Medicines & Healthcare products Regulatory Agency

Pregnancy testing and contraception for pregnancy prevention during treatment with medicines of teratogenic potential

- **Risk of pregnancy should be assessed prior to each teratogen prescription**
  - Risk of pregnancy may be high at start of a method or when switching between methods due to risk of pregnancy from unprotected sex prior to starting the method, unreliable use of the previous contraceptive method, and/or time needed to establish contraceptive efficacy at the start of the new method.
  - Pregnancy tests at start of contraceptive method may not detect an early pregnancy following unprotected sex in the last 3 weeks
- **Any starter on new method contraception should have a repeat pregnancy test at 3 weeks if there is any risk of pregnancy at start of contraceptive method**
- The duration of teratogen prescriptions may need to be shortened for patients who use contraceptive methods that require frequent pregnancy testing

Effectiveness of contraceptive in typical use[1]	Contraceptive method	Duration contraceptive method used / other situations	Pregnancy test needed before next teratogen prescription?
Highly effective methods **(Typical use failure rates less than 1%)**	Copper intrauterine device (copper IUD)	Established user more than 3 weeks to 5 to 10 years (depending on IUD[2])	No
	Levonorgestrel-releasing intrauterine system (LNG-IUS)	Established user more than 3 weeks to 3 to 8 years (depending on IUS[2])	No
	Progestogen Implant	Established user more than 3 weeks to 3 years	No
		Established user (more than 3 weeks), but concurrent use of interacting medicines which may affect efficacy[3]	Yes + review / refer for contraceptive advice
Effective methods **(Typical use failure rates greater than 1%)** **Additional barrier methods are advised during teratogen use**	Depot medroxyprogesterone acetate (DMPA) subcutaneous (SC) or intramuscular (IM) injections[4]	Established user (more than 3 weeks + repeat injections on schedule) and less than 13 weeks since last injection + documented as administered by healthcare professionals	No
		Established user (more than 3 weeks + repeat injections on schedule and less than 13 weeks since last injection) but self-administered or undocumented administration	Yes, test if any suspected risk of pregnancy
		More than 13 weeks since last injection (ie, beyond recommended duration of use of last injection)	Yes + review / refer for contraceptive advice
	Combined hormonal contraceptives (pills, patches or vaginal ring) or progestogen-only pills	Established user (more than 3 weeks), reliable and consistent use	Yes, test if any suspected risk of pregnancy
		Established user (more than 3 weeks) but with unreliable or inconsistent use of method, eg, • missed pills, late patch • diarrhoea or vomiting • use of other interacting medicines that may affect efficacy[3]	Yes + review / refer for contraceptive advice
	Other methods or no contraception	Any duration of use of other methods	Yes + review / refer for contraceptive advice;
		No contraception	Assess need for contraception + test if any suspected risk of pregnancy + review / refer for contraceptive advice

Explanatory notes:

1. Effectiveness of methods are based on failure rates in typical use (which includes risk of user error) rather than perfect use. Perfect use failure rates are similar for specific methods listed (0.03–0.6%) but risk of user error is higher for daily methods than for long-acting reversible contraceptive (LARC) methods and are highest for methods used at time of sexual intercourse. Highly effective methods are based on less than 1% failure rate in typical use; Less effective methods are based on greater than 1% failure rate (6–9%) in typical use (Trussell J. Contraception. 2011; 83: pages 397 to 404).
2. Refer to Product Information for specific products; patients should be reviewed / referred for contraception advice at the end of the recommended duration of use.
3. Implants are only considered as highly effective and combined hormonal contraceptives and progesterone-only pills are only considered as effective if interactions with any concurrent medicine are not a concern (see FSRH guidance on drug interactions with hormonal contraception [2022]).
4. DMPA (IM or SC) injection can be considered as highly effective if it is administered by healthcare professionals and continuous repeat use is documented as occurring within recommended duration of action (equivalent to perfect use, failure rate = 0.2%). Otherwise it is considered an effective contraceptive (typical use failure rate = 6%). The same rationale should be used for other injection products with different recommended duration of action (eg, norethisterone enanthate).

