Overview of Medication Abortion

Pharmacies that dispense mifepristone: https://genbiopro.com/roster/
To order mifepristone with overnight delivery, costs less than $60 per pill
https://www.reproductiveaccess.org/resource/order-mifepristone/
https://www.plancpills.org/
Clinician Warmlines 1-844-737-7644 (1-844-ReproHH), 8am to 4pm PST
1-877-432-7596**:** On-call help for providers managing patients who have taken mifepristone
FDA-mandated Patient Agreement Form - Sign one of these 2 documents prior to taking mifepristone
https://genbiopro.com/wp-content/uploads/2023/07/GBP-MIF-716-Patient-Agreement.pdf
https://www.earlyoptionpill.com/wp-content/uploads/2023/02/DANCO_PatientAgreement_ENG_Web.pdf
Patient Medication Guide - Review with patients (available in Spanish, Arabic, French, Chinese, Hindi, Vietnamese, Russian)
https://genbiopro.com/products/mifepristone/prescribers/abortion-resources/
http://www.earlyoptionpill.com/wp-content/uploads/2016/01/DAN_MedGuideEng_FINAL.pdf
Photos of early pregnancy tissue https://abortionpillcme.teachtraining.org/POC.png
Emotional support https://exhaleprovoice.org/ and https://www.faithaloud.org/
State Laws, Policies & Requirements
Reporting https://www.guttmacher.org/state-policy/explore/abortion-reporting-requirements
Shield laws https://www.kff.org/other/state-indicator/shield-laws
Training in Early Abortion for Comprehensive Healthcare (TEACH) – provider workbook https://www.teachtraining.org
National Abortion Federation (NAF) Clinical Policy Guidelines https://prochoice.org/providers/quality-standards/
Reproductive Health Access Project (RHAP)- patient & provider education https://www.reproductiveaccess.org/abortion/
Reproductive Health Education in Family Medicine - provider education https://rhedi.org/education/medication-abortion/

Why:

- **One of every four** individuals in the US of childbearing potential has an abortion[1] and at least as many have a miscarriage.
- **Early abortion or miscarriage** can be managed with a single dose of mifepristone followed by misoprostol.
- **Patients must travel increasing distances** to obtain clinical assistance with an abortion or miscarriage.[2] This is unfortunate as both can be easily and safely managed by primary care providers.[3,4]
- **Abortion pills** have no long-term adverse effects on health or fertility.[5] In contrast, those turned away after seeking abortion services report worse physical health[6] and more poverty[7] five years later.
- **More than half** of all abortions are medication abortions.[8]

Who: **Licensed physicians—and, in 24 states, advanced practice clinicians[9]**—can provide mifepristone. Most patients who received abortions from primary care providers are very satisfied with the experience,[10] and most general medicine patients felt their clinic should provide medication abortion.[11]

What:

- **Misoprostol** ("Miso") - a prostaglandin analogue, induces uterine contractions and cervical dilation. Marketed as Cytotec to prevent gastric ulcers,[12] it is used off-label for multiple gynecologic indications, including miscarriage management. Misoprostol alone can induce abortion[13] when dosed as 800mcg vaginally/sublingually every 3 hours for a total of 3 doses (i.e., Rx: Misoprostol 200mcg tablets #12. Place 4 tablets vaginally every 3 hours[14]). However, 7% using misoprostol alone to induce abortion have ongoing pregnancies and 22% require a uterine aspiration procedure.[15] When pregnancy continues after attempted medication abortion, misoprostol's teratogenic risk[16] must be considered.
- **Mifepristone** ("Mife," originally called RU486) - a progesterone-receptor antagonist, causes detachment of pregnancy tissue from the uterus and increases the effectiveness of misoprostol for abortion. Mifepristone alone is not very effective for medication abortion.[17]
- **Methotrexate** – historically used for early abortion[18] is less well tolerated than the combination of mifepristone with misoprostol for medication abortion (although methotrexate is still used to treat ectopic pregnancy).

When:

- **In 2000, the FDA approved mifepristone for medical termination of intrauterine pregnancy** through 49 days gestation. Over the last 24 years, millions of patients have safely used mifepristone. In 2016, the FDA updated the mifepristone package label for **use through 70 days gestation**.[19] Effectiveness varies by gestational age:
  - **<49 days**: <2% require more misoprostol or uterine aspiration.[20]
  - **<63 days:** 0.8% have continuing pregnancies and 3% require more misoprostol or uterine aspiration.[21]

- **63-70-days**: <3% have continuing pregnancies and <7% require more misoprostol or an aspiration procedure.[20] NAF guidelines suggest offering a 2nd dose of Miso 800 mcg 4 hours after the first dose, to decrease need for additional treatment to <1%.[21] Extra doses of miso are more important for patients in hostile communities.
- **>70 days:** repeated doses of misoprostol have been used after mifepristone to end pregnancies to 24 weeks;[22-23] NAF supports use of mifepristone to **77 days** with a 2nd dose of Miso 800 mcg taken 4 hours after the first dose,[25,26] which decreases need for more misoprostol or an aspiration procedure from 13% to <3%.[21]

- **When medically managing miscarriage** (off label), mifepristone 200 mg given before misoprostol increases effectiveness compared to misoprostol alone, reducing need for a procedure from 24% to 9% (NNT = 6).[27]

How:

- **The 2016 FDA-approved medication abortion regimen:** mifepristone 200 mg PO x 1 tab, followed 24-48 hours later by four 200 mcg tablets of misoprostol taken buccally (total 800 mcg misoprostol). An illustration[28] can be helpful in explaining how patients should place two misoprostol tablets between the cheek and gums for 30 minutes, after which any pill remnants can be swallowed. When misoprostol pills are simply swallowed more nausea is reported. The 2016 update to FDA labeling no longer requires providers watch patients swallow mifepristone, allowing greater flexibility for when a patient can initiate the regimen. Other evidence-based (but off-label) regimens include placing misoprostol vaginally (0-72 hours after mifepristone),[31-33] which may be useful for patients with nausea; vaginal misoprostol is most effective 24 hours after mifepristone. **Telehealth** can effectively support safe medication abortion.[29-30] Although some states have banned provision of medication abortion by telehealth, 22 states "shield" telehealth abortion providers caring for patients in states that restrict access to abortion.

- **Safety**: Using mifepristone and misoprostol to end a pregnancy is very safe, and at least 10 times safer than continuing a pregnancy to term.[34] Rare complications include bleeding requiring transfusion (0.05%).[35,36] Thus, risk of anemia should be assessed and those with a Hgb <9 may consider a procedure instead of abortion pills, although heavy bleeding is rare.[33] Prophylactic antibiotics are not recommended as endometritis rarely occurs after medication abortion.[37] STI testing should be offered to those with risk factors; if needed, antibiotics can be provided at the same time as mifepristone. After medication abortion, IV antibiotics are needed for endometritis extremely rarely (0.006% to 0.093%); only 0.04%-0.9% of those using mifepristone require hospitalization.[35]
- **Providing mifepristone:**
  (1) **Options counseling** and assure patient is certain of their decision to end the pregnancy.
  (2) **Date pregnancy** by LMP and assess for symptoms of ectopic pregnancy or infection. Ultrasound is not routinely required,[38] but is indicated if (a) uncertain gestational age or (b) concern of ectopic pregnancy.[39] Pelvic examination is only indicated if gestational age may be >10 weeks or patient has symptoms of ectopic pregnancy or infection.[39]
  (3) **No testing is required before providing mifepristone**[40]
    - if clinical concern for anemia, check hemoglobin level
    - Rh testing and anti-D immunoglobulin is NOT needed with abortion before 12 weeks.[41-43]
    - Clinical history with home urine pregnancy testing can confirm successful medication abortion.[44,45] Serial serum hCG is more reliable than ultrasound in confirming successful medication abortion. **Serum hCG should decline 50% by 3 days and 80% by 7 days after medication abortion.[46]** It is not necessary to follow hCG levels to zero. Residual uterine echogenic material and thickening are normal after medication abortion requiring no intervention unless accompanied by pain/cramping, excessive bleeding or concern of infection.[46]

  (4) **Rule out rare contraindications:**
    - Adrenal insufficiency or long-term oral steroids (inhaled and/or topical steroids NOT a contraindication)
    - Hemorrhagic disorders, or concurrent anticoagulant therapy (a procedure in monitored setting is advised)
    - Ectopic pregnancy or undiagnosed adnexal mass (treatment will not be effective)
    - Porphyria (risk of worsening or of precipitation of attacks)
    - Allergy to mifepristone, misoprostol, or other prostaglandins
    - IUD in place (must be removed first or cramping will be more painful).

  (5) **Counsel patient:**
    - When and how to take the medications
    - Expected side effects: spotting/bleeding or uterine cramping/contractions with mifepristone; after taking misoprostol, most people experience cramping and bleeding heavier than a typical period for < 6 hours.[47] Flu-like symptoms can occur (nausea, fever/chills, vomiting, diarrhea, and malaise) and should resolve within 6 to 24 hours. Spotting or bleeding for the next 1-2 weeks is common.[48,49] Few (<5%) patients have bothersome

bleeding after medication abortion;[35] those who do can be offered repeat misoprostol or a uterine aspiration.

- Pain management: NSAIDs are superior to acetaminophen for medication abortion pain.[50] Most patients taking ibuprofen alone are satisfied with their pain control.[47] In an RCT comparing therapeutic vs. prophylactic administration of ibuprofen for first-trimester medical abortion, pain was not significantly different; participants used substantially less ibuprofen in the "as needed" than "prophylactic" group.[51]

Patients should call for:

2 soaked pads/ hour for > 2 consecutive hours or **feel unwell > 24 hours after taking misoprostol.**
Excessive bleeding with dizziness, orthostatic hypotension, or a significant drop in hematocrit. This requires urgent evaluation [Very rare; only 0.03-0.06% of patients who take mifepristone need transfusion[20]] to rule out:

- Continuing pregnancy [Rare; 1.2-3.5%[20,52]] (managed with a repeat dose of misoprostol, or a uterine aspiration procedure.[39])
- Retained tissue or gestational sac (re-dose misoprostol; <4% require a procedure[20]),
- Endometritis [Rare; 0.5-0.9% treated for infection[20]], or
- Ectopic or molar pregnancy [Rare; <0.6%[35]].

NO significant bleeding after misoprostol warrants ultrasound to rule out:

- Continuing pregnancy [Rare; 1.2-3.5%[20]]
- Ectopic pregnancy [Very rare; <0.6%[35]].

Fever/chills or malaise >24 hours after misoprostol requires urgent evaluation and may indicate endometritis; however, IV antibiotics are needed extremely rarely (0.006% to 0.093%) after medication abortion.[35] Tachycardia, hypotension, leukocytosis, or hemoconcentration without fever >24 hours after taking misoprostol is extremely rare but requires prompt evaluation as toxic shock due to Clostridium Sordelli has been reported after medication abortion and can be fatal.[53]

Where:

- **In Dec 2021, the FDA allowed certified US pharmacies to dispense mifepristone**; previously US clinicians had to stock mifepristone in clinic and dispense mifepristone directly to patients. Clinics dispensing mifepristone do not need to have the ability to perform a uterine aspiration procedure. Prior to sending a pharmacy a prescription, clinicians must complete an online prescriber agreement (or fax the signed form to the pharmacy). Pills can be shipped overnight to clinics or directly to a patient's home by a mail-order pharmacy (eg AMOP or Honeybee), facilitating telehealth medication abortions.
- **In 2022, the Supreme Court decision in *Dobbs v. Jackson Women's Health* overturned *Roe v. Wade*,** leading to considerable state-level variation in the provision of abortion care. States restricting access to abortion pills may require in-person dispensing, restrict mailing of abortion pills, or specify that only physicians can prescribe medication abortion,[54] threatening that violators may be subject to civil and/or criminal penalties.[54]
- **"Shield laws"** in supportive states protect clinicians who provide abortions to patients in states where abortion is banned.[55] As shield laws do not patients in states with bans, some still opt to travel out of state for abortion care.
- **In Jan 2023, the FDA allowed retail US pharmacies to dispense mifepristone directly to patients.[55]** Prescribers who have a signed prescriber agreement on file with a participating pharmacy can prescribe mifepristone and patients can pick up and take the medication when they choose to. Ask your local pharmacies if they stock mifepristone.
- **In October 2025,** the FDA approved a second generic version of mifepristone produced by EvitaSolutions, LLC which is expected to be available January 2026, and will hopefully further lower medication costs
- **Mifepristone pills cost <$60/each** and have a shelf life of 18 months; unused, unopened pills can be returned to distributor for refund or exchange up to one year after expiration. Misoprostol is available in US pharmacies.

This means primary care providers can now safely and effectively use mifepristone to help their patients who need time-sensitive abortion or miscarriage management.

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