Implementation of an Outpatient Medication Therapy Management Program at the Military Treatment Facility with Oral Contraception Prescriptive Authority

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MAJ Sean K. O’Brien declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.
Target Audience: Pharmacists and Pharmacist Technicians

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Activity Type: Knowledge-based
Learning Objectives

- Discuss best practices to implement an outpatient pharmacy Medication Therapy Management (MTM) program at the Military Treatment Facility (MTF) with focus on an oral contraception pill (OCPs) prescriptive authority in order to maximize the medically ready force and ready medical force.

- Describe the mechanism of action, drug interactions, contraindications, side effects, health benefits and risks, and advantages and disadvantages of OCPs.

- Apply MTM by choosing or adjusting a patient’s OCP therapy based on pharmacologic properties of therapy and patient specific characteristics (lifestyle, physical findings, and laboratory values).
Allowing OCP prescriptive authority for MTF pharmacists in an outpatient MTM program allows them to practice at the top of their license, contributing to what focus of readiness?

- A. Medically Ready Force
- B. Ready Medical Force
- C. Combatant Command Guidance
- D. No Impact

A technician in your pharmacy asks a patient to complete the OCP self-screening tool, and then asks you, the pharmacist, what is one major risk of OCPs. Which of the following is an appropriate response?

- A. Endometrial Cancer
- B. Uterine Fibroids
- C. Thromboembolism
- D. Ovarian Cancer

A patient with a history of excessive weight gain, edema, bloating, headache, and depression mostly likely has a sensitivity to what component of an OCP?

- A. Progestin
- B. Androgen
- C. Estrogen
- D. Testosterone
**Military Health System (MHS) Quadruple Aim**

**Increased Readiness**
Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

**Better Care**
Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

**Better Health**
Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

**Lower Cost**
Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.
Maximizing the Role of a Pharmacist

- Identify the roles pharmacists and pharmacy technicians can play
- Decide how your practice can benefit from including a pharmacist
- Find your pharmacist and pharmacy technician match
- Prepare and set expectations from your team and patients
- Determine the resources the pharmacists needs and impact on the provider’s workflow
MTM is a distinct service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients.

5 core elements:
1. Medication therapy review
2. Personal medication record
3. Medication-related action plan
4. Intervention for referral
5. Documentation and follow-up
Medication Therapy Management (MTM)

- Immunization
- Health, wellness, public health
- Medication safety surveillance
- Medication therapy reviews
- OCP Prescriptive Authority
- Pharmacogenomics applications
- Pharmacotherapy consults
- Disease management coach/support
- Anticoagulation management
- Other clinical services
11 states and Washington, District of Columbia
- California, Colorado, Hawaii, Maryland, New Hampshire, New Mexico, Oregon, Tennessee, Utah, Washington, and West Virginia

Without a prior prescription via:
- Standing orders
- Practice protocols
- Expanded scope of practice

Different legality in each state

Impact on Readiness

- Ready Medical Force = attributes and knowledge, skills, and abilities (KSAs) that medical personnel need to possess to deploy with a combat medical unit or into a combat zone.

- Medically Ready Force = efforts and actions that ensure the fighting force of Service Members (Soldiers, Sailors, Marines, and Airmen) are medically ready to deploy to combat zone.
**Impact on Readiness**

<table>
<thead>
<tr>
<th>Ready Medical Force</th>
<th>Medically Ready Force</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pharmacists able to practice at the top of license</td>
<td>• Outpatient pharmacy is most accessible service at the Military Treatment Facility (MTF)</td>
</tr>
<tr>
<td>• OCP prescriptive authority</td>
<td>• Less burden on navigation throughout healthcare system</td>
</tr>
<tr>
<td>• Lab ordering</td>
<td>• Optimizing care for Active Duty Service Members</td>
</tr>
<tr>
<td>• Transition of outpatient pharmacy from a transaction to a service</td>
<td>• Clinical appropriateness</td>
</tr>
<tr>
<td>• Tech-check-tech</td>
<td>• Readiness based on Combatant Commands</td>
</tr>
<tr>
<td>• Knowledge, skills, abilities for austere environment</td>
<td>• Lab ordering</td>
</tr>
<tr>
<td>• Allows pharmacists more time for OCP prescriptive authority</td>
<td>• Human chorionic gonadotropin (HCG)</td>
</tr>
<tr>
<td>• Clinical assistance from technicians</td>
<td>• Pregnancy is non-deployable health condition</td>
</tr>
<tr>
<td>• Completion and assessment of OCP patient self-screening tool</td>
<td></td>
</tr>
</tbody>
</table>
KH is a 32 year old female Active Duty Soldier who presents to the outpatient pharmacy in Vicenza, Italy to ask the pharmacist about oral contraceptive pills (OCPs).

The pharmacy technician at the window asks specifically what questions she has for the pharmacist so the pharmacy team may best assist her needs today.

KH asks if this pharmacy prescribes and dispenses OCPs without a prescription from a provider.

The pharmacy technician excitedly responds, “Yes! We do, as part of our outpatient MTM program! Would you mind completing a screening tool before talking to the pharmacist?”

What types of questions would be on the screening tool provided by pharmacy technician for KH to complete before the pharmacist consultation?
Oral Contraceptives Pills (OCPs)

- Most popular method

- Availability
  - Combination estrogen and progestin pills (COCPs)
  - Progestin only pills (POPs)

Components of OCPs

Estrogenic Compounds
- Ethinyl estradiol (EE)
- Mestranol

Progestins
- Ethynodiol diacetate
- Desogestrel
- Norgestimate
- Norethindrone
- Norgestrel
- Levonorgestrel
- Drospirenone
Mechanism of Action

Supress ovulation

Change endometrium making implantation less likely

Reduce sperm transport in upper genital tract (Fallopian tubes)

Thicken cervical mucus (preventing sperm penetration)

OCPs

Monophasic

- Fixed ratio of estrogen and progestin
- Introduced in 1960
- Doses progressively decreased (150 mcg)
- Lowest dose available 20 mcg
- Highest dose available 50 mcg

Biphasic and Triphasic

- Dose of estrogen or progestin change
- Duplicate the pattern of the ovulatory menstrual cycle

OCPs Available Today

- Monophasic, biphasic, triphasic

- POPs
  - “Mini-pills”
  - Introduced in 1960
  - Generally used in women with contraindications to estrogen
Failure Rate of OCPs

- Most failures due to patient error in the first months of use
- No significant difference in failure rates between OCPs containing 20, 30, 35, or 50 mcg of estrogen
- Differences too small to justify using >35 mcg of estrogen
  - COCPs: Typical use: 8%; Perfect use: 0.3%
  - POPs: Typical use: 8%; Perfect use: 0.3%

OCP Health Benefits

- Endometrial Cancer
- Ovarian Cancer
- Benign Breast Disease
- Ovarian Cysts
- Uterine Fibroids
- Ectopic Pregnancies
- Menstrual problems

Endometrial Cancer
- COCPs for at least 12 months: Relative Risk (RR) 0.6 (95% Confidence Interval (CI) 0.3-0.9)
- Protective effect lasted 15 years after cessation of use

Ovarian Cancer
- 45 epidemiological studies: RR 0.73 (95% CI 0.70-0.76)
- Protective effect lasted for 30 years after cessation of use

Breast Cancer

- No sufficient evidence

- Nurses’ Health Study, Oxford-Family Planning Association Study, Cohort Studies
  - No association with an increased breast cancer risk

- Can we use OCPs in patients with a history of breast cancer?

Objective: To assess the risk of venous thrombosis in current users of different types of hormonal contraception, focusing on regimen, estrogen dose, type of progestin, and route of administration.

Conclusion:
- The risk of venous thrombosis in current users of COCPs decreases with duration of use and decreasing estrogen dose.
- For the same dose of estrogen and the same length of use, OCPs with desogestrel, gestodene, or drospirenone were associated with a significantly higher risk of venous thrombosis than oral contraceptives with levonorgestrel.
- Progestin-only pills and hormones releasing intrauterine devices were not associated with any increased risk of venous thrombosis.

BOTTOM LINE:
- SMALL RISK 1 clot for every 7400 women. If don’t need to use these progestins, then don’t; but if indicated (acne, hirsutism) use them.
- Keep doses to <35 mcg.

Cardiovascular Complications

- Myocardial infarction (MI)
- Cerebrovascular accident
- Thromboembolism

- Occurs primarily in women
  - > 35 in age
  - Smokers
  - Underlying medical problems, especially those that are predisposed to thrombosis

Cardiovascular Complications

- Absolute contraindication in smokers over 35
- Relative contraindication in younger, heavy smokers (> 15 cigarettes per day)
- Use lowest does estrogen (20 mcg)
- Progestin only methods are options

A Look at the Numbers

Annual number of birth or method related deaths per 100,000 women according to age and method

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No contraception*</td>
<td>7.0</td>
<td>7.4</td>
<td>9.1</td>
<td>14.8</td>
<td>25.7</td>
<td>28.2</td>
</tr>
<tr>
<td>OCPs non-smoker**</td>
<td>0.3</td>
<td>0.5</td>
<td>0.9</td>
<td>1.9</td>
<td>13.8</td>
<td>31.6</td>
</tr>
<tr>
<td>OCPs smoker**</td>
<td>2.2</td>
<td>3.4</td>
<td>6.6</td>
<td>13.5</td>
<td>51.1</td>
<td>61.2</td>
</tr>
</tbody>
</table>

*Birth Related Death  **Method Related Deaths

The pharmacy technician excitedly responds, “Yes! We do, as part of our outpatient MTM program! Would you mind completing a screening tool before talking to the pharmacist?”

- What types of questions would be on the screening tool provided by pharmacy technician for KH to complete before the pharmacist consultation?
- Please take out the patient self-screening tool
Choosing an OCP

- Smoking and now age 35 or older
- Moderate to severe hypertension
- Undiagnosed abnormal vaginal bleeding
- Diabetes with known vascular complications (or duration $> 20$ years)
- Deep vein thrombosis or pulmonary embolism or past history (PH) of ischemic heart disease
- Headaches with focal neurological symptoms or PH of stroke

- Current or PH of breast cancer
- Active viral hepatitis or mild or severe cirrhosis
- Breast-feeding exclusively
- Major surgery with immobilization within 1 month
- PH cholestasis with OCP use
- Family history of thrombosis

Choosing an OCP

YES: History positive for one or more of above conditions. May not be able to use COCs

Consider POPs, Depo-Provera™, progestin intrauterine device (IUD)

Consider also non-hormonal methods: Male or female condom, copper IUD, diaphragm, cervical cap, vasectomy, tubal sterilization

Older women with heavy periods should not cease OCPs and seek surgery. No evidence to suggest this is detrimental.

Choosing an OCP

NO: History negative for above; therefore, no reason to avoid estrogen-containing pill

May use any of the sub-50 mcg combined pills based on cost, availability, and prior experience of client or clinician

## Contraceptive Pill Activity

<table>
<thead>
<tr>
<th>Drug</th>
<th>Estrogenic Activity</th>
<th>Progestational Activity</th>
<th>Androgenic Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ovral</td>
<td>1.3</td>
<td>0.8</td>
<td>0.08</td>
</tr>
<tr>
<td>Noradr/Ortho-Novum 1/25</td>
<td>1.0</td>
<td>0.34</td>
<td></td>
</tr>
<tr>
<td>Ocean 50</td>
<td>1.0</td>
<td>0.58</td>
<td></td>
</tr>
<tr>
<td>Norlestrin 2/35</td>
<td>1.0</td>
<td>0.53</td>
<td></td>
</tr>
<tr>
<td>Demulen 1/20</td>
<td>1.0</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td>50-55 μg Estrogen Monophasic</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Noreth</td>
<td>1.0</td>
<td>0.25</td>
<td></td>
</tr>
<tr>
<td>Yuzuran/Ortho-Caps</td>
<td>1.0</td>
<td>0.15</td>
<td></td>
</tr>
<tr>
<td>Norinata</td>
<td>1.0</td>
<td>0.16</td>
<td></td>
</tr>
<tr>
<td>Ortho Cyclen</td>
<td>0.8</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Ortho-Novum 1/50</td>
<td>0.8</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Ortho-Novum 1/75</td>
<td>0.8</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Ortho-Novum 1/100</td>
<td>0.8</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Ovrette</td>
<td>1.0</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Lepetin E1/20</td>
<td>1.0</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Lepetin E20</td>
<td>1.0</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>20 μg Estrogen Monophasic</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Lepetin</td>
<td>1.0</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Lepetin 1/25</td>
<td>1.0</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Ajust</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Leptin 1/20</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Multiphasic</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>35 μg estrogens</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Ortho-Tricyclen</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Ortho-Novum 35/27</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Frankoll</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Ortho-Novum 1/150</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Ortho-Tricyclen</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Tricon</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Contraceptive</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Ovral</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Micronor NO 35</td>
<td>0.8</td>
<td>0.45</td>
<td></td>
</tr>
</tbody>
</table>

See accompanying document to view this chart.
When to Start

- Sunday Start = start taking active pills on the first Sunday after the onset of menstrual cycle

Vs.

- Day 1 Start = start taking active pills on day 1 of menstrual cycle

Estrogen Sensitivity

- History of migraine
- Heavy menstrual cramps
- Severe nausea and vomiting during pregnancy
- Pregnancy-induced hypertension
- Use pill with *low estrogenic activity*

Examples:
- Loestrin™ 1/20
- Loestrin™ 1.5/30
- Alesse™/Sronyx™

Progestin Sensitivity

- History of
  - Excessive weight gain
  - Appetite
  - Tiredness
  - Varicose veins
  - Toxemia during pregnancy

- Premenstrual syndrome (PMS): excessive edema, bloating, headache, depression

- Use pill with *low progestational activity*

- Examples:
  - Ortho Tri-Cyclen Lo™
  - Ortho Tri-Cyclen™/TriNessa™
  - Alesse™/Sronyx™

Androgenic Sensitivity

- History of irregular, heavy menses
- Physical exam may reveal oily skin, hirsutism, and acne
- Use pill with *high progestational activity and low androgenic activity*
  - Examples:
    - Yasmin™
    - Yaz™
- Patients with severe acne
  - Use pill with *high estrogenic activity and almost no androgenic activity*
  - Examples:
    - Yasmin™
    - Desogen™/Ortho-Cept™/Emoquette™
    - Ortho Cyclen™/MonoNessa™

Bleeding may be due to:

- Inadequate amounts of estrogen and progestin in the COCP
- Imbalance between estrogen and progestin
- Missed pills
- Drug interactions
- Endometrial infection

Switching OCPs

- Choose pill with greater endometrial activity, which may be achieved with:
  - Higher progestin doses
  - More androgenic progestins
  - Multi-phasic OCPs
  - Higher estrogen doses
  - Different ratios of estrogen and progestin

KH completes the self-screening tool, and meets with the pharmacist in the MTM consultation room.

She states she has been taking Alesse™ for 2 months and has been “bleeding and spotting” both cycles.

What do you tell her?

- This is common during the first 3 cycles

Would you recommend switching pills?

- Encourage KH to wait 3 cycles before switching OCPs
KH returns in 6 months for a refill for the Alesse™ and wishes to speak with pharmacist.

She states “her periods have been extremely heavy and all over the place.” She further claims, “I haven’t had pimples since high school, and they seem to be coming back.”

Would you recommend switching pills?
  - I would

If so, when and to what?
  - Now, during the MTM session
  - Yaz™, Yasmin™
Patient Instructions

- Patient Package Insert (PPI)
- When to start: Sunday or Day 1
- Active (1-21) vs. Inactive (22-29) pills
- One pill every day at the same time
- When to expect her period
- What to do if she misses a pill
- No barrier to sexually transmitted infections (STIs)
<table>
<thead>
<tr>
<th>Missed Pills: Sunday Start</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Missed 1 pill</th>
<th>Take as soon as possible. Take next pill at regular time.</th>
<th>No back-up method needed.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Missed 2 pills during weeks 1 or 2</th>
<th>Take 2 pills a day for 2 days at least 6 hours apart with food and finish pack.</th>
<th>Use back-up method for next 7 consecutive days.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Missed 2 pills during week 3</th>
<th>Take 1 pill every day until Sunday. Start NEW pack on Sunday.</th>
<th>Use back-up method for next 7 consecutive days.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Missed 3 or more pills</th>
<th>Take 1 pill every day till Sunday. Start NEW pack on Sunday.</th>
<th>If unprotected intercourse consult with your health care provider.</th>
<th>Use back-up method for next 7 consecutive days. You may not have a period, but this is normal.</th>
</tr>
</thead>
</table>

### Missed Pills: Day 1 Start

<table>
<thead>
<tr>
<th>Missed 1 pill</th>
<th>Take as soon as possible. Take next pill at regular time.</th>
<th>No back-up method needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed 2 pills during weeks 1 or 2</td>
<td>Take 2 pills a day for 2 days at least 6 hours apart with food and finish pack.</td>
<td>Use back-up method for next 7 consecutive days.</td>
</tr>
<tr>
<td>Missed 2 pills during week 3</td>
<td><strong>Stop using rest of pack. Start NEW pack same day.</strong></td>
<td>Use back-up method for next 7 consecutive days.</td>
</tr>
<tr>
<td>Missed 3 or more pills</td>
<td><strong>Stop using rest of pack. Start NEW pack same day.</strong></td>
<td>If unprotected intercourse consult with your health care provider. Use back-up method for next 7 consecutive days. You may not have a period, but this is normal.</td>
</tr>
</tbody>
</table>

Side Effects

- More common in the first 3 cycles
- Encourage patient to wait 3 cycles before requesting to change pill
- Spontaneously disappear
- Breakthrough bleeding

Side Effects

- Symptoms associated with pregnancy
  - Nausea
  - Weight gain, breast tenderness

- Other side effects
  - Amenorrhea
  - Acne
  - Headache
  - Depression
  - Rash

<table>
<thead>
<tr>
<th>Five Signals</th>
<th>Possible Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal pain (severe)</strong></td>
<td>Gallbladder disease, hepatic adenoma, blood clot, pancreatitis</td>
</tr>
<tr>
<td><strong>Chest pain (severe), SOB, or coughing up blood</strong></td>
<td>Blood clot in lungs or MI</td>
</tr>
<tr>
<td><strong>Headaches (severe)</strong></td>
<td>Stroke or hypertension or migraine headache</td>
</tr>
<tr>
<td><strong>Eye problems, blurred vision, flashing lights, or blindness</strong></td>
<td>Stroke or hypertension or temporary vascular problem of many possible sites</td>
</tr>
<tr>
<td><strong>Severe leg pain (calf or thigh)</strong></td>
<td>Blood clot in lungs</td>
</tr>
</tbody>
</table>

Drug Interactions

- Hepatic enzyme inducers
  - Phenobarbital
  - Phenytoin
  - Ethosuximide
  - Carbamazepine
  - Rifampin
  - St. John’s wort

- Use another contraceptive method or higher dose estrogen (50 mcg)

Drug Interactions: Antibiotics

- Ethinyl estradiol
  - Conjugated in the liver → excreted in the bile → hydrolyzed by intestinal bacteria → reabsorbed as active drug

- Antibiotics
  - Reduce the population of intestinal bacteria
  - Interrupt the enterohepatic circulation of estrogen
  - Decreased concentration of estrogen
  - Rifampin only antibiotic proven to decrease serum EE

Return of Fertility After OCP Use

- Average 2 month delay

- Recommend 3 normal menstrual cycles before attempting pregnancy

- Prenatal vitamins for 3 months prior

Lactation

Estrogens
► Inhibit the action of prolactin in breast tissue
► Decreased milk production (quantity)
► Decreased protein content (quality)
► Decreased duration of lactation

Progestins
► Lesser effect on lactation
► Injectable progestins have no effect or increase milk production
► Recommend POPs

POPs

- Less effective
  - (8 out of 100/year): Transition to COCPs if possible

- Increased risk of ectopic pregnancy

- Good choice in certain patients
  - Nursing mothers
  - Women with reasons to avoid estrogen
  - Smokers over 35 years of age
  - Less nausea and vomiting than COCPs

POPs

- Take on the first day of menses
- Continued every day
- Take at the same time of day
- Use back-up method for first cycle
- If 3 hours late or miss one pill, use back-up for 48 hours (manufacturer)
- Conservative recommendation: 7 days or remainder of the cycle

Emergency Contraception

- Probability of conception
  - Conception occurs only around the time of ovulation
  - Egg capable of fertilization for only about 24-72 hours

- Mechanism of action
  - High dose of estrogen or progestin
    - Delays development of follicles
    - Prevents ovulation
    - Interferes with fertilization
    - Prevents implantation of fertilized egg

- Prevents, not terminates pregnancy
  - Considered contraceptive, not abortifacient (controversial)

Emergency Contraception

- Candidates for use
  - Rape
  - Late withdrawal
  - Failure of barrier method

- Should not be used for routine contraception

# Emergency Contraception

<table>
<thead>
<tr>
<th>Tablet</th>
<th>Color</th>
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<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alesse™</td>
<td>5 pink</td>
<td>Levlen™</td>
<td>4 light orange</td>
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<tr>
<td>Levlite™</td>
<td>5 pink</td>
<td>Levora™</td>
<td>4 white</td>
</tr>
<tr>
<td>Lo/Ovral™</td>
<td>4 white</td>
<td>Nordette™</td>
<td>4 orange</td>
</tr>
<tr>
<td>Ovral™</td>
<td>2 white</td>
<td>Ovrette™</td>
<td>20 yellow</td>
</tr>
<tr>
<td>Plan B™</td>
<td>1 white</td>
<td>Preven™</td>
<td>2 light blue</td>
</tr>
<tr>
<td>Tri-levlen™</td>
<td>4 yellow</td>
<td>Triphasil™</td>
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</tr>
<tr>
<td>Trivora™</td>
<td>4 pink</td>
<td></td>
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</tbody>
</table>

If Plan A Fails…Go to Plan B

- Plan B One Step™: Levonorgestrel 1.5 mg per tablet
  - Take 1 tablet by mouth now; take within 72 hours

- Failure rate
  - When taken within 24 hours ~ 95% effective
  - When taken within 72 hours ~ 89% effective
  - Efficacy declines > 72 hours
  - Totally ineffective by 7 days

Military Health System (MHS) Quadruple Aim

**Increased Readiness**
Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

**Better Care**
Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

**Better Health**
Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

**Lower Cost**
Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.
MTM services with OCP prescriptive authority align with Military Medicine’s goals and priorities

- Incorporate readiness, preventative care, and wellness strategies into all practice settings
- Institute best business practices into daily operations that improve use of limited resources and staff
- Implement, sustain, or change to “Best Practices” that improves access and outcomes

MTM services with OCP prescriptive authority enhances Readiness

- Ready Medical Force ➔ pharmacists and pharmacy technicians practices at the top of their licenses
- Medically Ready Force ➔ less navigation through healthcare system, clinical appropriateness
Allowing OCP prescriptive authority for MTF pharmacists in an outpatient MTM program allows them to practice at the top of their license, contributing to what focus of readiness?

A. Medically Ready Force  B. Ready Medical Force  C. Combatant Command Guidance  D. No Impact

A technician in your pharmacy asks a patient to complete the OCP self-screening tool, and then asks you, the pharmacist, what is one major risk of OCPs. Which of the following is an appropriate response?

A. Endometrial Cancer  B. Uterine Fibroids  C. Thromboembolism  D. Ovarian Cancer

A patient with a history of excessive weight gain, edema, bloating, headache, and depression mostly likely has a sensitivity to what component of an OCP?

A. Progestin  B. Androgen  C. Estrogen  D. Testosterone
Closing Remarks

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