Telehealth Care for Medication Abortion Protocol

Overview (of the evidence, states may have tighter restrictions)

- The maximum gestational age is 77 days.[1]
- The mifepristone dosage is 200 milligrams (one pill). The FDA label allows clinicians and certified pharmacies to dispense mifepristone in-person or by mail. Verbal consent can be documented by the clinician in the EMR.
- Misoprostol (800 mcg) can be taken buccally, sublingually, or vaginally. Patients should insert misoprostol 24-48 hours after taking mifepristone. For patients with gestational age of 9 to 11 weeks, a second dose of misoprostol should be given for use 4 hours after the first.
- Patients in hostile environments should consider using misoprostol buccally or sublingually to avoid having pill fragments in the vagina in the rare instance that they need an in-person exam.
- Follow-up is optional. Patients should have instructions for contacting a clinician for questions/concerns. The urine pregnancy test to assure completion is done after 4 weeks and a communication from the patient that it was negative is ideal.
- The prescriber can be any prescribing clinician, including advanced practice clinicians.

Telehealth Care for Medication Abortion Process

The clinician should counsel the patient by phone or video chat about pregnancy options (and contraception if desired). Patients who choose medication abortion can then be counseled about the process. Patient information sheets can be emailed, faxed, or sent through patient portals.

Initial Assessment – Discussion of Home Medication Abortion

Counseling

1. Options counseling: Assure that the patient understands options: continuing or ending the pregnancy. Options for ending the pregnancy include medication and aspiration abortion.

2. Review of expected effects: Bleeding and cramping (usually heavier than with menses) are expected. Diarrhea and other gastrointestinal side effects are common. There is a very small risk of prolonged bleeding requiring an aspiration abortion or MVA. The patient should be instructed in how much bleeding would be considered excessive and when to call the clinician (more than 2 soaked pads per hour for two hours in a row).

[1] Dzuba, Ilana G., et al. "A non-inferiority study of outpatient mifepristone-misoprostol medical abortion at 64–70 days and 71–77 days of gestation." *Contraception* (2020).

3. **Adherence to protocol:** Explain to the patient the process and the importance of finishing the medication abortion protocol. Serious bleeding can occur if only the mifepristone is taken and not the misoprostol.

Compliance with State Requirements

Many states have specific requirements affecting abortion. Most of these laws apply both to medication and aspiration abortion. Some states prohibit telehealth for abortion and mailing the pills.[2] Providers must comply with mandatory waiting periods, parental notification, gestational age limits, and department of health reporting as required. To find out more about regulations in your state, visit the Guttmacher Institute's website.

Medical History

1. Confirm that the patient has had a positive urine pregnancy test.

2. Rule out contraindications:
   - IUD in place (may be removed by patient[3] or clinician prior to abortion)
   - Allergy to prostaglandins or mifepristone
   - Chronic adrenal failure
   - Long-term systemic corticosteroid therapy
   - Hemorrhagic disorders
   - Concurrent anticoagulant therapy (excluding aspirin, which is OK)

3. Patients should have instructions for contacting a clinician for questions/concerns.

4. Obtain gestational dating. If patient is uncertain about last menstrual period (LMP), has irregular menstrual cycles, or clinician is concerned about ectopic pregnancy (risk factors include history of previous ectopic pregnancy, vaginal bleeding since LMP, adnexal pain, IUD in place, history of tubal surgery, and history of treatment for PID), an ultrasound will need to be obtained. Ultrasound examination should also be performed if the LMP places the pregnancy at >11 weeks (77 days). If ultrasound is not indicated, gestational dating should be done by LMP.[4,5,6]

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[2] Guttmacher Institute. "Medication Abortion." (2022). https://www.guttmacher.org/state-policy/explore/medication-abortion

[3] Foster, Diana Greene, et al. "Interest in and experience with IUD self-removal." *Contraception* 90.1 (2014): 54-59.

[4] Bracken, H., et al. "Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone–misoprostol." BJOG: An International Journal of Obstetrics & Gynaecology 118.1 (2011): 17-23.

[5] Raymond, Elizabeth G., et al. "Simplified medical abortion screening: a demonstration project." Contraception 97.4 (2018): 292-296.

[6] Royal College of Obstetricians & Gynecologists. "Coronavirus (COVID-19) infection and abortion care." Version 1: published March 21, 2020.

5. Testing for Rh status can be considered if the patient's status is unknown, however the evidence supporting this practice is minimal. Based on current practice guidelines, it is reasonable to forgo this testing up to 77 days LMP. Institutional policies may vary and it is important to be familiar with the standards for your practice setting.[7]

Review the required provider/patient agreement and the consent form.

This can be done verbally, or by giving/showing the patient the consent forms. Obtain either verbal or written consent (depending on state requirements).

Determine if the patient would like the pills mailed or picked up.

If mailing is an option: the mifepristone 200-milligram tablet and 4 to 8 tablets of misoprostol should be put into envelopes and mailed to the patient's home or preferred address. If possible, a urine pregnancy test for the patient to assess abortion completion should be mailed as well, with the aftercare instructions and a copy of the consent form.

Misoprostol Administration

Buccal administration: The patient will administer four 200-microgram misoprostol tablets, holding two in each cheek for 30 minutes and then swallowing them with a drink, at a convenient time 24-48 hours after taking mifepristone.[8]

Vaginal administration: The patient will place four 200-microgram misoprostol tablets in the vagina 6-72 hours after taking the mifepristone. The patient will then lie down for 30 minutes. If the tablets fall out after 30 minutes, they can be discarded.[9] If your patient is concerned about privacy, you can counsel them to put the pills inside their cheeks or under their tongue. This way, there will be no pill fragments left behind.

Sublingual administration: Four 200-microgram misoprostol tablets are placed under the tongue 24 hours after taking the mifepristone. They are allowed to dissolve for 30 minutes and then the remains are swallowed with a drink.[10]

If gestational age is at 63-77 days, a second dose of misoprostol is recommended to increase efficacy. This should be taken four hours after the first dose of misoprostol.

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[7] National Abortion Federation. "Clinical Policy Guidelines 2022." (2022) https://prochoice.org/providers/quality-standards/.

[8] Chen, Melissa J., and Mitchell D. Creinin. "Mifepristone with buccal misoprostol for medical abortion: a systematic review." *Obstetrics & Gynecology* 126.1 (2015): 12-21.

[9] Schaff EA, Fielding SL, Westhoff C, Ellertson C, Eisinger SH, Stadalius LS, et al. Vaginal misoprostol administered 1, 2, or 3 days after mifepristone for early medical abortion: A randomized trial. JAMA 2000;284:1948-53.

[10] Von Hertzen, H., et al. "Misoprostol dose and route after mifepristone for early medical abortion: a randomised controlled noninferiority trial." *BJOG: An International Journal of Obstetrics & Gynaecology* 117.10 (2010): 1186-1196.

Advise patient on use of pain medications:

Prescriptions for acetaminophen with a narcotic and/or Ibuprofen 800 milligrams should be offered to the patient. Patients should be encouraged to fill the prescription/s in advance and to have the pain medications on hand to be taken as needed.

Make sure the patient knows how to reach the clinician on-call.

An information sheet with instructions about how to call or page the provider should be sent to each patient, and the information should be reviewed during the counseling to be sure they understand.

Follow-up is optional.

To assess the completeness of the abortion, clinicians may use any of the following criteria:

- history (patient's description of bleeding - which should be at least as much as their menses – with cramping and passage of clots accompanied by resolution of any pregnancy symptoms); or
- declining serum bhCG levels (by more than 80% at one week after the bleeding); or
- ultrasound; or
- negative home pregnancy test 4 weeks after mifepristone.[11,12]

If an at-home pregnancy test is still positive after 4 weeks after taking mifepristone, a repeat pregnancy test should be performed in office. If pregnancy is ongoing, i.e. a rising bhCG or an ultrasound with a growing pregnancy, an aspiration procedure can be performed. If the abortion is incomplete (i.e. an ultrasound showing no interval growth and no fetal cardiac activity, but with retained tissue and continued bleeding), the patient can choose a repeat dose of misoprostol or an aspiration procedure. If the pregnancy was being followed by quant hCGs and levels did not fall as expected, an urgent ultrasound should be obtained to assess for failed abortion vs ectopic pregnancy.

Review plans for post-abortion contraception:

Patients who choose combination hormonal contraceptives (oral, patch, ring) may begin the method as soon as the next day or on the most convenient day after taking

[11] Perriera LK, Reeves MF, Chen BA, Hohmann HL, Hayes J, Creinin MD. Feasibility of telephone follow-up after medical abortion. Contraception. 2010;81(2):143-9.

[12] Chen MJ, Rounds KC, Creinin MD, Casino C, Hou MY. Comparing office and telephone follow-up after medical abortion. Contraception. 2016;94(2):122-126.

misoprostol – even if bleeding persists. DMPA (depo-provera) may be prescribed for self-administered subcutaneous use. The implant or IUD insertion can take place at a follow-up visit if desired and a bridge method can be prescribed until that time. As soon as patients feel comfortable, they can resume using tampons and having penetrative vaginal intercourse. Patients who choose sterilization should be referred as appropriate to avoid delays, with a bridge method for the wait time.

Further follow-up

Patients should be instructed to call or return if bleeding persists beyond 4 weeks or becomes heavy again.