, 34].
- All patients seeking contraception who have not had a CST in the previous 5 years should be advised to see a medical practitioner for a CST, and a referral provided if the patient consents. They are still eligible for the service in the Pilot.

Clinical review

Clinical review with the pharmacist should occur in line with recommendations in the Therapeutic Guidelines and other relevant guidelines.

- Clinical review is recommended **3-4 months** after initiation of new contraceptive method (the patient has no recent experience of taking that type of contraception) to screen for adverse effects including hypertension.
- Clinical review, including measurement of the patient's BP, is recommended at 12 monthly intervals [35].
- Patients taking a regular contraceptive should have a review with a medical practitioner or other appropriate health service at least every 2 years.

Pharmacists should generally only prescribe (including repeats) a sufficient quantity of medicine for the period until the patient's next review.

Pharmacist resources

- Therapeutic Guidelines: Sexual and Reproductive Health
- Australian Medicines Handbook: Drugs for contraception
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine: Aboriginal and Torres Strait Islander People - STI Guidelines Australia Faculty of Sexual and Reproductive Health, Royal College of Obstetricians and Gynaecologists
    - UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) 2016
    - UKMEC Summary Table Hormonal and Intrauterine Contraception
    - Contraceptive Choices and Sexual Health for Transgender and Non-Binary People
- Pharmaceutical Society of Australia – Women's sexual and reproductive health
- World Health Organisation: Family Planning: A Global Handbook for Providers (2018)
- Queensland Health:
    - Aboriginal and Torres Strait Islander Adolescent Sexual Health Guideline
    - Sexual health services in Queensland
    - Online chlamydia and gonorrhoea test requests
- True relationships and reproductive health (Queensland Not for Profit organisation)
- 13 HEALTH Webtest online testing service for chlamydia and gonorrhoea – Information for health professionals

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