# Joel Kitchens

State Representative • 1st Assembly District


## Testimony for the Senate Committee on Health
## Senate Bill 30
## Tuesday, Feb. 9, 2021

Thank you Chairman Testin and committee members for holding a public hearing and giving me the opportunity to testify on Senate Bill 30, which will authorize pharmacists to prescribe certain contraceptives.

Under current state law, women can only obtain most birth control through a prescription from a physician or an advanced practice nurse who has met the required qualifications.

SB 30 would, under specific circumstances, allow a woman to obtain hormonal contraceptive patches and self-administered oral hormonal contraceptives, including common birth control pills, through a prescription from a pharmacist.

The rules to establish the standard procedures for pharmacists prescribing contraceptives will be promulgated by the Pharmacy Examining Board, after consulting with the Medical Examining Board, Board of Nursing and Department of Health Services

In order to acquire a prescription for birth control from a pharmacist, the person must complete a self-assessment questionnaire and undergo a blood pressure screening. The questionnaire must be developed in consideration of the guidelines established by the American College of Obstetricians and Gynecologists.

If there are any red flags, the pharmacist is not required to prescribe and dispense birth control and can instead refer the patient to their primary health care practitioner. If the woman is deemed a match, the pharmacist must dispense the contraceptive as soon as practicable and report the prescription to that individual's primary health care practitioners. Participation by pharmacists is voluntary and they will not be required to take part in this program if they have moral objections to birth control.

This bill only applies to women who are at least 18 years of age.


**Capitol Office:** Post Office Box 8952 • Madison, WI 53708-8952 • (608) 266-5350 • Toll-Free: (888) 482-0001 • Fax: (608) 282-3601
Rep.Kitchens@legis.wi.gov

One of the reasons we introduced SB 30 is because of the high costs associated with unplanned pregnancies.

According to the latest available statistics, nearly half of pregnancies in both Wisconsin and across the nation are unplanned, with the highest rates reported by women in their 20s and those who live in poverty.

A study from the Guttmacher Institute found that state and federal taxpayers spend about $21 billion annually on unplanned pregnancy-related care, with public insurance programs such as Medicaid financing 68 percent of unintended births, compared to 38 percent of planned births. This figure does not include additional costs that stem from an unplanned pregnancy's impact on educational attainment, family economics and a child's health and well-being.

Almost 63 percent of unplanned births are publically-funded in Wisconsin, with the federal and state governments spending $313.5 million each year on this care. Of that total, $221.4 million is paid for by federal tax dollars and $92.1 million by state tax dollars. The total public cost for unintended pregnancies in Wisconsin is $286 annually for every woman in the state, which is considerably higher than the national average of $201 per woman.

Significant intergenerational health effects also exist with unplanned pregnancies. According to the Institute of Medicine, women with unintended pregnancies are more likely to smoke or drink alcohol during pregnancy, have depression and experience domestic violence. They are also less likely to obtain prenatal care or breastfeed.

Furthermore, short interpregnancy intervals have been associated with adverse neonatal outcomes, including low birth weight and prematurity, which increase the chances of children having health and developmental problems throughout their lives. Plus, these youth are more likely to score worse on behavioral and developmental measures than children who were born as a result of a planned pregnancy.

An unintended pregnancy can also severely disrupt a woman's educational goals, which in turn has a tremendous influence on future earning potential and family financial well-being. Community colleges are typically the place first generation college students begin their post-secondary education. Nationally, unplanned births are the reason 10 percent of women drop out of community college and most never obtain their degree. This perpetuates the intergenerational cycle of poverty.

Knowing all of these sobering facts, we should not be putting up artificial barriers that deny women more choices when it comes to their reproductive healthcare.

When the common birth control pill became available in the United States in the 1960s, you could only obtain the oral contraceptives through a prescription from a doctor. That made sense at the time, particularly since the pills had incredibly high hormone levels and experts were not sure how the medication would affect women physiologically.

Fast-forward almost 60 years and things have definitely changed. Decades of research has shown us that formulations for oral contraceptives have become much more benign. While all drugs come with the potential for harmful side effects – even Aspirin can cause bleeding disorders – the consensus of the medical community is that birth control pills are no more dangerous than ibuprofen.

More than 100 countries across the world allow access to birth control without a prescription. Yet, women in the United States still need a prescription from their doctor or nurse practitioner to be able to obtain birth control pills. Even the morning-after pill, which is seven times more potent than your average oral contraceptive, is available over-the-counter and doesn't require a prescription.

To understand why we need to update our laws in Wisconsin, I would like to explain that there are only two factors that are supposed to be used to determine whether a medication should be prescribed by a physician. Drugs are made prescription-only because they either have high abuse potential or they have a low margin of safety which requires a doctor's oversight.

There is no documentation that birth control pills have ever been abused and the American College of Obstetricians and Gynecologists, American Academy of Family Physicians, the Wisconsin Medical Society, the American Medical Association and the Wisconsin Nurses Association all agree that birth control pills are so safe they should be available over-the-counter and with no prescription. While that may be their preferred direction, only the Federal Food and Drug Administration can make a medication over-the-counter.

Dr. Eliza Bennett, from the UW School of Medicine and Public Health's Department of Obstetrics and Gynecology, said that the "risks associated with pregnancy are infinitely greater than those associated with birth control."

The primary health risk that comes with taking birth control is the potential for developing blood clots. The blood pressure screening performed by the pharmacist will prevent most of these problems. According to the College of OB/Gyns, this problem is easily managed and there are now multiple brands of pills with ultra-low levels of estrogen that avoid this problem. The risk of blood clots is also far greater in pregnancies than birth control.

I have also heard concerns that because birth control pills use hormones to block pregnancy, they may overstimulate breast cells, which can increase the risk of breast cancer. While there in a slight increased risk, especially in older women, a study published by *Cancer Research* shows that using birth control pills with a low dose of estrogen has not been linked to a higher probability of being diagnosed with breast cancer. While saying that birth control pills are a Class I carcinogen for breast cancer sounds ominous, it is worth noting that alcoholic beverages and working the late shift are also listed as Class I carcinogens for breast cancer.

Research also has found that birth control pills can lower the risk of uterine and ovarian cancer by 50 percent. In fact, women with family histories of these two types of cancer are frequently put on birth control as a preventive measure.

I trust the medical community which overwhelmingly believes it is much safer than many current over-the-counter drugs and should be dispensed with no screenings at all.

I would like to shift gears now and address a couple of the criticisms I have heard coming from the opponents of this bill. While these critics may not agree with many of the things I'm about to say, if you have any questions regarding the validity of the forthcoming information, please contact my office and we will be happy to provide you with science-based documentation.

First, they will tell you that birth control is not effective and gives women a false sense of security. There is always room for some human error, but when used consistently and correctly, oral contraceptives are 99.9 percent effective.

In any given year, the two-thirds of American women at risk of unintended pregnancy who use contraceptives regularly throughout the year account for only 5 percent of all unplanned pregnancies. Meanwhile, 95 percent of unintended pregnancies are attributed to the one-third of women who do not use contraceptives or who use them inconsistently.

The primary cause of irregular use is a lack of access. I think it is ironic that the people who oppose increased access to birth control are citing ineffectiveness when that lack of access is the major contributor to failure. Many OBGYNs have told me that women will frequently run out of oral contraceptives and cannot get an appointment with their doctors in a timely fashion. A large number of women also forget to bring their pills with them when they go on vacation. This bill will help alleviate that.

Some opponents are also claiming that birth control pills are an abortifacient that works by blocking the implantation of a viable embryo. However, that claim is purely hypothetical – there is no scientific evidence that oral contraceptives work this way.

Birth control pills stop pregnancies from happening by blocking ovulation and thickening the cervical mucus, which prevents sperm from entering the uterus. OGBYNs tell me that if oral contraceptives did block the implementation of a viable embryo, we would expect to see large numbers of ectopic pregnancies with women on the pill – and that is simply not happening.

A report from the Committee on Health Care for Underserved Women that was provided to my office by the American College of Obstetricians and Gynecologists says clearly that none of the current forms of the pill that are available are abortifacients. The current label on birth control pills says that it may prevent implantation of a viable embryo. The College of Obstetricians and Gynecologists says that this label was written in 1999 and does not reflect current research nor the opinion of the medical community.

I am also hearing from critics of SB 30 that birth control actually increases the number of unplanned pregnancies and abortions in our state and country.

According to a 2018 report from the Centers for Disease Control, unintended pregnancy is the major contributor to induced abortion. "Increasing access to and use of effective contraception can reduce unintended pregnancies and further reduce the number of abortions performed in the United States," the report states.

Data from the Guttmacher Institute also shows that from 2008 to 2014, the steep drop in unintended pregnancies — including births and abortions— was likely driven by improved contraceptive use. The U.S. abortion rate decreased 25 percent between 2008 and 2014, while the rate of abortion, about 40 percent of unplanned pregnancies, has remained unchanged. The evidence suggests that contraception and fewer unintended pregnancies played a larger role than new abortion restrictions.

I would also like to point out that making birth control available with a prescription from a pharmacist is gaining popularity across the country.

At least 12 states currently allow women to get their birth control prescriptions from a pharmacy. Several other states are currently considering similar legislative proposals. This is not a Republican or Democratic issue. Blue states like California and Oregon, as well as red states like Utah and Tennessee, have passed similar legislation. Recently,

Oregon was the first state to pass the pharmacist/birth control law and the results so far have been very encouraging. According to research conducted by Oregon State University, Oregon prevented more than 50 unintended pregnancies and saved an estimated $1.6 million in associated taxpayer costs in the first two years the law went into effect.

As you can see, we are proposing SB 30 to give women more choices with their reproductive healthcare, decrease the number of unplanned pregnancies and abortions in our state, save taxpayer dollars and reduce generational poverty.

I respect the position of those who morally oppose birth control, but it is not the role of government to impose our morality onto others. We should not be putting up artificial barriers that prevent increased access to birth control – especially when there is no medical basis to do so.

I want to thank you for taking the time to listen to my testimony, and I hope you consider supporting SB 30. I am also extremely appreciate of all the work that my co-authors, Sen. Felzkowski and Rep. Magnafici, and their staff put into this bill. I am now happy to answer any questions if you have them.

# MARY FELZKOWSKI

STATE SENATOR • 12TH SENATE DISTRICT


**Testimony on Senate Bill 30**

Senate Committee on Health
Senator Mary Felzkowski
12th Senate District
February 9, 2021

Good morning Chairman Testin and Committee Members,

Thank you for taking the time to hear testimony on Senate Bill 30, which would allow pharmacists to prescribe oral birth control in Wisconsin.

As you just heard from my co-author, Representative Kitchens, this bill will expand access to a safe and commonly used method of birth control that many women across our state use and benefit from.

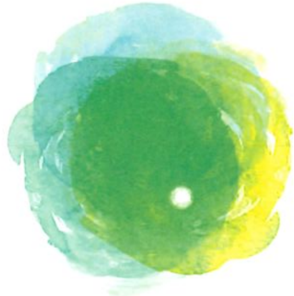
In order to get a prescription for birth control now, women must go and make an appointment with a physician or an advanced practice nurse. Those of us in rural areas know that these appointments are not easy to make. The shortage we are facing with rural healthcare providers extends to OB/GYNs and in fact, the American Medical Association estimates that 30% of Wisconsin counties do not have a single practicing OB/GYN. To see any physician and obtain a prescription, a woman in rural Wisconsin is faced with transportation costs and time constraints. This is an artificial barrier that we need to remove. The government should not play the role of gatekeeper in preventing women from accessing this medical tool.

One of the ways we can move forward on addressing the issue of access is to follow in the footsteps of the 11 states that have already passed this and allow pharmacists the authority to prescribe birth control. The Pew Research Center says that 93% of Americans live within 5 miles of a pharmacy. I can tell you that that reality is certainly reflected in my district and throughout the Northwoods.

As Representative Kitchens made clear, there is no medical reason that oral contraceptives need to be prescribed by a physician and OB/GYNs support making birth control available without a prescription at all. The government needs to remove the artificial red tape we have in place and allow women to access this medication without jumping through hoops.

Thank you for your time and consideration and I look forward to your questions.


**Capitol Office:** P.O. Box 7882 • Madison, WI 53707-7882 • (608) 266-2509 • **Toll-Free:** (800) 334-8775
**Cell:** (715) 966-3366 • Sen.Felzkowski@legis.wi.gov




**Testimony in Opposition to Senate Bill 30: permitting pharmacists to prescribe certain contraceptives**
**Senate Committee on Health**
**By Matt Sande, Director of Legislation**

**February 9, 2021**

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Good afternoon Chairman Testin and Committee members. My name is Matt Sande and I serve as director of legislation for Pro-Life Wisconsin. Thank you for this opportunity to express our opposition to Senate Bill (SB) 30, legislation permitting pharmacists to prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives to persons who are at least 18 years of age.

**Studies demonstrate that the bill authors' means to achieving lower unplanned pregnancies (easy contraceptive access and use) is unworkable.** A significant percentage of unintended pregnancies are in women using contraceptives, generally over 40% and in some studies up to 68%.

According to a March 2017 Guttmacher Institute study*, "A substantial proportion of unintended pregnancies occur despite women's and their partners' use of contraceptives. In 2001, some 48% of women experiencing an unintended pregnancy had been using a method in the month of conception." In the same study Guttmacher also reported that "about half of pregnancies terminated by induced abortions in 2008 occurred during use of contraceptives." Clearly, contraceptive use is not preventing unplanned pregnancies.

*(Perspectives on Sexual and Reproductive Health, Guttmacher Institute, Volume 49, Issue 1, March 2017, Pages 7-16, *Contraceptive Failure in the United States: Estimates from the 2006-2010 National Survey of Family Growth*)

A December 2015 study** out of Canada noted that "Imperfect contraceptive adherence was estimated to account for 124,024 of the 180,733 UPs [unplanned pregnancies] that occur annually in women age 18–44 years (Table 5)." That equates to over 68% of all unplanned pregnancies (18-44 years) in the study being due to imperfect contraceptive use. So you can give them the pills, but faulty or incorrect use makes them ineffective in reducing unplanned pregnancies.

**(Journal of Obstetrics and Gynaecology Canada, December 2015, Volume 37, Issue 12, Pages 1086–1097, *The Cost of Unintended Pregnancies in Canada: Estimating Direct Cost, Role of Imperfect Adherence, and the Potential Impact of Increased Use of Long-Acting Reversible Contraceptives*)

**At the core of our opposition to SB 30 is the abortifacient effect of hormonal contraceptives.** It is a medical fact that the morning-after pill (a high dosage of the birth control pill) and most if not all hormonal birth control drugs and devices including the intrauterine device (IUD), Depo Provera, the Patch, and the Pill can act to terminate a pregnancy by chemically

**PRO-LIFE WISCONSIN, INC**
PROLIFEWI.ORG
INFO@PROLIFEWI.ORG

P.O. BOX 221
BROOKFIELD, WI 53008
262.796.1111

FACEBOOK.COM/PROLIFEWI
TWITTER.COM/PROLIFEWI
YOUTUBE.COM/PROLIFEWI

altering the lining of the uterus (endometrium) so that a newly conceived child (human embryo) is unable to implant in the womb, thus starving and dying. This mechanism of action is termed a pre-implantation chemical abortion.

LO/OVRAL-28 is a standard birth control pill manufactured by Wyeth Laboratories. The Physicians' Desk Reference indicates that it can work to prevent a fertilized egg (a human embryo) from implanting in the uterine wall:

*LO/OVRAL®-28, a standard birth control pill. Combination oral contraceptives act by suppression of gonadotropins. Although the primary mechanism of this action is inhibition of ovulation, other alterations include* ***changes in the*** *cervical mucus (which increase the difficulty of sperm entry into the uterus) and the* ***endometrium (which reduce the likelihood of implantation)*** *(Physicians' Desk Reference (PDR). 56 ed. Montvale, NJ: Thompson PDR; 2002. 3533).*

WebMD also describes the pharmacological action of LO/OVRAL-28:

*This combination hormone medication is used to prevent pregnancy. It contains 2 hormones: a progestin and an estrogen. It works mainly by preventing the release of an egg (ovulation) during your menstrual cycle. It also makes vaginal fluid thicker to help prevent sperm from reaching an egg (fertilization) and* ***changes the lining of the uterus (womb) to prevent attachment of a fertilized egg. If a fertilized egg does not attach to the uterus, it passes out of the body.***

The United Kingdom's National Health Service (NHS) website describes the contraceptive patch's mechanism of action:

*The patch releases a daily dose of hormones through the skin into the bloodstream to prevent pregnancy. It contains the same hormones as the combined pill – oestrogen and progestogen – and works in the same way by preventing the release of an egg each month (ovulation). It also thickens cervical mucus, which makes it more difficult for sperm to move through the cervix,* ***and thins the womb lining so a fertilised egg is less likely to be able to implant itself.***

WebMD also describes the pharmacological action of the transdermal patch:

*The patch blocks conception by delivering the hormones estrogen and progestin through the skin into your bloodstream. The hormones keep your ovaries from releasing an egg, thicken the cervical mucus to deter the swimming sperm, and* ***make it harder for any fertilized egg to implant inside your womb.***

In the January 2019 Linacre Quarterly, a peer-reviewed publication of the Catholic Medical Association, medical researchers published a study*** entitled "Systematic Review of Ovarian Activity and Potential for Embryo Formation and Loss during the Use of Hormonal Contraception." The abstract of the study states, "...follicular ruptures and egg release with

subsequent low progesterone output have been documented in women using hormonal contraception...(this) suboptimal luteal progesterone production may be more likely than previously acknowledged, which may contribute to embryo loss. This information should be included in informed consent for women who are considering the use of hormonal contraception." In other words, the abnormally low progesterone production while taking hormonal contraceptives can lead to early embryo loss and women should be informed of this possibility.

***(The Linacre Quarterly, January 3, 2019, *Systematic Review of Ovarian Activity and Potential for Embryo Formation and Loss during the Use of Hormonal Contraception*)

When the Pill was first introduced it contained high estrogen levels with severe side effects. Today's pills contain dramatically lower hormone doses which allow for breakthrough ovulation, embryo formation in the fallopian tube, and then blockage of implantation of the embryo in the uterine wall. While admitting that hormonal birth control can inhibit the implantation of a fertilized egg, the makers of these drugs claim that they do not cause an abortion. For example, they argue that hormonal contraceptives "prevent pregnancy" or "will not affect an existing pregnancy." However, they intentionally define the term "pregnancy" as implantation of a fertilized egg in the lining of a woman's uterus, as opposed to "pregnancy" beginning at fertilization.

Whether one understands "pregnancy" as beginning at implantation or fertilization, the heart of the matter is when human life begins. Embryological science has clearly determined that human life begins at fertilization - the fusion of an egg and sperm immediately resulting in a new, genetically distinct human being. This is not a subjective opinion, but an irrefutable, objective scientific fact. Accordingly, any artificial action that works to destroy a human embryo is abortifacient in nature.

The authors contend that hormonal contraceptives have no "potentially harmful side effects that require a physician's oversight." We strongly disagree. **Hormonal contraceptives have been proven dangerous to women's health.** The World Health Organization has classified combined hormonal contraceptives as Group 1 carcinogens (carcinogenic to humans.) The United Nation's International Agency on Research of Cancer (IARC) reported in their Monograph 91 that estrogen-progestin combination drugs (the Pill) were a Group 1 carcinogen for breast, cervical and liver cancers. Users of the Pill have an increased risk of blood clotting and ectopic pregnancy, both of which can be fatal. Lawsuits have been filed blaming the Patch for several deaths due to blood clots, heart attacks and strokes. The Food and Drug Administration has cautioned that the Patch carries a higher risk of blood clots than the birth control pill.

Pro-Life Wisconsin is opposed to all forms of artificial contraception, both hormonal and barrier methods. When you delink or decouple sexual intercourse and procreation through

contraceptives, and a baby is conceived (as often happens when using the Pill or a condom), he or she is most often not welcomed as a blessing but rather considered a problem, a mistake. All problems have a solution, the abortion temptation sets in, and abortion is then used as a form of birth control. This is what we call the contraceptive mentality.

Alternatively, Pro-Life Wisconsin supports natural methods of achieving or avoiding pregnancy, or spacing children, that are organic, open to life, highly effective, and totally self-giving. We recommend natural family planning methods that pinpoint the fertile and infertile periods of a woman's cycle.

For the above reasons, we oppose legislation in whatever form that makes hormonal contraceptives more easily accessible or widely available. We urge you to NOT recommend SB 30 for passage.

Thank you for your consideration, and I am happy to answer any questions committee members may have for me. I am also happy to email any of the studies referenced in my testimony to committee members.

# WISCONSIN CATHOLIC MEDICAL GUILDS

*Upholding the Principles of the Catholic Faith in the Science and Practice of Medicine*

February 9, 2021

**To:** Members, Senate Committee on Health

**FROM:** Elizabeth Anderson, MD, Assistant State Director – Wisconsin Catholic Medical Guilds; President - Madison Catholic Medical Guild

**RE:** Senate Bill 30 – permitting pharmacists to prescribe certain contraceptives

Good afternoon Chairman Testin and Committee members. My name is Elizabeth Anderson. I am an emergency medicine physician here in Madison. I graduated from the Medical College of Wisconsin in 2005 and completed my residency at Froedtert Hospital in Milwaukee in 2008. I have been an ER physician here in Madison since then. I am also the current president of the Catholic Medical Guild of the Diocese of Madison and the Assistant Director of the Wisconsin Catholic Medical Guilds. I am here today on behalf of the Wisconsin Catholic Medical Guilds which represents the six guilds of the Catholic Medical Association throughout Wisconsin, with more than 100 physician and healthcare provider members.

**The Wisconsin Catholic Medical Guilds (WCMG) is opposed to Senate Bill (SB) 30 and strongly urges you to not pass this bill out of committee.**

As you know, SB 30 would allow pharmacists to prescribe either contraceptive patches or oral contraceptives to patients without the input of a medical doctor. WCMG is opposed to this practice for several reasons.

First, the patient-physician relationship is of utmost importance in providing safe, quality healthcare to individuals. This bill would eliminate that relationship, undermining the ongoing necessary healthcare that a patient should have with any prescription medication and any health condition. Primary care physicians have a unique relationship with their patients in which they can provide individualized counseling and recommendations, as well as discuss risks of prescription medications unique to each individual patient. This relationship and individualized care is eliminated if this bill moves forward.

Second, any prescription medication carries risks, which is why they require a prescription. A primary medical doctor has the ability to not only discuss these risks at the time of initial prescription but to monitor for signs/symptoms of these risks. Making contraceptives available, essentially as over-the-counter medications, ignores the significant risks associated with them. The CDC has produced a chart as reference for medical conditions that are affected by contraceptives. As you can see, it is extensive. A pharmacist does not have access to a patient's medical records and so is relying on a questionnaire that may or may not be answered correctly by the patient. I can assure you, that patients frequently do not remember or

embryo cannot implant due to the progesterone component of contraceptives altering the uterine lining.

Finally, the proposed legislation is reportedly to improve access to "healthcare" and birth control, with the anticipated effect of reducing unintended pregnancies. However, studies have shown this is not the case. A study from the Guttmacher Institute published March, 2017 found that almost half of unintended pregnancies occurred while the woman was using birth control. The same study also reported about half of pregnancies terminated by abortion had occurred while using contraceptives.

A second study done in Canada looked at the cost of unintended pregnancies and the role of imperfect adherence. They found that 68% of all unplanned pregnancies occurred while the woman had access to contraceptives, but had imperfect use. In other words, you can provide the contraceptives, but that does not solve the problem of unintended pregnancies.

In summary, the proposed bill allowing pharmacist prescription of contraceptives diminishes the value of the patient-physician relationship, ignores the significant medical risks of contraceptives and their abortifacient effect, and does not solve the problem of unintended pregnancies. As such, the WCMG opposes SB 30 and encourages you to do likewise.

Thank you for hearing my testimony, and I would be pleased to answer any questions from committee members.

References:

Oral contraceptive use and risk of breast, cervical, colorectal, and endometrial cancers: a systematic review. Gierisch JM, et al. Cancer Epidemiol Biomarkers Prev. 2013 Nov;22(11): 1931-43.

Contraceptive Failure in the United States: Estimates from the 2006-2010 National Survey of Family Growth. Sundaram A, et al. Perspectives on Sexual and Reproductive Health. 2017 Mar;49(1): 7-16.

The Cost of Unintended Pregnancies in Canada: Estimating Direct Cost, Role of Imperfect Adherence, and the Potential Impact of Increased Use of Long-Acting Reversible Contraceptives. Block et al. J. Oebstet Gynaecol Can. 2015 Dec;37(12):1086-97.

# Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Pages 1,2 ..................Color coded in the left column to match the corresponding question of the Oregon Hormonal Contraception Self-Screening Tool Questionnaire.

Pages 3,4 ..............Arranged alphabetically by disease state

| Key: | |
|---|---|
| 1 | No restriction (method can be used) |
| 2 | Advantages generally outweigh theoretical or proven risks |
| 3 | Theoretical or proven risks usually outweigh the advantages |
| 4 | Unacceptable health risk (method not to be used) |

**Updated November 2016.** This summary sheet only contains a subset of the recommendations from the US MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm

## Corresponding to the order of the Colorado Hormonal Contraception Self Screening Tool Questionnaire:

| Condition | Sub-condition | Combined pill, patch, ring | | Progestin-only pill | | Other Contraception Options Indicated for Patient |
|---|---|---|---|---|---|---|
| | | Initiating | Continuing | Initiating | Continuing | |
| Age | | Menarche to <40=1 | | Menarche to <18=1 | | Yes |
| | | ≥40=2 | | 18-45=1 | | Yes |
| | | | | >45=1 | | Yes |
| Smoking | a) Age < 35 | 2 | | 1 | | Yes |
| | b) Age ≥ 35, < 15 cigarettes/day | 3 | | 1 | | Yes |
| | c) Age ≥ 35, ≥15 cigarettes/day | 4 | | 1 | | Yes |
| Pregnancy | (Not Eligible for contraception) | NA* | | NA* | | NA* |
| Postpartum (see also Breastfeeding) | a) < 21 days | 4 | | 1 | | Yes |
| | b) 21 days to 42 days: | | | | | |
| | (i) with other risk factors for VTE | 3* | | 1 | | Yes |
| | (ii) without other risk factors for VTE | 2 | | 1 | | Yes |
| | c) > 42 days | 1 | | 1 | | Yes |
| Breastfeeding (see also Postpartum) | a) < 1 month postpartum | 3* | | 2* | | Yes |
| | b) 1 month or more postpartum | 2* | | 1* | | Yes |
| Diabetes mellitus (DM) | a) History of gestational DM only | 1 | | 1 | | Yes |
| | b) Non-vascular disease | | | | | |
| | b) Other abnormalities: | | | | | |
| | (i) non-insulin dependent | 2 | | 2 | | Yes |
| | (ii) insulin dependent‡ | 2 | | 2 | | Yes |
| | c) Nephropathy/ retinopathy/ neuropathy‡ | 3/4* | | 2 | | Yes |
| | d) Other vascular disease or diabetes of >20 years' duration‡ | 3/4* | | 2 | | Yes |
| Headaches | a) Non-migrainous | 1* | 2* | 1* | 1* | Yes |
| | b) Migraine: | | | | | |
| | i) without aura, age <35 | 2* | 3* | 1* | 2* | Yes |
| | ii) without aura, age ≥35 | 3* | 4* | 1* | 2* | Yes |
| | iii) with aura, any age | 4* | 4* | 2* | 3* | Yes |
| Hypertension | a) Adequately controlled hypertension | 3* | | 1* | | Yes |
| | b) Elevated blood pressure levels (properly taken measurements): | | | | | |
| | (i) systolic 140-159 or diastolic 90-99 | 3 | | 1 | | Yes |
| | (ii) systolic ≥160 or diastolic ≥100‡ | 4 | | 2 | | Yes |
| | c) Vascular disease | 4 | | 2 | | Yes |
| History of high blood pressure during pregnancy | | 2 | | 1 | | Yes |
| Hyperlipidemias | | 2/3* | | 2* | | Yes |
| Peripartum cardiomyopathy‡ | a) Normal or mildly impaired cardiac function: | | | | | |
| | (i) < 6 months | 4 | | 1 | | Yes |
| | (ii) ≥ 6 months | 3 | | 1 | | Yes |

| Condition | Sub-condition | Combined pill, patch, ring | | Progestin-only pill | | Other Contraception Options Indicated for Patient |
|---|---|---|---|---|---|---|
| | | Initiating | Continuing | Initiating | Continuing | |
| | b) Moderately or severely impaired cardiac function | 4 | | 2 | | Yes |
| Multiple risk factors for arterial cardiovascular disease | (such as older age, smoking, diabetes and hypertension) | 3/4* | | 2* | | Yes |
| Ischemic heart disease‡ | Current and history of | 4 | | 2 | 3 | Yes |
| Valvular heart disease | a) Uncomplicated | 2 | | 1 | | Yes |
| | b) Complicated‡ | 4 | | 1 | | Yes |
| Stroke‡ | History of cerebrovascular accident | 4 | | 2 | 3 | Yes |
| Thrombogenic mutations‡ | | 4* | | 2* | | Yes |
| Deep venous thrombosis (DVT) /Pulmonary embolism (PE) | a) History of DVT/PE, not on anticoagulant therapy | | | | | |
| | i) higher risk for recurrent DVT/PE | 4 | | 2 | | Yes |
| | ii) lower risk for recurrent DVT/PE | 3 | | 2 | | Yes |
| | b) Acute DVT/PE | 4 | | 2 | | Yes |
| | c) DVT/PE and established on anticoagulant therapy for at least 3 months | | | | | |
| | i) higher risk for recurrent DVT/PE | 4* | | 2 | | Yes |
| | ii) lower risk for recurrent DVT/PE | 3* | | 2 | | Yes |
| | d) Family history (first-degree relatives) | 2 | | 1 | | Yes |
| | e) Major surgery | | | | | |
| | (i) with prolonged immobilization | 4 | | 2 | | Yes |
| | (ii) without prolonged immobilization | 2 | | 1 | | Yes |
| | f) Minor surgery without immobilization | 1 | | 1 | | Yes |
| History of bariatric surgery‡ | a) Restrictive procedures | 1 | | 1 | | Yes |
| | b) Malabsorptive procedures | COCs: 3 | | 3 | | Yes |
| Breast disease/ Breast Cancer | a) Undiagnosed mass | 2* | | 2* | | Yes |
| | b) Benign breast disease | 1 | | 1 | | Yes |
| | c) Family history of cancer | 1 | | 1 | | Yes |
| | d) Breast cancer:‡ | | | | | |
| | i) current | 4 | | 4 | | Yes |
| | ii) past and no evidence of current disease for 5 years | 3 | | 3 | | Yes |

# Alphabetical Listing of USMEC Contraceptive Eligibility By Disease State

| Condition | Sub-condition | Combined pill, patch, ring | | Progestin-only pill | | Other Contraception Options Indicated for Patient |
|---|---|---|---|---|---|---|
| | | Initiating | Continuing | Initiating | Continuing | |
| Pelvic inflammatory disease | a) Past, (assuming no current risk factors of STIs) | | | | | |
| | (i) with subsequent pregnancy | 1 | | 1 | | Yes |
| | (ii) without subsequent pregnancy | 1 | | 1 | | Yes |
| | b) Current | 1 | | 1 | | Yes |
| Peripartum cardiomyopathy‡ | a) Normal or mildly impaired cardiac function | | | | | |
| | (i) < 6 months | 4 | | 1 | | Yes |
| | (ii) ≥ 6 months | 3 | | 1 | | Yes |
| | b) Moderately or severely impaired cardiac function | 4 | | 2 | | Yes |
| Postabortion | a) First trimester | 1* | | 1* | | Yes |
| | b) Second trimester | 1* | | 1* | | Yes |
| | c) Immediately post-septic abortion | 1* | | 1* | | Yes |
| Postpartum (see also Breastfeeding) | a) < 21 days | 4 | | 1 | | Yes |
| | b) 21 days to 42 days | | | | | |
| | (i) with other risk factors for VTE | 3* | | 1 | | Yes |
| | (ii) without other risk factors for VTE | 2 | | 1 | | Yes |
| | c) > 42 days | 1 | | 1 | | Yes |
| Postpartum (in breastfeeding or non-breastfeeding women, including post-cesarean section) | a) < 10 minutes after delivery of the placenta | | | | | |
| | b) 10 minutes after delivery of the placenta to < 4 weeks | | | | | |
| | c) ≥ 4 weeks | | | | | |
| | d) Puerperal sepsis | | | | | |
| Pregnancy | | NA* | | NA* | | NA* |
| Rheumatoid arthritis | a) On immunosuppressive therapy | 2 | | 1 | | Yes |
| | b) Not on immunosuppressive therapy | 2 | | 1 | | Yes |
| Schistosomiasis | a) Uncomplicated | 1 | | 1 | | Yes |
| | b) Fibrosis of the liver‡ | 1 | | 1 | | Yes |
| Severe dysmenorrhea | | 1 | | 1 | | Yes |
| Sexually transmitted infections (STIs) | a) Current purulent cervicitis or chlamydial infection or gonorrhea | 1 | | 1 | | Yes |
| | b) Other STIs (excluding HIV and hepatitis) | 1 | | 1 | | Yes |
| Sexually transmitted infections (cont.) | c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis) | 1 | | 1 | | Yes |
| | d) Increased risk of STIs | 1 | | 1 | | Yes |
| Smoking | a) Age < 35 | 2 | | 1 | | Yes |
| | b) Age ≥ 35, < 15 cigarettes/day | 3 | | 1 | | Yes |
| | c) Age ≥ 35, ≥15 cigarettes/day | 4 | | 1 | | Yes |
| Solid organ transplantation‡ | a) Complicated | 4 | | 2 | | Yes |
| | b) Uncomplicated | 2* | | 2 | | Yes |
| Stroke‡ | History of cerebrovascular accident | 4 | | 2 | 3 | Yes |
| Superficial venous thrombosis | a) Varicose veins | 1 | | 1 | | Yes |
| | b) Superficial thrombophlebitis | 2 | | 1 | | Yes |
| Systemic lupus erythematosus‡ | a) Positive (or unknown) antiphospholipid antibodies | 4 | | 3 | | Yes |
| | b) Severe thrombocytopenia | 2 | | 2 | | Yes |
| | c) Immunosuppressive treatment | 2 | | 2 | | Yes |
| | d) None of the above | 2 | | 2 | | Yes |
| Thrombogenic mutations‡ | | 4* | | 2* | | Yes |

| Condition | Sub-condition | Combined pill, patch, ring | | Progestin-only pill | | Other Contraception Options Indicated for Patient |
|---|---|---|---|---|---|---|
| | | Initiating | Continuing | Initiating | Continuing | |
| Thyroid disorders | Simple goiter/ hyperthyroid/hypothyroid. | 1 | | 1 | | Yes |
| Tuberculosis‡ (see also Drug Interactions) | a) Non-pelvic | 1* | | 1* | | Yes |
| | b) Pelvic | 1* | | 1* | | Yes |
| Unexplained vaginal bleeding | (suspicious for serious condition) before evaluation | 2* | | 2* | | Yes |
| Uterine fibroids | | 1 | | 1 | | Yes |
| Valvular heart disease | a) Uncomplicated | 2 | | 1 | | Yes |
| | b) Complicated‡ | 4 | | 1 | | Yes |
| Vaginal bleeding patterns | a) Irregular pattern without heavy bleeding | 1 | | 2 | | Yes |
| | b) Heavy or prolonged bleeding | 1* | | 2* | | Yes |
| Viral hepatitis | a) Acute or flare | 3/4* | 2 | 1 | | Yes |
| | b) Carrier/Chronic | 1 | 1 | 1 | | Yes |
| Antiretroviral therapy (All other ARVs are 1 or 2 for all methods) | Fosamprenavir (FPV) | 3* | | 2* | | Yes |
| Anticonvulsant therapy | a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine) | 3* | | 3* | | Yes |
| | b) Lamotrigine | 3* | | 1 | | Yes |
| Antimicrobial therapy | a) Broad spectrum antibiotics | 1 | | 1 | | Yes |
| | b) Antifungals | 1 | | 1 | | Yes |
| | c) Antiparasitics | 1 | | 1 | | Yes |
| | d) Rifampicin or rifabutin therapy | 3* | | 3* | | Yes |
| SSRIs | | 1 | | 1 | | Yes |
| St. John's Wort | | 2 | | 2 | | Yes |

I = initiation of contraceptive method; C = continuation of contraceptive method; NA = Not applicable
* Please see the complete guidance for a clarification to this classification: www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm
‡ Condition that exposes a woman to increased risk as a result of unintended pregnancy.

PO Box 7486 • Madison WI 53707-7486
608-268-5074 (Madison) • 866-849-2536 (toll-free) • 608-256-3370 (fax)
info@wifamilyaction.org • www.wifamilyaction.org

**TESTIMONY IN OPPOSITION TO SENATE BILL 30**
**SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES**
**TUESDAY, FEBRUARY 9, 2021**
**JULAINE K. APPLING, PRESIDENT**

Thank you, Chairman Testin and committee members, for the opportunity to testify on Senate Bill 286. Wisconsin Family Action opposes this bill. We acknowledge the stated intent of the authors, but we believe the problems that come with this proposal far outweigh the good intentions.

First, let me clarify our organizational position on contraceptives in general. We do not take a position on whether or not a married couple should use contraception, unless a contraceptive method can result in the destruction of the fertilized egg, which generally happens because a contraceptive drug or device often prevents a fertilized egg from implanting in the uterine wall. We have never promoted contraception for unmarried persons because that position is inconsistent with our belief that what is in the best interest of unmarried individuals is to remain sexually abstinent until marriage and faithful to their spouse when they do marry.

Allowing pharmacists to prescribe and dispense contraception, at least to some degree, promotes unmarried individuals engaging in sexual activity. The argument that these individuals will get contraceptives somewhere, and it may as well be from a pharmacist who can't perform an abortion, rings hollow. Pharmacies often are much more convenient in location and hours than are other places where contraceptives might be obtained, increasing the likelihood that more women will turn to pharmacists for their prescriptions. Should the contraception fail, and studies show it surely does at times, and a woman becomes pregnant, that the woman received the contraception from a pharmacist rather than from an organization that performs abortions will not deter the woman from having an abortion if that is what she is determined to do.

I think it is also important to note that this proposed change in the scope of practice for pharmacists is not about health-care. Contraception is not health care. Contraception is about the personal choices and decisions of individual women, typically made under the advice and guidance of a doctor because of the potency of the pharmaceuticals involved. To talk in terms of this being about women's health care is, at a minimum, disingenuous.

In addition, some contraceptives are known to cause a pre-implantation chemical abortion, as I referenced earlier. Scientifically, we know life begins at conception. Contraceptives that make it impossible for this newly conceived human being to implant in the uterine wall destroy the human being in the earliest stages of development.

Further, we are concerned about the well-being of the individual woman seeking the contraception. The bill provides that the person must complete "a self-assessment questionnaire and undergo a blood pressure screening." Based on this very limited information, most of which is self-reporting, the pharmacist must determine whether it is safe to prescribe a contraceptive for a given individual. The presumption is, of course, that the individual is accurately reporting his/her medical situation historically and currently. Inaccurate medical information could be dangerous, even in some instances fatal.

This same law is in effect in Colorado, and the self-assessment questionnaire that state uses is available online, as is the Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use (copy attached). That chart makes it clear a significant number of medical conditions pose a "theoretical or proven risk" or even an "unacceptable health risk" for contraceptives. If the individual has an undisclosed condition that dictates that contraceptives should not be used and the pharmacist, in good faith, prescribes and dispenses some form of contraception, the individual's health is at a minimum compromised.

Should this burden rest on a pharmacist who is severely limited in what he or she can learn about the real health of the individual seeking the contraception? Blood pressure is only one measure of one's health; it is certainly not something physicians typically rely on in isolation (or even in conjunction with a self-administered assessment) to determine one's overall health or the appropriateness of a certain prescription. Pharmacists cannot do further diagnostic testing or assessments.

Additionally, what is to prevent a woman who has a severe reaction to the prescribed and dispensed contraception from suing the pharmacist and/or the pharmacy? The language of the bill does not address the liability of the pharmacist or the pharmacy, which presumably would have some culpability since the pharmacist is acting in his/her official capacity as an employee of the pharmacy. Last session during a public hearing, a committee member asked a testifying pharmacist about liability. The pharmacist speaking in support of the proposal said, "We don't know about liability." When I followed up with my testimony and addressed this issue, a committee member responded to me by saying, "You know we frequently pass bills where we don't know who is liable." I suggested that perhaps this is not the wisest course of action for the state legislature, particularly in this instance and especially in the ultra-litigious society in which we live.

We also oppose this bill because it puts pharmacists who may have religious or conscience objections to prescribing contraception in general and in particular contraception that is known to be abortifacient, in a difficult position. We currently have no specific statutory protection for the religious or conscience rights of pharmacists. While the bill does not force any pharmacy to take part in this prescription-writing authority, it's safe to say many will. Imagine a pharmacist working for a pharmacy that decides to do this and thereby requires its pharmacists to either write prescriptions for contraception or face disciplinary action, which could even involve dismissal.

For these reasons, we urge this committee to oppose this bill that is not in the best interest of those seeking contraception or in the best interest of the pharmacists.

Thank you for your attention and thoughtful consideration of our position on this proposal.

# Hormonal Contraceptive Self-Screening Questionnaire (form updated Nov16)

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 ☐ No☐ |
| 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?<br>Have you previously had contraceptives prescribed to you by a pharmacist? | Yes ☐ No ☐<br>Yes ☐ No ☐ |
| | Did you ever experience a bad reaction to using hormonal birth control? | Yes ☐ No ☐ |
| | - If yes, what kind of reaction occurred? | __________ |
| | Are you currently using any method of birth control including pills, or a birth control patch, ring or shot/injection? | Yes ☐ No ☐ |
| | - If yes, which one do you use? | __________ |
| 4 | Have you ever been told by a medical professional not to take hormones? | Yes ☐ No ☐ |
| 5 | Do you smoke cigarettes? | Yes ☐ No ☐ |

***Medical History:***

| | | |
|---|---|---|
| 6 | Have you given birth within 21 days? If yes, how long ago? | Yes ☐ No ☐ |
| 7 | Are you currently breastfeeding? | Yes ☐ No ☐ |
| 8 | Do you have diabetes? | Yes ☐ No ☐ |
| 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 ☐ No ☐ |
| 10 | Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication) | Yes ☐ No ☐ |
| 11 | Have you ever had a heart attack or stroke, or been told you had any heart disease? | Yes ☐ No ☐ |
| 12 | Have you ever had a blood clot? | Yes ☐ No ☐ |
| 13 | Have you ever been told by a medical professional that you are at risk of developing a blood clot? | Yes ☐ No ☐ |
| 14 | Have you had recent major surgery or are you planning to have surgery in the next 4 weeks? | Yes ☐ No ☐ |
| 15 | Have you had bariatric surgery or stomach reduction surgery? | Yes ☐ No ☐ |
| 16 | Do you have or have you ever had breast cancer? | Yes ☐ No ☐ |
| 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 ☐ No ☐ |
| 18 | Do you have lupus, rheumatoid arthritis, or any blood disorders? | Yes ☐ No ☐ |
| 19 | Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? | Yes ☐ No ☐ |
| | - If yes, list them here: | |
| 20 | Do you have any other medical problems or take any medications, including herbs or supplements? | Yes ☐ No ☐ |
| | - If yes, list them here: | |
| 21 | Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.) | |

**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* ☐ verified DOB* with valid photo ID ☐ BP Reading _______/______

Pharmacist Name ________________________ Pharmacist Signature ________________________

☐ Drug Prescribed__________________ Rx# ____________ -or- ☐ Patient Referred-circle reason(s)

Sig: ____________________(Pharmacy Phone ____________ Address ____________________ )

Notes: ______________________________________________________________

# Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

| Condition | Sub-Condition | Cu-IUD I | Cu-IUD C | LNG-IUD I | LNG-IUD C | Implant I | Implant C | DMPA I | DMPA C | POP I | POP C | CHC I | CHC C |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | | Menarche to <20 yrs:2<br>≥20 yrs:1 | | Menarche to <20 yrs:2<br>≥20 yrs:1 | | Menarche to <18 yrs:1<br>18-45 yrs:1<br>>45 yrs:1 | | Menarche to <18 yrs:2<br>18-45 yrs:1<br>>45 yrs:2 | | Menarche to <18 yrs:1<br>18-45 yrs:1<br>>45 yrs:1 | | Menarche to <40 yrs:1<br>≥40 yrs:2 | |
| Anatomical abnormalities | a) Distorted uterine cavity | 4 | | 4 | | | | | | | | | |
| | b) Other abnormalities | 2 | | 2 | | | | | | | | | |
| Anemias | a) Thalassemia | 2 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Sickle cell disease‡ | 2 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | c) Iron-deficiency anemia | 2 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Benign ovarian tumors | (*including cysts*) | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Breast disease | a) Undiagnosed mass | 1 | | 2 | | 2* | | 2* | | 2* | | 2* | |
| | b) Benign breast disease | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | c) Family history of cancer | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | d) Breast cancer‡ | | | | | | | | | | | | |
| | i) Current | 1 | | 4 | | 4 | | 4 | | 4 | | 4 | |
| | ii) Past and no evidence of current disease for 5 years | 1 | | 3 | | 3 | | 3 | | 3 | | 3 | |
| Breastfeeding | a) <21 days postpartum | | | | | 2* | | 2* | | 2* | | 4* | |
| | b) 21 to <30 days postpartum | | | | | | | | | | | | |
| | i) With other risk factors for VTE | | | | | 2* | | 2* | | 2* | | 3* | |
| | ii) Without other risk factors for VTE | | | | | 2* | | 2* | | 2* | | 3* | |
| | c) 30-42 days postpartum | | | | | | | | | | | | |
| | i) With other risk factors for VTE | | | | | 1* | | 1* | | 1* | | 3* | |
| | ii) Without other risk factors for VTE | | | | | 1* | | 1* | | 1* | | 2* | |
| | d) >42 days postpartum | | | | | 1* | | 1* | | 1* | | 2* | |
| Cervical cancer | Awaiting treatment | 4 | 2 | 4 | 2 | 2 | | 2 | | 1 | | 2 | |
| Cervical ectropion | | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Cervical intraepithelial neoplasia | | 1 | | 2 | | 2 | | 2 | | 1 | | 2 | |
| Cirrhosis | a) Mild (*compensated*) | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Severe‡ (*decompensated*) | 1 | | 3 | | 3 | | 3 | | 3 | | 4 | |
| Cystic fibrosis‡ | | 1* | | 1* | | 1* | | 2* | | 1* | | 1* | |
| Deep venous thrombosis (DVT)/Pulmonary embolism (PE) | a) History of DVT/PE, not receiving anticoagulant therapy | | | | | | | | | | | | |
| | i) Higher risk for recurrent DVT/PE | 1 | | 2 | | 2 | | 2 | | 2 | | 4 | |
| | ii) Lower risk for recurrent DVT/PE | 1 | | 2 | | 2 | | 2 | | 2 | | 3 | |
| | b) Acute DVT/PE | 2 | | 2 | | 2 | | 2 | | 2 | | 4 | |
| | c) DVT/PE and established anticoagulant therapy for at least 3 months | | | | | | | | | | | | |
| | i) Higher risk for recurrent DVT/PE | 2 | | 2 | | 2 | | 2 | | 2 | | 4* | |
| | ii) Lower risk for recurrent DVT/PE | 2 | | 2 | | 2 | | 2 | | 2 | | 3* | |
| | d) Family history (*first-degree relatives*) | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | e) Major surgery | | | | | | | | | | | | |
| | i) With prolonged immobilization | 1 | | 2 | | 2 | | 2 | | 2 | | 4 | |
| | ii) Without prolonged immobilization | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | f) Minor surgery without immobilization | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Depressive disorders | | 1* | | 1* | | 1* | | 1* | | 1* | | 1* | |

**Key:**

| | |
|---|---|
| 1 No restriction (method can be used) | 3 Theoretical or proven risks usually outweigh the advantages |
| 2 Advantages generally outweigh theoretical or proven risks | 4 Unacceptable health risk (method not to be used) |

| Condition | Sub-Condition | Cu-IUD I | Cu-IUD C | LNG-IUD I | LNG-IUD C | Implant I | Implant C | DMPA I | DMPA C | POP I | POP C | CHC I | CHC C |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes | a) History of gestational disease | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Nonvascular disease | | | | | | | | | | | | |
| | i) Non-insulin dependent | 1 | | 2 | | 2 | | 2 | | 2 | | 2 | |
| | ii) Insulin dependent | 1 | | 2 | | 2 | | 2 | | 2 | | 2 | |
| | c) Nephropathy/retinopathy/neuropathy‡ | 1 | | 2 | | 2 | | 3 | | 2 | | 3/4* | |
| | d) Other vascular disease or diabetes of >20 years' duration‡ | 1 | | 2 | | 2 | | 3 | | 2 | | 3/4* | |
| Dysmenorrhea | Severe | 2 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Endometrial cancer‡ | | 4 | 2 | 4 | 2 | 1 | | 1 | | 1 | | 1 | |
| Endometrial hyperplasia | | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Endometriosis | | 2 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Epilepsy‡ | (*see also Drug Interactions*) | 1 | | 1 | | 1* | | 1* | | 1* | | 1* | |
| Gallbladder disease | a) Symptomatic | | | | | | | | | | | | |
| | i) Treated by cholecystectomy | 1 | | 2 | | 2 | | 2 | | 2 | | 2 | |
| | ii) Medically treated | 1 | | 2 | | 2 | | 2 | | 2 | | 3 | |
| | iii) Current | 1 | | 2 | | 2 | | 2 | | 2 | | 3 | |
| | b) Asymptomatic | 1 | | 2 | | 2 | | 2 | | 2 | | 2 | |
| Gestational trophoblastic disease‡ | a) Suspected GTD (immediate postevacuation) | | | | | | | | | | | | |
| | i) Uterine size first trimester | 1* | | 1* | | 1* | | 1* | | 1* | | 1* | |
| | ii) Uterine size second trimester | 2* | | 2* | | 1* | | 1* | | 1* | | 1* | |
| | b) Confirmed GTD | | | | | | | | | | | | |
| | i) Undetectable/non-pregnant ß-hCG levels | 1* | 1* | 1* | 1* | 1* | | 1* | | 1* | | 1* | |
| | ii) Decreasing ß-hCG levels | 2* | 1* | 2* | 1* | 1* | | 1* | | 1* | | 1* | |
| | iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease | 2* | 1* | 2* | 1* | 1* | | 1* | | 1* | | 1* | |
| | iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease | 4* | 2* | 4* | 2* | 1* | | 1* | | 1* | | 1* | |
| Headaches | a) Nonmigraine (mild or severe) | 1 | | 1 | | 1 | | 1 | | 1 | | 1* | |
| | b) Migraine | | | | | | | | | | | | |
| | i) Without aura (includes menstrual migraine) | 1 | | 1 | | 1 | | 1 | | 1 | | 2* | |
| | ii) With aura | 1 | | 1 | | 1 | | 1 | | 1 | | 4* | |
| History of bariatric surgery‡ | a) Restrictive procedures | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Malabsorptive procedures | 1 | | 1 | | 1 | | 1 | | 3 | | COCs: 3<br>P/R: 1 | |
| History of cholestasis | a) Pregnancy related | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | b) Past COC related | 1 | | 2 | | 2 | | 2 | | 2 | | 3 | |
| History of high blood pressure during pregnancy | | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| History of Pelvic surgery | | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| HIV | a) High risk for HIV | 1* | 1* | 1* | 1* | 1 | | 1 | | 1 | | 1 | |
| | b) HIV infection | | | | | 1* | | 1* | | 1* | | 1* | |
| | i) Clinically well receiving ARV therapy | 1 | 1 | 1 | 1 | If on treatment, see Drug Interactions | | | | | | | |
| | ii) Not clinically well or not receiving ARV therapy‡ | 2 | 1 | 2 | 1 | If on treatment, see Drug Interactions | | | | | | | |

**Abbreviations:** ARV = antiretroviral; C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring; SSRI=selective serotonin reuptake inhibitor; ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification. https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm

# Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

| Condition | Sub-Condition | Cu-IUD I | Cu-IUD C | LNG-IUD I | LNG-IUD C | Implant I | Implant C | DMPA I | DMPA C | POP I | POP C | CHC I | CHC C |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hypertension | a) Adequately controlled hypertension | 1* | | 1* | | 1* | | 2* | | 1* | | 3* | |
| | b) Elevated blood pressure levels (*properly taken measurements*) | | | | | | | | | | | | |
| | i) Systolic 140-159 or diastolic 90-99 | 1* | | 1* | | 1* | | 2* | | 1* | | 3* | |
| | ii) Systolic ≥160 or diastolic ≥100‡ | 1* | | 2* | | 2* | | 3* | | 2* | | 4* | |
| | c) Vascular disease | 1* | | 2* | | 2* | | 3* | | 2* | | 4* | |
| Inflammatory bowel disease | (*Ulcerative colitis, Crohn's disease*) | 1 | | 1 | | 1 | | 2 | | 2 | | 2/3* | |
| Ischemic heart disease‡ | Current and history of | 1 | | 2 | 3 | 2 | 3 | 3 | | 2 | 3 | 4 | |
| Known thrombogenic mutations‡ | | 1* | | 2* | | 2* | | 2* | | 2* | | 4* | |
| Liver tumors | a) Benign | | | | | | | | | | | | |
| | i) Focal nodular hyperplasia | 1 | | 2 | | 2 | | 2 | | 2 | | 2 | |
| | ii) Hepatocellular adenoma‡ | 1 | | 3 | | 3 | | 3 | | 3 | | 4 | |
| | b) Malignant‡ (hepatoma) | 1 | | 3 | | 3 | | 3 | | 3 | | 4 | |
| Malaria | | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Multiple risk factors for atherosclerotic cardiovascular disease | (e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels) | 1 | | 2 | | 2* | | 3* | | 2* | | 3/4* | |
| Multiple sclerosis | a) With prolonged immobility | 1 | | 1 | | 1 | | 2 | | 1 | | 3 | |
| | b) Without prolonged immobility | 1 | | 1 | | 1 | | 2 | | 1 | | 1 | |
| Obesity | a) Body mass index (BMI) ≥30 kg/m² | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | b) Menarche to <18 years and BMI ≥ 30 kg/m² | 1 | | 1 | | 1 | | 2 | | 1 | | 2 | |
| Ovarian cancer‡ | | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Parity | a) Nulliparous | 2 | | 2 | | 1 | | 1 | | 1 | | 1 | |
| | b) Parous | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Past ectopic pregnancy | | 1 | | 1 | | 1 | | 1 | | 2 | | 1 | |
| Pelvic inflammatory disease | a) Past | | | | | | | | | | | | |
| | i) With subsequent pregnancy | 1 | 1 | 1 | 1 | 1 | | 1 | | 1 | | 1 | |
| | ii) Without subsequent pregnancy | 2 | 2 | 2 | 2 | 1 | | 1 | | 1 | | 1 | |
| | b) Current | 4 | 2* | 4 | 2* | 1 | | 1 | | 1 | | 1 | |
| Peripartum cardiomyopathy‡ | a) Normal or mildly impaired cardiac function | | | | | | | | | | | | |
| | i) <6 months | 2 | | 2 | | 1 | | 1 | | 1 | | 4 | |
| | ii) ≥6 months | 2 | | 2 | | 1 | | 1 | | 1 | | 3 | |
| | b) Moderately or severely impaired cardiac function | 2 | | 2 | | 2 | | 2 | | 2 | | 4 | |
| Postabortion | a) First trimester | 1* | | 1* | | 1* | | 1* | | 1* | | 1* | |
| | b) Second trimester | 2* | | 2* | | 1* | | 1* | | 1* | | 1* | |
| | c) Immediate postseptic abortion | 4 | | 4 | | 1* | | 1* | | 1* | | 1* | |
| Postpartum (*nonbreastfeeding women*) | a) <21 days | | | | | 1 | | 1 | | 1 | | 4 | |
| | b) 21 days to 42 days | | | | | | | | | | | | |
| | i) With other risk factors for VTE | | | | | 1 | | 1 | | 1 | | 3* | |
| | ii) Without other risk factors for VTE | | | | | 1 | | 1 | | 1 | | 2 | |
| | c) >42 days | | | | | 1 | | 1 | | 1 | | 1 | |
| Postpartum (*in breastfeeding or non-breastfeeding women, including cesarean delivery*) | a) <10 minutes after delivery of the placenta | | | | | | | | | | | | |
| | i) Breastfeeding | 1* | | 2* | | | | | | | | | |
| | ii) Nonbreastfeeding | 1* | | 1* | | | | | | | | | |
| | b) 10 minutes after delivery of the placenta to <4 weeks | 2* | | 2* | | | | | | | | | |
| | c) ≥4 weeks | 1* | | 1* | | | | | | | | | |
| | d) Postpartum sepsis | 4 | | 4 | | | | | | | | | |

| Condition | Sub-Condition | Cu-IUD I | Cu-IUD C | LNG-IUD I | LNG-IUD C | Implant I | Implant C | DMPA I | DMPA C | POP I | POP C | CHC I | CHC C |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pregnancy | | 4* | | 4* | | NA* | | NA* | | NA* | | NA* | |
| Rheumatoid arthritis | a) On immunosuppressive therapy | 2 | 1 | 2 | 1 | 1 | | 2/3* | | 1 | | 2 | |
| | b) Not on immunosuppressive therapy | 1 | | 1 | | 1 | | 2 | | 1 | | 2 | |
| Schistosomiasis | a) Uncomplicated | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Fibrosis of the liver‡ | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Sexually transmitted diseases (STDs) | a) Current purulent cervicitis or chlamydial infection or gonococcal infection | 4 | 2* | 4 | 2* | 1 | | 1 | | 1 | | 1 | |
| | b) Vaginitis (*including trichomonas vaginalis and bacterial vaginosis*) | 2 | 2 | 2 | 2 | 1 | | 1 | | 1 | | 1 | |
| | c) Other factors relating to STDs | 2* | 2 | 2* | 2 | 1 | | 1 | | 1 | | 1 | |
| Smoking | a) Age <35 | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | b) Age ≥35, <15 cigarettes/day | 1 | | 1 | | 1 | | 1 | | 1 | | 3 | |
| | c) Age ≥35, ≥15 cigarettes/day | 1 | | 1 | | 1 | | 1 | | 1 | | 4 | |
| Solid organ transplantation‡ | a) Complicated | 3 | 2 | 3 | 2 | 2 | | 2 | | 2 | | 4 | |
| | b) Uncomplicated | 2 | | 2 | | 2 | | 2 | | 2 | | 2* | |
| Stroke‡ | History of cerebrovascular accident | 1 | | 2 | | 2 | 3 | 3 | | 2 | 3 | 4 | |
| Superficial venous disorders | a) Varicose veins | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Superficial venous thrombosis (acute or history) | 1 | | 1 | | 1 | | 1 | | 1 | | 3* | |
| Systemic lupus erythematosus‡ | a) Positive (or unknown) antiphospholipid antibodies | 1* | 1* | 3* | | 3* | | 3* | 3* | 3* | | 4* | |
| | b) Severe thrombocytopenia | 3* | 2* | 2* | | 2* | | 3* | 2* | 2* | | 2* | |
| | c) Immunosuppressive therapy | 2* | 1* | 2* | | 2* | | 2* | 2* | 2* | | 2* | |
| | d) None of the above | 1* | 1* | 2* | | 2* | | 2* | 2* | 2* | | 2* | |
| Thyroid disorders | Simple goiter/ hyperthyroid/hypothyroid | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Tuberculosis‡ (*see also Drug Interactions*) | a) Nonpelvic | 1 | 1 | 1 | 1 | 1* | | 1* | | 1* | | 1* | |
| | b) Pelvic | 4 | 3 | 4 | 3 | 1* | | 1* | | 1* | | 1* | |
| Unexplained vaginal bleeding | (suspicious for serious condition) before evaluation | 4* | 2* | 4* | 2* | 3* | | 3* | | 2* | | 2* | |
| Uterine fibroids | | 2 | | 2 | | 1 | | 1 | | 1 | | 1 | |
| Valvular heart disease | a) Uncomplicated | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | b) Complicated‡ | 1 | | 1 | | 1 | | 1 | | 1 | | 4 | |
| Vaginal bleeding patterns | a) Irregular pattern without heavy bleeding | 1 | | 1 | 1 | 2 | | 2 | | 2 | | 1 | |
| | b) Heavy or prolonged bleeding | 2* | | 1* | 2* | 2* | | 2* | | 2* | | 1* | |
| Viral hepatitis | a) Acute or flare | 1 | | 1 | | 1 | | 1 | | 1 | | 3/4* | 2 |
| | b) Carrier/Chronic | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | 1 |
| **Drug Interactions** | | | | | | | | | | | | | |
| Antiretrovirals used for prevention (PrEP) or treatment of HIV | Fosamprenavir (FPV)<br>All other ARVs are 1 or 2 for all methods. | 1/2* | 1* | 1/2* | 1* | 2* | | 2* | | 2* | | 3* | |
| Anticonvulsant therapy | a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine) | 1 | | 1 | | 2* | | 1* | | 3* | | 3* | |
| | b) Lamotrigine | 1 | | 1 | | 1 | | 1 | | 1 | | 3* | |
| Antimicrobial therapy | a) Broad spectrum antibiotics | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Antifungals | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | c) Antiparasitics | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | d) Rifampin or rifabutin therapy | 1 | | 1 | | 2* | | 1* | | 3* | | 3* | |
| SSRIs | | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| St. John's wort | | 1 | | 1 | | 2 | | 1 | | 2 | | 2 | |

**Updated in 2020.** This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm. Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condom reduces the risk of STDs and HIV.

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UWHealth | School of Medicine and Public Health
UNIVERSITY OF WISCONSIN-MADISON

**Contact: Connie Schulze**
Director, Government Affairs
608/516-2552
cschulze@uwhealth.org

**Senate Committee on Health**
**Testimony submitted by Laurel Rice, MD**
**Chair, Department of Obstetrics/Gynecology**
**RE: Support for SB30**
**February 9, 2021**

Dear Chairman Testin and members of the committee:

Thank you for this opportunity to share my support for Senate Bill 30 (SB30) as introduced by Sen. Mary Felzkowski and Rep. Joel Kitchens. I currently serve as the Chair of the Department of Obstetrics and Gynecology and as a professor in the Division of Gynecologic Oncology at the University of Wisconsin School of Medicine and Public Health. However, I began my career in health care as a licensed pharmacist, having worked my way through medical school from behind the pharmacy counter. The understanding of women's health care that I have gleaned from both roles makes me uniquely qualified to weigh-in on this legislation.

In practice both as an OB/GYN and as a pharmacist, I have seen first-hand the need for easily accessible and reliable contraceptives. Women, children and families benefit from contraceptives that help to prevent unplanned pregnancies. Efforts to expand access to birth control options like the "patch" and the "pill" should be supported because they are safe and effective. While it's true they are only available by prescription, decades of research has demonstrated there is little chance of abuse with these medications and the side effects are minimal. So much so that many experts in health care believe the FDA should make them readily available over-the-counter, as is the case in many other developed nations.

With access in-mind, I see SB30 as a step in the right direction. Wisconsin faces a growing physician shortage and the consequence of that shortage is limited access to care in many areas of the state. In fact, data released by the American Medical Association in 2017 indicates 29 of Wisconsin's 72 counties have only one OB/GYN or none at all. By expanding access to safe and reliable contraceptives like the patch and the pill through licensed pharmacists, we are offering a work around to that shortage. Of course, as a physician I feel strongly that all health care providers should practice to the top of their license but not outside the scope of their expertise. I am confident Wisconsin's licensed pharmacists are qualified to undertake the task of prescribing and dispensing hormonal contraceptives which is already the practice in 12 states.

As you explore the implications of the proposed public policy, I'll leave you with one final thought. That is the financial burden of unplanned pregnancy. The Guttmacher Institute has researched associated costs and determined in Wisconsin, almost 63 percent of unplanned births are publicly-funded, with federal and state governments spending $313.5 million each year on this care. Of that total, $221.4 million is paid for by federal tax dollars and $92.1 million by state tax dollars. The total public cost for unintended pregnancies in Wisconsin is $286 per woman, which is considerably higher than the national average of $201 per woman. Nevertheless, we can turn the tide. A similar law passed in Oregon and it was found to have prevented more than 50 unintended pregnancies and saved an estimated $1.6 million in associated taxpayer costs in the first two years the law went into effect, according to a study from Oregon State University.

For the reasons I have outlined above, I hope you see fit to join me in supporting SB30. Thank you for your consideration.

WISCONSIN CATHOLIC CONFERENCE

**SENATE COMMITTEE ON HEALTH**
**TESTIMONY REGARDING SENATE BILL 30:**
**PHARMACIST CONTRACEPTIVE PRESCRIBING**
**Presented by Kim Vercauteren, Executive Director**
**February 9, 2021**

The Wisconsin Catholic Conference (WCC), the public policy voice of the Catholic bishops of Wisconsin, urges you to oppose Senate Bill 30, which allows pharmacists to prescribe certain hormonal contraceptives. This bill not only impacts women's health in Wisconsin, but also alters established medical standards and impacts the individual conscience rights of pharmacists.

The Catholic Church opposes the use of artificial contraception. However, the Church's objection to artificial contraception is not about trying to penalize or control individuals. It is about prizing the most creative power that we human beings possess. It is about protecting the human dignity of parents and their unborn children. It is about reminding society that women should not have to radically delay childbirth, artificially suppress their fertility, or ingest strong chemicals in order to get an education and participate in the workforce at every level.

The Church teaches that the use of artificial contraception restricts the total self-giving of spouses and introduces a "false note" in a marriage, sometimes causing one or both spouses to treat each other more like objects rather than people. In some cases, the failure of contraception may tempt couples to seek an abortion when an unwanted life is conceived. In other cases, hormonal contraception interferes with implantation, thus ending a new human life. Finally, scientists now recognize that the growing presence of hormonal contraceptives in our waterways is having an adverse effect on the environment and on aquatic species. For all these reasons, the Church encourages all to "go organic" and utilize Natural Family Planning rather than artificial hormonal contraception.

In addition to these concerns, pharmacist prescription of contraceptives could have adverse health impacts on both a woman and her unborn child. This is because under SB 30, there would be no requirements that a pharmacist test for pregnancy, order diagnostic exams that would provide a comprehensive assessment of a woman's current health status, or even have access to a woman's complete medical history and records, all of which normally inform the medical decision-making process. For example, hormonal contraception may be contraindicated if a woman has certain health conditions, such as hypertension, diabetes, certain types of migraines, or multiple risk factors for heart disease. A doctor would have access to the woman's full medical history, as well as diagnostic tests, but a pharmacist would not.

Furthermore, while SB 30 charges certain state entities with designing the standards and rules for implementing pharmacist prescribing, these requirements are limited by the bounds of state law regarding who may engage in the practice of medicine.

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131 W. Wilson Street • Suite 1105 • Madison, WI 53703
Tel 608/257-0004 • Fax 608/257-0376 • Website http://www.wisconsincatholic.org

Lastly, in an era when public health advocates and policy makers are trying to improve comprehensive and high-quality primary care through regular patient-provider interactions, it is difficult to understand the need for a law that discourages individuals from annually meeting with their primary provider.

In permitting pharmacists to prescribe contraceptives, the bill also significantly alters the current legal requirements for dispensing prescriptions. Currently under Wisconsin Statutes s. 450.095, the duty to dispense lies with a pharmacy, not the individual pharmacist. A pharmacy may forgo filling a prescription if it is incompatible with another drug or device prescribed for the patient, is prohibited by state or federal law, or is fraudulent, among other reasons.

Under SB 30, once a pharmacist opts to prescribe contraceptives, the bill directs the pharmacist to then dispense the contraception. However, what if a pharmacist were to learn, after writing the prescription, of new information that would trigger a need to forgo dispensation, such as the customer committed fraud and lied about their age? It is uncertain, given the SB 30's mandate to dispense, whether the pharmacist must continue to dispense in these circumstances.

Also, the current pharmacy duty to dispense preserves an individual pharmacist's right of conscience. This aligns with Article I, Section 18 of our Wisconsin Constitution, which explicitly affirms, "nor shall any control of, or interference with, the rights of conscience be permitted." Should SB 30 become law, commercial pharmacy chains will likely make corporate policies instituting mandatory prescribing for their pharmacists, negating the permissive choice for pharmacists highlighted by SB 30's supporters. Facilitating a commercial market where pharmacists will be expected to prescribe contraception will drive pharmacists of conscience to other states, including those that surround Wisconsin, where no such pressure to prescribe contraceptives exists.

As a Church, we recognize an inherent and inalienable dignity in every human being. Our health care system should preserve this dignity by ensuring that best practice standards are observed when prescribing synthetic hormonal medications to women. Legislation that fails to promote and protect our humanity and coerces the conscience of medical professionals should not be supported. We urge you to oppose SB 30.

Thank you.