Promoting Autonomy: Supporting Clients with Self-Directed Contraceptive Care Options

November 4, 2026

Clinician Survey for NYS FP Providers



- We need your input for 2027!
- Please complete this 7-question survey by November 30, 2026.

New York State Family Planning Training Center
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NYSDOH Update 10/09/2026 - Penicillin Shortage

- Food and Drug Association (FDA) has extended the expiration dates on certain batches of Bicillin L-A (Penicillin G Benzathine Injectable Suspension)
- Penicillin G benzathine - only known effective antimicrobial for treating fetal infection and preventing congenital syphilis.
- Lentocilin® (Benzathine Benzylpenicillin Tetrahydrate) - alternative for non-pregnant persons if Penicillin G benzathine unavailable
- DoxyPEP

NEW YORK STATE | Department of Health

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To: Healthcare Providers, Hospitals, Local Health Departments, Sexual Health Providers, Family Planning Providers, Emergency Rooms, Community Health Centers, College Health Centers, and Internal Medicine, Family Medicine, Pediatric, Adolescent Medicine, Infectious Disease, Primary Care Providers, Higher Education Institution Health Clinics, Urgent Care providers, Community Based Organizations, County Jails, Emergency Rooms, Substance Use Disorder Treatment Facilities, Local Health Departments, and Planned Parenthoods.

From: New York State Department of Health, AIDS Institute

Date: October 9, 2026

UPDATE: The Food and Drug Administration (FDA) has announced extensions of some expiration dates of Bicillin® L-A (Penicillin G Benzathine Injectable Suspension).

Dear Clinicians:

This is an update to earlier health advisories on August 1,2025 and March 10,2026 related to the recall and shortage of Bicillin® L-A (Penicillin G Benzathine Injectable Suspension). We have just received news that the Food and Drug Association (FDA) has extended the expiration dates on certain batches of the medication. Bicillin® L-A (Penicillin G Benzathine Injectable Suspension) remains the only known effective antimicrobial for treating fetal infection and preventing congenital syphilis.

The following Bicillin L-A lot numbers are now permitted for extended use (use beyond their current labeled expiration date):



CEI Conference November 9, 2026 Albany, NY

New York State Family Planning Training Center
nysfptraining.org

Upcoming NYSFPTC Events

- **Administrators and Clinic Managers Affinity Group**

  November 19, 2026 12-1 PM; Register here

- **FQHC Affinity Group**

  December 15, 2026 12-1 PM; Register here

Financial Relationship Disclosures

None of the individuals in control of content have relevant financial relationships to disclose.

CME Accreditation Statement

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Medical Society of the State of New York (MSSNY) and the New York State Family Planning Training Center.

The Medical Society of the State of New York designates this live activity for a maximum of 1.00 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Learning Objectives

By the end of this activity participants will be able to:



State increased knowledge and competence in providing evidence-based counseling for self-directed contraceptive options.

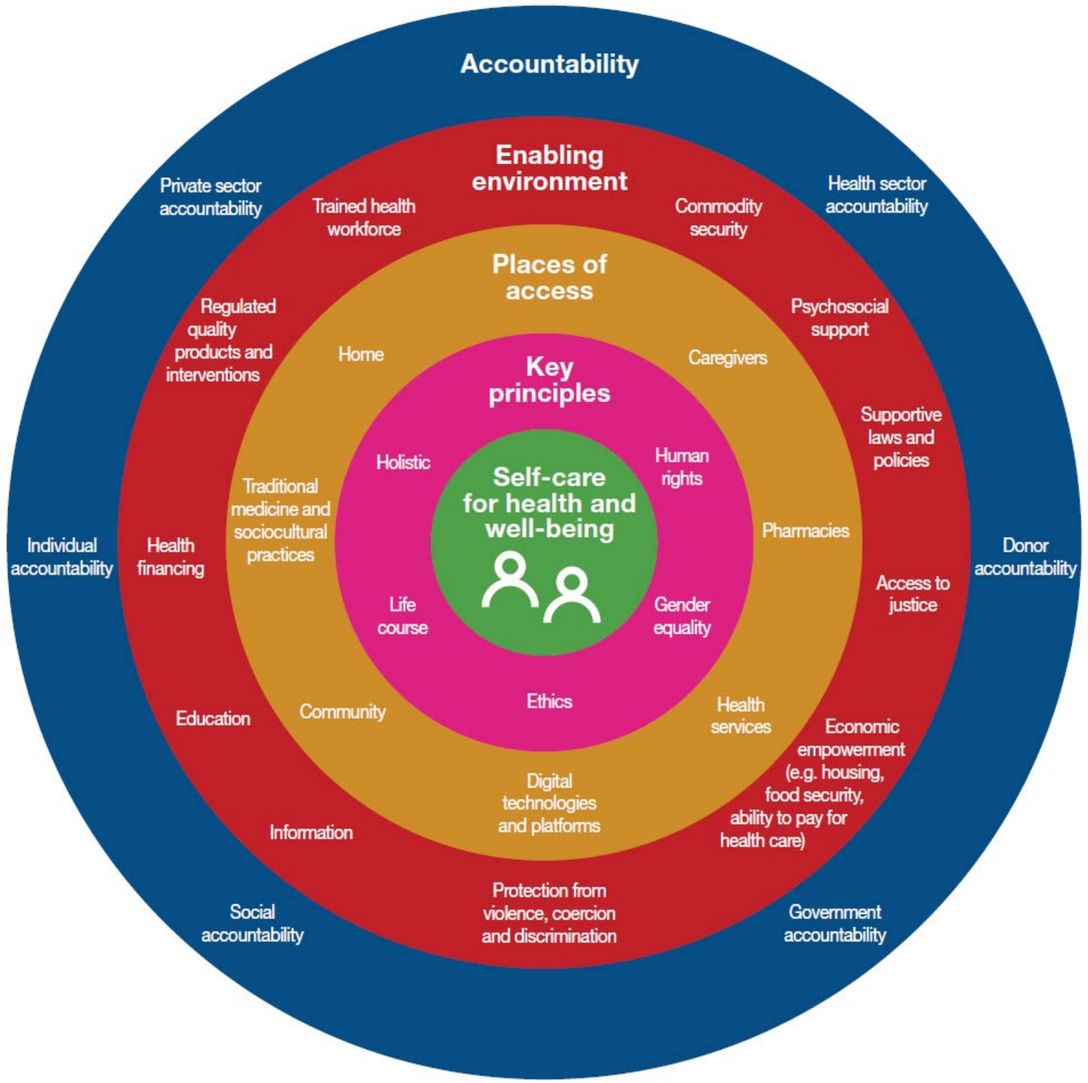


Identify two strategies to expand contraceptive access.



Evaluate candidates for DMPA-SC and apply appropriate clinical guidelines for provision.

What Is Self-Care?



Source: adapted from Narasimhan M, Allotey P, Hardon A. Self-care interventions to advance health and well-being: a conceptual framework to inform normative guidance. BMJ. 2019;365:l688. doi:10.1136/bmj.l688.

- *WHO definition: Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare provider.*

Self-Directed Contraceptive Care

- **What is self-directed contraceptive care?**
  - Interventions that give individual the ability to promote health and manage their contraceptive needs with reduced reliance on a clinic or provider.

- **Why offer self-directed care?**
  - Help overcome barriers to care
  - Increase autonomy
  - Adapt to the evolving landscape of access, medical innovation, technology, and clinical guidelines

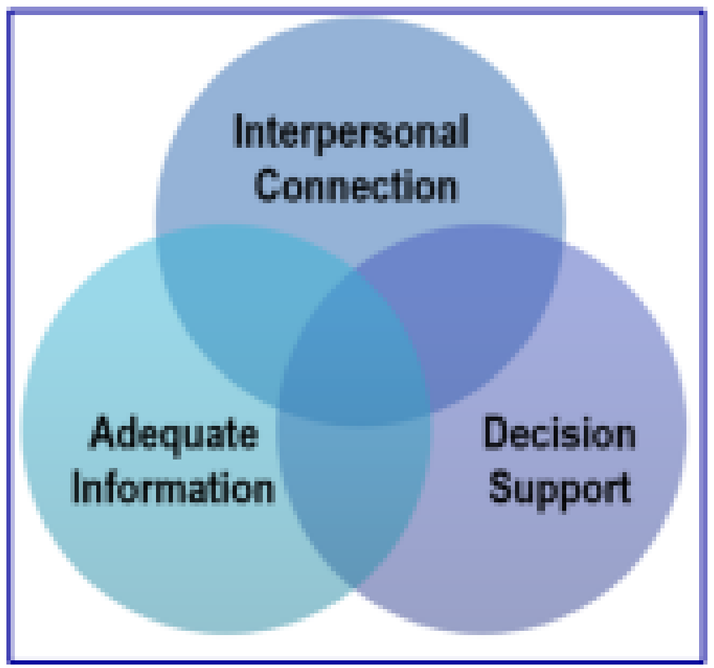


Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41−S86.

Importance of Honoring Reproductive Autonomy

- Patients are the experts on their own lives
- Acknowledge and undo history of racism and other forms of bias in contraceptive care
  - Coercion to use birth control generally and especially LARC methods
  - Lack of trust in our patients

Self-Directed Options and Person-Centered Contraceptive Care



Domains of high-quality counseling

- Utilize shared decision making
- Provide non-coercive education
- Incorporate communication best practices

Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41−S86; UCSF The Person Centered Contraceptive Counseling Measure

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What Are the Options for Self-Directed Contraception?

- **Key tenet: User-administered**
- Methods requiring provider to start (e.g. Contraceptive pills, rings, patch, injection, IUDs)
- Methods client can start/stop on their own
- And strategies to enable patients to access methods without a provider.

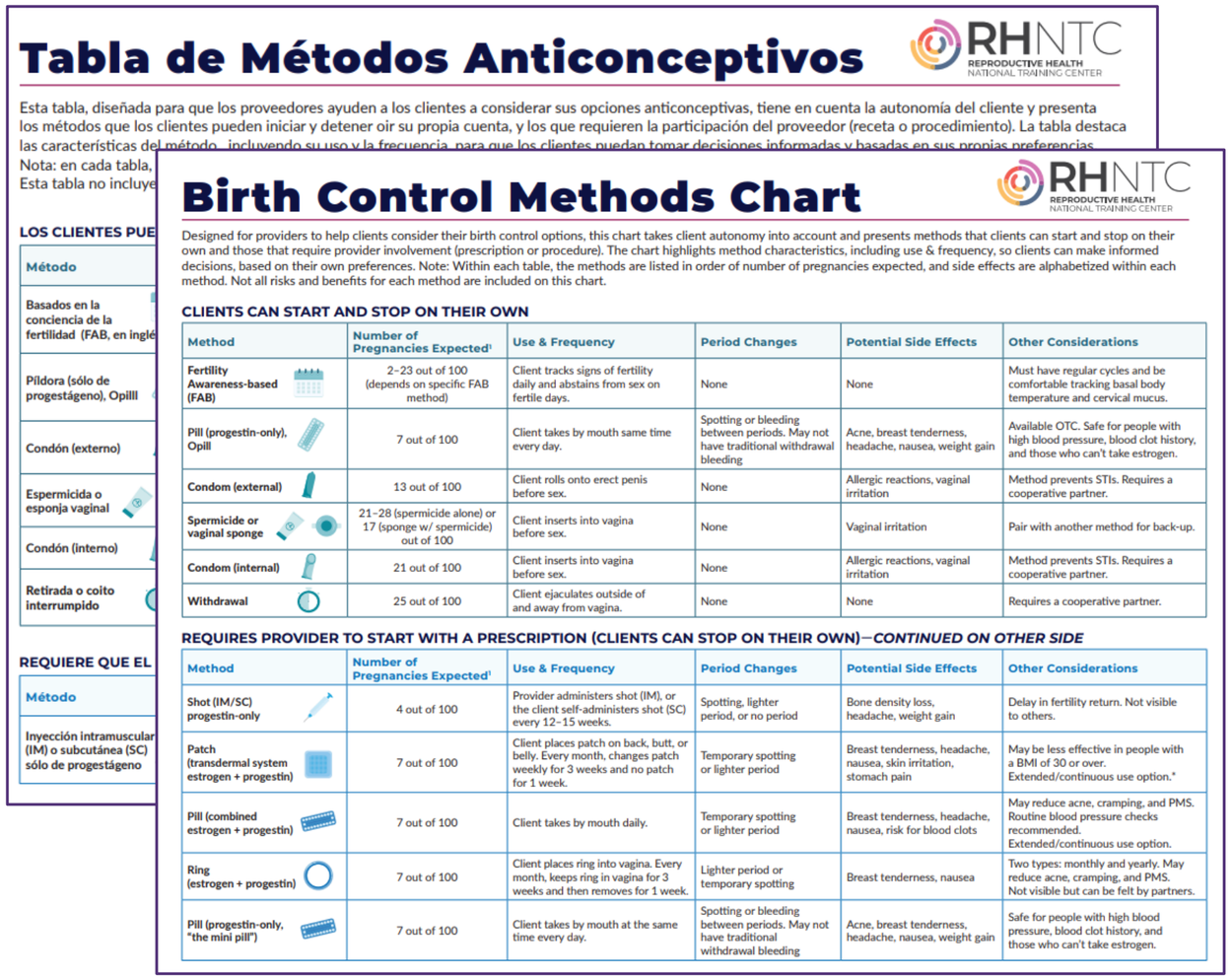

Tabla de Métodos Anticonceptivos

RHNTC REPRODUCTIVE HEALTH NATIONAL TRAINING CENTER

Esta tabla, diseñada para que los proveedores ayuden a los clientes a considerar sus opciones anticonceptivas, tiene en cuenta la autonomía del cliente y presenta los métodos que los clientes pueden iniciar y detener oir su propia cuenta, y los que requieren la participación del proveedor (receta o procedimiento). La tabla destaca las características del método, incluyendo su uso y la frecuencia, para que los clientes puedan tomar decisiones informadas y basadas en sus propias preferencias.
Nota: en cada tabla,
Esta tabla no incluye

LOS CLIENTES PUE

Método
Basados en la conciencia de la fertilidad (FAB, en inglé
Píldora (sólo de progestágeno), Opilll
Condón (externo)
Espermicida o esponja vaginal
Condón (interno)
Retirada o coito interrumpido

REQUIERE QUE EL

Método
Inyección intramuscular (IM) o subcutánea (SC) sólo de progestágeno

Birth Control Methods Chart

RHNTC REPRODUCTIVE HEALTH NATIONAL TRAINING CENTER

Designed for providers to help clients consider their birth control options, this chart takes client autonomy into account and presents methods that clients can start and stop on their own and those that require provider involvement (prescription or procedure). The chart highlights method characteristics, including use & frequency, so clients can make informed decisions, based on their own preferences. Note: Within each table, the methods are listed in order of number of pregnancies expected, and side effects are alphabetized within each method. Not all risks and benefits for each method are included on this chart.

CLIENTS CAN START AND STOP ON THEIR OWN

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Fertility Awareness-based (FAB)	2–23 out of 100 (depends on specific FAB method)	Client tracks signs of fertility daily and abstains from sex on fertile days.	None	None	Must have regular cycles and be comfortable tracking basal body temperature and cervical mucus.
Pill (progestin-only), Opill	7 out of 100	Client takes by mouth same time every day.	Spotting or bleeding between periods. May not have traditional withdrawal bleeding	Acne, breast tenderness, headache, nausea, weight gain	Available OTC. Safe for people with high blood pressure, blood clot history, and those who can't take estrogen.
Condom (external)	13 out of 100	Client rolls onto erect penis before sex.	None	Allergic reactions, vaginal irritation	Method prevents STIs. Requires a cooperative partner.
Spermicide or vaginal sponge	21–28 (spermicide alone) or 17 (sponge w/ spermicide) out of 100	Client inserts into vagina before sex.	None	Vaginal irritation	Pair with another method for back-up.
Condom (internal)	21 out of 100	Client inserts into vagina before sex.	None	Allergic reactions, vaginal irritation	Method prevents STIs. Requires a cooperative partner.
Withdrawal	25 out of 100	Client ejaculates outside of and away from vagina.	None	None	Requires a cooperative partner.

REQUIRES PROVIDER TO START WITH A PRESCRIPTION (CLIENTS CAN STOP ON THEIR OWN)—*CONTINUED ON OTHER SIDE*

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Shot (IM/SC) progestin-only	4 out of 100	Provider administers shot (IM), or the client self-administers shot (SC) every 12–15 weeks.	Spotting, lighter period, or no period	Bone density loss, headache, weight gain	Delay in fertility return. Not visible to others.
Patch (transdermal system estrogen + progestin)	7 out of 100	Client places patch on back, butt, or belly. Every month, changes patch weekly for 3 weeks and no patch for 1 week.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, skin irritation, stomach pain	May be less effective in people with a BMI of 30 or over. Extended/continuous use option.*
Pill (combined estrogen + progestin)	7 out of 100	Client takes by mouth daily.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, risk for blood clots	May reduce acne, cramping, and PMS. Routine blood pressure checks recommended. Extended/continuous use option.
Ring (estrogen + progestin)	7 out of 100	Client places ring into vagina. Every month, keeps ring in vagina for 3 weeks and then removes for 1 week.	Lighter period or temporary spotting	Breast tenderness, nausea	Two types: monthly and yearly. May reduce acne, cramping, and PMS. Not visible but can be felt by partners.
Pill (progestin-only, "the mini pill")	7 out of 100	Client takes by mouth at the same time every day.	Spotting or bleeding between periods. May not have traditional withdrawal bleeding	Acne, breast tenderness, headache, nausea, weight gain	Safe for people with high blood pressure, blood clot history, and those who can't take estrogen.

Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41–S86; RHNTC Birth Control Methods Chart

Self-Directed Contraceptive Methods



No Provider or Prescription Needed

CLIENTS CAN START AND STOP ON THEIR OWN

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Fertility Awareness-based (FAB) 	2–23 out of 100 (depends on specific FAB method)	Client tracks signs of fertility daily and abstains from sex on fertile days.	None	None	Must have regular cycles and be comfortable tracking basal body temperature and cervical mucus.
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Source(s): RHNTC Birth Control Methods Chart

Fertility Apps

- Assist patients evaluate FDA-cleared FABMs apps
- Two apps are approved for contraception - *Natural Cycles* and *Clue*
- Others claim to be - but not approved by FDA for contraception
- Data privacy variable

Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41–S86; RHNTC Using Fertility Awareness-Based Methods (FABMs) to Prevent Pregnancy job aid

Using Fertility Awareness-Based Methods (FABMs) to Prevent Pregnancy

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FABMs are methods for achieving or preventing pregnancy that require female clients to monitor biomarkers, or fertility indicators, to estimate when they may be fertile. Healthcare professionals can use this resource to explain fertility indicators and FABMs to clients who want to prevent pregnancy. The information in this resource is not intended to replace training in proper provision and use of individual FABMs.

FABMs and Fertility Indicators

- With FABMs, clients use fertility indicators to estimate the fertile window: the time during the ovulatory-menstrual cycle when having sex is most likely to result in pregnancy.
- Common fertility indicators include the menstrual cycle length, cervical fluid secretions, urinary hormones, and basal body temperature. Using multiple fertility indicators at a time may improve estimation of the fertile window.
- To avoid pregnancy, clients can either use an alternate contraceptive method or abstain from sex during their estimated fertile window.
- Tracking fertility indicators can help clients identify irregular patterns that may warrant further evaluation for underlying health conditions that can impact fertility.

Using Fertility Indicators for Preventing Pregnancy

	FERTILITY INDICATOR			
	MENSTRUAL CYCLE	**CERVICAL SECRETIONS**	**URINARY HORMONES**	**BASAL BODY TEMPERATURE**
Fertility indicator's relationship to fertility and the fertile window	In most menstrual cycles, ovulation occurs around the middle of the cycle.	A change in the amount, appearance, and/or sensation of cervical secretions signals the fertile window. Beginning of fertile window: abundant, clear, slippery, and/or stretchy secretions. End of fertile window: absent, white, thick, and/or sticky secretions.	A rise in E3G, the urinary metabolite of estradiol, precedes the rise in urinary luteinizing hormone (LH). LH rises 24–36 hours before ovulation.	Basal body temperature (BBT) is lower in the first part of the cycle, rises at least 0.4°F around the time of ovulation, and remains elevated until around the time the next menstrual cycle begins.
How to use the fertility indicator	Clients with cycles that are 26–32 days long should consider days 8–19 of the menstrual cycle as the estimated fertile window.	Observe cervical secretions throughout the day, particularly before and after urination. Identify changes that indicate fertility.	To predict ovulation, use a test that monitors LH. To estimate the fertile days before ovulation, use a test that monitors E3G and LH.	Record daily BBT on a chart or app to estimate when ovulation happened and when the fertile window ended. Use other indicators to estimate the beginning of the fertile window.
FABMs that use the fertility indicator	Standard Days Method (11–14% typical use pregnancy rate)*	Billings Ovulation Method (11–23% typical use pregnancy rate)* TwoDay Method (14% typical use pregnancy rate)* Sensiplan™ Method (2% typical use pregnancy rate* when using cervical secretions and BBT)	Marquette Model (2–7% typical use pregnancy rate)*	Natural Cycles Method (6–10% typical use pregnancy rate)†‡ Sensiplan™ Method (2% typical use pregnancy rate* when using BBT and cervical secretions)
Key counseling points	Days 8–19 of every cycle are considered fertile days in cycles that are 26–32 days long. To accurately estimate the fertile window, FABMs that use this indicator are appropriate for clients whose cycles are consistent month to month (i.e., regular) and are 26–32 days long.	During the fertile window, secretions typically first appear scant, whitish, or cloudy, and then become abundant, clear, stretchy, and slippery. Ovulation is likely to occur one day before, during, or one day after the last day of abundant, clear, stretchy, slippery secretions. Monitoring cervical secretions can be used by clients with irregular cycles.	To get the most accurate results, follow hormone monitor instructions carefully.	At the same time each day before getting out of bed, and after six hours of uninterrupted sleep, take BBT using a basal thermometer. When a client records three continuous temperatures above baseline, they are no longer in the fertile window.

Over-the-Counter Progestin-Only Pills

- OTC progesterone-only birth control pill
- Approved by FDA in 2023
- Supported by ACOG



Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41−S86; RHNTC Birth Control Methods Chart

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Additional methods clients can start and stop on their own

- Condoms - internal and external
  - NYS Condom Program
- Spermicide
- Vaginal sponge (with spermicide)
- Withdrawal



Source(s): RHNTC Birth Control Methods Chart

User-Directed Contraceptive Methods Requiring a Provider/Prescription to Start



REQUIRES PROVIDER TO START WITH A PRESCRIPTION (CLIENTS CAN STOP ON THEIR OWN)—*CONTINUED ON OTHER SIDE*

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Shot (IM/SC) progestin-only 	4 out of 100	Provider administers shot (IM), or the client self-administers shot (SC) every 12–15 weeks.	Spotting, lighter period, or no period	Bone density loss, headache, weight gain	Delay in fertility return. Not visible to others.
Patch (transdermal system estrogen + progestin) 	7 out of 100	Client places patch on back, butt, or belly. Every month, changes patch weekly for 3 weeks and no patch for 1 week.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, skin irritation, stomach pain	May be less effective in people with a BMI of 30 or over. Extended/continuous use option.*
Pill (combined estrogen + progestin) 	7 out of 100	Client takes by mouth daily.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, risk for blood clots	May reduce acne, cramping, and PMS. Routine blood pressure checks recommended. Extended/continuous use option.
Ring (estrogen + progestin) 	7 out of 100	Client places ring into vagina. Every month, keeps ring in vagina for 3 weeks and then removes for 1 week.	Lighter period or temporary spotting	Breast tenderness, nausea	Two types: monthly and yearly. May reduce acne, cramping, and PMS. Not visible but can be felt by partners.
Pill (progestin-only, "the mini pill") 	7 out of 100	Client takes by mouth at the same time every day.	Spotting or bleeding between periods. May not have traditional withdrawal bleeding	Acne, breast tenderness, headache, nausea, weight gain	Safe for people with high blood pressure, blood clot history, and those who can't take estrogen.
Diaphragm or cervical cap (both w/spermicide) 	17 (diaphragm) and 22–23 (cap) out of 100	Client inserts into vagina with spermicide before sex.	None	Allergic reactions, UTI, vaginal irritation	Same device may be used for two years.
Vaginal contraceptive gel (Phexxi) 	28 out of 100	Client inserts into vagina before sex.	None	Allergic reactions, UTI, vaginal irritation	May act as lubricant for dryness.

Source(s): RHNTC Birth Control Methods Chart

Poll 1: Are you prescribing DMPA-SC at your agency or at your clinic?

A. Yes

B. No

C. I don’t know

Self-Administered DMPA-SC

- Subcutaneous depot medroxyprogesterone acetate (DMPA-SC/DMPA-SQ) is an FDA-approved, 104 mg progestin-only injectable administered every 12 to 14 weeks.
- How is it different from DMPA-IM?
  - Delivered subcutaneously in anterior thigh or abdomen
  - Smaller needle
  - Less liquid
  - Lower overall dose (104mg vs 150mg)

Source(s): CTC-SRH A Toolkit for Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate

How Does DMPA-SC Work?

- **Progestin-only contraceptive method**
  - Prevents follicles from maturing and stops ovulation
  - Thickens and decreases amount of cervical mucus
  - Things the lining of the uterus
- **Typical use failure rate** - 4%
- **Benefits** (in addition to pregnancy prevention)
  - Reduction of endometriosis pain
  - Lower risk of uterine cancer (when in use long-term)
- **Common side effects**
  - Amenorrhea
  - Weight gain
  - Delay in return of fertility
  - Irregular bleeding

Source(s): CTC-SRH A Toolkit for Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate

Who Can Use DMPA-SC?

Good for Those Who:

- Need birth control, but don't want to use a daily method
- Should avoid estrogen
- Have conditions that benefit from hormonal therapy
- Want the freedom to control their own contraception
- Desire privacy
- Face difficulties returning to the clinic every three months.

Postpartum initiation of DMPA-SC:

- Can be initiated postpartum according to CDC U.S. SPR guidance
- Recommendations differ by breastfeeding status and timing postpartum
- Consult the current U.S. SPR for detailed timing recommendations

Previous experience with self-injection is not required

Source(s): CTC-SRH A Toolkit for Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate

DMPA-SC U.S. Medical Eligibility Criteria (MEC)

Contraindications/U.S. MEC Cat 4

- If the patient has had breast cancer within the last 5 years.

U.S. MEC Category 3 (please refer to U.S. MEC for details)

- Cardiovascular disease
- Diabetes
- Breast cancer
- Liver disease
- Autoimmune disorder (SLE)
- Gyn conditions (unexplained bleeding)
- Transplant related
- Chronic kidney disease

For accessible version, please see the summary of classifications at https://www.cdc.gov/contraception/hcp/usmec/

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)

Updated in 2024. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: https://www.cdc.gov/contraception/hcp/usmec/. Most contraceptive methods do not protect against STIs. Consistent and correct use of the external (male) latex condom reduces the risk of STIs and HIV.
Please see NIH guidelines for up to date recommendations on hormonal contraception and ARVs: https://clinicalinfo.hiv.gov/en/guidelines/perinatal/prepregnancy-counseling-childbearing-age-overview?view=full#table-3 and https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/drug-interactions-overview?view=full.

KEY: 1 = No restriction (method can be used) | 2 = Advantages generally outweigh theoretical or proven risks | 3 = Theoretical or proven risks usually outweigh the advantages | 4 = Unacceptable health risk (method not to be used)

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <20 yrs: 2		Menarche to <20 yrs: 2		Menarche to <18 yrs: 1		Menarche to <18 yrs: 2		Menarche to <18 yrs: 1		Menarche to <40 yrs: 1	
		≥20 yrs: 1		≥20 yrs: 1		18–45 yrs: 1		18–45 yrs: 1		18–45 yrs: 1		≥40 yrs: 2	
						>45 yrs: 1		>45 yrs: 2		>45 yrs: 1			
Anatomical abnormalities	a. Distorted uterine cavity	4		4									
	b. Other abnormalities	2		2									
Anemia, iron-deficiency		2		1		1		1		1		1	
Benign ovarian tumors	(including cysts)	1		1		1		1		1		1	
Breast disease	a. Undiagnosed mass	1		2*		2*		2*		2*		2*	
	b. Benign breast disease	1		1		1		1		1		1	
	c. Family history of cancer	1		1		1		1		1		1	
	d. Breast cancer[2]												
	i. Current	1		4		4		4		4		4	
	ii. Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a. <21 days postpartum					2*		2*		2*		4*	
	b. 21 to <30 days postpartum												
	i. With other risk factors for VTE					2*		2*		2*		3*	
	ii. Without other risk factors for VTE					2*		2*		2*		3*	
	c. 30–42 days postpartum												
	i. With other risk factors for VTE					1*		2*		1*		3*	
	ii. Without other risk factors for VTE					1*		1*		1*		2*	
	d. >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Chronic kidney disease[3]	a. Current nephrotic syndrome	1	1	2	2	2		3		2/4*		4	
	b. Hemodialysis	1	1	2	2	2		3		2/4*		4	
	c. Peritoneal dialysis	2	1	2	2	2		3		2/4*		4	
Cirrhosis	a. Compensated (*normal liver function*)	1		1		1		1		1		1	
	b. Decompensated[3] (*impaired liver function*)	1		2		2		3		2		4	
Cystic fibrosis[3]		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)[3]	a. Current or history of DVT/PVE, receiving anticoagulant therapy (*therapeutic dose*)	2*		2*		2*		2*		2*		3*	
	b. History of DVT/PE, receiving anticoagulant therapy (*prophylactic dose*)												
	i. Higher risk for recurrent DVT/PE	2*		2*		2*		3*		2*		4*	
	ii. Lower risk for recurrent DVT/PE	2*		2*		2*		2*		2*		3*	
	c. History of DVT/PE, not receiving anticoagulant therapy												
	i. Higher risk for recurrent DVT/PE	1		2		2		3		2		4	
	ii. Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	d. Family history (*first-degree relatives*)	1		1		1		1		1		2	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes	a. History of gestational disease	1		1		1		1		1		1	
	b. Nonvascular disease												
	i. Non-insulin dependent	1		2		2		2		2		2	
	ii. Insulin dependent[2]	1		2		2		2		2		2	
	c. Nephropathy, retinopathy, or neuropathy[2]	1		2		2		3		2		3/4*	
	d. Other vascular disease or diabetes of >20 years' duration[2]	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer[2]		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy[2]	(see also *Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a. Asymptomatic	1		2		2		2		2		2	
	b. Symptomatic												
	i. Current	1		2		2		2		2		3	
	ii. Treated by cholecystectomy	1		2		2		2		2		2	
	iii. Medically treated	1		2		2		2		2		3	
Gestational trophoblastic disease (GTD)[3]	a. Suspected GTD (*immediate postevacuation*)												
	i. Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii. Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b. Confirmed GTD												
	i. Undetectable or non-pregnant β-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii. Decreasing β-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii. Persistently elevated β-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv. Persistently elevated β-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a. Nonmigraine (*mild or severe*)	1		1		1		1		1		1*	
	b. Migraine												
	i. Without aura (*includes menstrual migraine*)	1		1		1		1		1		2*	
	ii. With aura	1		1		1		1		1		4*	
History of bariatric surgery[3]	a. Restrictive procedures	1		1		1		1		1		1	
	b. Malabsorptive procedures	1		1		1		1		3		COCs: 3 P/R: 1	
History of cholestasis	a. Pregnancy related	1		1		1		1		1		2	
	b. Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of pelvic surgery	(see also *Postpartum [including cesarean delivery]*)	1		1		1		1		1		1	
HIV	a. High risk for HIV	1*	1*	1*	1*	1		1		1		1	
	b. HIV infection					1*		1*		1*		1*	
	i. Clinically well receiving ARV therapy	1	1	1	1	If on ARV, see also *Drug Interactions*.							
	ii. Not clinically well or not receiving ARV therapy[4]	2	1	2	1	If on ARV, see also *Drug Interactions*.							

Abbreviations: ARV = antiretroviral; C = continuation of contraceptive method; CHC = combined hormonal contraceptive (pill, patch, and ring); COC = combined oral contraceptive; Cu-IUD = copper intrauterine device; DMPA = depot medroxyprogesterone acetate; I = initiation of contraceptive method; LNG-IUD = levonorgestrel intrauterine device; NA = not applicable; POP = progestin-only pill; P/R = patch/ring; SSRI = selective serotonin reuptake inhibitor; STI = sexually transmitted infection; VTE = venous thromboembolism. [1]Condition associated with increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/contraception/hcp/usmec/.

Source(s): CTC-SRH A Toolkit for Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate; U.S. Medical Eligibility Criteria for Contraceptive Use, 2024; U.S. Selected Practice Recommendations for Contraceptive Use, 2024

Prescribing DMPA-SC

Initiation

- No exams or tests are needed before prescribing
- Patient can record weight and BMI at time of prescription
- Initiate anytime it is reasonably certain patient is not pregnant

Prescription

- Depo-subQ provera 104 (104 mg/0.65 mL) (NDC code 0009-4709-13) for 4 refills q 3 months.
- Prefilled, single-dose syringes
- Store at room temperature
- Repeat injections can be given up to 2 weeks late (up to 15 weeks)

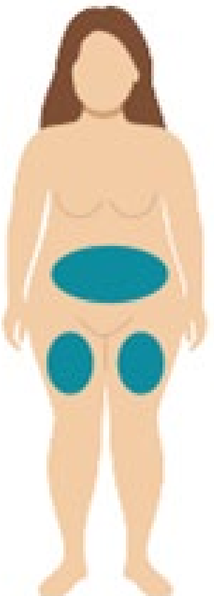
Source(s): CTC-SRH A Toolkit for Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate; Bedsider Providers, DMPA-SQ A Provider's Guide

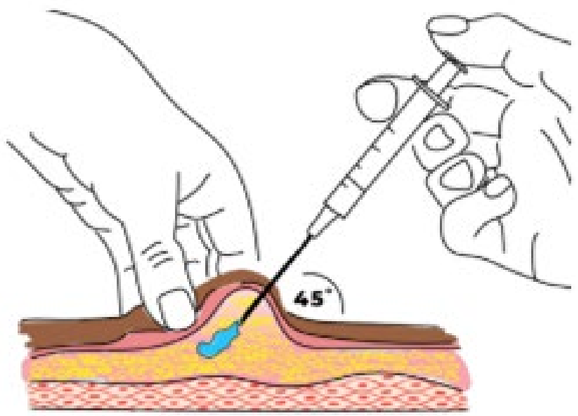
Administering DMPA-SC

How to self-administer DMPA-SQ:

1) Wash your hands.
2) Remove the pre-filled syringe from box and shake for 1 minute.
3) Hold the syringe with the needle pointing up and tap the syringe to shake air bubbles to the top.
4) Gently push plunger of syringe until air bubbles come out (keep the cap on the needle).
5) Choose injection site (either the abdomen or top of the thigh) and wipe it with an alcohol pad.
6) Take the cap off needle and hold the syringe in your dominant hand.
7) Grab the skin around injection site with your non-dominant hand and insert the needle all the way at 45-degree angle.
8) Press the plunger of the syringe all the way and keep needle in place while counting to 5.
9) Remove the needle and dispose of it into a sharps' container.
10) Apply pressure to the injection site, but don't rub.
11) If all the medication is not injected, reinject the remaining medication at the site previously wiped with the alcohol pad.

BEDSIDER PROVIDERS





Source(s): Bedsider Providers, DMPA-SQ A Provider's Guide; This is how I teach Self injection DMPA-SC video

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Billing and Coding for DMPA-SC

- Billing varies by state and private insurance.
- CMS HCPCS code J1050 (billed per 1 mg, requiring providers to report 104 units for DMPA-SC).

Codes for DMPA-SubQ dispensed by medical provider (in-person or curbside):

Name	Depo Sub-Q Provera 104 (Generic name: Depo Provera)
NDC #	00009-4709-13
HCPCS	J1050 (Injection, medroxyprogesterone acetate, 1 mg)
Units	104 units

Common ICD-10 Diagnosis Codes to support the counseling, instruction and prescribing of DMPA:

Z30.013	Initial prescription of injectable contraceptive
Z30.42	Surveillance of injectable contraceptive *(includes refill prescriptions of DMPA)*
Z30.09	General contraceptive management advice *(includes general counseling on all methods available to the client)*
Include other relevant ICD codes as indicated	

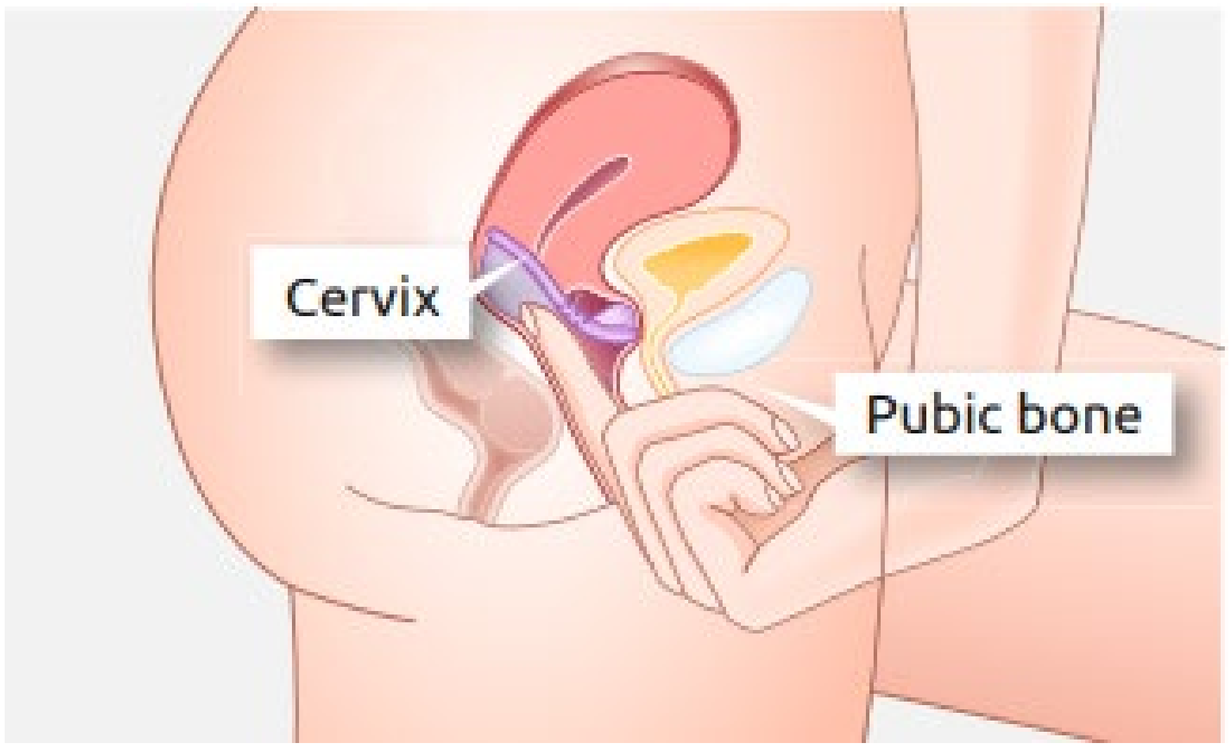
Common Procedure Codes to capture the counseling, instruction and prescribing of method:

99202-99215	Office/outpatient E/M (Evaluation and Management) including counseling and instruction *Select E/M based on total time or medical decision making (MDM)*	Add Modifier 95 (Telemedicine) if the visit is performed via audio/visual platform	Report location or POS "02" if service was provided as telehealth on medical claim
99401-404	Preventive medicine counseling *Select code based on documented time*		
99441-443	Telephonic E/M services *Select code based on documented time*	No modifier typically needed	
99421-423	E visit - online digital E/M services *Select code based on documented time*		
G2010	Virtual check-in		

Source(s): CTC-SRH A Toolkit for Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate; Bedsider Providers, DMPA-SQ A Provider's Guide

Diaphragm

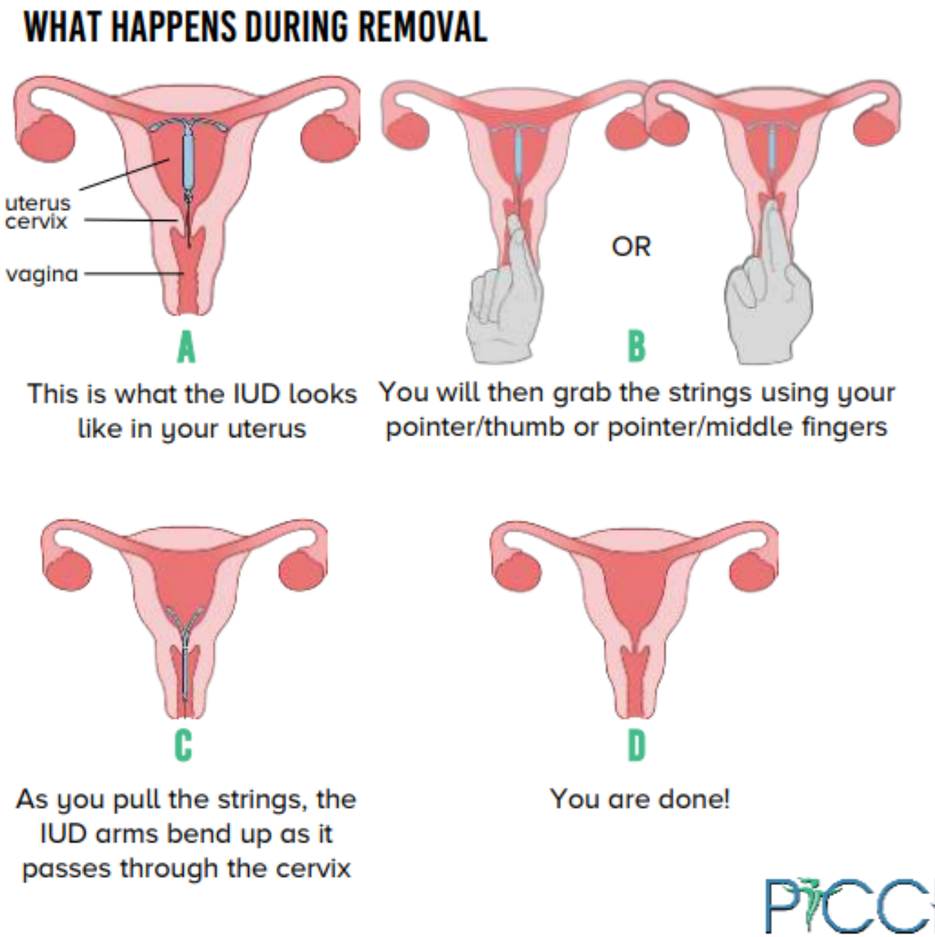
- Prescription needed - telehealth or one's own provider
- Available at most pharmacies
- Reusable for up to 2 years
- Latex and hormone free
- Fits *most*



Source(s): RHNTC Birth Control Methods Chart; Caya contoured diaphragm

Patient Autonomy in Discontinuation and IUD Removal

- Proactively discuss IUD discontinuation
- Ensure same-day removal of IUDs or implants
- Help support IUD self-removal
- Patient resources for IUD self-removal
  - Reproductive Access Project IUD Self Removal Fact Sheet
  - PICCK How to remove your IUD by yourself



Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41−S86; Reproductive Access Project IUD Self Removal Fact Sheet; PICCK How to remove your IUD by yourself

Poll 2: Are you and/or clinical providers at your clinic or agency counseling patients about IUD self-removals?

A. Yes
B. No
C. I don’t know

Advance Provision of Emergency Contraception (EC)

Offer an advance supply of EC pills to ensure immediate accessibility.



For medicaid patients, Levonorgestrel 1.5mg (plan B and other brand names) can only be written for quantity 1 with no refills



For medicaid patients, Ulipristal (Ella), may be written for a quantity of 2 tablets with up to 11 refills

Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41−S86; eMedNY Medicaid Pharmacy List of Reimbursable Drugs

Poll 3: At my clinic/agency, we provide an advanced supply of emergency contraceptive pills.

A. Yes, I have it on-site to provide
B. Yes, I send a prescription to the pharmacy with refills
C. Both A & B
D. No
E. I don't know

Extended Contraceptive Supply

Recommend prescribing a full year's supply (13 cycles) of combined hormonal methods or DMPA-SC syringes at the time of the visit to minimize access barriers.

Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41−S86

Poll 4: At my clinic/agency, we prescribe a full year's supply of pills/patches/rings.

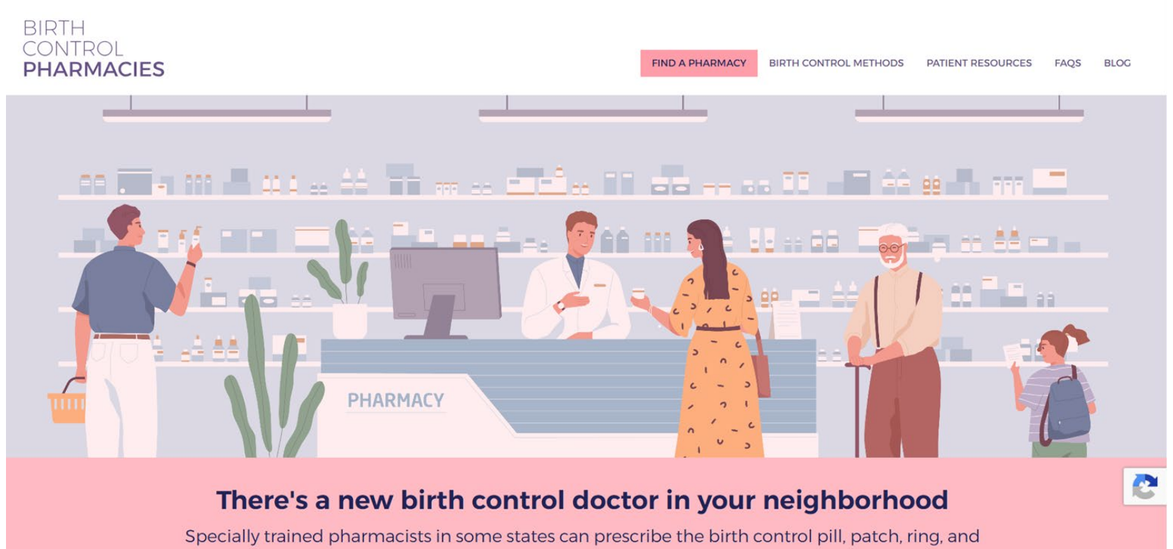
A. Yes
B. No
C. I don't know

Vaginal Contraceptive Gel

- Phexx (formerly Phexxi) - hormone-free birth control gel
  - Pre-filled single-dose vaginal applicators
  - 5 grams of gel containing lactic acid, citric acid, and potassium bitartrate - lowers vaginal pH
- **On-demand use**
  - Administer vaginally immediately before (or up to one hour before) sex
  - *If more than one act of vaginal intercourse occurs within one hour, an additional dose must be applied*
- **Ok to use:**
  - With hormonal contraceptives, condoms, diaphragms, and other products for vaginal infection (e.g. miconazole)
  - During any part of the menstrual cycle
- **Most common side effects:** vulvovaginal burning and itching
- **Avoid use with:** vaginal rings; in people with history of recurrent UTIs or urinary tract abnormalities

Expanding and Improving Access Through Other Self-Directed Strategies

Pharmacist Prescribing



- **NYS allows pharmacists to prescribe self-administered hormonal contraception directly**
  - Optional and training required
  - May dispense up to 12 months of contraception
- Find out if pharmacists in your area prescribe contraceptives: https://birthcontrolpharmacies.com/

Utilizing Telehealth Services

- Contraceptive counseling
- Method prescription
- Side effect management
- Counseling prior to IUD and implant placement or removal

How is your clinic using telehealth in practice?

Please come off mute or share in the chat.

Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41−S86

Managing Side Effects and Streamlining Follow-up

- Proactive side effect counseling
- Anticipatory planning for challenges - missed pill, late injection, managing side effects
- Follow-up options - Telehealth



Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41–S86

Patient-Directed Method Switching and Discontinuation

- Normalize discontinuation
- Create pathways for no-barrier switching
- Minimize physical exam barriers
- Quick-start methods



Source(s): Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024). Romer et al. American Journal of Preventive Medicine, 2024;67(6S):S41−S86

Q&A

Clinician Survey for NYS FP Providers



- We need your input for 2027!
- Please complete this 7-question survey by November 30, 2026.

New York State Family Planning Training Center
nysfptraining.org

Thank you!

Contact | nysfptraining.org/
Connect | nysfptraining.org/enews/

Resources

- Dear Colleague Letter: Extensions of Some Expiration of Biciliin L-A https://www.health.ny.gov/diseases/aids/providers/health_advisories/docs/health_advisory_bicillin_expiration.pdf
- New York State Condom Program: http://www.health.ny.gov/nyscondom
- CTC-SRH User-Administration of Subcutaneous Depot Medroxyprogesterone Acetate: https://ctcsrh.org/ctcsrh-resource/user-administration-of-subcutaneous-depot-medroxyprogesterone-acetate-dmpa-sc/
- Safe Needle Disposal: https://safeneedledisposal.org/
- Billing and Coding for Self-Administered Subcutaneous DMPA: https://ctcsrh.org/ctcsrh-resource/billing-and-coding-for-self-administered-subcutaneous-dmpa/
- Caya Contoured Diaphragm: https://www.caya.us.com/
- Reproductive Access Project IUD Self Removal Fact Sheet: https://www.reproductiveaccess.org/wp-content/uploads/2024/05/2025-04-IUD-Self-Removal_Final.pdf
- PICCK How to remove your IUD by yourself: https://picck.org/wp-content/uploads/2022/08/PICCK-How-to-Remove-Your-Intrauterine-Device-IUD-By-Yourself.pdf
- Medicaid Pharmacy List of Reimbursable Drugs: https://www.emedny.org/info/formfile.aspx
- Find Birth Control Pharmacies: https://birthcontrolpharmacies.com/
- FAQs Pharmacist Dispensing Hormonal Contraception in NYS: https://www.health.ny.gov/community/reproductive_health/faqs_pharmacist_dispensed_hormonal_contraception.htm

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