CONTRACEPTIVE TECHNOLOGY UPDATE®
A Monthly Newsletter for Health Professionals

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

SEPTEMBER 2004
VOL. 25, NO. 9 • (pages 97-108)

New labeling for the Pill: Will it change how you prescribe oral contraceptives?

Guidance now under review may not reflect most current information

When it comes to using combined oral contraceptives (OCs), clinicians and patients look to drug package labeling for the most current information on how the Pill may be safely and effectively used.

If new industry guidance for package labeling goes into effect, however, combined OC labels may not reflect the most current thinking in contraceptive provision. While the guidance offers a more simplified approach to the label and patient instructions, several women's health groups have called for the directive to contain more updated medical information, a more thorough explanation about contraceptive method failure rates, and expanded information on the noncontraceptive benefits of the Pill.

EXECUTIVE SUMMARY

The Food and Drug Administration is reviewing proposed industry guidance for labeling combined oral contraceptives (OCs). While the proposed labeling offers a more simplified approach to the label and patient instructions, several women's health groups have voiced concerns.

- The proposed guidance calls for an annual history and physical with the prescription of OCs. A 2001 review of existing recommendations for hormonal contraceptives found that, in most cases, waiting to schedule such exams prior to prescribing represents an unnecessary and potentially dangerous delay.
- The proposed guidance needs more up-to-date scientific information and an expanded list of the noncontraceptive benefits of the Pill, say women's health advocates.

Contraceptive Technology Update® (ISSN 0274-726X), including **STD Quarterly**™, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Contraceptive Technology Update**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. **Back issues**, when available, are $75 each.(GST registration number R128870672.) **Photocopying:** No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact Thomson American Health Consultants. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. World Wide Web: http://www.ahcpub.com.

Editor: **Rebecca Bowers**.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney @thomson.com).
Editorial Group Head: **Valerie Loner**, (404) 262-5475, (valerie.loner@thomson.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@thomson.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

Questions or comments? Call **Joy Daughtery Dickinson** (229) 551-9195.

Statement of financial disclosure: **Dr. Hatcher** (editorial board chairman and peer reviewer) discloses that he is a consultant for Pharmacia Corp., performs research for Ortho, and is on the speaker's bureau for Ortho, Wyeth, Organon, Berlex, and Pharmacia Corp. **Dr. Kaunitz** (board member) discloses that he does continuing medical education presentations and publications for Aventis, Organon, Ortho-McNeil, Pharmacia Corp., and Wyeth-Ayerst, is a consultant for Aventis, Barr Laboratories, Berlex, Johnson & Johnson, Lilly, and Pharmacia Corp., and is a stockholder in Aventis and Johnson & Johnson, and performs research for Barr Laboratories, Berlex, Galen, Lilly, Merck, National Institutes of Health, Organon, Parke Davis, Pfizer, Pharmacia Corp., R.W. Johnson Pharmaceutical Research Institute, and Solvay. **Ms. Dominguez** (board member) discloses that she is on the speaker's bureau for Ortho, Pfizer, Roche, and Organon. **Ms. Wysocki** (board member) discloses that she is on the speaker's bureau for Ortho-McNeil, Wyeth Ayerst Pharmaceuticals, Berlex, Organon, Pharmacia Corp., Pfizer, and Bristol Myers Squibb. **Dr. Nelson** (board member) serves on the speaker's bureau for Berlex Laboratories, Gynetics, Eli Lilly & Co., 3M Pharmaceuticals, Ortho-McNeill, Organon, Parke-Davis, Pfizer, Pharmacia Corp., and Wyeth Ayerst; she conducts research for Ortho-McNeil, Pfizer, and Pharmacia Corp. **Dr. Rosenfield** (board member) is a stockholder and board member of Biotechnology General Corp., a consultant for Organon; serves on the speaker's bureau for Organon, Wyeth-Ayerst, and Parke-Davis; and conducts research for Organon, Wyeth-Ayerst, Ortho-McNeil, and Parke-Davis.

This publication does not receive commercial support.

THOMSON
AMERICAN HEALTH CONSULTANTS

"My understanding is that package labeling is intended to provide accurate and up-to-date drug information for consumers and providers," says **David Grimes**, MD, vice president of biomedical affairs at Family Health International in Research Triangle Park, NC. "The proposed labeling I reviewed was neither accurate nor up to date."

Groups such as the American College of Obstetricians and Gynecologists (ACOG), National Association of Nurse Practitioners in Women's Health (NPWH), both based in Washington, DC; Planned Parenthood Federation of America (PPFA) in New York City; and drug manufacturers such as Raritan, NJ-based Ortho-McNeil Pharmaceutical and Philadelphia-based Wyeth Pharmaceuticals, have filed comments with the regulatory agency. The deadline for filing comments was May 4, 2004. The FDA is analyzing the comments, says **Susan Cruzan**, FDA spokeswoman.

Kirsten Moore, president of the Washington, DC-based Reproductive Health Technologies Project, says, "Our concern is that the current draft label falls short of the clinical literature and represents a step back in time — overstating the health risks associated with oral contraceptive pill use and underestimating some of the benefits. While that may just be the work of cautious officials, the more conservative approach gives some of us cause to worry that information about birth control may be the latest victim in the abuse and misuse of science to fit a politically motivated, ideologically driven agenda."

Review the history

The guidance now under review includes wording for health care provider labeling and patient instructions that manufacturers will use for new drug applications and abbreviated new drug applications. The FDA issued a first guidance for comment in June 2000; the one now under review includes changes from the original draft. (To review the current draft guidance, go to the FDA web site, www.fda.gov. Under "Products FDA Regulate," click on "Drugs"; under "Quick Info Links," click on "Guidances"; then scroll down to "Labeling (Draft)." You may view the draft guidance, "Labeling for Combined Oral Contraceptives.")

The 2000 rendition of the guidance was "much better," says **Susan Wysocki**, RNC, NP, NPWH president and chief executive officer.

"We provided comments about the new

labeling," says Wysocki. "There were a number of issues that seemed to be backward slides."

One concern shared by ACOG, NPWH, and PPFA is the draft guidance's call for combined pill users to have an annual examination and laboratory tests. The guidance currently states, "Women who are using oral contraceptives should have an annual history and physical examination, including special reference to blood pressure, breasts, abdomen, and pelvic organs, as well as cervical cytology and relevant laboratory tests."[1]

Medical opinion has shifted from requiring breast and pelvic examinations prior to initiation of hormonal contraception to encouraging exams as part of routine care. A 2001 review of existing recommendations for hormonal contraceptives found that in most cases, waiting to schedule such exams prior to prescribing represents an unnecessary and potentially dangerous delay.[2] **(*Contraceptive Technology Update* reported on the research in the article, "Should access to birth control be streamlined?" October 2001, p. 117.)**

"Indeed, the United States Agency for International Development, the World Health Organization, the International Planned Parenthood Federation, the American College of Obstetricians and Gynecologists, the Society of Obstetricians and Gynaecologists of Canada, the Royal College of Obstetricians and Gynaecologists, and the American Academy of Pediatrics all conclude that pelvic examinations are not necessary prior to the initiation of OCs, even among adolescents," stated PPFA's written comments to the FDA.[3]

Where are the benefits?

Family planning clinicians regularly include discussion of the noncontraceptive benefits of the Pill, such as protection against endometrial and ovarian cancers, when discussing birth control choices. The noncontraceptive benefits section of the draft guidance lists only menstrual-related benefits, says Wysocki.

The current draft omits additional health benefits published in previous guidance and supported by current medical literature such as decreased incidence of ovarian cysts, ectopic pregnancy, endometrial cancer, ovarian cancer, and benign breast tumors, stated RHTP's written comments to the FDA.[4] Research has shown that educating patients on the benefits of OCs increases compliance rates, the comments noted.[4]

"The proposed labeling lacks balance," observes Grimes. "It provides a listing of putative health risks, yet largely ignores the well-documented health benefits known for decades, including powerful protection against two cancers."

How to teach about use?

When counseling women on "will the Pill work?" clinicians include a discussion on typical and perfect use failure rates to help women understand the efficacy of the method. The probability table, a standard inclusion in *Contraceptive Technology* and current manufacturers' combined OC labels,[5] has been modified in the draft guidance and does not include perfect use information.

"This simplification overestimates the effectiveness of typical use of combined OCs and underestimates the effectiveness of condom use in preventing pregnancy," stated ACOG's written comments to the FDA.[6]

By including perfect-use data, clinicians can help women increase their compliance with their chosen method by motivating them to achieve maximum protection against unintended pregnancy, stated PPFA's written comments to the FDA.

The literature cited in support of the proposed labeling is obsolete, says Grimes. Important recent articles were missing, as were comprehensive reviews by organizations such as the Geneva-based World Health Organization (WHO). One such document is the WHO's recently revised Medical Eligibility Criteria for Contraceptive Use. **(Review the latest changes in the *CTU* article, "Update your practice: check new WHO Medical Eligibility Criteria," June 2004, p. 61.)**

Reinforcing providers' instructions through pill packaging inserts helps women use OCs more consistently — if women understand the instructions. A study of Western European women showed that women who read and understood the information in pill packaging inserts were least likely to miss one or more pills per pack.[7] Among those who understood little or none of the insert information, about 30% missed one or more pills per pack.

"Each year, thousands of health care providers prescribe millions of cycles of combined OCs to millions of women in the United States," added NPWH's comments to the FDA. "It is imperative that the package insert and patient labeling that accompanies each cycle of combined OCs be complete, accurate, and clear; only then will providers be able to make sound medical recommendations

and women be provided with the tools necessary to make informed decisions."[8]

References

1. U.S. Department of Health and Human Services. Food and Drug Administration. Center for Drug Evaluation and Research. *Guidance for Industry. Labeling for Combined Oral Contraceptives. Draft Guidance.* March 2004. Accessed at: www.fda.gov/cder/guidance/5197dft.doc.

2. Stewart FH, Harper CC, Ellertson CE, et al. Clinical breast and pelvic examination requirements for hormonal contraception. *JAMA* 2001; 285:2,232-2,239.

3. Cullins V. Re: Docket number 200D-1350, "Draft Guidance for Industry on Labeling for Combined Oral Contraceptives" [letter]. Accessed at: www.fda.gov/ohrms/dockets/dailys/04/may04/050504/00d-1350-c00019-vol6.pdf.

4. Moore K. Re: Docket No. 2000D-1350 in the *Federal Register* 5 March 2004 (Volume 69) [letter]. Accessed at: www.fda.gov/ohrms/dockets/dailys/04/may04/050404/00d-1350-c00015-vol6.pdf.

5. Hatcher RA, Trussell J, Stewart F, et al. *Contraceptive Technology*. Bridging the Gap; 2004 [in press].

6. Hale RW. Re: "Draft Labeling for Industry on Labeling for Combined Oral Contraceptives; Availability" (Docket No. 2OOOD-1350. Accessed at: www.fda.gov/ohrms/dockets/dailys/04/may04/051104/00d-1350-c00021-vol6.pdf.

7. Rosenberg MJ, Waugh MS, Meehan TE. Use and misuse of oral contraceptives: Risk indicators for poor pill taking and discontinuation. *Contraception* 1995; 51:283-288.

8. Wysocki S. Re: Docket No. 2000D-1350 in the *Federal Register* 5 March 2004 (Volume 69) [letter]. Accessed at: www.fda.gov/ohrms/dockets/dailys/04/may04/051104/00d-1350-c00022-vol6.pdf. ■

Mandatory EC provision raises debate in Alabama

Is providing emergency contraception (EC) a problem for clinicians in your facility? Since January 2004, eight nurses within the Alabama Department of Public Health system have retired or resigned with letters of resignation that listed dispensing EC as at least one of their reasons for leaving.

According a statement issued by **Tom Miller**, MD, director of the bureau of family health services at the Alabama agency, the employees left without seeking an accommodation or without allowing the department time to resolve their request for accommodation.[1] Five employees have requests pending for accommodations. The agency is working with them to find appropriate assignments, according to Miller's statement.

The Alabama health department began providing EC as a routine service in April 2004. The state is the last in the Southeast to implement EC as a standard service, according to the statement issued by Miller. Some county clinics already were offering EC if patients asked for it, but not all clinics provided the service.[2] In April, the state health department mandated that EC be available, as are all other forms of contraception, at all health departments.[2]

EC is recognized as a method of contraception; according to a 1997 Department of Health and Human Services memorandum issued to all Title X regional health administrators, "grantees should consider the availability of emergency contraception the same as any other method which has been established as safe and effective."[3] The Alabama health department receives $4.9 million in federal family planning funds.[4]

The need for EC in Alabama exists. Planned Parenthood of Alabama provided the method to 770 women in 2003 at its four health centers in Birmingham, Huntsville, Mobile, and Montgomery, according to **Larry Rodick**, president and chief executive officer.

"It remains to be seen if we will see that many this year with the Health Department getting into it," he says. "We don't have a problem with that; emergency contraception needs to be out there."

Refusal clauses rise

The last two years have seen a revival of refusal clause legislation on the state level, says **Erica Smock**, a legislative analyst with the New York City-based Center for Reproductive Rights. Such

EXECUTIVE SUMMARY

Distribution of emergency contraception (EC) in public health settings has come under fire in Alabama, with some employees refusing to distribute pills on religious or moral grounds.

- Eight nurses within the Alabama Department of Public Health system have retired or resigned since January 2004, with letters of resignation that listed dispensing EC as at least one of their reasons for leaving. Five employees have requests pending for accommodations.
- Refusal clauses allow health care providers to refuse provision of medical services on religious or ethical grounds. Refusal clauses are rooted in the struggle over abortion rights. There has been a recent rise in state legislative activity concerning refusal clauses.

legislation allows health care providers to refuse provision of medical services on religious or ethical grounds. Refusal clauses are rooted in the struggle over abortion rights. Because some of those opposed to abortion consider EC an abortifacient, the situation in Alabama may be an example of clinicians refusing to provide services on religious or ethical grounds, she notes.

According to the New York City-based Alan Guttmacher Institute, at least one state, Mississippi, has passed refusal-clause legislation in 2004. Gov. Haley Barbour signed legislation in May, allowing health care providers, including pharmacists or other pharmacy employees, counselors, social workers, health insurers, and health care facilities, to refuse to provide medical services, including counseling and referral, on religious or ethical grounds.[5] The new law also prohibits the denial of public benefits because of a refusal to provide or pay for services.[5]

The Michigan House in April approved a measure to allow individual medical providers, including pharmacists, to refuse to provide health care services because of a moral, ethical, or religious objection.[5] Although the measure would prohibit a provider from refusing to provide contraceptive services, it would limit that protection to services provided "in advance of sexual intercourse," which would allow a provider to refuse to provide EC. The measure is awaiting consideration in the Senate.[5]

Check WA record

Providing EC hasn't proven to be a problem for many state agencies. Check the experience of Washington State's Department of Social and Health Services Medical Assistance Administration and Department of Health Office of Family Planning and Reproductive Health. These agencies have had a successful experience, reports **Jane Hutchings**, senior program officer with the Seattle-based Program for Appropriate Technology in Health (PATH).

In 1999, the agencies decided to incorporate EC pills (ECPs) into family planning services and other programs serving women at risk of unintended pregnancy. Working with PATH, the departments collaborated in integrating EC in their efforts to reduce unintended pregnancy. By working with all involved, the agencies have implemented the following progressive steps:

- The First Steps program for pregnant women and new mothers now provides EC information and supplies as part of its family planning services.
- Clients in the Take Charge family planning waiver program, which reaches Washington State residents lacking full family planning insurance coverage, can obtain ECPs free of charge from participating clinics and participating pharmacies, which are reimbursed by the medical assistance administration.
- The Drug and Alcohol Substance Abuse program, which includes a program for pregnant and parenting women, automatically includes ECPs with other family planning methods.[6]

"All participants — from policy-makers to local communities — must view family planning as a norm and promote EC within the context of family planning," say state officials in a report on the subject. "EC is an addition to the mix of family planning methods, not an end in itself."[6]

References

1. Miller T. Health Department issues statement on emergency contraception. June 25, 2004. Accessed at: www.adph.org/NEWSRELEASES/default.asp?TemplateNbr=0&DeptID=107&TemplateId=2712.
2. Velasco A. Group fights morning-after pill availability. *Birmingham Post-Herald*. June 17, 2004. Accessed at: www.al.com/news/birminghamnews/index.ssf?/base/news/1087463941228310.xml.
3. Department of Health and Human Services (DHHS), Office of Population Affairs, Memorandum: OPA program instruction series, OPA 97-2: Emergency contraception, Washington, DC; April 23, 1997.
4. Witt E. Path of logic has political pitfalls for Giles. *Birmingham Post-Herald*. June 26, 2004. Accessed at: www.postherald.com/co062604.shtml.
5. Alan Guttmacher Institute. *Monthly State Update: Major Developments in 2004*. July 1, 2004. Accessed at www.guttmacher.org/statecenter/updates/index.html#contrefusal.
6. Weldin M, Hutchings J, Kelly K, et al. *Expanding Access to Emergency Contraception Through State Systems: The Washington State Experience*. Seattle; June 2004. ■

And then there was one: Barr withdraws Preven

Rewind to September 1998. Gynétics of Somerville, NJ, introduces the Preven Emergency Contraceptive Kit, the first product for emergency contraception (EC) approved by the Food and Drug Administration (FDA). Now fast-forward six years to the present. The drug's new owner, Barr Pharmaceuticals of Pomona, NY,

EXECUTIVE SUMMARY

Barr Pharmaceuticals has announced that it will no longer manufacture the Preven Emergency Contraceptive Kit. The removal of the product from U.S. pharmacy shelves leaves one branded emergency contraceptive on the market, Plan B.

- According to the manufacturer, it recently discontinued manufacturing the active ingredient used in the product and will no longer manufacture commercial quantities of Preven.
- Providers can use Plan B or opt to use one of the 19 other contraceptive pills approved for EC use by the Food and Drug Administration.

announces that it will no longer manufacture the product.

Family planning providers who wish to use a dedicated EC product now have just one option: Plan B, which is also manufactured by Barr Pharmaceuticals. Barr acquired Plan B from Washington, DC-based Women's Capital Corp. in 2003 and Preven from Gynétics in early 2004. **(See *Contraceptive Technology Update*'s article, "Barr set to acquire Plan B: EC access to expand?" December 2003, p. 138.)** Providers also can opt to use one of the 19 other contraceptive pills approved for EC use by the FDA. **(See list, below right.)**

"As a result of our acquisition of Women's Capital Corp., Barr acquired Plan B emergency contraceptive and made the decision not to market two different emergency contraceptive products," says **Carol Cox**, Barr Pharmaceuticals spokeswoman. "As a result, we are focusing our efforts on Plan B emergency contraceptive, a product that is better tolerated and has a better safety profile."[1]

When it's out, it's gone

The pills in the Preven Emergency Contraceptive Kit contain 0.25 mg levonorgestrel and 0.05 mg ethinyl estradiol. According to Cox, Barr manufactured Preven for Gynétics for many years, but it recently discontinued manufacturing the active ingredient used in the product and no longer manufactures commercial quantities of Preven.

While there still is Preven product in the trade channels, Barr is no longer manufacturing new quantities, she confirms. The last remaining inventory of Preven product was shipped in April 2004; the company is starting to see outages of product, says Cox.

"This will increase over time since there is no additional product to ship; however we will be making every effort to notify patients and customers that Plan B is available in all pharmacies and at the wholesalers," she reports. "We will also make every effort to let patients know that Plan B is a better-tolerated product and has a better safety profile than Preven."

If results of the 2003 *CTU* Contraceptive Survey are any indication, the removal of Preven may not be a hardship when it comes to dispensing EC. About 58% of 2003 survey responses indicated Plan B use, while just 12% named Preven. Eighteen percent said they used one of the 19 other contraceptive pills approved for EC use by the FDA. About 12% provided no response.

Get the word out

The Preven web site, www.preven.com, still is active. When will it be taken off-line if the product is no longer available for sale?

"The Preven web site is still active and will remain active as the Preven product is still is available in the trade channels today and for sometime in to the future," states Cox. "Prescriptions are still being written and filled for Preven, and because the Preven package makes reference to the web site, the web site will remain available so that patients can access it."

Although the web site will remain active for a time, Cox says Barr Labs is working to update it so that in the future, if patients visiting the web site have a need for EC, they will be aware of the Plan B product and the fact that it is replacing Preven. The company also intends to link the web site to the Plan B web site, www.go2planb.com, and to Barr's web site, www.barrlabs.com, she adds.

Contraceptive Pills Approved for EC

- **Wyeth-Ayerst, Philadelphia:** Ovral, Lo/Ovral, Ovrette, Triphasil, and Alesse
- **Watson Pharmaceuticals, Corona, CA:** Ogestrel, Low-Ogestrel, Levora, and Trivora
- **Berlex Laboratories, Montville, NJ:** Levlen, Levlite, and Tri-Levlen
- **Barr Laboratories, Pomona, NY:** Aviane, Lessina, Portia, Enpresse, Cryselle, and Seasonale
- **King Pharmaceuticals, Bristol, TN:** Nordette

As of *CTU* press time, the Preven web site had not been updated, a fact that concerns **James Trussell**, PhD, professor of economics and public affairs and director of the Office of Population Research at Princeton (NJ) University, who works with the EC web site, www.not-2-late.com.

"Keeping the [Preven] web site unchanged is a disservice to providers and women," he says. The EC web site carries a notice on its site that Preven no longer is available, Trussell reports.

Reference

1. Task Force on Postovulatory Methods of Fertility Regulation. Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet* 1998; 352:428-433. ■

Plan B seeks OTC status for women ages 16-plus

The emergency contraceptive (EC) Plan B may be available over the counter (OTC) to women ages 16 and older if the Food and Drug Administration (FDA) approves Pomona, NY-based Barr Pharmaceuticals' revised request for OTC status.

Barr announced the submission of the addition to its Supplemental New Drug Application on July 22. The proposed change to seek dual marketing of the drug came after the FDA denied the company's original request for OTC status. ***(Contraceptive Technology Update* reported on the FDA's action in the article, "What is next for over-the-counter access to emergency contraception?" July 2004, p. 73.)** In a press release issued by the regulatory agency, the FDA says it based its action on the lack of data surrounding OTC use of Plan B among teens younger than age 16.

The new proposal would keep Plan B, a levonorgestrel-only EC, as a prescription drug to women ages 15 and younger and as an OTC product for women ages 16 and older.

According to a statement issued by the company, the FDA will have six months to review Barr's application and make a determination. In the meantime, the company says it is focused on advancing awareness about Plan B among women and health care providers, as well as working toward increasing the number of states where Plan B is available in pharmacies without an advance prescription. ■

New methods may rate, but are they covered?

While your family planning patients may be asking about the latest contraceptive methods, they may change their mind about using them if their insurance carriers won't cover the costs. A just-issued nationwide survey shows that newer reproductive health options such as the contraceptive patch, the contraceptive vaginal ring, and hysteroscopic sterilization are poorly covered by insurance companies when compared to more traditional methods such as the birth control pill.[1]

While many new contraceptive options are now approved in the United States, the delay in covering such methods is limiting women's access to them, says **Wayne Shields**, president and chief executive officer of the Washington, DC-based Association of Reproductive Health Professionals (ARHP). ARHP co-sponsored the survey, along with the New York City-based Planned Parenthood Federation of America and the Washington, DC-based Black Women's Health Imperative.

"Many newer contraceptive methods have the same efficacy and safety as more traditional methods, but are more convenient and cost-effective for women," says Shields. "As a result, women from all social environments, races, and economic conditions benefit from having access to a broader range of contraceptive options because they help reduce the rates of unintended pregnancies and abortions."

The survey, which included comments from 250 benefits managers representing mid- to large-sized companies throughout the United States, looked specifically at female reproductive health coverage.

EXECUTIVE SUMMARY

A new survey of insurance benefits managers shows that new reproductive health options such as the patch and the vaginal ring are poorly covered by insurance companies when compared to more traditional methods such as the pill.

- The pill was the most broadly covered method, according to the survey, with 81% of companies offering partial or full coverage. Emergency contraception was the least covered, with just 18% issuing coverage.
- Just more than half of the benefits managers surveyed said their companies covered new methods such as the patch (59%) and the vaginal ring (54%).

While contraceptives, in some form or another, were covered by 89% of companies; disparity was found in coverage of various methods. The birth control pill was the most broadly covered method, with 81% of companies offering partial or full coverage, while emergency contraception was the least covered, with just 18% issuing coverage.

Just more than half of the benefits managers said their companies covered new methods such as the contraceptive patch (59%) and the contraceptive vaginal ring (54%). Forty percent of companies cover the cost of intrauterine devices (IUD), 42% cover IUD placement, but removal is only covered by 35%, survey results show.

When it comes to permanent contraception, tubal ligation and vasectomies are covered partially or in full by 54%, yet hysteroscopic sterilization, introduced in 2002, is covered by only 36%, according to the survey results.

Who is making the decisions on reproductive health coverage? According to the survey, the majority of reproductive health coverage decisions are driven by the insurer, not benefits managers, employees, or even recommendations by professional medical societies.[1]

As popularity of new contraceptive methods grows, look to more insurers to pick up the costs for such options. According to company data, most managed care organizations and third-party prescription benefit plans are covering NuvaRing, the contraceptive vaginal ring manufactured by Organon of West Orange, NJ, says **Amanda Mason**, company spokeswoman. Organon is continuing to work at the plan and provider level, as well as with employer groups, to further increase coverage of the method, she adds.

Women are seeing better coverage of birth control methods; nearly nine in 10 group insurance plans purchased by employers for their employees now cover a full range of prescription contraceptives, which is three times as many as just a decade ago, according to results of a recent study from the New York City-based Alan Guttmacher Institute (AGI).[2] In 2002, 86% of employer-purchased plans typically covered the full range of contraceptive methods, compared with just 28% in 1993; the proportion of plans covering no method at all dropped from 28% to just 2% during the same time period.[2]

State laws have played a critical role in this improvement; almost half of all U.S. states have laws in place requiring insurers to provide contraceptive coverage to their employees if they cover other prescription drugs. Plans in states with these laws have significantly more extensive coverage than plans that are designed specifically to provide coverage in states without such mandates, study results show.[2] (Check the AGI web site, www.guttmacher.org, for an up-to-date overview of state coverage. Click on "State Center," "Prevention & Contraception," and "Insurance Coverage of Contraceptives.")

However, half of all U.S. women live in the 30 states that do not require plans to cover contraceptives, and plans designed for these states offer inferior coverage compared with plans designed for mandate states, according to the study.[2] In addition, about half of all Americans with employer-based insurance coverage obtain that coverage from employers who choose to self-insure, rather than purchase a plan from an insurance company. By law, self-insured plans are exempt from state coverage requirements, and the extent of contraceptive coverage in self-insured plans nationally is unknown, according to AGI.

References

1. Association of Reproductive Health Professionals. *Female Reproductive Health Coverage*. Accessed at: www.arhp.org/contraceptivecoveragesurvey.

2. Sonfield A, Gold RB, Frost JJ, et al. U.S. insurance coverage of contraceptives and the impact of contraceptive coverage mandates, 2002. *Perspect Sex Reprod Health* 2004; 36:72-79. ■

New microbicides enter trials in United States

Two potential candidates in the microbicide research pipeline are set to be examined in clinical trials this fall, with research to focus on the safety and acceptability in healthy women and women infected with HIV.

Two agents are scheduled to be studied at the Hope Clinic of the Emory Vaccine Center in Decatur, GA, says **Lisa Grohskopf**, MD, MPH, a medical epidemiologist with the Atlanta-based Centers for Disease Control and Prevention (CDC), which is sponsoring the research. The agents are UC-781, a nonnucleoside reverse transcriptase inhibitor, and cellulose acetate phthalate, a pharmaceutical excipient used for enteric film coating of tablets and capsules.

UC-781 works by blocking reverse transcriptase, a protein that HIV needs to make more copies of itself, she explains. Cellulose acetate phalate has a

EXECUTIVE SUMMARY

The Centers for Disease Control and Prevention has issued funding for Phase I and II testing of vaginal use of two topical microbicides: UC-781, a nonnucleoside reverse transcriptase inhibitor, and cellulose acetate phthalate, a pharmaceutical excipient used for enteric film coating of tablets and capsules.

- UC-781 works by blocking reverse transcriptase, a protein that HIV needs to make more copies of itself. Cellulose acetate phalate appears to inactivate the HIV virus.
- Female-controlled methods of HIV prevention are needed, as many females do not have the autonomy to require condom use or monogamy from their male partners.

less specific form of action; it appears to inactivate the virus, she notes.

The first study, which should begin enrolling this fall, will be a phase I study of the safety and acceptability of UC-781 gel, says **Frances Priddy**, MD, MPH, associate director at the clinic and assistant professor of medicine at Emory University. Scientists will test the gel in approximately 36 healthy, HIV-negative women and also will test the gel for safety in a smaller number of HIV-infected women, she states.

It is important that the public understands that testing a microbicide in HIV-infected women is not done because scientists believe the agent can cure HIV, Priddy points out. Any microbicide that is licensed for use may be used by a wide variety of women — some of whom are likely to be HIV-infected — so it is important to test for safety in this population as well, she explains.

"Also, we are interested in seeing if use of a microbicide will reduce the amount of HIV virus present in the genital tract of HIV-infected women, which could reduce the rate of HIV transmission to their sexual partners," adds Priddy. This first study will last about 14 days, she says.

UC-781 originally was developed by scientists at Greenwich, CT-based Crompton Corp., a producer and marketer of specialty chemicals and polymer products, to combat pathogenic fungi in crops. Early research indicated that UC-781 demonstrated potential activity against HIV.[1] Biosyn of Huntingdon Valley, PA, is pursuing development of the compound as a potential topical microbicide.

The Contraceptive Research and Development Program (CONRAD) in Norfolk, VA, recently concluded a single-center Phase I placebo-controlled randomized study of UC-781 to evaluate the safety and acceptability of daily intravaginal dosing of the product in 48 healthy, abstinent women. Data now are under analysis, according to CONRAD officials.

Researchers at the University of Pittsburgh and Magee-Women's Research Institute, both in Pittsburgh, also are examining UC-781 as a potential microbicide candidate. The National Institutes of Health awarded a five-year, $8 million grant in 2003 to the university to conduct laboratory and clinical studies of the experimental microbicide.[2] Research at Pitt is focusing on:

- evaluating the microbial activity of UC-781, alone and in combination with other active components, against a variety of strains of HIV;
- determining the toxicity and efficacy of UC-781 on HIV transmission rates;
- formulating UC-781 with other active agents to improve potency, effectiveness, and ease of use.[3]

Scientists at the New York Blood Center in New York City reported in 1999 that cellulose acetate phthalate, a pharmaceutical excipient commonly used in the production of enteric tablets and capsules, displayed antiviral activity against HIV-1 and several herpes viruses.[4] Further research indicates the agent may be effective in inactivating HIV-1.[5]

Female-controlled methods of HIV prevention are needed, as many women and teen-age females do not have the autonomy to require condom use or monogamy from their male partners, says Priddy. This lack of autonomy is especially prevalent in some developing countries, she notes. "As the number of women infected with HIV through heterosexual sex continues to rise, it makes sense to work toward a female-controlled method of HV prevention such as an effective topical microbicide."

References

1. Borkow G, Barnard J, Nguyen TM, et al. Chemical barriers to human immunodeficiency virus type 1 (HIV-1) infection: Retrovirucidal activity of UC781, a thiocarboxanilide nonnucleoside inhibitor of HIV-1 reverse transcriptase. *J Virol* 1997; 71:3,023-3,030.

2. Spice B. Pitt gets $8 million grant to study AIDS-blocking gel. *Pittsburgh Post-Gazette*. Jan. 10, 2003. Accessed at: www.post-gazette.com/healthscience/20030110hivhealtj2p2.asp.

3. Baum M. Grant funds research to develop microbicide barrier to HIV. Jan. 9, 2003. Press release. Accessed at: news bureau.upmc.com/Magee/Uc781Grant.htm.

4. Neurath AR, Strick N, Li YY, et al. Design of a 'microbicide' for prevention of sexually transmitted diseases using

'inactive' pharmaceutical excipients. *Biologicals* 1999; 27:11-21.

5. Neurath AR, Strick N, Li YY, Debnath AK. Cellulose acetate phthalate, a common pharmaceutical excipient, inactivates HIV-1 and blocks the coreceptor-binding site on the virus envelope glycoprotein gp120. *BMC Infect Dis* 2001; 1:17. Epub Sep 25, 2001. ■

Give teens more info to bridge information gap

Your next patient is a 17-year-old female who is interested in contraception. While she says she knows about the contraceptive patch and the vaginal ring, when you ask her about their effectiveness in preventing sexually transmitted diseases (STDs), she gives you a puzzled look.

Results from a recent Menlo Park, CA-based Kaiser Family Foundation/*Seventeen* magazine survey show that while teens ages 15-17 have a fairly high degree of awareness about various contraceptive methods, there are significant gaps in their actual knowledge.[1] About one in five of teens surveyed who had heard of new hormonal methods such as the patch and the ring thought these new methods were either "not too" or "not at all" effective at pregnancy prevention, even though both the patch and the ring have levels of effectiveness comparable to combined oral contraceptives. **(Review the *Contraceptive Technology Reports* supplements on these methods; check the February 2002 issue for the contraceptive vaginal ring and the May 2003 issue for the contraceptive patch.)**

When it comes to knowledge of STD protection, adolescents surveyed were even less informed: While more than 75% said they had heard of birth control pills, more than one in four didn't know that oral contraceptives offer no protection against sexually transmitted diseases.[1]

Why is it so important that teens get the message when it comes to protection? Recent research estimates that by the time they reach 25, one in two sexually active young people will have contracted an STD.[2,3] ***(CTU* reported on this research in the article, "Youth are at risk for sexually transmitted diseases: What can providers do to stem the tide?" in the *STD Quarterly* supplement inserted in the May 2004 issue.)**

EXECUTIVE SUMMARY

Results from a recent survey show that while ages 15-17 have a fairly high degree of awareness about various contraceptive methods, there are significant gaps in their actual knowledge.

- About one in five of teens surveyed who had heard of new hormonal methods such as the patch and the ring thought new methods were either "not too" or "not at all" effective at pregnancy prevention.
- When it comes to knowledge of protection against sexually transmitted diseases (STDs), adolescents surveyed were even less informed. While more than 75% said they had heard of birth control pills, more than one in four didn't know that oral contraceptives offer no protection against STDs.

How can you help teens bridge the information gap? Start by looking at how they think, suggests **Eduardo Lara-Torre**, MD, a pediatric and adolescent gynecologist in private practice in Milford, DE. Lara-Torre presented information on new contraceptive methods for adolescents at the recent annual clinical meeting of the Hockessin, DE-based North American Society for Pediatric and Adolescent Gynecology (NASPAG) in San Diego.

It is hard for adolescents to grasp the concept that the one single thing they use — contraception — only protects against one certain thing and doesn't cover the rest, he explains. Teens believe that by protecting themselves against pregnancy, everything else is going to be fine, he notes.

When seeing an adolescent patient, Lara-Torre explains that while current contraceptive methods are good at preventing pregnancy, there still is a chance for method failure, especially if they are not used consistently and correctly. He then asks, "if there is a way that you could do something to guarantee that it is even less likely you will get pregnant, would you do it?" Most teens say, "Yes," which Lara-Torre follows up with an explanation of condom use. During this point in the dialogue, he mentions the condom's role in STD protection

COMING IN FUTURE MONTHS

- What's the impact of new sexuality education?
- Azithromycin and syphilis: Is treatment effective?
- DMPA and impact on bone: Look at new research
- How to reach teens: One clinic's story
- Review research on potential HIV vaccines

and specifically talks about HIV/AIDS prevention.

"Teens don't think of gonorrhea or chlamydia as such bad diseases, but when you mention AIDS, it clicks in their mind that maybe the condom isn't such a bad idea," he states.

Let adolescents tell you what they know about contraceptive methods, says **Melanie Gold**, DO, associate professor of pediatrics at the University of Pittsburgh School of Medicine. When misconceptions come up, Gold says she asks the teen for permission to offer information that is different from has been heard and follows up with the statement, "it might help you make better decisions for yourself."

If the teen is interested in receiving information, she provides medically accurate information, then asks what the teen makes of the new information and if it changes anything for her/him. If the teen does not want the information, Gold notes, "it sounds like you are not ready to hear about the information now, but when you change your mind, I am always open to giving you medically accurate information." This approach helps the teen to know that she is not there to lecture on contraception.

When it comes to STDs, Gold will ask if the teen has had a previous infection and what she/he perceives as her/his chances of getting an STD in the future. "When there is a past history of an STD, I ask whether getting diagnosed with an STD was a surprise or if she suspected she had one," explains Gold, who presented on motivating reproductive behavior at the NASPAG meeting. "Most often, there were no symptoms, and we talk about the fact that it is really hard to tell when one has an STD."

When a teen expresses confidence that risk to STD exposure from a monogamous partner is little or none, Gold discusses condoms in the context of added pregnancy protection rather than trying to convince the teen that risks do exist.

"What is important is the condom use and finding the teen's individual motivation for using condoms, not trying to make her own up to the fact she might be at risk for an STD when she is not ready to acknowledge that," she notes.

When it comes to emergency contraception (EC), results from the Kaiser Family survey show about six in 10 teen-agers have heard of the method.[1] However, among those who had heard of EC, about 25% said it causes an abortion. Check Gold's approach in providing factual information on EC:

- Ask a teen to describe the way EC works.
- If the teen says EC causes an abortion or miscarriage, ask the teen to explain how a girl gets pregnant.
- If there is misinformation, ask permission to review the process of getting pregnant in terms of ovulation, fertilization, tubal transport, and implantation, using a anatomical diagram that shows these steps.
- Explain that EC works mostly by preventing ovulation (point to the ovary on the diagram), but note there is a possibility it might work some of the time by preventing the fertilized egg from sticking to the lining of the uterus.
- Reinforce the fact that once the egg is stuck to the uterus lining and starts growing there (which is called a pregnancy), that EC no will longer work and will not "unstick" the pregnancy from the lining. Explain that the "unsticking the pregnancy from the lining" is called an abortion or a miscarriage.

"I ask whether the way EC works is consistent with her beliefs about what is acceptable to use to prevent pregnancy and what is not," Gold concludes.

References

1. Kaiser Family Foundation and *Seventeen* magazine. *National Survey of Teens: Birth Control and Protection*. Menlo Park, CA; July 2004.
2. Weinstock H, Berman S, Cates Jr. W. Sexually transmitted diseases among American youth: Incidence and prevalence estimates, 2000. *Perspect Sex Reprod Health* 2004; 36:6-10.
3. Cates JR, Herndon NL, Schulz SL, et al. *Our Voices, Our Lives, Our Futures: Youth and Sexually Transmitted Diseases.* Chapel Hill, NC: School of Journalism and Mass Communication, University of North Carolina at Chapel Hill; 2004. ■

CE/CME Instructions

Physicians and nurses participate in this continuing medical education/continuing education program by reading the articles, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers and refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE/CME Questions

After reading *Contraceptive Technology Update*, the participant will be able to:

- **Identify** clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services. **(See "New microbicides enter trials in the United States.")**
- **Describe** how those issues affect service delivery and note the benefits or problems created in patient care in the participant's practice area. **(See "And then there was one: Barr withdraws Preven.")**
- **Cite** practical solutions to problems and integrate information into daily practices, according to advice from nationally recognized family planning experts. **(See "New labeling for the Pill: Will it change how you prescribe oral contraceptives?" and "Give teens more facts to bridge information gap.")**

9. What two forms of cancer do combined oral contraceptives aid in preventing?
A. Endometrial and ovarian cancer
B. Endometrial and breast cancer
C. Cervical and ovarian cancer
D. Cervical and breast cancer

10. What are the two active ingredients in the Preven Emergency Contraceptive Kit?
A. Norgestimate and ethinyl estradiol
B. Levonorgestrel and ethinyl estradiol
C. Gestodene and ethinyl estradiol
D. Norethindrone and ethinyl estradiol

11. What is UC-781?
A. A spermicide
B. An HIV fusion inhibitor
C. A pharmaceutical excipient
D. A nonnucleoside reverse transcriptase inhibitor

12. According to recent research, how many sexually active young people will have contracted a sexually transmitted disease by the time they reach age 25?
A. One in two
B. One in three
C. One in four
D. One in five

Answers: 9. A; 10. B; 11. D; 12. A.

Contraceptive Technology Update *is endorsed by the National Association of Nurse Practitioners in Women's Health and the Association of Reproductive Health Professionals as a vital information source for health care professionals.*