

Hormonal Contraceptive Self-Screening Questionnaire

Name _____ Health Care Provider's Name _____ Date _____
 Date of Birth _____ Age* _____ Weight _____ Do you have health insurance? Yes / No
 What was the date of your last women's health clinical visit? _____
 Any Allergies to Medications? Yes / No If yes, list them here: _____

Background Information:

1	Do you think you might be pregnant now?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	What was the first day of your last menstrual period?	_ / _ / _
3	Have you ever taken birth control pills, or used a birth control patch, ring, or injection? Have you previously had contraceptives prescribed to you by a pharmacist?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
	Did you ever experience a bad reaction to using hormonal birth control? - If yes, what kind of reaction occurred?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
	Are you currently using any method of birth control including pills, or a birth control patch, ring or shot/injection? - If yes, which one do you use?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
4	Have you ever been told by a medical professional not to take hormones?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Do you smoke cigarettes?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Medical History:

6	Have you given birth within the past 6 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7	Are you currently breastfeeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8	Do you have diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9	Do you get migraine headaches? If so, have you ever had the kind of headaches that start with warning signs or symptoms, such as flashes of light, blind spots, or tingling in your hand or face that comes and goes completely away before the headache starts?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10	Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)	Yes <input type="checkbox"/> No <input type="checkbox"/>
11	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
12	Have you ever had a blood clot?	Yes <input type="checkbox"/> No <input type="checkbox"/>
13	Have you ever been told by a medical professional that you are at risk of developing a blood clot?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15	Have you had bariatric surgery or stomach reduction surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
16	Do you have or have you ever had breast cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
17	Do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, or do you have jaundice (yellow skin or eyes)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
18	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>
19	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? - If yes, list them here:	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
20	Do you have any other medical problems or take any medications, including herbs or supplements? - If yes, list them here:	Yes <input type="checkbox"/> No <input type="checkbox"/> _____

Do you have a preferred method of birth control that you would like to use?

A pill you take each day A patch that you change weekly Other (ring, injectable, implant, or IUD)

Internal use only	<input type="checkbox"/> verified DOB* with valid photo ID	<input type="checkbox"/> BP Reading _____ / _____
Pharmacist Name _____	Pharmacist Signature _____	
<input type="checkbox"/> Drug Prescribed _____	Rx# _____	-or- <input type="checkbox"/> Patient Referred-circle reason(s)
Sig: _____	(Pharmacy Phone _____)	Address _____
Notes: _____		

NEW HAMPSHIRE MODEL STATE-WIDE PROTOCOL FOR DISPENSING HORMONAL CONTRACEPTIVES WITHOUT A PRIOR PRESCRIPTION

This pharmacy statewide drug therapy protocol authorizes qualified New Hampshire-licensed pharmacists ("Pharmacists") to perform the pertinent physical assessments and initiate hormonal contraceptives under the conditions of this protocol and according to and in compliance with all applicable state and federal laws and rules.

Definitions

- (1) "Clinical visit" means a consultation with a healthcare practitioner, other than a pharmacist, for women's health, which should address contraception and age-appropriate screening.
- (2) "Hormonal contraceptives" means pills, shots, patches and rings which the U.S. FDA classifies as available by prescription for the purpose of contraception or emergency contraception. It does not include similar items classified as "over the counter" by the FDA.
- (3) "Outpatient contraceptive services" means hormonal contraceptive initiation of therapy and dispensing services provided by the licensed pharmacist as specified in RSA 318:47-1.

Training Program

Licensed New Hampshire pharmacists with their license in good standing may dispense hormonal contraceptives without a prior prescription via a standing order provided that they complete a Board-approved Accreditation Council for Pharmacy Education (ACPE) training program. In addition, pharmacists shall comply with the most current United States Medical Eligibility Criteria (USMEC) and selective practice recommendations for Contraceptive Use as adopted by the U.S. Centers for Disease Control and Prevention (CDC).

Continuing Education

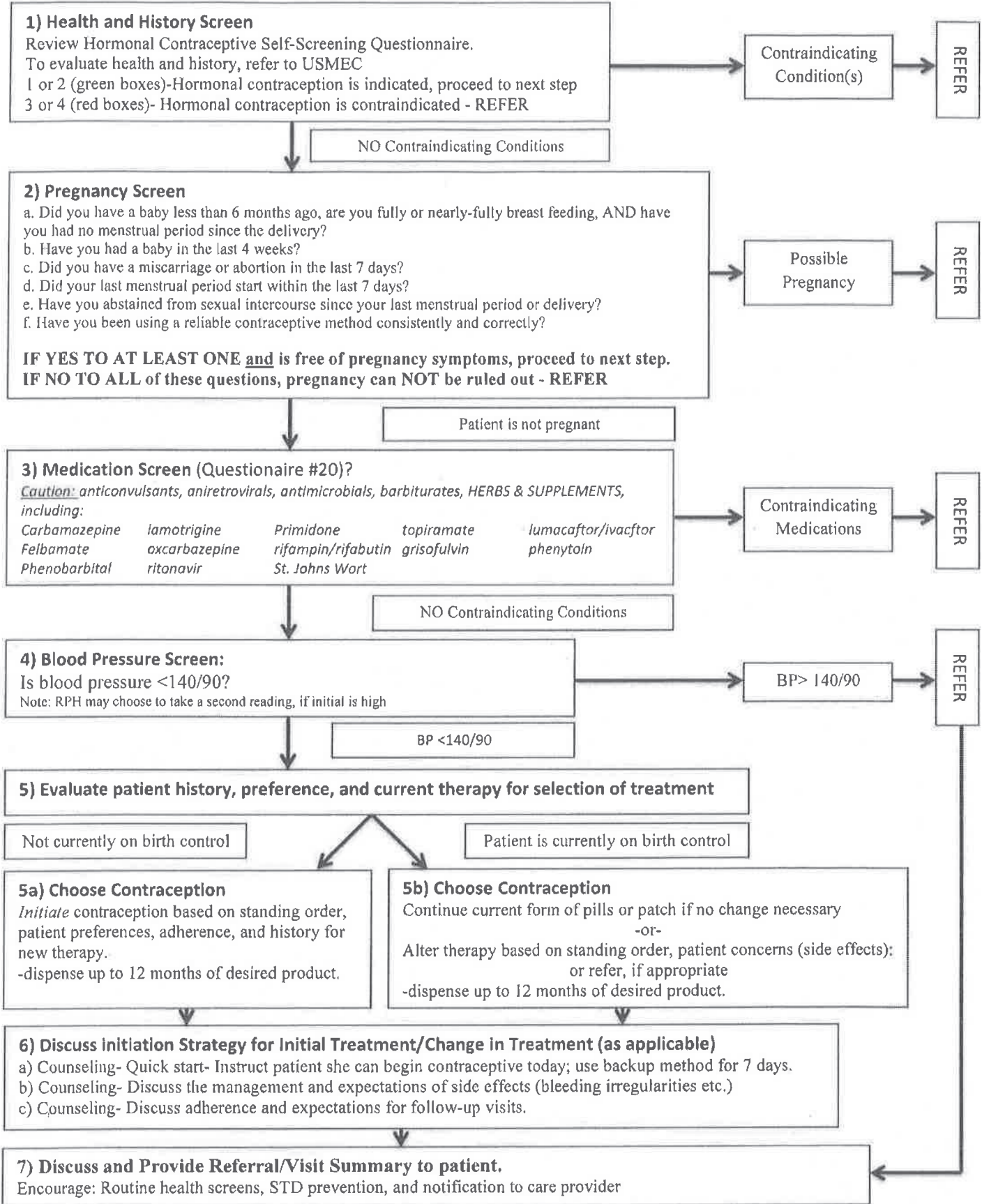
All ACPE Board-approved training course certifications expire in two years from the date of certification. Pharmacists shall attend a refresher training course (ACPE-accredited Board-approved) biennially and maintain records of completion that is readily retrievable and provided to the Board upon request.

Further Requirements

- (1) Each participating pharmacist shall follow all aspects in Pharmacy Board Rules Ph 2403 regarding the initiating and dispensing of hormonal contraceptive treatment.
- (2) For each new patient requesting contraceptive services and returning patients every 12 months, participating pharmacists must complete the following steps:

- (a) Obtain a completed New Hampshire Self-Screening Risk Assessment Questionnaire;
 - (b) Utilize and follow the New Hampshire Standard Procedures Algorithm to perform patient assessment;
 - (c) Provide, if clinically appropriate, the hormonal contraceptive as soon as practicable after issuing the prescription, or refer to a healthcare practitioner;
 - (d) Label the prescription bottle in accordance to Ph 601.15;
 - (e) Based upon a patients request, transmit electronically, by fax, or in writing within 24 hours to the patient's primary care practitioner a copy of the NH Self-Screening Questionnaire, the hormonal contraceptive that was given, and any other relevant notes. Patients without a primary care practitioner shall be provided contact information for one, and may choose not to see that practitioner. If the patient refuses to see a primary care practitioner, the pharmacist is obligated to provide a written copy of the NH Self-Screening Questionnaire to the patient;
 - (f) Provide the patient with a Visit summary;
 - (g) Provide the patient with the standardized Board-approved information sheet regarding the hormonal contraceptive;
 - (h) Provide counseling to the patient;
- (3) If the hormonal contraceptive is dispensed, it must be done as soon as practicable after the pharmacist issues the prescription and shall include any relevant educational materials.
- (4) A pharmacist shall not:
- a. Require a patient to schedule an appointment with the pharmacist for the council or dispensing of a hormonal contraceptive, and
 - b. Initiate hormonal contraceptive therapy in instances where the New Hampshire Standard Procedures Algorithm requires referral to a provider.
- (5) Recordkeeping:
- a. Pharmacists shall comply with all aspects of procedures established in Pharmacy Board Rules Ph 2403.05 with respect to maintenance of proper records.
 - b. A process shall be in place for the pharmacist to communicate with the patient's primary care provider and document changes to the patient's medical record. If the patient does not have a primary care provider, or is unable to provide contact information for his or her primary care provider, the pharmacist shall provide the patient with a written record of the drugs or devices furnished and advise the patient to consult an appropriate health care professional of the patient's choice.

STANDARD PROCEDURES ALGORITHM FOR NEW HAMPSHIRE RPH PRESCRIBING OF CONTRACEPTIVES





**State of New Hampshire
Board of Pharmacy**
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Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.oplc.nh.gov

**APPLICATION FEE:
\$25.00**
NO CASH – CHECK OR MONEY
ORDER PAYABLE TO:
Treasurer, State of New Hampshire

**Pharmacist Initiation and Dispensing of Hormonal Contraceptives
Initial Application
(Per NH RSA 318:47-L & Ph 2400)**

ALL SECTIONS MUST BE COMPLETED.

PRINT CLEARLY IN BLACK OR BLUE INK ONLY. ILLEGIBLE, OUT-DATED, COPIED, OR INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.

1. GENERAL INFORMATION				
Applicant's Name		First	Middle	Last
Mailing Address				
City	State	Zip Code	Home or Cell Phone ()	
NH Pharmacist License Number		E-Mail Address (must be entered to receive your updated license with contraceptive dispensing endorsement)		

2. PHARMACY WHERE PROPOSED HORMONAL CONTRACEPTION DISPENSING WILL TAKE PLACE
Name of Pharmacy
Complete Address of Pharmacy

3. REQUIRED ATTACHMENTS & APPLICANT'S STATEMENT
<p>The following attachments must be included with this application for it to be accepted and processed:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Check for \$25.00 payable to "Treasurer – State of NH"; <input type="checkbox"/> Copy of the Standing Order signed and approved by a NH healthcare practitioner authorized to prescribe; <input type="checkbox"/> Copy of your proof of Liability Insurance Coverage (which covers the services performed under the standing order for hormonal contraceptives); <input type="checkbox"/> Copy of your proof of ACPE Training on Hormonal Contraceptives (continuing education certificates); <input type="checkbox"/> Photos of confidential room required per Ph 2403; <input type="checkbox"/> Copy of pharmacy's written policies for hormonal contraception prescribing/dispensing. <p><i>I certify that I am the person described and identified in this application; that I have read Ph 2400 of the NH Code of Administrative Rules, and that I have met the requirements for pharmacist prescribing/dispensing of hormonal contraceptives per NH RSA 318:47-L; and that I have answered all questions truthfully and completely. Should I furnish any false or misleading information on this application, I hereby understand that such an act shall constitute cause for the denial or revocation of my registration as a pharmacist able to prescribe/dispense hormonal contraceptives in the State of New Hampshire.</i></p> <p>Signature: _____ Date: _____</p> <p align="center"><i>Your updated pharmacist license showing this vaccine endorsement will be issued within 2 weeks of receipt of your completed application. Your updated license with endorsement must be posted or kept on file at your pharmacy of employment & presented to state pharmacy inspectors upon request.</i></p>