Example Policy: Postpartum Nexplanon Insertion, Part B

11 May 2017

Department Standard Operating Procedure

SUBJECT: Nexplanon Insertion

1. Scope. The guidelines for this policy apply to all Labor and Delivery and Mother/Baby personnel.
2. Responsibility: All Labor and Delivery and Mother/Baby personnel
3. General.
4. **NEXPLANON INSERTION**
    a. Patients considering Nexplanon etongestrel implant for postpartum contraception should receive appropriate patient education and counseling by a provider. Patients desiring Nexplanon will be identified and counseled at the time of admission to L&D. The patient's desire for postpartum Nexlpanon insertion will be documented in the electronic medical record. A Nexplanon certified provider will insert the subdermal contraceptive in the postpartum period, prior to hospital discharge. Please refer to "Logistics for Insertion of Nexplanon" #6 for further instructions regarding placement.
    b. Prior to Nexplanon insertion, the provider will order the Nexplanon and corresponding supplies via use of an EPIC order set.
    c. Nexplanon will be inserted according to ACOG/manufacturer's guidelines.
5. **NEXPLANON REMOVAL**
    a. The Nexplanon can be removed at any time in the patient's menstrual cycle.

SUPERVISION FOR NEXPLANON COUNSELING AND INSERTIONS

1. Insertion of Nexplanon etonogestrel implant contraception should be performed by a physician, certified nurse midwife, or nurse practitioner privileged for Nexplanon insertion or by an OB/GYN resident with an appropriate degree of supervision as based on his/her experience and demonstrated competence.

COUNSELING FOR NEXPLANON

1. Both the privileged clinician and any trainee involved should read and be familiar with readily available information on hormonal implants and long-acting reversible contraception (LARC) including (but not limited to) the following:
    a. ACOG Practice Bulletin # 121: Long-Acting Reversible Contraception: Implants and Intrauterine Devices
    b. ACOG Committee Opinion #670: Immediate Postpartum Long-Acting Reversible Contraception

c. ACOG Committee Opinion #672: Clinical Challenges of Long-Acting Reversible Contraceptive Methods
d. ACOG Committee Opinion #539: Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices
e. Prescribing Information for the Nexplanon etonogestrel implant
f. Patient Information package inserts supplied with the Nexplanon implant

2. A privileged clinician or appropriately supervised trainee must counsel the patient regarding all various contraceptive options (LARC in particular) and answer all of the patient's questions about contraception.
3. The clinician and the patient should review together and sign a 'Patient Consent'.
4. It is also highly recommended to provide the patient with a copy of the patient information package insert for future reference.

CONTRAINDICATIONS, WARNINGS, AND PRECAUTIONS

1. New research reinforces the efficacy and safety of contraceptive hormonal implants. Any questions about appropriate candidates should be referred to an experienced and up to date OB/GYN physician.
2. The following remain contraindications:
    a. Know or suspected pregnancy, possibility of pregnancy, or planned pregnancy in the next year
    b. Abnormal uterine bleeding of unknown etiology
    c. Current or history of thrombosis or thromboembolic disorders
    d. Acute or active liver disease or liver tumor (benign or malignant)
    e. Known or suspected breast cancer or other progestin-sensitive cancer, present or past
    f. Hypersensitivity to any component of the Nexplanon etonogestrel implant
3. These are NOT contraindications:
    a. Nulliparity
    b. Adolescents (WHO considers Nexplanon acceptable anytime after menarche – Medical Eligibility Criteria 1).
    c. Prior ectopic pregnancy
    d. Breastfeeding
    e. Abnormal Papanicolaou smear
    f. PID or STI

LOGISTICS FOR NEXPLANON INSERTION

1. Nexplanon insertions are to be performed on 3N and/or 3S during the postpartum period, anytime prior to hospital discharge.
2. It is not necessary to do GC/CT cultures, wait for Pap smear results, or give prophylactic antibiotics prior to Nexplanon insertion.
3. Counseling is important for patient satisfaction and continuation. It is expected that patients who express desire for Nexplanon contraception during their established prenatal care are thoroughly counseled at their prenatal visits and again prior to insertion.
4. In the event that the patient has not established prenatal care or has not had prior counseling, it is appropriate to insert the Nexplanon during her postpartum course if counseling is completed during admission, her decision is firm, and there are no known contraindications to insertion.
5. Nexplanon may be inserted during any part of menstrual cycle if pregnancy ruled out. In the immediate postpartum period, pregnancy is not a concern.
6. Clinicians are encouraged to review the brief insertion instructions provided in the package insert before each insertion.

7. As hormonal contraceptive will be placed immediately postpartum, a back up form of contraception is not necessary. However, all patients should be counseled to continue the use of condoms for STI prevention.

POST NEXPLANON INSERTION FOLLOW-UP

1. The patient should have a postpartum visit in 4-6 weeks, which may also serve as a follow up to document the presence of the Nexplanon device. This visit can also increase compliance by answering the patient's questions and concerns about possible side effects she may have experienced.
2. She should have pelvic examinations annually thereafter.
3. The Nexplanon is approved for up to for three years of use. Removal and replacement can occur at the same visit.
4. Patient is instructed to call the OB/GYN clinic immediately for pain, rash, or redness at the insertion site, fever/chills, malodorous or purulent discharge.
5. These problems should always prompt immediate evaluation by a gynecologist:
    a. Infections or vaginitis
    b. Heavy bleeding
    c. Severe headaches
    d. Requests for removal
    e. Pregnancy
    f. Cannot palpate the device
    g. Expulsion or migration of the device