A Toolkit for User Administration of Subcutaneous Depot Medroxyprogesterone Acetate
Acknowledgements

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Overview

This toolkit is a collection of evidence-based resources related to user-administered subcutaneous depot medroxyprogesterone acetate (DMPA-SC), an FDA-approved, progestin-only injectable contraceptive method. This toolkit is intended for Title X staff but includes resources that can be shared with DMPA-SC users as well. The goal of the DMPA-SC toolkit is to assist clinics in adopting best practices and provide clinical recommendations for DMPA-SC. The toolkit does not have to be used sequentially and any topic can be accessed according to your needs and interests.

Each section provides more detail on DMPA-SC, followed by resources relevant to that section. Resources are hyperlinked to external websites and PDF files. Except where noted, the tools in this collection have not been created by the National Clinical Training Center for Family Planning (NCTCFP) but have been vetted by NCTCFP subject matter experts for relevance and appropriateness.

Terminology Used in This Toolkit

In this toolkit, we refer to subcutaneous depot medroxyprogesterone acetate as DMPA-SC, but it is also sometimes called DMPA-SQ.

Similarly, we use the term "user-administered" rather than "self-administered" to acknowledge that some patients may have a friend or family member administer the injection. However, we have kept the linked resource names and descriptions as the authors wrote them.

Lastly, we use the term "individuals" rather than "women" in order to be inclusive of all people eligible to use DMPA-SC, regardless of gender identity. However, when describing specific resources and studies, we have used the terms employed by the authors.
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What Is DMPA-SC?

DMPA-SC is an FDA-approved, progestin-only injectable contraceptive method (also known by its brand name, depo-subQ provera 104®, depo-provera, or "depo" or "the shot" for short). It contains 104 mg of medroxyprogesterone acetate in a depot formulation. It is similar to intramuscular DMPA (DMPA-IM) but delivered subcutaneously (under the skin) in the anterior thigh or abdomen every 12 to 14 weeks, using a smaller needle, less liquid, and lower overall dose of medroxyprogesterone acetate.\(^1\)

DMPA was first used in the U.S. in 1959 for menstruation management and was approved by the FDA for use as a contraceptive in 1992.\(^2\) The CDC reports that during 2017–2019, 2% of U.S. women aged 15–49 years used DMPA (IM or SC) for contraception; younger women (aged 15–24 years), non-Hispanic Black women, and women with lower income were the most likely to use it.\(^3\)

User-administration of DMPA-SC has been used internationally for decades. It has become an important option in international family planning programs, particularly in Sub-Saharan Africa, where it is used under the brand name Sayana® Press using the needleless Unject system.\(^4, 5\)

In the U.S., DMPA-SC was approved in 2004 by the Food and Drug Administration (FDA) for administration only by a healthcare professional.\(^6\) It is supplied as a prefilled syringe and is manufactured by Pfizer as depo-subQ provera 104; there are no generic products available at this time.

Given the evidence that DMPA-SC is safe and effective for both provider- and user-administration, the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) recommend that user-administered injectable contraception should be made available as an additional approach to deliver injectable contraception to persons of reproductive age.\(^7, 8, 9, 10, 11\) User-administered DMPA-SC has higher continuation rates and comparable rates of pregnancy and side effects/adverse events versus provider-administered DMPA (SC and IM).\(^12\) Because it is "user-controlled," user-administered DMPA-SC offers the potential to improve contraceptive access, increase reproductive autonomy, and has been shown to increase continuation rates.\(^13, 14\)
Relevant Resources

**Depo-SubQ Provera 104 for Patients and Providers**
*Pfizer*

Find clinical and pharmacological information on DMPA-SC for pharmacists, providers, and patients, including what it is and how it works, effectiveness, prescribing information, contraindications, and ingredients.

Link type Website

**Self-Administration of Injectable Contraception (PDF)**
*National Family Planning and Reproductive Health Association (NFPRHA)*

In response to the barriers that COVID-19 presented for in-office DMPA injections, this document highlights the differences between DMPA-SC and DMPA-IM, FDA approval, and clinical considerations.

Link type PDF

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**How Does DMPA Work?**

As with other progestin-only contraceptive methods, DMPA works by preventing follicles from maturing and stopping ovulation, thickening and decreasing the amount of cervical mucus, and thinning the lining of the uterus.\(^1\) It has a typical use failure rate of 4%.\(^1\)\(^6\),\(^1\)\(^7\) Other benefits beyond pregnancy prevention include reduction of endometriosis pain and a lower risk of uterine cancer (when used long-term).\(^1\)\(^8\) It does not protect against sexually transmitted infections (STIs).

Common side effects of DMPA include amenorrhea, weight gain, delay in return of fertility, and irregular bleeding. These bleeding irregularities are not harmful and often decrease with continued use. The FDA includes a boxed warning (commonly referred to as a “black box warning”) on DMPA due to bone mineral density loss, indicating it should only be used for more than 2 years if other birth control methods are “inadequate;” however, the American College of Obstetrics and Gynecology (ACOG), the CDC, and the WHO disagree with this characterization, noting that the resulting bone loss is not associated with fractures and is reversible with discontinuation, thus suggesting that DMPA generally can be used by adolescents and adults.\(^1\)\(^9\),\(^2\)\(^0\)}
Relevant Resources

DMPA and Bone Effects
American College of Obstetrics and Gynecology
This is a direct link to ACOG’s statement regarding the use of DMPA and bone loss.

Progestin-Only Hormonal Birth Control: Pill and Injection
American College of Obstetrics and Gynecology
Answers to frequently asked questions regarding progestin-only pills and injections, including information on what it is, how it works, benefits, and risks are included.

DMPA Contraceptive Injection: Use and Coverage
Kaiser Family Foundation
This factsheet provides an overview of the types of contraceptive injection, use, awareness, availability, and insurance coverage of the injection in the U.S.
Who Can Use DMPA-SC?

DMPA-SC may be offered as an option to individuals seeking birth control. DMPA may be of particular interest for those who do not wish to use a daily method, need to avoid estrogen, or have other conditions that might benefit from treatment from hormonal therapy including, but not limited to sickle cell disease, pelvic inflammatory disease (PID), uterine fibroids, endometriosis, and seizure disorders.

Contraindications for DMPA-SC are the same as DMPA-IM. The only U.S. Medical Eligibility Criteria (MEC) category 4 condition (a condition which represents an unacceptable health risk if the contraceptive method is used) associated with its use is if the patient has had breast cancer within the last 5 years.

Other U.S. MEC category 3 conditions for which the theoretical or proven risks usually outweigh the advantages of using the method include:

- Multiple risk factors for atherosclerotic cardiovascular disease (e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)
- Systolic ≥160 mm Hg or diastolic ≥100 mm Hg
- Hypertension with vascular disease
- Current and history of ischemic heart disease
- Breast cancer in the past — no evidence of recurrent disease for 5 years
- Diabetes with nephropathy, retinopathy, or neuropathy, or other vascular disease
- Diabetes of more than 20 years’ duration
- Cirrhosis — severe, decompensated
- History of benign or malignant liver tumor
- History of stroke
- Unexplained vaginal bleeding (suspicious for serious condition before evaluation)
- Systemic lupus erythematosus:
  - Positive (or unknown) antiphospholipid antibodies (initiation and continuation of the method)
  - Severe thrombocytopenia (initiation of the method only — continuation of DMPA is Category 2)

Good for Those Who

Need birth control, but don’t want to use a daily method

Should avoid estrogen

Have conditions that benefit from hormonal therapy
Relevant Resources

U.S. Medical Eligibility Criteria for Contraceptive Use
Centers for Disease Control and Prevention
The U.S. MEC, developed by the CDC after review of the scientific evidence and consultation with national experts, can be referenced to determine medical eligibility for DMPA-SC. The U.S. MEC is comprised of recommendations for the use of specific contraceptive methods by patients who have certain characteristics or medical conditions. The CDC notes that although these recommendations are meant to serve as a source of clinical guidance, health care providers should always consider the individual clinical circumstances of each person seeking family planning services.

U.S. Selected Practice Recommendations for Contraceptive Use
Centers for Disease Control and Prevention
The U.S. Selected Practice Recommendations (U.S. SPR), developed by the CDC after review of the scientific evidence and consultation with national experts, “addresses a select group of common, yet sometimes controversial or complex, issues regarding initiation and use of specific contraceptive methods.” It includes a section on injectables, and DMPA-SC specifically.

CDC Contraception App
Centers for Disease Control and Prevention
Developed by the Division of Reproductive Health, this downloadable app covers more than 60 characteristics or medical conditions (U.S. MEC) and numerous clinical situations (U.S. SPR). These recommendations are intended to assist healthcare providers when they counsel women, men, and couples about contraceptive method choice and use.
Identification of Candidates for DMPA-SC

Candidates for DMPA-SC include individuals who are interested in an autonomous form of contraception, and those who may have difficulty returning to a clinic for provider-administered contraception.

Data suggest that user-administered DMPA-SC may have better continuation rates than provider-administered DMPA (SC and IM), with comparable low pregnancy rates and no additional safety concerns.\textsuperscript{21, 22} User-administered DMPA-SC also offers client privacy, convenience, and autonomy. Candidates for DMPA-SC include those for DMPA generally who are interested in a more autonomous form of contraception, as well as those who have previously injected medications like insulin or infertility medications. However, no previous experience with self-injection is necessary for successful initiation of DMPA-SC.\textsuperscript{23} DMPA-SC may also improve access to care by removing the need to return to a provider’s office every 3 months.\textsuperscript{24}

One injection is effective for 3 months which can be an advantage over daily pills.

Some of the disadvantages of user-administered DMPA-SC may include time to learn how to user-inject the medication. Some users experienced local site irritation and soreness on the first and second injection. This irritation and soreness may improve over time.\textsuperscript{25} According to the label, 1 in 100 clients experienced dimpling at the injection site.

Relevant Resource

Self-Administration of Injectable Contraception: A Systematic Review and Meta-Analysis (PDF)

\textit{BMJ Global Health}

This systematic review and meta-analysis compares self-administration versus provider-administration of injectable contraception on outcomes of pregnancy, side effects/adverse events, contraceptive uptake, contraceptive continuation, self-efficacy/empowerment, and social harms. Results suggest that self-administration of DMPA can lead to higher continuations rates than provider-administration, with comparable rates of pregnancy and side effects/adverse events.
Prescribing DMPA-SC

DMPA-SC is available in the United States as depo-subQ provera 104. It is available in prefilled, single-dose syringes and should be stored at room temperature. Recommendations for initiation, follow-up, and reinjection of DMPA-SC are the same as the IM formulation. Among healthy individuals, no examinations or tests are needed before initiating DMPA. However, baseline weight and BMI may be useful to monitor over time since some studies have shown weight gain with DMPA use.

DMPA can be initiated anytime it is reasonably certain the individual is not pregnant. If there is concern that the patient could be pregnant, providers may recommend the patient take a pregnancy test before initiating DMPA-SC. However, as suggested in the CDC’s U.S. SPR, “the benefits of starting to use a contraceptive method likely exceed any risk,” even in situations in which the health care provider is uncertain whether the individual is pregnant. As such, the risks of not starting to use contraception should be weighed against the risks of initiating contraception in an individual who might already be pregnant. Studies also have shown no increased risk for neonatal or infant death or developmental abnormalities among infants exposed in utero to DMPA. Therefore, the health care provider can consider having patients start using DMPA at any time, with a follow-up pregnancy test in 2 to 4 weeks.

Prescriptions for depo-subQ provera 104 should include a quantity of 4 syringes to allow for a 1-year supply. Reinjection should be administered every 13 weeks (3 months). Repeat DMPA injections can be given up to 2 weeks late (up to 15 weeks from the last injection) without needing additional contraceptive protection.

Relevant Resources

How to Be Reasonably Certain that a Woman Is Not Pregnant

Centers for Disease Control and Prevention

This section of the U.S. Selected Practice Recommendations for Contraceptive Use, 2016, includes the criteria, as well as the evidence summary, to be reasonably certain that a woman is not pregnant before prescribing contraception.

Link type Website
DMPA-SQ: A Provider's Guide

_Bedsider Providers_

A quick reference guide and resources for providers on prescribing and managing subcutaneous (SQ) administration of the birth control shot at home.

Link type Website

Guidelines for DEPO-SubQ Provera 104 Self-Injection (PDF)

_PICCK_

This handout provides information for providers on how to send in a prescription for DMPA-SC and has information about how to administer DMPA-SC at home.

Link type PDF

An Implementation Project to Expand Access to Self-Administered DMPA (PDF)

_Contraception_

This peer-reviewed research article describes the implementation and results of a proactive patient outreach project to offer self-administered DMPA-SC to interested patients at a California safety-net clinic following expanded state Medicaid coverage. Results indicate that there is interest in and successful initiation of self-administered DMPA-SC among patients at an urban safety net hospital-based primary care clinic who have used DMPA-IM in the last year. Supplemental materials (Appendix A) include a script for discussing the option of DMPA-SC with patients as well as resources for patients and providers.

Link type PDF

Clinical Template Protocol: DMPA SQ and Self-Administration Procedures

_National Family Planning and Reproductive Health Association_

This fillable template supports the creation of organization-specific protocols for offering DMPA SQ to patients for self-administration as a strategy to remove barriers that individuals may encounter, and also provides a blueprint for other clinical protocols that a health center may wish to develop to decrease the need for in-person
access. The template includes a sample script for staff to assess patient interest in DMPA SQ self-administration. The protocol is available under the “Clinical Guidance” subheading.

Patient Counseling and Communication

The quality of interpersonal communication affects health care outcomes including patient satisfaction, use of preventive care, and adherence to medication. Patient-centered care is one of the 6 domains of healthcare quality and is defined by the National Academy of Medicine as care that is “respectful of, and responsive to, individual patient preferences, needs and values.”

Providers offering contraceptive counseling should understand the history that racism and intersecting oppressions, such as sexism and classism, have played in reproductive medicine and health care, particularly as it pertains to the U.S.’s history of reproductive oppression and eugenics. Further, there has been a long history of institutional medicine and the state controlling the means of reproduction. Enslaved African women were considered property and had no control over their own bodies or reproduction. They were both forced to have children who were also considered property and were often taken away from them.

After emancipation, inequities and assertation of control over the bodies of people of color continued. For example, the State non-consensually sterilized poor women and women of color in the 1960s–1970s, targeted the marketing of DMPA injection to people of color, immigrants, and people of lower economic status, and allowed the unethical testing of the oral contraceptive pill on people in Puerto Rico. Further, our Native communities have had to endure a long history of reproductive injustices inflicted upon them including genocide, forced boarding schools, and unethical and coercive sterilization. Providers should consider how this history affects the individuals that interact with the health care system, including members of the LGBTQIA+ community, and orient their approach to care alongside the leaders in our communities of color who have long led us through their activism to address these injustices.
With this context in mind, contraceptive counseling should be provided through equitable, client-centered, shared decision-making that is non-coercive. The patient-provider relationship is a hierarchical one with providers traditionally having more power than patients. We recommend acknowledging these power dynamics and ensuring that there is a process of shared decision-making so that individuals are offered the full range of options and can make the best decision for themselves.

Shared decision-making has multiple definitions, one of which is “an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences.” As such, it is recommended that user-administered DMPA-SC should be available in addition to provider-administered DMPA and should be offered as part of access to the full range of contraceptive methods.

This kind of patient-centered approach which utilizes shared decision-making includes not only the content of the counseling but also the modality of counseling. Given that there are no requirements for in-person examination or laboratory evaluation for the use of DMPA-SC, patients should be offered contraceptive care that is in-person, over the phone, or over video—whichever modality works best for the patient. While some clinics do not have the ability to offer video, telephone visits are also appropriate for counseling and prescribing DMPA-SC given that providers do not necessarily need to see patients directly. No matter how patients would like to access services, it is important to assure confidentiality and privacy as well as identity confirmation with name, date of birth (DOB), medical record number (MRN), and location.

Please remember that individuals learn differently—some learn from visual aids, some learn from verbal descriptions, and some learn from physical interaction. Whether in-person or via telehealth, make sure to provide visual aids, videos, and real-time instruction to teach about injections. Also remember to practice “teach-back” methods that allow patients to explain to you their understanding of the material if new instruction is provided.

**Relevant Resources**

**Beyond Same-Day Long-Acting Reversible Contraceptive Access: A Person-Centered Framework for Advancing High-Quality, Equitable Contraceptive Care**

*American Journal of Obstetrics and Gynecology*

The authors of this peer-reviewed research state that “efforts to expand contraceptive access in the United States over the last decade have predominantly focused on long-acting reversible contraceptive methods, with relative neglect of other aspects of contraceptive access and resulting failure to ensure reproductive autonomy.” In response, they provide a practical framework for researchers, program implementers, and policy makers to develop and evaluate efforts to improve equitable access to and quality of contraceptive care.
Contraception: Counseling and Selection

*UpToDate*

This online, expert-written and reviewed article presents the goals of quality contraceptive counseling, reviews different approaches to counseling and its relationship to health equity, and provides a step-by-step guide to providing high-quality, patient-centered counseling. Information specific to each contraceptive method is presented in detail separately.

Link type **Website**

Contraceptive Counseling: Best Practices to Ensure Quality Communication and Enable Effective Contraceptive Use

*Clinical Obstetrics and Gynecology*

The authors identify aspects of relational and task-oriented communication in family planning care that can assist providers in meeting their patients’ needs. Approaches to optimizing individuals’ experiences of contraceptive counseling include working to develop a close, trusting relationship with patients and using a shared decision-making approach that focuses on eliciting and responding to patient preferences. Providing counseling about side effects and using strategies to promote contraceptive continuation and adherence can also help optimize individuals’ use of contraception.

Link type **Website**

Racism and Disparities in Women’s Use of the Depo-Provera Injection in the Contemporary USA

*Critical Sociology*

This article reports that, “from its inception, the development of Depo-Provera (DP) was fraught with charges of discrimination against women of color because women of color disproportionately served as ‘guinea pigs’ to test this drug both internationally and within the USA.” From 1967 through 1978, the largest known test of DP on humans was carried out using a disproportionate number of African American women and low-income European American women. In the 1985 documentary film, *The Ultimate Test Animal*, Karen Branan and Bill Turnley interviewed several of the thousands of African American women who were unaware at the time that they were participating in a clinical trial of DP at the Grady Clinic in Atlanta, GA.

Link type **Website**
Sexual Health Questions to Ask All Patients
National Coalition for Sexual Health
This tool includes sexual health and wellness questions to ask as part of the overall medical history. These inclusive and comprehensive questions will help providers better understand their patient’s sexual health, determine frequency of STI/HIV screenings, vaccinations and/or medications, and guide counseling.

Telehealth - National Family Planning and Reproductive Health Association
National Family Planning and Reproductive Health Association
NFPRHA offers a wealth of resources related to the use of telehealth in family planning and reproductive health care, including online learning modules, telehealth workflows, consent, coding and billing, and other considerations.

NWHN-SisterSong Joint Statement of Principles on LARCs
National Women’s Health Network
This is a direct link to the National Women’s Health Network (NWHN) and SisterSong’s joint statement on equitable best practices in contraceptive care. Although LARCs are effective treatments for preventing unintended pregnancies, people seek contraceptives for other health conditions as well. This statement highlights the history of coercion and oppression that is tied with LARCs, communities of color, and low-income individuals.
Teaching How to Inject

When counseling about DMPA-SC, providers should:

1. Screen patients for contraindications to DMPA
2. Counsel patients about side effects
3. Teach patients how to inject
4. Educate patients about interval of injection and how to set reminders for continued injections
5. Remind patients how to store medications
6. Review information about safe needle disposal with patients

Individuals can be prescribed and taught to administer DMPA-SC via a telehealth visit (ideally synchronous audio/video) or during an in-person visit. DMPA-SC is a good choice for those who are comfortable with user-injection whether they are new to DMPA or want to switch to this delivery method. However, previous experience with user-injection is not necessary for successful use of user-administered DMPA-SC.

Relevant Resources

This Is How I Teach: Self-Injection DMPA-SC

*Innovating Education in Reproductive Health*

This video shows providers how they can teach their patients to do self-injection of DMPA-SC.

Link type Website

Take These Steps When Giving Yourself a Sub-Q Depo Shot

*Tri-County Health Department*

This video is for individuals to learn about using Depo Sub-Q at home.

Link type Website
Subcutaneous DP Instructions
Harbor-ULCA OBGYN
This video provides visual step-by-step instructions on how patients can give themselves a DMPA-SC shot at home. The video also provides information on the DMPA-SC shot including is effectiveness rate, benefits, and side effects. There are 2 videos, one in English and one in Spanish.

Link type Website

Depo-Provera Sub-Q User Guide
Reproductive Health Access Project
This handout explains the basics of how to use DMPA-SC. It also answers common questions such as: How does depo work? How do I use depo? What if I am late for the next shot? Does depo have risks? This is a printable resource available in English, Spanish, Chinese, Hindi, and Vietnamese.

Link type Website

How to Perform a Subcutaneous Self-Injection
Planned Parenthood of Greater Texas
Planned Parenthood of Greater Texas created a 9-minute-long video that guides patients on how to give themselves DMPA-SC shot. The video lists the supplies needed and explains how to dispose of sharps. This video is also available in Spanish: SubQ Self Injections SP.

Link type Website

How to Give Yourself a Hormone Injection – Subcutaneous (PDF)
Planned Parenthood of Greater Texas
Detailed, written guidelines for patients on how to give yourself a depo shot are described in this printable handout. The handout is also available in Spanish: Cómo ponerse usted mismo una inyección de hormonas – subcutánea (PDF).

Link type PDF
Depo SubQ: The Do-It-Yourself Birth Control Shot

Bedsider

This article provides step-by-step instructions on administering your own DMPA-SC shot at home. It also explains the difference between DMPA-SC and DMPA-IM.

Safe Needle Disposal

SafeNeedleDisposal.org

A featured video about safe needle disposal, by NeedyMeds, shows how to create your own sharps container from a laundry detergent bottle if you cannot obtain a verified sharps container. An interactive map allows users to select the state they reside in for specific guidance and regulation of sharps. The website also has various downloadable materials on safe needle disposal.

Billing and Advocacy for DMPA-SC Coverage

While user-administered DMPA-SC has been in use around the world for over a decade, DMPA-SC is currently approved by the FDA only for administration by a health care professional in the U.S. However, in May 2021, the CDC updated recommendations in the U.S. SPR for Contraceptive Use to state that, "self-administered DMPA-SC should be made available as an additional approach to deliver injectable contraception."43

According to the CDC, "although the FDA label states that DMPA-SC is only to be administered by a health care professional, health care providers might prescribe an FDA-approved drug for off-label use (including administering a drug in a different way, such as self-administration) when medically indicated, as determined by the health care provider, for their patient."44, 45

Coverage Varies

Though some states and insurance plans provide coverage for user-administered DMPA-SC, billing still varies state by state and by private insurance.
During the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (CMS) issued waivers under section 1135 of the Social Security Act to facilitate local health departments’ responses to the pandemic. Some states such as California used the 1135 waiver to expand coverage and pay for DMPA-SC and after successful implementation will continue paying for DMPA-SC ongoing for their patients. Other state Medicaid programs including those in Massachusetts, New York, Louisiana, and Washington, already covered DMPA-SC and/or expanded its coverage during and after the pandemic.

Though some states and insurance plans provide coverage, billing still varies state by state and by private insurance. It is important to check the formulary for your patients’ plans to determine co-pay and burden of cost. Additionally, insurers may place utilization requirements such as prior approval upon its use, so provide an explanation if a prior approval (TAR) is issued by the insurer. Finally, as many insurers do not routinely cover DMPA as a pharmacy benefit, some patients may only access it at provider offices. In cases like this, clinics can offer to mail it to patients directly.

Providers should document contraceptive counseling services provided, including the time spent with the patient, to bill and be paid optimally for their services. DMPA-SC may be dispensed in person, including curbside, or delivered/mailed by the clinic or pharmacy.

The HCPCS code for DMPA (J1050) is per 1 mg, so it is necessary to report total units based on the dosage (i.e., report 104 units for DMPA-SC or 150 units for DMPA-IM). The billed charge should also be reported per 1 mg. It is a billing best practice to check individual payer guidance for expected codes and reporting units and review DMPA payments for accuracy. Claims with low payments for the drug should be corrected to avoid revenue loss.

There may be some extra steps in advocating for coverage on behalf of our patients, but it is worth it for them to get to choose a safe and reliable method of contraception that works for them!

Relevant Resources

Sample Letter for Advocacy for DMPA-SC (MS-Word)

National Clinical Training Center for Family Planning

This letter provides a sample argument to advocate for coverage of DMPA-SC as a pharmacy benefit. You can use this letter as a request to State Medicaid programs and Family Planning Waiver programs as well as to private insurers. While written generically, the language in this letter can also be applied to TAR if requested by the insurer for an individual patient. If using it for that purpose, please describe why it is important for the client to autonomously provide the medication and the additional risk or burden of coming to the clinic to receive the IM formulation.

Link type Word document
Podcast Discussion between Two Providers Who Expanded DMPA-SC in California

Contraception Podcast

This 17-minute interview with Dr. Jennifer Karlin by Dr. Jennifer Russo from the October 2020 Contraception Podcast discusses barriers and successes to implementing the expansion of DMPA-SC in California during COVID-19 pandemic. It discusses some of the background for the implementation project published in the journal Contraception and is helpful for developing strategies for advocating for coverage of DMPA-SC.

Link type Website

Self-Injectable Contraception: What Is the Evidence?

National Family Planning Clinical Training Center

This 1-hour video presentation from the 2021 Virtual National Reproductive Health Conference reviews not only the evidence behind the use of user-administered DMPA-SC but also discusses the implementation strategies employed by two providers in California and Louisiana to expand the option of user-administered DMPA-SC to their patients during the COVID-19 pandemic. Both providers successfully employed creative solutions to respond to barriers unique to their local settings. This presentation can offer providers an approach to implementing the expansion of DMPA-SC in their own settings.

Link type Website

Pharmacy-Based Contraceptive Care During COVID-19

Birth Control Pharmacist

This online home study course should increase knowledge and comfort in providing contraception care, including prescribing hormonal contraception, in community pharmacy practice settings during COVID-19. Participants can earn up to 1 contact hour of Accreditation Council for Pharmacy Education continuing pharmacy education (ACPE-CPE) credit with this course. There is also a downloadable Contraceptive Care Best Practices During COVID-19 (PDF) and patient education handout: The Shot Fact Sheet (PDF).

Link type Website
Coding and Billing Recommendations for Counseling, Education and Ongoing Monitoring of Patients Electing to use DMPA Subcutaneously via Self-administration (PDF)

National Clinical Training Center for Family Planning

This resource includes CPT, ICD-10, and common procedure codes to capture the counseling, instruction, and prescribing for DMPA-SQ for medical providers and pharmacists.

References


13 (Kaiser Family Foundation, 2020)

14 (Curtis, 2021)


20 (WHO, 2019)

21 (Kennedy, 2019)

22 (Burke, 2020)


24 (Katz, 2020)

25 (Burke, 2020)

26 (Curtis, 2021)


28 Ibid

29 Ibid


33 (Curtis, 2021)


43 (Curtis, 2021)

44 (Curtis, 2021)

45 (Katz, 2020)