Pharmacy Name: _____

Pharmacy Permit Number: _____

SELF-CARE CONDITIONS PROTOCOL: EMERGENCY CONTRACEPTION
V2

Approved 07/15/2026

PURPOSE
This protocol specifies the criteria and procedures for pharmacist(s) to initiate the dispensing of self-care emergency contraception.

PHARMACIST EDUCATION AND TRAINING
Prior to initiating the dispensing of emergency contraception therapy under this protocol, pharmacist(s) must have received education and training on emergency contraception from a provider accredited by the Accreditation Council for Pharmacy Education, or by a comparable provider approved by the Kentucky Board of Pharmacy.

CRITERIA
Pharmacist(s) authorized to initiate the dispensing of emergency contraception therapy will follow the most current practice guidelines for dispensing of emergency contraception set forth by the American College of Obstetricians and Gynecologists.[1]

Inclusion criteria:

- Any individual, 18 years or older, who presents up to 5 days after unprotected or inadequately protected sexual intercourse and who does not desire pregnancy.

Exclusion criteria:

- Individuals who are currently pregnant
- Adolescents under 18 years of age
- Individuals presenting more than 5 days following unprotected or inadequately protected intercourse

[1] Emergency contraception. Practice Bulletin No. 152. American College of Obstetricians and Gynecologists. Obstet Gynecol. 2015;126:e1–11 (2024).

MEDICATIONS
This protocol authorizes pharmacist(s) to initiate the dispensing of one of the following medication regimens to an individual meeting the criteria:

- **Ulipristal acetate 30mg as soon as possible following unprotected or inadequately protected sexual intercourse**

- **Levonorgestrel 0.75mg as soon as possible following unprotected or inadequately protected sexual intercourse; a second dose should be taken 12 hours after the first dose**

- **Levonorgestrel 1.5mg as soon as possible following unprotected or inadequately protected sexual intercourse**

PROCEDURES FOR INITIATION OF THERAPY
Emergency contraception initiation will follow current guidelines[1] and will be individualized based on relevant medical, sexual, and social history, patient preferences, and consideration of contraindications and precautions of therapy as outlined below. Refer patient as needed if the patient wishes to seek more effective alternatives

Relevant Medical and Social History

- Past medical history
- Sexual history
- Current medications
- Allergies and hypersensitivities

Contraindications

- Known hypersensitivity to levonorgestrel, ulipristal acetate, or any component of the formulation

Precautions

- Conditions/circumstances that may reduce the effectiveness of oral emergency contraception, including:
    - BMI greater than 25kg/m^2
    - Presenting more than 72 hours following unprotected or inadequately protected sexual intercourse (levonorgestrel)
    - Presenting more than 120 hours following unprotected or inadequately protected sexual intercourse (ulipristal acetate)
    - Concurrent medications that may decrease effectiveness
    - Restarting other hormonal contraception within five days of ulipristal acetate use

EDUCATION REQUIREMENTS

Individuals receiving emergency contraception therapy under the protocol will receive education regarding:

- Education regarding safe sexual practices, including how to access appropriate methods of long-term contraception. Refer as needed for provision of ongoing contraception, sexually transmitted infection testing, and well-woman care.
- Education specific to the individual medication dispensed.
- Education regarding the necessity of a visit to a primary care provider or urgent/emergency treatment facility if any of the following occur:
    - Lower abdominal pain
    - Persistent irregular bleeding
    - Menses delayed one week or more past the expected time

DOCUMENTATION

Pharmacist(s) shall document via prescription record each person who receives emergency contraception therapy under this protocol, including:

1. Documentation as required in 201 KAR 2:171 for the dispensing of prescription medication; and
2. Documentation that the individual receiving the emergency contraception (or caregiver) was provided with the required education pursuant to this protocol
3. Documentation of the history and assessment, the plan of care implemented, and follow-up monitoring and evaluation as needed.

NOTIFICATION

Pharmacist(s) shall ask all persons receiving emergency contraception therapy under this protocol for the name and contact information of the individual's primary care provider and shall provide notification of the medications dispensed under the protocol to the identified primary care provider within two (2) business days. Any individual affirmatively stating that the individual does not have a primary care provider may still be provided emergency contraception therapy under this protocol provided all other applicable requirements of the protocol are met.

[If directed by the authorizing prescriber, the pharmacist(s) shall provide written notification via fax or other secure electronic means to the authorizing prescriber of persons receiving medications under this protocol within 7 days of initiating dispensing]

TERMS
This protocol is authorized pursuant to 201 KAR 2:380 and is effective when it is submitted to the registry. Any termination shall require prior notice to all parties no later than 30 days after discontinuing the protocol.

SIGNATURES

_____ _____
Prescriber Name Date

_____
Prescriber Kentucky License Number

_____
Prescriber Signature

_____ _____
Pharmacist Name Date

_____
Pharmacist Kentucky License Number

_____
Pharmacist Signature

Course Taken for Training: _____

Provider of Training: _____

Date Training Completed: _____

Any pharmacist not party to the protocol will be subject to discipline should they utilize the protocol. A pharmacist utilizing the protocol must be employed by or contracted with the permit listed in the executed protocol.

For additional pharmacists party to this protocol, the pharmacy should keep a list of the additional pharmacists and their training at the pharmacy.

ADDITIONAL SIGNATURE PAGE

By signing below, I attest that I read and understand the Board-authorized protocol, entitled : _____
and that I will follow all guidelines and requirements included in the Board-authorized protocol.

_____ _____
Pharmacist Name Date

_____
Pharmacist Kentucky License Number

_____
Pharmacist Signature

Course Taken for Training: _____

Provider of Training: _____

Date Training Completed: _____