**Because WOCBP are more likely typical birth control users rather than perfect users, to ensure the safety of the subject and to prevent unintended pregnancies, one should consider using 2 forms of acceptable methods as a backup.**

**The ICH M3 (R2) has defined "highly effective" BCM as those alone or in combination resulting in a "low failure rate" or "very low failure rate" (e.g. less than 1% per year).**

**The aim of this guidance is to harmonize definition terms for what constitutes a WOCBP vs. WONCBP across studies**

Most times, hormonal contraception agents could be deemed viable options for WOCBP during Phase I/Phase II trials. However, study sites (IPs) may potentially interact with estrogens and progestagens, specifically through the hepatic cytochrome (CYP) (P450) metabolic system that may either increase or decrease the efficacy of hormonal contraceptives. Therefore, prior to recommending hormonal contraception on clinical trials, a thorough analysis of predicated in vivo and in vitro studies such as the evaluation of a study IP on whether it is a CYP substrate, inducer or inhibitor would be prudent to avoid decreased hormonal BCM efficacies and unintended pregnancies. Of note, there are several other molecular enzymes (e.g. urophilins, UGTs and glucuronidation) that may also metabolize BCMs. Therefore, the IP should be evaluated for its potential to interact with hormonal BCMs. Additionally, pregnant women should be excluded from all Clinical Pharmacology trials.