

1 ROBERT W. FERGUSON
 Attorney General
 2 NOAH GUZZO PURCELL, WSBA #43492
 Solicitor General
 3 KRISTIN BENESKI, WSBA #45478
 First Assistant Attorney General
 4 COLLEEN M. MELODY, WSBA #42275
 Civil Rights Division Chief
 5 ANDREW R.W. HUGHES, WSBA #49515
 LAURYN K. FRAAS, WSBA #53238
 6 Assistant Attorneys General
 TERA M. HEINTZ, WSBA #54921
 7 (application for admission forthcoming)
 Deputy Solicitor General
 8 800 Fifth Avenue, Suite 2000
 Seattle, WA 98104-3188
 9 (206) 464-7744

10
 11 **UNITED STATES DISTRICT COURT
 EASTERN DISTRICT OF WASHINGTON**

12 STATE OF WASHINGTON;
 STATE OF OREGON; STATE OF
 13 ARIZONA; STATE OF
 COLORADO; STATE OF
 14 CONNECTICUT; STATE OF
 DELAWARE; STATE OF
 15 ILLINOIS; ATTORNEY GENERAL
 OF MICHIGAN; STATE OF
 16 NEVADA; STATE OF NEW
 MEXICO; STATE OF RHODE
 17 ISLAND; and STATE OF
 VERMONT,

18 Plaintiffs,

19 v.

20 UNITED STATES FOOD AND
 DRUG ADMINISTRATION;
 21 ROBERT M. CALIFF, in his official
 capacity as Commissioner of Food
 22 and Drugs; UNITED STATES

NO.
 COMPLAINT

1 DEPARTMENT OF HEALTH AND
2 HUMAN SERVICES; and XAVIER
3 BECERRA, in his official capacity as
Secretary of the Department of
Health and Human Services,

4 Defendants.

5
6 **I. INTRODUCTION**

7 1. The availability of medication abortion has never been more
8 important. As states across the country have moved to criminalize and civilly
9 penalize abortion, the Plaintiff States have preserved the right to access abortion
10 care, and have welcomed people from other states who need abortion care. The
11 extremely limited availability of abortion in other states, and the growing threat
12 to abortion access nationwide, makes patients' access to medication abortion
13 paramount. Medication abortion through a combination of mifepristone and
14 misoprostol is the "gold standard" for early termination of pregnancy, used by
15 the majority of people in the U.S. who choose to have an abortion.

16 2. More than 22 years ago, the United States Food and Drug
17 Administration (FDA) approved mifepristone (under the brand name Mifeprex)
18 to be used with the drug misoprostol, in a two-drug medication regimen to end
19 an early pregnancy. Approval was based on a thorough and comprehensive
20 review of the scientific evidence, which established that mifepristone is safe and
21 effective.
22

1 3. Since this regimen was approved in 2000, mifepristone has been
2 used approximately 5.6 million times in the United States.¹ As FDA
3 acknowledged in 2016, mifepristone “has been increasingly used as its efficacy
4 and safety have become well-established by both research and experience, and
5 serious complications have proven to be extremely rare.”² Mifepristone is safer
6 than many other common drugs FDA regulates, such as Viagra and Tylenol.

7 4. Medication abortion is now the most common method of abortion
8 in the United States. For example, almost 60% of abortions in Washington State
9 are medication abortions.

10 5. But FDA has continued to hamper access by singling out
11 mifepristone—and the people in the Plaintiff States who rely on it for their
12 reproductive health care—for a unique set of restrictions known as a
13 Risk Evaluation and Mitigation Strategy (REMS). The restrictions on
14 mifepristone are a particularly burdensome type of REMS known as Elements to
15

16 ¹FDA, Mifepristone U.S. Post-Marketing Adverse Events Summary
17 through 06/30/2022, <https://www.fda.gov/media/164331/download>
18 (“Mifepristone U.S. Post-Marketing Adverse Events”), attached hereto as Ex. A.

19 ²FDA, Ctr. for Drug Evaluation & Research, No. 020687Orig1s020,
20 Mifeprex Medical Review(s) at 12 (Mar. 29, 2016),
21 https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020M
22 [edR.pdf](#) (“FDA 2016 Medical Review”), attached hereto as Ex. B.

1 Assure Safe Use (ETASU), which strictly limit who can prescribe and dispense
2 the drug. FDA’s decision to continue these burdensome restrictions in
3 January 2023 on a drug that has been on the market for more than two decades
4 with only “exceedingly rare” adverse events has no basis in science. It only serves
5 to make mifepristone harder for doctors to prescribe, harder for pharmacies to
6 fill, harder for patients to access, and more burdensome for the Plaintiff States
7 and their health care providers to dispense.³ Not only that, but the REMS require
8 burdensome documentation of the patient’s use of mifepristone for the purpose
9 of abortion, making telehealth less accessible and creating a paper trail that puts
10 both patients and providers in danger of violence, harassment, and threats of
11 liability amid the growing criminalization and outlawing of abortion in other
12 states.

13 6. FDA has imposed REMS for only 60 of the more than 20,000⁴ FDA-
14 approved prescription drug products marketed in the U.S. These cover dangerous
15 drugs such as fentanyl and other opioids, certain risky cancer drugs, and high-
16 dose sedatives used for patients with psychosis.⁵

17
18
19 ³Ex. B (FDA 2016 Medical Review) at 47.

20 ⁴Office of the Commissioner, *FDA at a Glance: FDA Regulated Products*
21 *and Facilities*, FDA (Nov. 2021), <https://www.fda.gov/media/154548/download>.

22 ⁵*Id.*

1 16. Washington additionally brings this suit in its capacity as
2 *parens patriae* to protect its quasi-sovereign interest in the health and well-being
3 of Washington residents.

4 **Oregon**

5 17. Plaintiff State of Oregon is represented by its Attorney General, who
6 is the chief law officer for the State. Oregon has a strong interest in the proper
7 provision of health care within the state, particularly at public hospitals, and joins
8 in its capacity as *parens patriae* to protect its quasi-sovereign interest in the health
9 and well-being of Oregon residents.

10 **Arizona**

11 18. The Attorney General is the chief legal adviser to the State. The
12 Attorney General's powers and duties include acting in federal court on behalf of
13 the State on matters of public concern.

14 19. As the operator of facilities that provide reproductive health care and
15 pharmaceutical services, Arizona is directly subject to the January 2023 REMS
16 and has standing to vindicate its proprietary interests in delivering high-quality
17 patient care.

18 20. Arizona also has standing because the 2023 REMS create and
19 maintain substantial and costly administrative burdens for health care and
20 pharmaceutical services provided in state owned or operated facilities.

1 21. Arizona additionally brings this suit in its capacity as *parens patriae*
2 to protect its quasi-sovereign interest in the health and well-being of Arizona
3 residents.

4 **Colorado**

5 22. Plaintiff the State of Colorado is a sovereign state of the
6 United States of America. This action is brought on behalf of the State of
7 Colorado by Attorney General Phillip J. Weiser, who is the chief legal
8 representative of the State of Colorado, empowered to prosecute and defend all
9 actions in which the state is a party. Colo. Rev. Stat. § 24-31-101(1)(a).

10 **Connecticut**

11 23. The State of Connecticut is a sovereign state. The Attorney General
12 is Connecticut's chief civil legal officer, responsible for supervising and litigating
13 all civil legal matters in which Connecticut is an interested party, including
14 federal court matters.

15 24. Medication abortion is indispensable to reproductive health care in
16 Connecticut. According to the Centers for Disease Control, more than 65% of
17 Connecticut abortions are medication abortions using mifepristone.

18 25. Access to mifepristone for medicated abortions is increasingly
19 critical in Connecticut. An ongoing wave of hospital closures and consolidations
20 threaten to leave swaths of the state without access to on-site reproductive
21
22

1 healthcare, even as demand for abortion care has increased in the aftermath of
2 *Dobbs*.

3 26. Connecticut is directly subject to the January 2023 REMS and has
4 standing to vindicate its proprietary interests in delivering high-quality patient
5 care. Connecticut funds and operates the John Dempsey Hospital of the
6 University of Connecticut Health Center (UConn Health) and its associated
7 pharmacy. The Hospital provides reproductive health services, including
8 prescribing mifepristone for medication abortions. The pharmacy dispenses
9 mifepristone to patients.

10 27. Connecticut also has standing because the 2023 REMS create and
11 maintain substantial and costly administrative burdens, including burdens to
12 UConn Health and its associated pharmacy.

13 28. Connecticut additionally brings this suit in its capacity as
14 *parens patriae* to protect its quasi-sovereign interest in the health and well-being
15 of Connecticut residents.

16 **Delaware**

17 29. Plaintiff the State of Delaware is a sovereign state of the
18 United States of America. This action is brought on behalf of the State of
19 Delaware by Attorney General Kathleen Jennings, the “chief law officer of the
20 State.” *Darling Apartment Co. v. Springer*, 22 A.2d 397, 403 (Del. 1941).

21
22

1 Attorney General Jennings also brings this action on behalf of the State of
2 Delaware pursuant to her statutory authority. Del. Code Ann. tit. 29, § 2504.

3 **Illinois**

4 30. Plaintiff the State of Illinois is a sovereign state of the United States
5 of America. This action is brought on behalf of the State of Illinois by Attorney
6 General Kwame Raoul, the State’s chief legal officer. *See* Ill. Const. art. V, § 15;
7 15 ILCS 205/4.

8 31. Illinois has standing because the 2023 REMS create barriers to
9 accessing medically necessary abortion and miscarriage care, leading to
10 subsequent health care costs, including emergency care, some of which is borne
11 by the state through Medicaid expenditures.

12 32. Illinois additionally brings this suit in its capacity as *parens patriae*
13 to protect its quasi-sovereign interest in the health and well-being of Illinois
14 residents.

15 **Attorney General of Michigan**

16 33. Attorney General Dana Nessel is the chief legal adviser to the State
17 of Michigan. The Attorney General’s powers and duties include acting in federal
18 court on behalf of the State on matters of public concern.

19 34. The Attorney General brings this suit in her capacity as
20 *parens patriae* to protect its quasi-sovereign interest in the health and well-being
21 of Michigan residents.

22

1 **Nevada**

2 35. Plaintiff State of Nevada is represented by its Attorney General. The
3 Attorney General is the chief legal officer of the State.

4 36. The Nevada Attorney General may commence or defend a suit in
5 state or federal court when in his opinion a suit is necessary to protect and secure
6 the interest of the State.

7 37. Nevada provides reproductive healthcare services including
8 medication abortions using mifepristone.

9 38. As a provider of reproductive healthcare services, Nevada is subject
10 to the January 2023 REMS program.

11 39. Nevada has standing to challenge the REMS because it imposes
12 financial and administrative burdens on Nevada reproductive healthcare service
13 providers seeking to prescribe and distribute mifepristone for medication
14 abortions.

15 40. Nevada also has standing to challenge the program because the
16 program interferes with its inherent authority to provide for the health and welfare
17 of its residents. It imposes medically unnecessary barriers to Nevada's provision
18 of reproductive healthcare using the least intrusive and most cost-effective
19 means.

1 **New Mexico**

2 41. Plaintiff State of New Mexico, represented by and through its
3 Attorney General, is a sovereign state of the United States of America.
4 Attorney General Raúl Torrez is the chief legal officer of the State of
5 New Mexico. He is authorized to prosecute all actions and proceedings on behalf
6 of New Mexico when, in his judgment, the interest of the State requires such
7 action. N.M. Stat. Ann. § 8-5-2(B). Likewise, he shall appear before federal
8 courts to represent New Mexico when, in his judgment, the public interest of the
9 state requires such action. N.M. Stat. Ann. § 8-5-2(J). This challenge is brought
10 pursuant to Attorney General Torrez’s statutory authority.

11 42. As an operator of medical facilities that provide reproductive health
12 care services and pharmacies that dispense mifepristone, New Mexico is directly
13 subject to the 2023 REMS and has standing to vindicate its proprietary interests
14 in delivering high-quality patient care.

15 43. New Mexico also has standing because the 2023 REMS will impose
16 substantial and costly administrative burdens for State-operated hospitals, clinics,
17 and pharmacies.

18 44. New Mexico additionally brings this suit in its capacity as
19 *parens patriae* to protect its quasi-sovereign interest in the health and well-being
20 of New Mexico residents.

21
22

1 **Rhode Island**

2 45. The Rhode Island Attorney General is the chief legal officer for the
3 State of Rhode Island. The Rhode Island Attorney General’s powers and duties
4 include acting in federal court on behalf of the State on matters of public concern.

5 46. Rhode Island has standing because the 2023 REMS create barriers
6 to accessing medically necessary abortion and miscarriage care, leading to
7 subsequent health care utilization, including emergency care, some cost of which
8 is borne by the state through Medicaid expenditures.

9 47. Rhode Island additionally brings this suit in its capacity as
10 *parens patriae* to protect its quasi-sovereign interest in the health and well-being
11 of Rhode Island residents.

12 **Vermont**

13 48. The Attorney General is the chief legal adviser to the State. The
14 Attorney General’s powers and duties include representing the State in civil
15 causes when, in her judgment, the interests of the State so require.

16 49. Vermont brings this suit in its capacity as *parens patriae* to protect
17 its quasi-sovereign interest in the health and well-being of Vermont residents.

18 **Plaintiff States**

19 50. The Plaintiff States collectively represent more than 59 million
20 Americans with protected rights to abortion care.

21
22

1 **Defendants**

2 51. Defendant United States Food and Drug Administration (FDA) is an
3 agency of the federal government within the United States Department of Health
4 and Human Services (HHS). FDA is responsible for administering the provisions
5 of the federal Food, Drug, and Cosmetic Act that are relevant to this Complaint.

6 52. Robert M. Califf is the Commissioner of the United States Food and
7 Drug Administration and is sued in his official capacity. He is responsible for
8 administering FDA and its duties under the federal Food, Drug, and
9 Cosmetic Act.

10 53. Defendant HHS is a federal agency within the executive branch of
11 the federal government.

12 54. Defendant Xavier Becerra is the Secretary of HHS and is sued in his
13 official capacity. He is responsible for the overall operations of HHS, including
14 FDA.

15 **IV. ALLEGATIONS**

16 **A. Statutory Background**

17 55. Under the Food, Drug and Cosmetic Act (FDCA), a new drug
18 cannot be marketed and prescribed until it undergoes a rigorous approval process
19 to determine that it is safe and effective. *See generally* 21 U.S.C. § 355. An
20 approved prescription medication is subject to robust safeguards to ensure that it
21 is used safely and appropriately, including the requirement of a prescription by a
22

1 licensed medical provider, patient informed-consent laws, scope of practice laws,
2 professional and ethical guidelines, and state disciplinary laws regulating the
3 practice of medicine and pharmacy, as well as additional warnings, indications,
4 and instructions that FDA may impose specific to the medication.

5 56. FDA relies on this set of safeguards to ensure the safe and effective
6 use of the *vast* majority of prescription drugs.

7 57. A “Risk Evaluation and Mitigation Strategy” (REMS) is an
8 additional set of requirements, beyond the usual network of safeguards, that FDA
9 may impose in the rare case when—and only when—“necessary to ensure that
10 the benefits of the drug outweigh the risks of the drug[.]”
11 21 U.S.C. § 355-1(a)(1).

12 58. The most burdensome type of REMS are “Elements to Assure Safe
13 Use” (ETASU), which FDA may impose only when necessary because of a
14 drug’s “inherent toxicity or potential harmfulness.” *Id.* § 355-1(f)(1).

15 59. By statute, FDA may impose ETASU only for medications that
16 demonstrate risks of serious side effects such as death, incapacity, or birth
17 defects, and only where the risk of side effects is sufficiently severe that FDA
18 could not approve, or would have to withdraw approval of, the medication, absent
19 the ETASU. *Id.* §§ 355-1(b)(5), (f)(1)(A).

20 60. ETASU must not be “unduly burdensome on patient access to the
21 drug, considering in particular . . . patients in rural or medically underserved
22

1 areas,” and must “minimize the burden on the health care delivery system[.]”
2 *Id.* §§ 355-1(f)(2)(C)–(D).

3 61. In light of these stringent statutory limitations, REMS, and in
4 particular an ETASU, are exceptionally rare: of the more than 20,000 prescription
5 drug products approved by FDA and marketed in the U.S.,⁶ there are only
6 60 REMS in place, 56 of which include an ETASU, covering dangerous drugs
7 like fentanyl and other opioids.⁷

8 **B. FDA’s Approval of Mifepristone and the History of the Mifepristone**
9 **REMS Program**

10 62. The current FDA-approved regimen for the medical termination of
11 early pregnancy involves two drugs: (1) *mifepristone*, which interrupts early
12 pregnancy by blocking the effect of progesterone, a hormone necessary to
13 maintain a pregnancy, and (2) *misoprostol*, which causes uterine contractions that
14 expel the pregnancy from the uterus. Shortly after taking mifepristone and then
15 misoprostol, a patient will experience a miscarriage.⁸

16 _____
17 ⁶*Supra* n.5.

18 ⁷Ex. C (FDA Approved REMS).

19 ⁸Taken alone, misoprostol also acts as an abortifacient—but it is less
20 effective and causes more negative side effects than the mifepristone/misoprostol
21 regimen. Misoprostol, however, it is not subject to a REMS; patients may obtain
22 it from any provider and have it filled at retail or mail-order pharmacies.

1 63. Mifepristone was first approved for medical termination of early
2 pregnancy in France in 1988 and its approval expanded to the United Kingdom
3 and European countries throughout the 1990s.

4 64. In 1996, the Population Council, a non-profit organization based in
5 the United States, sponsored a New Drug Application (NDA) for Mifeprex for
6 use in combination with misoprostol for the medical termination of early
7 pregnancy. In 1999, the Population Council contracted with Danco Laboratories,
8 L.L.C. (Danco) to manufacture and market the medication.

9 65. FDA approved the marketing of mifepristone under the brand name
10 Mifeprex in September 2000,⁹ concluding that mifepristone is safe and effective
11 for medical termination of intrauterine pregnancy through 49 days' gestation
12 when used in a regimen with the already-approved drug, misoprostol. In granting
13 its approval, FDA extensively reviewed the scientific evidence and determined
14 that mifepristone's benefits outweigh any risks.¹⁰

15 66. FDA's review included three clinical trials that together involved
16 4,000 women: two French trials that were complete at the time of the application,
17 and one then-ongoing trial in the United States for which summary data on
18 _____

19 ⁹FDA NDA 20-687 Approval Memo, Sept. 28, 2000, attached hereto as
20 Ex. D.

21 ¹⁰Food and Drug Administration Approval and Oversight of the Drug
22 Mifeprex, <https://www.gao.gov/assets/gao-08-751.pdf>, attached hereto as Ex. E.

1 serious adverse events were available.¹¹ FDA has explained that “[t]he data from
2 these three clinical trials . . . constitute substantial evidence that Mifeprex is safe
3 and effective for its approved indication in accordance with the [FDCA].”¹² FDA
4 also considered: (1) results from other European trials from the 1980s and 1990s
5 in which mifepristone was studied alone or in combination with misoprostol or
6 similar drugs; (2) a European postmarket safety database of over 620,000 women
7 who used medication to terminate a pregnancy, approximately 415,000 of whom
8 had received a mifepristone/misoprostol regimen¹³; and (3) data on the drug’s
9 chemistry and manufacturing.¹⁴

10 67. Despite the strong findings on the safety and efficacy of Mifeprex
11 from clinical trials and European post-market experience, FDA originally
12 approved Mifeprex under Subpart H of the FDCA regulations (the predecessor
13 to the REMS statute) and imposed “restrictions to assure safe use”—a restricted
14

15
16 ¹¹*Id.* at 5.

17 ¹²2016 FDA Letter to Am. Ass’n of Pro-Life Obstetricians &
18 Gynecologists, Christian Medical & Dental Ass’ns, and Concerned Women for
19 Am. denying 2002 Citizen Petition, Docket No. FDA-2002-P0364 (Mar. 29,
20 2016) (Citizen Petition Denial) at 8, Mar. 29, 2016, attached hereto as Ex. F.

21 ¹³*Id.* at 8.

22 ¹⁴Ex. E, supra n.11.

1 distribution system—as a condition of approval.¹⁵ For example, FDA imposed an
2 in-person dispensing requirement (later “ETASU C,” pursuant to
3 21 U.S.C. § 355-1(f)(3)(C)) and permitted the drug to be dispensed only in a
4 hospital, clinic, or medical office, by or under the supervision of a “certified
5 provider” (discussed more below), who at that time could only be a physician.
6 FDA also imposed a prescriber-certification ETASU (later “ETASU A,”
7 pursuant to 21 U.S.C. § 355-1(f)(3)(A)), which prohibited health care providers
8 from prescribing the drug unless they first attested to their clinical abilities in a
9 signed form kept on file by the manufacturer, and agreed to comply with
10 reporting and other REMS requirements. FDA also imposed a Patient Form
11 ETASU (later “ETASU D,” pursuant to 21 U.S.C. § 355-1(f)(3)(D)), requiring
12 the prescriber and patient to review and sign a special form with information
13 about the mifepristone regimen and risks, and required the prescriber to provide
14 the patient with a copy and place a copy in the patient’s medical record. The same
15 information contained in the patient form is also included in the
16 “Medication Guide” that is part of the FDA-approved labeling provided to
17 patients with mifepristone.

18 _____
19 ¹⁵Although the Subpart H regulations are sometimes referred to as FDA’s
20 “accelerated approval” regulations, FDA has explained elsewhere that its 2000
21 approval of Mifeprex, which occurred more than four years after the new drug
22 application was submitted to FDA, did not involve an accelerated review.

1 68. FDA’s decision to subject Mifeprex to an ETASU under Subpart H
2 was highly unusual. In the fifteen years from 1992 (the year the Subpart H
3 regulations were promulgated) to February 2007 (just before the creation of the
4 REMS statute), only seven NDAs, including Mifeprex, were approved subject to
5 ETASU under Subpart H.¹⁶ By comparison, FDA approved 961 NDAs with no
6 additional restrictions in the roughly thirteen years from January 1993 to
7 September 2005.¹⁷

8 69. The Food and Drug Administration Amendments Act of 2007
9 effectively replaced Subpart H of the FDCA regulations with the REMS statute.
10 All drugs previously approved under Subpart H—including Mifeprex—were
11 deemed by the Amendments Act to have a REMS in place. Following passage of
12 the 2007 FDCA, Mifeprex continued to be subject to the same ETASU as before.

13 70. In 2011, FDA issued a new REMS for Mifeprex incorporating the
14 same restrictions under which the drug was approved eleven years earlier.
15
16
17

18 ¹⁶*Id.* at 27.

19 ¹⁷U.S. Gov’t Accountability Off., *New Drug Development: Science,*
20 *Business, Regulatory, and Intellectual Property Issues Cited as Hampering Drug*
21 *Development Efforts*, GAO-07-49, 20 (Nov. 2006),
22 <http://www.gao.gov/assets/gao-07-49.pdf>.

1 71. In 2013, FDA reviewed the existing REMS and reaffirmed the
2 restrictions already in place.¹⁸

3 72. In May 2015, Mifeprex’s manufacturer (Danco) submitted a
4 supplemental NDA proposing to update the label to reflect evidence-based
5 practice across the country—mainly, the use of 200 mg of mifepristone instead
6 of 600 mg. In July 2015, Danco also submitted its statutorily required REMS
7 assessment, proposing minor modifications.

8 73. This submission prompted a review of the Mifeprex label and
9 REMS by FDA in 2015-2016. As part of that review, FDA received letters from
10 more than 40 medical experts, researchers, advocacy groups, and professional
11 associations who asked, *inter alia*, that the REMS be eliminated in their entirety.

12 74. Signatories requesting that FDA eliminate the Mifeprex REMS
13 included the American College of Obstetricians and Gynecologists (ACOG), the
14 leading professional association of physicians specializing in the health care of
15 women, which represents 58,000 physicians and partners in women’s health; the
16 American Public Health Association (APHA), the nation’s leading public health
17 organization; the Director of Stanford University School of Medicine’s Division
18 of Family Planning Services and Research; the Chair of the Department of
19 Obstetrics and Gynecology at the University of New Mexico School of Medicine;

20 _____
21 ¹⁸FDA Final Risk Evaluation and Mitigation Strategy (REMS) Review
22 (Oct. 10, 2013), attached hereto as Ex. G.

1 and the Senior Research Demographer in the Office of Population Research at
2 Princeton University.

3 75. As one letter explained: “Although the FDA may have decided
4 15 years ago that the balance of risk and burden came out in favor of restricting
5 mifepristone’s indicated use and distribution, today both science and the current
6 conditions surrounding patient access to abortion care call strongly for a
7 reevaluation of the mifepristone label and REMS restrictions, especially its
8 Elements to Assure Safe Use (ETASU).”¹⁹ In asking FDA to “[e]liminate the
9 REMS and ETASU for mifepristone,” the letter specifically asked FDA to,
10 among other things, (i) “[e]liminate the Prescriber Agreement certification
11 requirement” and (ii) “remove the confusing and unnecessary
12 Patient Agreement.”²⁰

13 76. The signatory organizations explained that the
14 Prescriber Agreement certification requirement should be eliminated, because,
15 among other things²¹:

18 ¹⁹Letter from SFP, *et al.*, to Stephen Ostroff, M.D., Robert M. Califf, M.D.,
19 & Janet Woodcock, M.D., 1 (Feb. 4, 2016) (SFP Letter to FDA), attached hereto
20 as Ex. H.

21 ²⁰*Id.* at 2–4.

22 ²¹*Id.* at 3.

- 1 a. *“The Prescriber’s Agreement is unnecessary for the safe*
2 *dispensation of mifepristone. . . . [H]ealth care professionals are*
3 *already subject to many laws, policies, and ordinary standards of*
4 *practice that ensure they can accurately and safely understand and*
5 *prescribe medications. Provider certification is not required for*
6 *health care professionals to dispense other drugs, including drugs*
7 *that carry black box, or boxed, warnings about their medical risks.*
8 *Accutane, for example, has a boxed warning that describes the*
9 *potential risks of the drug, but Accutane prescribers are not required*
10 *to submit a certification form in order to prescribe it. Mifeprex also*
11 *has a boxed warning and there is no medical reason for a*
12 *Prescriber’s Agreement to be required in addition.”*
- 13 b. *“The Prescriber’s Agreement forces providers to identify themselves*
14 *as abortion providers to a centralized entity (Danco Laboratories)*
15 *inspected and regulated by the FDA, which could discourage some*
16 *from offering medication abortion care to their patients. In 2014,*
17 *more than half of U.S. health care facilities that provide abortions*
18 *(52%) experienced threats and other types of targeted intimidation,*
19 *and one in five experienced severe violence, such as blockades,*
20 *invasions, bombings, arsons, chemical attacks, physical violence,*
21 *stalking, gunfire, bomb threats, arson threats, or death threats.*
22 *Robert Dear’s November 27, 2015, standoff at a Planned Parenthood health center in Colorado, which resulted in*
three deaths, provides one recent and chilling example of
anti-abortion violence. Given such escalating harassment and
violence against known abortion providers, clinicians may be
understandably reluctant to add their names to a centralized database
of mifepristone providers.”
- c. *“The Prescriber’s Agreement would be incompatible and*
unnecessary if there were an expanded distribution system. If
dispensing venues are expanded as proposed . . . ordinary standards
of practice and state regulations would govern pharmacists’ and
providers’ distribution of mifepristone, and a specific certification
process would be unnecessary. Furthermore, a distribution system
that incorporates the Prescriber’s Agreement would be extremely
difficult to maintain as a practical matter. Pharmacists would need
to check the certification status of each prescriber before filling a
prescription, which they do not normally have to do when filling
other prescriptions.”

1 77. The organizations also argued that the Patient Agreement was
2 unnecessary, explaining: “This requirement is medically unnecessary and
3 interferes with the clinician-patient relationship. It should be eliminated
4 entirely.”²²

5 78. The letter also urged FDA to “[c]onsider the current legal and social
6 climate,” explaining that “[t]he overall legal and social climate around abortion
7 care intensifies all of the burdens that the mifepristone REMS places on patients
8 and makes it even more critical that the FDA lift medically unnecessary
9 restrictions on the drug.”²³ The letter concludes:

10 Mifepristone continues to hold immense promise for patient access
11 to a safe and effective early abortion option, but medically
12 unnecessary regulations are impeding its full potential. Extensive
13 scientific and clinical evidence of mifepristone’s safety and
14 efficacy, and the ever-increasing burden on patient access to
15 abortion care, clearly demonstrate that mifepristone’s REMS
16 program is not needed to protect patients. In light of the FDA’s
17 statutory mandate from Congress to consider the burden caused to
18 patients by REMS, and the agency’s own stated commitment to
19 ensuring that the drug restrictions do not unduly burden patient
20 access, we ask that the FDA lift mifepristone’s REMS²⁴

21 79. FDA summarized these “Advocacy Group Communications” as
22 follows:

²²*Id.* at 4.

²³*Id.* at 5.

²⁴*Id.* at 6.

1 The Agency received three letters from representatives from
2 academia and various professional organizations In general,
3 these advocates requested FDA to revise labeling in a manner that
4 would reflect current clinical practice, including the new dose
5 regimen submitted by the Sponsor, and proposing to extend the
6 gestational age through 70 days. Other requests were that the
7 labeling not require that the drug-taking location for both Mifeprex
8 and misoprostol be restricted to the clinic, and that labeling not
9 specify that an in-person follow-up visit is required. The advocates
10 also requested that any licensed healthcare provider should be able
11 to prescribe Mifeprex and that the REMS be modified or eliminated,
12 to remove the Patient Agreement and eliminate the prescriber
13 certification, while allowing Mifeprex to be dispensed through retail
14 pharmacies.²⁵

80. A multidisciplinary FDA review team considered the requested
15 changes. This review concluded that “no new safety concerns have arisen in
16 recent years, and that the known serious risks occur rarely,” and that “[g]iven that
17 the numbers of . . . adverse events appear to be stable or decreased over time, it
18 is likely that . . . serious adverse events will remain acceptably low.”²⁶

81. Following the multidisciplinary review team’s analysis, FDA made
19 several changes to Mifeprex’s indication, labeling, and REMS. Relying on safety
20 and efficacy data from multiple studies, FDA increased the gestational age limit
21 from 49 to 70 days.²⁷ FDA also reduced the number of required in-person clinic

18 ²⁵FDA, Ctr. for Drug Evaluation & Research, 020687Orig1s020,
19 Cross Discipline Team Leader Review 25 (Mar. 29, 2016), attached as Ex. I.

20 ²⁶Ex. B (FDA 2016 Medical Review) at 9, 39, 47, 49.

21 ²⁷The overwhelming majority (80%) of abortions occur within the first 70
22 days (10 weeks) of pregnancy. Katherine Kortsmit, et al., *Abortion Surveillance*

1 visits to one (whereas patients had previously been required to visit a clinic
2 setting twice in order to receive the medication). FDA determined that at-home
3 administration of misoprostol is safe because multiple studies showed that
4 administration of the drug was “associated with exceedingly low rates of serious
5 adverse events” and because administering misoprostol at home would more
6 likely result in patients being in an “appropriate and safe location” when
7 cramping and bleeding caused by the drug would begin.²⁸ FDA also found no
8 significant difference in outcomes based on whether patients had follow-up
9 appointments via phone call or in-person or based on the timing of those
10 appointments. Additionally, FDA allowed a broader set of healthcare providers,
11 rather than only physicians, to prescribe mifepristone, finding no serious risk to
12 patients from expanding the types of healthcare providers who could become

13
14
15
16
17 — *United States, 2020*, 71 CDC Morbidity & Mortality Weekly Report 10 at 12
18 (Nov. 25, 2022), [https://www.cdc.gov/mmwr/volumes/71/ss/pdfs/ss7110a1-](https://www.cdc.gov/mmwr/volumes/71/ss/pdfs/ss7110a1-H.pdf)
19 [H.pdf](https://www.cdc.gov/mmwr/volumes/71/ss/pdfs/ss7110a1-H.pdf).

20 ²⁸U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Research,
21 020687Orig1s020, Mifeprex Summary Review at 15 (Mar. 29, 2016)
22 (2016 Summary Review), attached hereto as Ex. J.

1 certified under the 2016 REMS.²⁹ But FDA still required that mifepristone, the
2 first drug in the regimen, be administered in a clinic setting.

3 82. In addition, FDA expert review team and the Director of FDA’s
4 Center for Drug Evaluation and Research recommended eliminating the
5 Patient Agreement Form because it contains “duplicative information already
6 provided by each healthcare provider or clinic,” “does not add to safe use
7 conditions,” and “is a burden for patients.”³⁰ But they were overruled by the FDA
8 Commissioner, who directed the Form be retained.³¹ FDA retained the in-person
9 dispensing requirement and provider certification as well.

10 83. In 2019, FDA approved a different manufacturer’s abbreviated new
11 drug application for a generic version of mifepristone. When it approved the
12

13 ²⁹U.S. Food & Drug Admin., Ctr. for Drug Evaluation &
14 Research, 020687Orig1s020, Mifeprex REMS (Mar. 2016),
15 https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020Re
16 [msR.pdf](#) (hereinafter 2016 REMS).

17 ³⁰Ex. J (2016 Summary Review) at 25.

18 ³¹U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Research,
19 020687Orig1s020, Mifeprex Risk Assessment and Risk Mitigation Review(s):
20 Letter from Janet Woodcock, M.D., Ctr. for Drug Evaluation & Research,
21 Regarding NDA 020687, Supp 20, 1 (Mar. 28, 2016) (hereinafter “Woodcock
22 Patient Agreement Memo”), attached hereto as Ex. K.

1 abbreviated NDA, FDA also established the Mifepristone REMS Program, which
2 covers both Mifeprex and the generic.

3 84. In May 2020, the American College of Obstetricians and
4 Gynecologists sued FDA, challenging the Mifepristone REMS Program's in-
5 person dispensing requirement in light of the COVID-19 pandemic. *See Am. Coll.*
6 *of Obstetricians & Gynecologists v. FDA*, 472 F. Supp. 3d 183 (D. Md. 2020),
7 *stayed by FDA v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578,
8 578 (2021) (mem.). Over FDA's objection that "based on FDA's scientific
9 judgment, the In-Person Requirements are necessary to assure safe use of
10 mifepristone and thus to protect patients' safety," *id.* at 228, the U.S. District
11 Court for the District of Maryland preliminarily enjoined the in-person
12 dispensing requirements, allowing healthcare providers to forgo it based on their
13 medical judgment for the duration of the declared COVID-19 public health
14 emergency. *Id.* at 233.

15 85. In April 2021, FDA suspended the in-person dispensing requirement
16 during the COVID-19 public health emergency because, during the six-month
17 period in which the in-person dispensing requirement had been enjoined, the
18 availability of mifepristone by mail showed no increases in serious patient safety
19 concerns. Thereafter, FDA commenced a formal REMS review.

20 86. Finally, on January 3, 2023, FDA modified the REMS by, *inter alia*,
21 removing the in-person dispensing requirement entirely. However, as discussed
22

1 further below, the Mifepristone REMS continue to impose both the
2 Prescriber Agreement Form and the Patient Agreement Form. The 2023 REMS
3 also added a new pharmacy-certification requirement.³²

4 **C. The Safety of Mifepristone**

5 87. Mifepristone is extremely safe and effective for terminating early
6 pregnancies.

7 88. As discussed above, FDA’s approval of mifepristone in 2000 rested
8 on a comprehensive evaluation of the scientific data, and FDA reasonably
9 determined, in its expert judgment, that the evidence showed mifepristone is safe
10 and effective for abortion of early pregnancy.

11 89. When FDA conducted another medical review of mifepristone in
12 2016 (based on the then 2.5 million uses of Mifeprex for medication abortion in
13 the U.S. since the drug’s 2000 approval) it found: “[Mifeprex] has been
14 increasingly used as its efficacy and safety have become well established by both
15 research and experience, and serious complications have proven to be extremely
16

17
18
19 ³²FDA Risk Evaluation and Mitigation Strategy (REMS) Single Shared
20 System for Mifepristone 200 MG (2023 REMS),
21 https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_01_03_REMS_Full.pdf, attached hereto as Ex. L.
22

1 rare.”³³ FDA observed at that time that “[m]ajor adverse events . . . are reported
2 rarely in the literature on over 30,000 patients. The rates, when noted, are
3 exceedingly rare, *generally far below 0.1%* for any individual adverse event.”³⁴
4 The Agency further stated that “[t]he safety profile of Mifeprex is
5 well-characterized and its risks well-understood after more than 15 years of
6 marketing. Serious adverse events are rare and the safety profile of Mifeprex has
7 not substantially changed.”³⁵ Since that 2016 medical review, mifepristone has
8
9

10 ³³Ex. B (FDA 2016 Medical Review) at 12; *see also* U.S. Food
11 & Drug Admin., Full Prescribing Information for
12 Mifeprex 7–8, Tables 1 & 2 (approved Mar. 2016),
13 https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf
14 (“Mifeprex Labeling”), attached hereto as Ex. M.

15 ³⁴Ex. B (FDA 2016 Medical Review) at 47 (emphasis added); *see also*
16 Ex. M (Mifeprex Labeling) at 8, Table 2; *see also* Kelly Cleland et al., Significant
17 Adverse Events and Outcomes After Medical Abortion, 121 OBSTETRICS &
18 GYNECOLOGY 166, 166 (2013) (“Medical research has consistently
19 demonstrated that mifepristone is safe and effective and that adverse events and
20 outcomes are exceedingly rare, occurring in less than a fraction of 1% of cases.”).

21 ³⁵U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Research,
22 020687Orig1s020, Mifeprex Risk Assessment and Risk Mitigation Review(s):

1 | been used an additional 3 million times in the United States for medication
2 | abortion.

3 | 90. From the time mifepristone was approved in 2000, there have only
4 | been 28 reported associated deaths out of 5.6 million uses—an associated fatality
5 | rate of .00005%.³⁶ Further, FDA acknowledges that *none* of these deaths can be
6 | causally attributed to mifepristone. The 28 reported deaths were included in the
7 | adverse events summary “regardless of causal attribution to mifepristone” and
8 | included cases of homicide, drug overdose, ruptured ectopic pregnancy, and
9 | sepsis (a life-threatening immune response to an infection).³⁷ And in its 2016
10 | review, FDA noted that, while roughly half the deaths to that point were
11 | associated with Clostridial septic infections, “[t]here have been no Clostridial
12 | septic deaths reported in the US since 2009.”³⁸

13 | 91. In other cases of fatal infections associated with mifepristone, FDA
14 | has acknowledged that “the critical risk factor” is not mifepristone but
15 |
16 |

17 | _____
18 | REMS Modification Memorandum at 3 (Mar. 29, 2016) (hereinafter 2016 REMS
19 | Modification Memorandum), attached hereto as Ex. N.

20 | ³⁶Ex. A (Mifepristone U.S. Post-Marketing Adverse Events Summary).

21 | ³⁷*Id.*

22 | ³⁸*Id.*

1 “pregnancy itself,” as similar infections “have been identified both in pregnant
2 women who have undergone medical abortion and those who have not[.]”³⁹

3 92. The specific serious complications identified in the FDA-approved
4 labeling for Mifeprex are “Serious and Sometimes Fatal Infections or Bleeding.”
5 But the labeling specifies that such “serious and potentially life-threatening
6 bleeding, infections, or other problems can occur following a miscarriage,
7 surgical abortion, medical abortion or childbirth”—in other words, any time after
8 the pregnant uterus is emptied—and that “[n]o causal relationship between the
9 use of MIFEPREX and misoprostol and [infections and bleeding] has been
10 established.”⁴⁰

11 **D. The January 2023 Mifepristone REMS**

12 93. Despite this undisputed evidence of safety and effectiveness, FDA
13 continues to impose a 2023 REMS with ETASU for mifepristone.

14 94. The current REMS was approved in January 2023 (the
15 2023 REMS).⁴¹

16 95. The 2023 REMS imposes three primary hurdles to accessing
17 mifepristone. Two of these are continuing restrictions and the third is a new
18

19 _____
20 ³⁹Ex. F at 26 n.69.

21 ⁴⁰Ex. M (Mifeprex Labeling) at 2, 16.

22 ⁴¹Ex. L (2023 REMS).

1 restriction. Each hurdle unduly restricts mifepristone access without any
2 corresponding medical benefit.

3 96. *First*, the REMS continues to provide that mifepristone can only be
4 prescribed by a health care provider who has undergone a “special[]
5 certif[ication]” process in which they attest that they can accurately date a
6 pregnancy, diagnose an ectopic pregnancy, and provide surgical intervention or
7 referral in the event of any complications.⁴² This “special certification” must be
8 submitted to each certified pharmacy to which a provider intends to submit
9 Mifreprex prescriptions, and must also be submitted to the distributor if a
10 prescriber intends to dispense in-office.

11 97. For many healthcare providers, becoming specially certified is
12 unduly burdensome and raises safety concerns. Some providers are deterred by
13 the unusual step of having to become certified to prescribe the medication; others,
14 misled by mifepristone’s REMS designation, misperceive it is a dangerous
15 medication or out of the prescriber’s scope of practice; and still others are not
16 comfortable having their names compiled in a list of medication abortion
17 prescribers for fear that they or their families may be targeted by anti-abortion
18 activists. This fear is particularly acute for doctors who hold medical licenses in
19 multiple states (with abortion laws different from the Plaintiff States’), and for
20 medical residents in the Plaintiff States who intend to eventually practice in a

21 _____
22 ⁴²Mifepristone Prescriber Agreement Forms, attached as Ex. O.

1 state that heavily restricts abortion. These concerns, which FDA was made aware
2 of as far back as 2016, are heightened now due to the growing criminalization
3 and penalization of abortion, including laws that subject health care providers to
4 criminal penalties and significant monetary liability.

5 98. *Second*, although the 2023 REMS allows mifepristone to be
6 dispensed directly by pharmacies (as opposed to being dispensed by a provider
7 in a healthcare clinic, as prior REMS required), the REMS unnecessarily requires
8 dispensing pharmacies to be “specially certified” by the drug’s sponsor.⁴³

9 99. Special certification requires pharmacies to verify that mifepristone
10 prescriptions are written only by “certified” providers and to adhere to additional
11 burdensome communication, recordkeeping, and training requirements beyond
12 what is required for the vast majority of prescription drugs. Under the REMS, a
13 pharmacy cannot dispense mifepristone to a patient until it confirms that the
14 provider who wrote the prescription is specially certified.⁴⁴ This hurdle creates
15 new costs and administrative burdens for pharmacies—and worse, threatens
16 unnecessary delay patients seeking time-sensitive medication.

17 100. Further, by limiting mifepristone dispensing to “certified”
18 pharmacies, the REMS requires healthcare providers to track which pharmacies
19 are certified to dispense mifepristone, rather than allowing patients to select their
20

21 ⁴³Mifepristone Pharmacy Agreement Forms, attached as Ex. P.

22 ⁴⁴*Id.*

1 pharmacy of choice. And the reverse is true as well—pharmacies that wish to
2 dispense mifepristone must go through the added step of confirming that each
3 mifepristone prescription comes from a “specially certified” provider.

4 101. *Third*, the 2023 REMS retains the requirement that each patient sign
5 a Patient Agreement Form in order to receive a mifepristone prescription.⁴⁵ This
6 form, among other things, requires a patient to certify: “I have decided to take
7 mifepristone and misoprostol to end my pregnancy.”⁴⁶ This Patient Agreement
8 Form must be signed by both the patient and provider, a copy must be placed into
9 the patient’s medical record, and a copy must be given to the patient along with
10 the Medication Guide.

11 102. This Patient Agreement Form creates significant privacy and safety
12 issues for both patients and providers. It specifically identifies the patient as
13 taking the medication for the purpose of ending their pregnancy—as opposed to,
14 for instance, miscarriage management, for which the medication is also
15 frequently prescribed. Anyone who obtains access to the patient’s medical record
16 will thus have evidence that the patient received the medication for abortion,
17 which is a particular concern for patients who receive care from a provider in a
18 state where abortion is legal but reside in a state where abortion is illegal. Making
19 matters worse, for patients who receive mifepristone for miscarriage

21 ⁴⁵Mifepristone Patient Agreement Form, attached as Ex. Q.

22 ⁴⁶*Id.*

1 management, the evidence will be false. The form also identifies the provider to
2 anyone who obtains access to the patient’s medical record or sees the copy of the
3 form that must be provided to the patient—potentially including, for example, a
4 patient’s spouse, partner, or parent. This exposes providers and patients to threats
5 of potential violence, threats of legal liability (even when the care provided is
6 lawful in the relevant Plaintiff State), or other life-altering consequences. On top
7 of that, because patients who take the medication for miscarriage management
8 are also required to sign the Patient Agreement Form, it may be traumatizing for
9 individuals experiencing a miscarriage to nonetheless have to attest that they are
10 “decid[ing]” to “end [their] pregnancy.”

11 103. None of the harms caused by the Patient Agreement Form is
12 necessary, as the information contained on the form is duplicative of the
13 information already provided to patients in the five-page Medication Guide that
14 accompanies mifepristone. The comprehensive Medication Guide answers
15 questions such as: “What symptoms should I be concerned with?”; “Who should
16 not take Mifepristone tablets?”; “What should I tell my healthcare provider
17 before taking Mifepristone tablets?”; “How should I take Mifepristone tablets?”;
18 and “What are the possible side effects of Mifepristone tablets?”⁴⁷ The
19 Patient Agreement Form is also duplicative of provider counseling, as medical
20

21
22 ⁴⁷Mifepristone Medication Guide, attached as Ex. R.

1 ethics require providers to counsel patients on the risks and benefits of all
2 medications.

3 104. *In sum*, although the 2023 REMS improved on the prior REMS by
4 dropping the requirement to dispense mifepristone in person, the REMS
5 nonetheless retains unduly burdensome, harmful, and unnecessary dispensing
6 and prescribing requirements, continues to expose providers and patients to
7 unnecessary privacy and safety risks, and creates new hurdles that further burden
8 an already overstretched health care system.

9 **E. The 2023 REMS Violate the FDCA**

10 105. FDA’s imposition of the burdensome 2023 REMS requirements is
11 contrary to the FDCA.

12 106. As noted above, FDA may impose an ETASU on a medication only
13 if the medication is “associated with a serious adverse drug experience,” which
14 the statute defines as one that “results in” death or “immediate risk of death,”
15 “inpatient hospitalization or prolongation of existing hospitalization,” “persistent
16 or significant incapacity or substantial disruption of the ability to conduct normal
17 life functions,” or “a congenital anomaly or birth defect,” or that “may jeopardize
18 the patient and may require a medical or surgical intervention to prevent [such]
19 an outcome” 21 U.S.C. §§ 355-1(f)(1)(A), (b)(4)(A)–(B). And an ETASU
20 may be imposed only where “required . . . to mitigate a specific serious risk” of
21 a serious adverse drug experience, and only where such risk is sufficiently severe
22

1 that absent the ETASU, FDA would not approve or would withdraw approval of
2 the medication. *Id.* §§ 355-1(b)(5), (f)(1)(A).

3 107. Mifepristone does not meet these stringent standards because it is
4 not “associated with a serious adverse drug experience.” To the contrary, FDA
5 itself has concluded that serious adverse events following mifepristone use are
6 “exceedingly rare.”⁴⁸

7 108. Since mifepristone was approved in 2000, there have been only
8 28 reported associated deaths out of 5.6 million uses—an associated fatality rate
9 of .00005%. And not a single one of these deaths can be causally attributed to
10 mifepristone.⁴⁹ By contrast, thousands of deaths have been associated with
11 phosphodiesterase type-5 inhibitors for the treatment of erectile dysfunction
12 (e.g., Viagra)—which are not subject to a REMS.⁵⁰ And “other drugs with higher
13

14 ⁴⁸Ex. B (FDA 2016 Medical Review) at 47; *see also* Ex. A (Mifepristone
15 U.S. Post-Marketing Adverse Events Summary).

16 ⁴⁹*Id.*

17 ⁵⁰Advancing New Standards in Reproductive Health, *Analysis of*
18 *Medication Abortion Risk and the FDA report “Mifepristone U.S. Post-*
19 *Marketing Adverse Events Summary through 12/31/2018”*, Mifepristone safety:
20 Issue Brief (Apr. 2019),
21 https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety
22 [_4-23-2019.pdf](https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety).

1 complication rates, such as acetaminophen, aspirin, loratadine, and sildenafil, do
2 not have REMS restrictions[.]”⁵¹

3 109. Moreover, the ETASU violates the FDCA’s requirement that such
4 restrictions not be “*unduly burdensome* on patient access to the drug, considering
5 in particular . . . patients in rural or medically underserved areas,” and must
6 “minimize the burden on the health care delivery system[.]”
7 21 U.S.C. §§ 355-1(f)(2)(C)–(D) (emphasis added).⁵²

8 110. As explained in more detail below, the 2023 REMS significantly
9 burdens patient access to mifepristone without *any* appreciable safety benefits.
10 These burdens fall particularly heavily on rural patients in the Plaintiff States
11 because the vast majority of “specially certified” providers practice in cities. Plus,
12 with a number of states imposing severe restrictions on access to abortion care
13 that used to be constitutionally protected, many patients in these medically
14 underserved areas of the country are turning to Plaintiff State providers for this
15 care. This is particularly pronounced in Plaintiff States sharing borders with states

17 ⁵¹2018 Congress of Delegates, *Resolution No. 506 (Co-Sponsored C) –*
18 *Removing Risk Evaluation and Mitigation Strategy (REMS) Categorization on*
19 *Mifepristone*, Am. Acad. Of Fam. Physicians (2019),
20 [https://www.reproductiveaccess.org/wp-content/uploads/2019/02/Resolution-](https://www.reproductiveaccess.org/wp-content/uploads/2019/02/Resolution-
21 No.-506-REMS.pdf)
21 [No.-506-REMS.pdf](https://www.reproductiveaccess.org/wp-content/uploads/2019/02/Resolution-
22 No.-506-REMS.pdf).

22 ⁵²*Supra* n.52.

1 that allow little to no access—for example, in Washington, Oregon, and Nevada,
2 which border Idaho, in Illinois, which borders Missouri and Indiana, and in New
3 Mexico, which borders Texas. Against this backdrop, the 2023 REMS
4 significantly and unduly burdens health care delivery in the Plaintiff States by
5 imposing substantial, unjustified burdens on health care providers, clinics,
6 pharmacies, and hospitals.

7 **F. The 2023 REMS Are Unsupported by Science**

8 111. The 2023 REMS requirements are not supported by scientific
9 evidence.

10 112. First, the Patient Agreement Form remains in place even though the
11 team of expert reviewers at FDA’s Center for Drug Evaluation and Research
12 (CDER) unanimously recommended eliminating it in 2016 because it is
13 duplicative of informed consent laws and standards, “does not add to safe use
14 conditions[,] . . . and is a burden for patients.”⁵³ But this team of experts was
15 overruled by the agency head.⁵⁴

16 113. Similarly, the requirement that clinicians certify that they are
17 competent to prescribe mifepristone provides no additional safety benefit beyond
18 the numerous existing laws and safety standards already in place to ensure health
19 care providers practice only within their competency. The certification

21 ⁵³Ex. H (2016 Summary Review) at 25.

22 ⁵⁴Ex. I (Woodcock Patient Agreement Memo) at 1.

1 requirement is also out of step with how FDA regulates other, less safe
2 medications. Physicians are allowed to prescribe countless higher-risk drugs
3 without first attesting to their competency to make an accurate diagnosis or
4 provide follow-up care in the event of a complication.

5 114. The REMS requirement that pharmacies, too, must be “specially
6 certified” in order to dispense mifepristone is similarly baseless. It requires
7 pharmacies to confirm they have met the unnecessary provider-certification
8 requirement before filling prescriptions, affords no patient safety benefits on top
9 of the laws and standards governing the practice of pharmacy, and, instead, acts
10 as a significant barrier to patient access to a time-sensitive medication.

11 115. Accordingly, the mifepristone REMS is opposed by leading medical
12 organizations, including the American College of Obstetricians and
13 Gynecologists (ACOG), the American Academy of Family Physicians (AAFP),
14 and the American Medical Association (AMA).

15 116. Since at least 2016, ACOG’s position has been “that a Risk
16 Evaluation and Mitigation Strategy (REMS) is no longer necessary for
17 mifepristone, given its history of safe use. The REMS requirement is inconsistent
18
19
20
21
22

1 with requirements for other drugs with similar or greater risks, especially in light
2 of the significant benefit that mifepristone provides to patients.”⁵⁵

3 117. And since at least 2018, AAFP’s position has been that the REMS
4 restrictions “are not based on scientific evidence”; are overly burdensome on
5 practitioners and impede patient access to care, particularly “for patients who
6 might prefer to go to their own physician and for rural patients who have no other
7 access points beyond their local physician”; cause “delays in care, thereby
8 increasing second-trimester and surgical abortions, both of which have increased
9 complication rates”; and create “a barrier to safe and effective off-label uses of
10 mifepristone, such as for anti-corticoid treatment of Cushing’s disease, term labor
11 induction, and miscarriage management[.]”⁵⁶

12 118. In a June 21, 2022, letter to FDA Commissioner Califf, ACOG and
13 AMA urged the Agency to “eliminate the requirement for patients to sign a form
14 to get the drug” and “lift the requirement that prescribers acquire a certification
15 from the manufacturer,” noting that “[b]arriers to accessing mifepristone do not
16
17
18

19 ⁵⁵Advocacy and Health Policy, *ACOG Statement on Medication*
20 *Abortion*, ACOG (Mar. 30, 2016) [https://www.acog.org/news/news-](https://www.acog.org/news/news-releases/2016/03/acog-statement-on-medication-abortion)
21 [releases/2016/03/acog-statement-on-medication-abortion](https://www.acog.org/news/news-releases/2016/03/acog-statement-on-medication-abortion).

22 ⁵⁶*Supra* n.52.

1 make care safer, are not based on medical evidence, and create barriers to patient
2 access to essential reproductive health care.”⁵⁷

3 119. Further, in 2022, ACOG, along with 48 other organizations,
4 submitted a citizen petition to FDA seeking to add miscarriage management as
5 an indication to the drug’s label, to eliminate or modify the REMS for that use,
6 and more generally requesting the removal of the mifepristone REMS.⁵⁸

7 120. The petition asked that “the Patient Agreement Form be removed
8 entirely because it is medically unnecessary and repetitive of informed consent,
9 as a previous review conducted by [FDA Center for Drug Evaluation and
10 Research] determined in 2016.”⁵⁹

11
12 _____
13 ⁵⁷Letter from Maureen G. Phipps, Am. Coll. of Obstetricians &
14 Gynecologists, to Robert Califf, MD (Jun. 21, 2022), [https://searchlf.ama-
15 assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lf
16 dr.zip/2022-6-21-Joint-ACOG-AMA-Letter-to-FDA-re-Mifepristone.pdf](https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/ldr.zip/2022-6-21-Joint-ACOG-AMA-Letter-to-FDA-re-Mifepristone.pdf).

17 ⁵⁸Citizen Petition from Am. Coll. of Obstetricians & Gynecologists to
18 Lauren Roth, Assoc. Comm’r for Pol’y, U.S. FDA (Oct. 4, 2022),
19 [https://emaaproject.org/wp-content/uploads/2022/10/Citizen-Petition-from-the-
20 American-College-of-Obstetrician-and-Gynecologists-et-al-10.3.22-EMAA-
21 website.pdf](https://emaaproject.org/wp-content/uploads/2022/10/Citizen-Petition-from-the-American-College-of-Obstetrician-and-Gynecologists-et-al-10.3.22-EMAA-website.pdf).

22 ⁵⁹*Id.* at 12.

1 121. ACOG further explained that “the Certified Provider Requirement
2 serves no benefit to patient safety,” but is instead “redundant and unnecessary.”⁶⁰
3 Moreover, ACOG noted that the provider-certification requirement has
4 disproportionately affected rural patients because “clinicians who have already
5 navigated mifepristone REMS compliance to provide abortion care . . . are
6 almost always located in cities.”⁶¹ Making matters worse, “rural residents are
7 more likely to lack access to OBGYNs, meaning that surgical management is also
8 less likely to be an option.”⁶² Moreover, “clinicians might have reasonable
9 reservations about opting into a prescription system that could, if their
10 certification were leaked, suggest they were an abortion provider and open them
11 up to violence and harassment.”⁶³

12
13 ⁶⁰*Id.* at 13.

14 ⁶¹*Id.* at 14 (citing Bearak JM, Burke KL, Jones RK. *Disparities and change*
15 *over time in distance women would need to travel to have an abortion in the USA:*
16 *a spatial analysis.* *Lancet Public Health.* 2017; 2:e493–500 and Committee on
17 Health Care for Underserved Women. *Health Disparities in Rural Women.*
18 *American College of Obstetricians and Gynecologists.* *Obstet Gynecol.*
19 2014;123:384-388).

20 ⁶²*Id.* (citation omitted).

21 ⁶³*Id.*; *see also id.* (“Research has shown that without certification, more
22 clinicians would prescribe mifepristone.”) (citing Neill S, Goldberg AB, Janiak

1 122. The ACOG’s citizen petition also urged FDA not to include a
2 pharmacy-certification requirement because “research . . . suggests that the
3 pharmacy requirement is unnecessary to ensure that mifepristone’s benefits
4 outweigh its risks and unduly burden[s] access.”⁶⁴ The petition pointed
5 specifically to a study “conducted . . . in California and Washington state
6 suggest[ing] that pharmacies are already equipped to dispense the drug without
7
8
9

10 E., *Medication management of early pregnancy loss: the impact of the US Food*
11 *and Drug Administration Risk Evaluation and Mitigation Strategy* [A289].
12 *Obstet Gynecol.* 2022 May;139: 83S; Calloway D, Stulberg DB, Janiak E.
13 *Mifepristone restrictions and primary care: Breaking the cycle of stigma through*
14 *a learning collaborative model in the United States.* *Contraception.* 2021 July;
15 104(1):24-28; Mokashi M, Boulineaux C, Janiak E, Boozer M, Neill S. “There’s
16 *only one use for it”: stigma as a barrier to mifepristone use for early pregnancy*
17 *loss in Alabama.* [A31]. *Obstet Gynecol.* 2022 May;139:9S-10S; and Razon N,
18 Wulf S, Perez C, McNeil S, Maldonado L, et al. *Exploring the impact of*
19 *mifepristone’s risk evaluation and mitigation strategy (REMS) on the integration*
20 *of medication abortion into US family medicine primary care clinics.*
21 *Contraception* 2022;109(5):19-24).

22 ⁶⁴*Id.* at 15.

1 special certification.”⁶⁵ “As with the certified provider requirement,” ACOG
2 noted, “the burdens associated with the certified pharmacy requirement will also
3 fall disproportionately on poor and rural [patients], contrary to the REMS
4 statute.”⁶⁶

5 123. Finally, as ACOG pointed out, recent scholarship demonstrates that
6 removing the REMS restrictions does not negatively affect patient safety:

7 After Canada removed all restrictions on prescribing mifepristone
8 for abortion, thereby allowing it to be prescribed and dispensed like
9 any other drug (“normal prescribing”), there was no increase in
10 complications from mifepristone use. [A] 2022 study . . . found no
11 difference in the rate of any complication (0.67% vs. 0.69%) or in
12 the rate of serious adverse events (0.03% vs. 0.04%) between the
13 ten-month period when mifepristone was distributed with
14 REMS-like restrictions and the twenty-eight-month period of
15 normal prescribing after all such restrictions were lifted and
16 mifepristone was prescribed with no special self-certification and
17 dispensed routinely from pharmacies.⁶⁷

18 _____
19 ⁶⁵*Id.* (citing Grossman D, Baba CF, Kaller S, Biggs MA, Raifman S, et al.
20 *Medication abortion with pharmacist dispensing of mifepristone.* *Obstet Gynecol*
21 2021;137(4):613-622).

22 ⁶⁶*Id.* at 16.

⁶⁷*Id.* at 17 (citing Schummers L, Darling EK, Dunn S, McGrail K,
Gayowsky A, et al. *Abortion Safety and Use with Normally Prescribed*
Mifepristone in Canada. *N Engl J Med.* 2022 Jan 6;386(1):57-67.)

1 124. FDA rejected ACOG’s citizen petition.⁶⁸

2 125. In fact, FDA has repeatedly rejected the concerns raised by leading
3 medical organizations and retained the medically unfounded REMS restrictions:
4 renewing them in 2016,⁶⁹ 2019,⁷⁰ 2021,⁷¹ and yet again in 2023.⁷² FDA retained
5 these restrictions notwithstanding its periodic reviews of the post-marketing data,
6 which have not identified any new safety concerns with the use of mifepristone
7 for medical termination of pregnancy through 70 days’ gestation (10 weeks).⁷³

8
9 ⁶⁸U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Research, Letter
10 from Patrizia Cavazzoni, M.D., Regarding Docket No. FDA-2022-P-2425,
11 (Jan. 3, 2023), <https://www.regulations.gov/document/FDA-2022-P-2425-0003>,
12 attached hereto as Ex. S.

13 ⁶⁹Danco Labs., LLC, Mifeprex REMS (Mar. 2016),
14 <https://www.fda.gov/media/164649/download>.

15 ⁷⁰Danco Labs., LLC, Mifepristone REMS (Apr. 2019),
16 <https://www.fda.gov/media/164650/download>.

17 ⁷¹Danco Labs., LLC, Mifepristone REMS (May 2021),
18 <https://www.fda.gov/media/164651/download>.

19 ⁷²Ex. L (2023 REMS).

20 ⁷³U.S. Food & Drug Admin., *Questions and Answers on Mifepristone for*
21 *Medical Termination of Pregnancy Through Ten Weeks Gestation* (Jan. 4, 2023),
22 <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and->

1 126. Even as mifepristone has remained subject to the unduly
2 burdensome REMS restrictions, a less safe mifepristone product for the treatment
3 of Cushing’s syndrome has been available for over a decade with no similar
4 restrictions. In 2012, FDA approved Korlym (mifepristone) tablets, 300 mg, as
5 treatment for Cushing’s syndrome *without* a REMS.⁷⁴ This was done even
6 though, as FDA noted in its 2016 Medical Review, Korlym “is taken in higher
7 doses, in a chronic, daily fashion unlike the single 200 mg dose of
8 Mifeprex . . . [and] the rate of adverse events with Mifeprex is much lower.”⁷⁵
9 Patients who are prescribed Korlym take one to four pills *daily*—which is 1.5 to
10 6 times the recommended dose for Mifeprex.⁷⁶

11 _____
12 [providers/questions-and-answers-mifepristone-medical-termination-pregnancy-](#)
13 [through-ten-weeks-gestation.](#)

14 ⁷⁴HHS, Food & Drug Admin., Ctr. for Drug Evaluation & Research,
15 *Application Number: 202107Orig1s000, Approval Letter* (Feb. 17, 2012),
16 https://www.accessdata.fda.gov/drugsatfda_docs/nda/2012/202107Orig1s000A
17 [pprov.pdf](#).

18 ⁷⁵Ex. B (2016 Medical Review) at 10.

19 ⁷⁶U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Research,
20 *Application Number: 202107Orig1s000, Labeling* (Feb. 17, 2012),
21 https://www.accessdata.fda.gov/drugsatfda_docs/nda/2012/202107Orig1s000Lb
22 [l.pdf](#).

1 127. The risks associated with mifepristone are also lower than those of
 2 many other common medications, such as Viagra, Tylenol, anticoagulants (blood
 3 thinners), and penicillin. Again, since 2000, mifepristone has been used 5.6
 4 million times with only 28 reported associated deaths, none of which can be
 5 causally attributed to mifepristone.⁷⁷ And in nearly all cases of fatal infections
 6 associated with mifepristone, FDA has acknowledged that “the critical risk
 7 factor” is not mifepristone but “pregnancy itself,” as similar infections “have
 8 been identified both in pregnant women who have undergone medical abortion
 9 and those who have not[.]”⁷⁸

10 128. By contrast, as the American Academy of Family Physicians has
 11 noted, “other drugs with higher complication rates, such as acetaminophen,
 12 aspirin, loratadine, and sildenafil, do not have REMS restrictions[.]”⁷⁹

13 129. Medications for erectile dysfunction have a mortality rate more than
 14 six times greater than mifepristone, and penicillin has a mortality rate three times
 15 greater than mifepristone.⁸⁰

17
 18 ⁷⁷Ex. A (Mifepristone U.S. Post-Marketing Adverse Events Summary).

19 ⁷⁸Ex. F at 26.

20 ⁷⁹*Supra* n.52.

21 ⁸⁰Greer Donley, *Medication Abortion Exceptionalism*, 107 CORNELL L.
 22 REV. 627, 651–52 (2022).

1 130. Likewise, acetaminophen (Tylenol) toxicity is the most common
2 cause of liver transplantation in the U.S. and is responsible for 56,000 emergency
3 department visits, 2,600 hospitalizations, and 500 deaths per year in the
4 United States.⁸¹

5 131. But none of these drugs is subject to a REMS.

6 132. And even though opioids are highly addictive and cause tens of
7 thousands of fatalities per year from overdoses, the opioid REMS does not
8 require providers to do anything; it only requires that opioid manufacturers *offer*
9 optional training to healthcare providers who prescribe opioids, who may or may
10 not choose to take it. FDA acknowledges that “[t]here is no mandatory federal
11 requirement that prescribers or other [health care providers] take the training and
12 no precondition to prescribing or dispensing opioid analgesics to patients.”⁸²

13
14
15 ⁸¹Suneil Agrawai and Babek Khazaeni, *Acetaminophen Toxicity*, National
16 Library of Medicine (Aug. 1, 2022),
17 <https://www.ncbi.nlm.nih.gov/books/NBK441917/#:~:text=It%20is%20responsible%20for%2056%2C000,is%20contained%20in%20combined%20products.>

18
19 ⁸²Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS),
20 U.S. FOOD & DRUG ADMIN. (Sept. 2018),
21 [https://www.fda.gov/drugs/information-drug-class/opioid-analgesic-risk-](https://www.fda.gov/drugs/information-drug-class/opioid-analgesic-risk-evaluation-and-mitigation-strategy-rems.)
22 [evaluation-and-mitigation-strategy-rems.](https://www.fda.gov/drugs/information-drug-class/opioid-analgesic-risk-evaluation-and-mitigation-strategy-rems.)

1 133. Mifepristone use is also far safer than continuing a pregnancy. A
2 person who carries a pregnancy to term is at least fourteen times more likely to
3 die than a person who uses mifepristone to end a pregnancy.⁸³ Unequal access to
4 adequate health care exacerbates the risk for those with less privilege. For
5 example, Black women are three to four times more likely than white women to
6 die a pregnancy-related death in the U.S.⁸⁴

7 134. The two risks listed on the mifepristone label are also associated
8 with many common obstetrical and gynecological procedures, such as vaginal
9 delivery, surgical or medical miscarriage management, or insertion of an
10 intrauterine long-acting reversible contraceptive (IUD). As the Mifepristone
11 Medication Guide acknowledges: “Although cramping and bleeding are an
12

13 ⁸³Elizabeth G. Raymond & David E. Grimes, *The Comparative Safety of*
14 *Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics &*
15 *Gynecology* 215, 215 (2012).

16 ⁸⁴Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe*
17 *Maternal Morbidity and Mortality*, 61:2 *Clinical Obstetrics & Gynecology* 387,
18 387 (2018); *see also* Claire Cain Miller, Sarah Kliff, Larry Buchanan, *Childbirth*
19 *is Deadlier for Black Families Even When They’re Rich, Expansive Study Finds*,
20 N.Y. Times (Feb. 12, 2023),
21 [https://www.nytimes.com/interactive/2023/02/12/upshot/child-maternal-](https://www.nytimes.com/interactive/2023/02/12/upshot/child-maternal-mortality-rich-poor.html?smid=url-share)
22 [mortality-rich-poor.html?smid=url-share](https://www.nytimes.com/interactive/2023/02/12/upshot/child-maternal-mortality-rich-poor.html?smid=url-share).

1 expected part of ending a pregnancy, rarely, serious and potentially
 2 life-threatening bleeding, infections, or other problems can occur following a
 3 *miscarriage, surgical abortion, medical abortion, or childbirth.*” (Emphasis
 4 added.)⁸⁵

5 **G. The 2023 REMS Unduly Burdens Access to Healthcare**

6 135. The mifepristone REMS have significantly impeded access to
 7 abortion care. And the 2023 REMS is even more unduly burdensome than prior
 8 REMS in light of dramatically restricted access to care across the United States.

9 136. Even before *Dobbs v. Jackson Women’s Health Organization*,
 10 142 S. Ct. 2228 (2022), only a small fraction of counties in the United States had
 11 a clinician providing surgical abortions.⁸⁶ Mifepristone offers the possibility of
 12 vastly increased access to care by enabling primary care physicians to integrate
 13 abortion care into the services they provide. But the mifepristone REMS impedes
 14 the availability of medication abortion care, and so abortion care remains beyond
 15

16
 17 ⁸⁵Ex. R (Mifepristone Medication Guide).

18 ⁸⁶Na’amah Razon, Sarah Wulf, et al., *Exploring the impact of*
 19 *mifepristone’s risk evaluation and mitigation strategy (REMS) on the integration*
 20 *of medication abortion into US family medicine primary care clinics*,
 21 109 Contraception 19 (May 2022),
 22 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9018589/>.

1 the reach of many—even in states like the Plaintiff States in which abortion care
2 is lawful and protected in various ways.⁸⁷

3 137. According to one recent study, approximately 40 percent of “family
4 physicians interviewed . . . either named or described the REMS criteria as a
5 barrier to providing medication abortion.”⁸⁸ These family physicians explained
6 that “the REMS impede their ability to provide medication abortion within
7 primary care” because they “require substantial involvement of clinic
8 administration, who can be unsupportive,” and because “[t]he complexity of
9 navigating the REMS results in physicians and clinic administration . . . viewing
10 medication abortion as not worth the effort, since it is only a small component of
11 services offered in primary care.”⁸⁹

12
13
14 ⁸⁷*Id.*

15 ⁸⁸*Id.*

16 ⁸⁹*Id.*; see also Sara Neill, MD, et al., *Medication Management of Early*
17 *Pregnancy Loss: The Impact of the U.S. Food and Drug Administration Risk*
18 *Evaluation and Mitigation Strategy* (describing a survey of
19 obstetrician-gynecologists in which “[n]early all interviewees (17 of 19, 89%)
20 listed the REMS as a barrier to mifepristone use. Barriers included [the] belief
21 that the REMS indicated mifepristone was not available to general
22 ob-gyns . . . and concerns about signing the required prescriber agreement”).

1 138. Another recent study of primary care physicians and administrators
2 noted that “[a]bortion with mifepristone is safe and effective” and “falls well
3 within the scope of primary care in the United States, as it involves patient
4 assessment and health education for which primary care providers are extensively
5 trained.” But, the article concluded, the REMS are the “linchpin of a cycle of
6 stigmatization that continues to keep mifepristone out of primary care practice.”⁹⁰

7 139. This, in turn, harms patients. Under the REMS, a person who turns
8 to their trusted health care provider—often a family doctor or primary care
9 physician—for a medication abortion cannot obtain that care unless the clinician
10 is specially certified (or is willing to become specially certified), and either the
11 clinician has arranged to stock the drug or a pharmacy serving the patient’s area
12 has also gone through the process to be specially certified. This is so even though
13 that same provider can simply write the same patient a prescription for
14 misoprostol, the second drug in FDA’s approved regimen for medication
15 abortion, or virtually any other prescription drug that the clinician deems
16 medically appropriate—and a pharmacy can simply dispense it—without the
17 need for any special certifications.

18
19
20 ⁹⁰Danielle Calloway, Debra B Stulberg, & Elizabeth Janiak, *Mifepristone*
21 *restrictions and primary care: Breaking the cycle of stigma through a learning*
22 *collaborative model in the United States*, 104 *Contraception* 24 (July 2021).

1 140. Forcing patients to go to “specifically certified” providers, as
2 opposed to their primary care or family physicians, disrupts continuity of care,
3 stigmatizes routine health care, and discourages patients from making the best
4 healthcare choices for themselves and their families. This burden is especially
5 harsh for patients whose access to healthcare is already diminished by poverty,
6 language barriers, lack of transportation, racial discrimination, or other factors.
7 And it is particularly burdensome given the limited time window in which
8 medication abortion is available.

9 141. This results in worse health outcomes for patients who might
10 otherwise rely on mifepristone to safely terminate their pregnancies, but are
11 unable to obtain a medication abortion given the limited number of
12 REMS-certified prescribers or pharmacies.

13 142. Some patients will effectively be unable to access abortion, and will
14 carry an unwanted pregnancy to term, due to the limited number of providers who
15 are able to prescribe mifepristone because of the REMS. A landmark study shows
16 that patients denied abortion are more likely to: experience serious complications
17 from the end of pregnancy, including eclampsia and death; stay tethered to
18 abusive partners; suffer anxiety and loss of self-esteem in the short term after
19
20
21
22

1 being denied abortion; and experience poor physical health for years after the
2 pregnancy, including chronic pain and gestational hypertension.⁹¹

3 143. Still others will opt for surgical abortion, which FDA describes as a
4 more “invasive medical procedure that increases health risks for some patients
5 and that may be otherwise inaccessible to others.”⁹² As FDA acknowledges,
6 access to mifepristone is particularly critical “[f]or patients for whom
7 mifepristone is the medically indicated treatment because of the patient’s
8 pre-existing health condition.”⁹³

9 144. “For example,” FDA has explained:

10 surgical abortion involves anesthesia, but people who are allergic to
11 anesthesia can experience a sudden drop in blood pressure with
12 cardiorespiratory arrest, and death. And . . . patient populations for
13 whom medication abortion is more appropriate than a surgical
14 abortion include patients who are survivors of abuse, including rape
and incest, for whom pelvic exams can recreate severe trauma,
adolescent patients, who have not yet had a pelvic exam, and
patients in the intensive care unit or trauma patients who have
difficulty with the positioning required for suction D&C.

15 (Internal quotations and citations omitted.)⁹⁴

16
17 ⁹¹Our Studies, *The Turnaway Study*, Advancing New Standards in
18 Reproductive Health, <https://www.ansirh.org/research/ongoing/turnaway-study>.

19 ⁹²Defs.’ [FDA] Opp’n to Pls.’ Mot. for a Prelim. Inj., *All. for Hippocratic*
20 *Med. v. FDA*, No. 2:22-cv-00223-Z (N.D. Tex. Jan. 13, 2023), ECF No. 28 at 38.

21 ⁹³*Id.* at 39.

22 ⁹⁴*Id.*

1 145. Moreover, FDA itself has repeatedly confirmed and re-confirmed
2 that mifepristone is safe and effective. According to FDA, mifepristone provides
3 a “meaningful therapeutic benefit to patients” as compared to other treatments.

4 146. By unduly burdening patients’ access to mifepristone through the
5 2023 REMS, FDA deprives patients of the therapeutic benefit of the drug without
6 any scientific basis.

7 **H. Injury to the Plaintiff States and Their Residents**

8 **Washington**

9 147. The State of Washington’s injuries exemplify those of other
10 Plaintiff States caused by the mifepristone REMS.

11 148. In Washington, mifepristone is a critical medicine for providing safe
12 and effective abortion care as well as for supporting miscarriage management.

13 149. In 2021 (the most recent year for which complete data is available),
14 there were 15,358 abortions in Washington. Of those, 9,060—59%—were
15 medication abortions using mifepristone. Fewer than 0.1% of mifepristone
16 abortions in 2021 resulted in a complication that required hospitalization.

17 150. Washington providers have been hindered in providing care, and
18 patients have been hindered in receiving care, due to the mifepristone REMS.
19 The 2023 REMS requirements pose substantial challenges to providers and
20 patients, and have resulted in significant expenses for state institutions, including
21 the University of Washington (UW).
22

1 151. The State of Washington, through the UW, its largest institution of
2 higher education, operates UW Medicine, a group of multiple public and private
3 nonprofit entities sharing the mission to improve the health of the public. This
4 includes the UW's two campuses of the University of Washington Medical
5 Center, the UW Medicine Primary Care Clinics, the UW Medical School, and
6 through a contract with King County, Harborview Medical Center. As an owner
7 and operator of medical facilities that provide reproductive health care services
8 and pharmacies that dispense mifepristone, Washington is subject to and harmed
9 by the January 2023 REMS.

10 152. At the UW, for instance, implementation of the 2023 REMS
11 requirements is currently being overseen by a subcommittee of more than
12 20 UW physicians, administrators, and staff. To date, the subcommittee members
13 have expended hundreds of hours on REMS implementation work, with many
14 outstanding tasks still to complete. This is valuable time that these
15 UW employees could otherwise spend treating patients, conducting research, or
16 attending to other critical job functions.

17 153. One area in which UW has dedicated substantial resources is in its
18 work to make the REMS-required Patient Agreement Form available to its
19 telemedicine patients. The 2023 REMS continues to require that the
20 Patient Agreement Form be signed by both the patient and a certified provider
21 before a prescription can be filled by a certified pharmacy. Completing the form
22

1 is usually a simple task in person, but it poses significant challenges in the
2 telehealth setting. UW staff have worked more than 100 hours on both
3 operational and technical elements to implement this REMS component,
4 including making the Patient Agreement Form accessible to telemedicine patients
5 in a HIPAA-compliant form and designing a method to securely transmit the form
6 to the patient for their signature and then securely re-route the form back to the
7 provider.

8 154. This work has been further complicated by the fact that some
9 patients may not have access to or comfort with certain technologies (such as
10 smartphones with scanning apps), making it challenging for UW to create a
11 technology process that does not exacerbate inequities in patient access to
12 abortion care.

13 155. Another area of significant time and expense has been
14 implementation of the provider-certification requirement for telehealth providers.
15 UW has hundreds of providers who are eligible to provide telehealth services. To
16 ensure UW providers who may want to prescribe mifepristone are in compliance
17 with the 2023 REMS requirements, UW is currently conducting outreach to
18 ensure all interested, qualified providers are aware of the 2023 REMS
19 requirements. UW operational staff then has to work with each provider who
20 expresses an interest in prescribing mifepristone to ensure that the physician
21 completes the Prescriber Agreement Form and transmits it to the UW Pharmacy.
22

1 Providers then have to be trained on the new technology interfaces required for
2 the Patient Agreement Form as well as the additional steps required in order to
3 submit a mifepristone prescription for a medication abortion to a UW pharmacy.
4 This outreach will likewise need to be done for UW's medical residents. This will
5 require ongoing work as new healthcare providers and residents join UW.

6 156. UW has also had to devote significant time to designing electronic
7 safeguards to help protect the safety of its providers. Some UW physicians, for
8 instance, have expressed concern that by completing the Prescriber Agreement
9 Form and having their name on a list of certified medication abortion prescribers,
10 they could become a target of anti-abortion violence or harassment in the event
11 the list were leaked or compromised.⁹⁵ Given the growing criminalization and
12

13 ⁹⁵Abortion providers have long faced stigma, harassment, and violence. In
14 2021, 182 death threats were made against abortion providers. *See* National
15 Abortion Federation, *2021 Violence & Disruption Statistics*,
16 https://prochoice.org/wp-content/uploads/2021_NAF_VD_Stats_Final.pdf; *see*
17 *also, e.g.*, U.S. Dep't of Justice, *Recent Cases on Violence Against Reproductive*
18 *Health Care Providers* (Oct. 18, 2022), [https://www.justice.gov/crt/recent-cases-](https://www.justice.gov/crt/recent-cases-violence-against-reproductive-health-care-providers)
19 [violence-against-reproductive-health-care-providers](https://www.justice.gov/crt/recent-cases-violence-against-reproductive-health-care-providers); Megan Burbank, *Planned*
20 *Parenthood awarded \$110K after Spokane clinic protests*, CROSSCUT (Dec. 20,
21 2022), [https://crosscut.com/news/2022/12/planned-parenthood-awarded-110k-](https://crosscut.com/news/2022/12/planned-parenthood-awarded-110k-after-spokane-clinic-protests)
22 [after-spokane-clinic-protests](https://crosscut.com/news/2022/12/planned-parenthood-awarded-110k-after-spokane-clinic-protests)]; Ted McDermott, *Windows smashed at Planned*

1 penalization of abortion following the *Dobbs* decision, these concerns are further
2 heightened for doctors who hold medical licenses in multiple states (including
3 states where abortion laws differ from Plaintiff States’) and for medical residents
4 who later intend to practice in states where abortion is illegal or heavily
5 restricted.⁹⁶ While UW is working hard to protect its providers—by, for example,
6 creating additional interfaces so that a telehealth appointment for a medication

7 _____
8 *Parenthood in Spokane Valley; suspect arrested*, THE SPOKESMAN-REVIEW (July
9 5, 2021), [https://www.spokesman.com/stories/2021/jul/05/windows-smashed-
10 at-planned-parenthood-in-spokane-v/](https://www.spokesman.com/stories/2021/jul/05/windows-smashed-at-planned-parenthood-in-spokane-v/).

11 ⁹⁶Recognizing the reality of potential prosecution of Washington abortion
12 providers, the Washington’s Office of the Insurance Commissioner (OIC)
13 recently approved coverage to reimburse physician policyholders for legal fees
14 and expenses incurred in defending against a criminal action that comes from
15 providing direct patient care, including abortions. As Insurance Commissioner
16 Mike Kreidler explained, “As states like Texas threaten legal and criminal action
17 against physicians, the OIC is determined to counter this by assisting medical
18 malpractice insurers wherever we can.” Press Release, Office of the Insurance
19 Commissioner, New insurance coverage approved to help doctors who face
20 criminal charges for providing legal abortions (Sept. 27, 2022),
21 [https://www.insurance.wa.gov/news/new-insurance-coverage-approved-help-
22 doctors-who-face-criminal-charges-providing-legal](https://www.insurance.wa.gov/news/new-insurance-coverage-approved-help-doctors-who-face-criminal-charges-providing-legal).

1 abortion can only be booked with a telehealth clinic (not a specific provider),
2 thereby ensuring that an individual provider’s name is not made available before
3 the appointment—many physicians remain concerned about having to become a
4 “certified prescriber” of medication abortion. The provider-certification
5 requirement thus creates additional, unnecessary risks for Washington
6 employees, providers, and residents that would not exist without the REMS.
7 These risks have become exponentially higher in the post-*Dobbs* era, even as
8 Washington continues to protect the right to choose and provide abortion care.

9 157. FDA recognizes such concerns, but disregarded them in issuing the
10 2023 REMS. FDA shields the identities of its own employees whose work relates
11 to mifepristone to protect their health and safety, in light of the violence and
12 harassment surrounding the provision of abortion.

13 158. The January 2023 REMS also places a significant burden on
14 UW’s pharmacies. Prior to the January 2023 REMS, UW pharmacies did not
15 distribute mifepristone for medication abortion, as those medications had to be
16 provided directly to the patient by the provider at an in-patient visit in a
17 UW clinic (or, during the COVID-19 pandemic, by the provider via mail). With
18 the easing of the in-patient and provider-only distribution requirements, UW is
19 now working to stock mifepristone at both its inpatient pharmacies and through
20 its mail-order pharmacy for its telehealth patients. But the requirements
21
22

1 associated with becoming a certified pharmacy have created a significant
2 additional workload for UW pharmacy team members.

3 159. Most significant is the requirement that UW pharmacies verify that
4 each prescriber of mifepristone has a signed Prescriber Agreement Form on file
5 with the pharmacy before a prescription can be filled. This has required extensive
6 work by both UW operations and IT staff to determine how to host a dynamic list
7 of certified providers in a secure but easily verifiable manner for UW pharmacy
8 personnel.

9 160. Under the 2023 REMS program requirements, UW's pharmacies are
10 also required to ensure that the drug is dispensed within four calendar days after
11 the pharmacy receives the prescription (or the pharmacy must engage in
12 additional consultation with the prescribing physician), which has required an
13 additional workflow to ensure compliance. The same is true for the REMS
14 requirement that authorized pharmacies record the National Drug Code (a unique
15 identifier for drug packages) and lot number from each package of mifepristone
16 dispensed. To date, UW pharmacy staff has expended approximately 80–100
17 hours on implementation work to comply with the 2023 REMS, and this work is
18 not yet complete. The pharmacy needs additional hours to finalize these
19 workflows and to train staff on the mifepristone REMS program requirements.

20 161. As demonstrated by the hundreds of hours being spent by
21 UW physicians and staff to implement the 2023 REMS program requirements,
22

1 compliance with the REMS program creates an expensive and substantial burden
2 for Washington’s hospitals, clinics and pharmacies. This is a financial and
3 administrative burden that many hospitals, clinics, and pharmacies in
4 Washington—particularly small or family-operated ones—cannot shoulder.

5 162. As a result, the 2023 REMS requirements unnecessarily limit the
6 number of providers in Washington who can prescribe mifepristone and the
7 patients’ options for filling a mifepristone prescription. These unnecessary
8 limitations, in turn, unduly burden access to mifepristone for
9 Washington patients.

10 163. In eastern Washington, the student medical center at
11 Washington State University (WSU), Cougar Health Services, has no
12 REMS-certified providers nor is its campus pharmacy REMS-certified.
13 WSU students seeking medication abortion cannot obtain medication abortion
14 services at the student medical center or have a mifepristone prescription filled
15 at the campus pharmacy, but are instead referred off-campus. This referral
16 process is time-sensitive, requires many students to establish care at a new
17 facility, and often creates undue stress for the student attempting to access care.

18 164. As the WSU example highlights, the harms caused by the REMS are
19 particularly pronounced in central and eastern Washington, where access to
20 abortion is already limited by a smaller density of providers and more rural
21 population. Of the 20 eastern Washington counties, only nine have abortion
22

1 providers. By irrationally limiting who may prescribe and dispense mifepristone,
2 the REMS ensure that abortion care remains unavailable to many rural
3 Washingtonians.

4 165. The REMS certification requirements pose particular hardships in
5 eastern Washington for providers and pharmacies who serve patients from other
6 states—including Idaho—or who may live in Idaho themselves. For these
7 providers and pharmacists, putting themselves on a list of abortion providers
8 raises serious concerns about criminal or civil liability under Idaho’s draconian
9 anti-abortion laws.

10 166. Moreover, the REMS pharmacy requirements also limit the number
11 of specially certified pharmacies in Washington, thereby limiting drug
12 availability for patients, particularly in rural communities underserved by large
13 pharmacy chains. While mail-order prescriptions may be desirable for some, they
14 may be infeasible or impossible for others, including patients experiencing
15 housing insecurity; traveling from other states; close to the gestational limit;
16 living in rural areas dependent on P.O. boxes for mail delivery—which are
17 ineligible for mail-order prescriptions; or for whom receipt of abortion
18 medication at home may trigger domestic violence or housing loss. For these
19 patients, local pharmacy pick-up may be necessary—but unavailable due to the
20 2023 REMS requirements.

21
22

1 167. For patients receiving medical care in Washington, the Patient
2 Agreement Form creates an additional, unnecessary risk. While medical
3 institutions and providers have enacted safeguards to ensure the safety and
4 privacy of all medical records, the simple fact that a patient has an additional
5 document in their medical record attesting to their medication abortion creates an
6 added risk for patients—particularly for those patients who travel to Washington
7 for medical treatment from states where the abortion would be illegal.
8 Abortion providers have been targets for hackers seeking to steal information
9 about both patients and providers. In 2021, for example, hackers accessed data
10 about roughly 400,000 patients from Planned Parenthood Los Angeles.⁹⁷ Here in
11 Washington, providers report frequent phishing attacks aimed at illegally
12 obtaining information about patients and providers.

13 168. This risk is compounded by the fact that providers are required to
14 provide patients with a copy of the Patient Agreement Form, which could, in turn,
15 be found by a patient’s spouse, partner, or parent (who might otherwise be
16 unaware of the patient’s medication abortion), potentially putting the patient at
17 risk of violence or abuse. And the Patient Agreement Form is uniquely
18

19 ⁹⁷Gregory Yee and Christian Martinez, *Hack exposes personal information*
20 *of 400,000 Planned Parenthood Los Angeles patients*, LOS ANGELES TIMES
21 (Dec. 1, 2021), [https://www.latimes.com/california/story/2021-12-01/data-](https://www.latimes.com/california/story/2021-12-01/data-breach-planned-parenthood-los-angeles-patients)
22 [breach-planned-parenthood-los-angeles-patients](https://www.latimes.com/california/story/2021-12-01/data-breach-planned-parenthood-los-angeles-patients).

1 problematic for patients who receive mifepristone for miscarriage management,
2 as they must falsely attest that they are “decid[ing] . . . to end [their] pregnancy”
3 and then have that document placed into their medical record. And again, all of
4 these risks are compounded for individuals traveling to Washington to receive
5 care they cannot access in their home state.

6 **Oregon**

7 169. As in Washington, mifepristone is a critical medicine for providing
8 safe and effective abortion care as well as for supporting miscarriage
9 management in Oregon. The prescription and use of mifepristone with
10 misoprostol is the standard of care for miscarriage management and medication
11 abortion in Oregon.

12 170. According to state data for 2021, 4,246 medication abortions were
13 administered by Oregon medical providers. Based on information available at the
14 time of filing, it is likely that most of those medication abortions were effected
15 with a mifepristone prescription.

16 171. Those 4,246 medication abortions constitute about 60 percent of
17 abortions in Oregon in 2021. At the time of filing, the State of Oregon is not
18 aware of any Oregon patient who has experienced serious adverse effects or death
19 as the result of being prescribed and using mifepristone for miscarriage
20 management or medication abortion.

21
22

1 172. Oregon providers have been hindered in providing care, and patients
2 have been hindered in receiving care, due to the mifepristone REMS. Medical
3 providers, hospital administrators, and staff spend many hours implementing
4 REMS requirements, including making Patient Agreement Forms available to
5 patients and protecting the security of Provider Agreement Forms.

6 173. The REMS requirements also add to the amount of provider time
7 required for each patient. Even at a conservative estimate of two to three minutes
8 per patient, over a hundred—potentially hundreds—of provider hours are spent
9 each year for the review, discussion, and signing of the Patient Agreement Forms.
10 That is valuable time that those medical providers could otherwise spend treating
11 patients or attending to other important work.

12 174. Those requirements are also duplicative of the counseling that
13 Oregon providers already provide to their patients, namely in discussing risks and
14 benefits, explaining the treatment and alternatives, and obtaining informed
15 consent.

16 175. Oregon patients seeking care for miscarriage management have also
17 experienced the same issues as similarly situated Washington patients. Namely,
18 because the Patient Agreement Form is written specifically for the context of
19 medication abortion, it requires them to inaccurately attest that they have decided
20 to “end [their] pregnancy.” That causes unnecessary confusion for those patients.

21
22

1 176. In addition to the unnecessary (and sometimes frightening)
2 confusion, the Patient Agreement Form has caused unwarranted additional
3 anguish in some seeking care for miscarriage management. That is because the
4 form does not distinguish between the use of mifepristone for miscarriage
5 management and its use for the intentional termination of a pregnancy.
6 Consequently, for those already dealing with the distress of losing a pregnancy,
7 the medically unjustified REMS impose the additional emotional burden of
8 requiring the patient to incorrectly attest that the pregnancy loss was intentional
9 as a prerequisite for obtaining medically appropriate healthcare for their
10 miscarriage.

11 177. The REMS requirements also reduce access to essential
12 reproductive healthcare in Oregon. Namely, many rural providers in Oregon do
13 not have the volume of patient care to justify the onerous steps required to comply
14 with the REMS for mifepristone. As a result, rather than seek certification
15 themselves, they often refer patients to other providers. That requires patients to
16 see a second provider for something that their original provider otherwise could
17 have handled quickly and safely, results in reduced patient choice, and also places
18 the burden of additional patient loads on those certified providers that accept
19 referrals.

20 178. And similar to Washington patients, the reduced access to essential
21 reproductive health care results in additional delays to patients receiving
22

1 healthcare. For example, it takes time for the patient to receive the referral from
2 their primary provider. It takes time for the patient to establish care with the
3 second provider. It can take additional time if the patient seeks in-person
4 consultation and needs to travel for care. And it takes time for the patient to wait
5 for any healthcare delays caused by the patient-load resulting from the number
6 of referrals. Those are delays to healthcare for conditions for which time is of the
7 essence. And those delays often contribute to patients having reduced availability
8 of healthcare options and adverse effects to patient health.

9 **Arizona**

10 179. Access to safe and effective medication abortion is critically
11 important for Arizonans. Arizonans experience harms as a result of the 2023
12 REMS that are similar to those experienced by residents of the Plaintiff States.

13 **Colorado**

14 180. The State of Colorado, through the University of Colorado, its
15 largest institution of higher education, operates a woman's health clinic. As an
16 owner and operator of a medical clinic that provides reproductive health care
17 services and dispenses mifepristone, Colorado is subject to and harmed by the
18 January 2023 REMS.

19 181. Providers and staff at the University of Colorado have expended
20 time and resources complying with the 2023 REMS requirement, including
21 developing and processing the Prescriber Agreement Form and the
22

1 Patient Agreement Form. Further, the 2023 REMS prevent non-certified
2 providers from prescribing mifepristone to their patients. As a result, those
3 patients often must make additional clinic visits—sometimes at different
4 locations—to obtain mifepristone.

5 182. Further, patients in Colorado suffer the same harms experienced by
6 patients in other states outlined above and below.

7 **Connecticut**

8 183. Access to safe and effective medication abortion is critically
9 important for Connecticut residents. Connecticut residents experience harms as a
10 result of the 2023 REMS that are similar to those experienced by residents of the
11 Plaintiff States.

12 **Delaware**

13 184. Like Washington, Delaware residents rely on mifepristone to access
14 safe and effective abortion care and management of miscarriages. Analysis of
15 data from 2014 to 2020 shows that Delawareans have increasingly relied on
16 medication abortion for early pregnancy termination. In 2014, there were 2,937
17 abortions in Delaware. Of those, 1,292—44%—were medical abortions using
18 mifepristone. In 2020 (the most recent year for which complete data is available),
19 there were 2,281 abortions in Delaware. Of those, 1,492—65.4%—were medical
20 abortions using mifepristone.

21
22

1 185. Restricting access to mifepristone needlessly harms Delawareans
2 who increasingly rely on it.

3 **Illinois**

4 186. In Illinois, mifepristone is a critical medicine for providing safe and
5 effective abortion care as well as for supporting miscarriage management.

6 187. In 2020 (the most recent year for which public data), there were
7 46,243 reported abortions in Illinois. Of those, 23,765—51%—were medication
8 abortions using mifepristone.

9 188. The mifepristone REMS requirements impede drug availability for
10 Illinois residents by limiting the providers that can prescribe and the pharmacies
11 that can dispense the medication, while creating additional barriers to patient
12 access through the Patient Agreement Form requirement.

13 189. Limited access to abortion and miscarriage management medication
14 increases other health care costs, including more expensive procedural or later-
15 stage abortion care, emergency care, and care related to complications due to
16 unwanted pregnancies, childbirth, and miscarriage.

17 190. A significant proportion of this cost is borne by the State, which is
18 one of only 16 states that goes beyond federal Medicaid limits and uses state
19 funds to cover abortion care for people enrolled in Medicaid. From January 2019
20 to May 2022, the State covered approximately 29,000 mifepristone prescriptions.

21
22

1 191. State Medicaid reimbursement rates are higher for procedural
2 abortions and abortions taking place later in gestation. The bundled State
3 Medicaid reimbursement rate for medication abortion is \$558. In contrast, the
4 lowest rate for a procedural abortion is \$798. Because the 2023 REMS
5 requirements artificially limit the number of providers who can prescribe
6 mifepristone and the pharmacies that can fill prescriptions, fewer people have
7 access to mifepristone abortions. This restriction results in more higher-cost
8 procedural abortions. Broad mifepristone access is a critical tool for addressing
9 the financial impact on the State.

10 192. As Illinois's neighboring states have curtailed abortion access,
11 Illinois has seen a 28% increase in abortions from April 2022 to August 2022,
12 creating additional strain on Illinois providers and healthcare systems. The
13 REMS certification requirements pose particular hardships for Illinois providers
14 and pharmacies because Illinois is an abortion oasis in the Midwest and a
15 significant portion of patients seeking abortion care in Illinois are traveling from
16 Indiana, Missouri, and other nearby states where abortion is restricted. For these
17 providers and pharmacists, as well as patients traveling from out of state, the
18 REMS certification requirements and Patient Agreement Form create additional
19 risks of civil or criminal liability.

20
21
22

1 **Attorney General of Michigan**

2 193. Access to safe and effective medication abortion is critically
3 important for Michiganders. Michiganders experience harms as a result of the
4 2023 REMS that are similar to those experienced by residents of the Plaintiff
5 States.

6 **Nevada**

7 194. In Nevada, mifepristone is widely used in combination with
8 misoprostol as a safe, effective, FDA-approved regimen for medication
9 abortions. It is also used in the medical management of early pregnancy loss.

10 195. Medication abortions represent the largest share of pregnancy
11 termination procedures performed in Nevada. From December 2021 to
12 November 2022, 49% of all abortions performed in Nevada were medication
13 abortions.

14 196. The Nevada Department of Health and Human Services, Division of
15 Health Care Financing and Policy (DHHS) administers the Medicaid program in
16 Nevada. It is responsible for ensuring high quality, cost-effective care to
17 Medicaid recipients while maintaining compliance with federal Medicaid
18 requirements.

19 197. Nevada Medicaid fee-for-service covers mifepristone.

20 198. The reduced availability of mifepristone will financially impact
21 DHHS. Providers and patients will be forced to adopt alternatives including
22

1 surgical abortions which are more invasive, costly, and can expose patients to
2 higher health risks, e.g., excessive bleeding.

3 199. Since the *Dobbs* decision, Nevada has experienced a marked
4 increase in out-of-state patients seeking abortion care in state. In 2021, Nevada
5 experienced an average of 47 out-of-state patients per month over a six-month
6 period. In the first half of 2022, the average increased to 55 out-of-state patients.
7 Post-*Dobbs*, there was an immediate spike of 113 in July 2022, after which the
8 average leveled to 80 out-of-state patients per month.

9 200. The reduced availability of mifepristone will financially burden
10 Nevada reproductive healthcare providers attempting to service this increased
11 patient load.

12 201. The Mifepristone REMS program imposes medically unnecessary
13 barriers to the prescription, distribution, and use of mifepristone by Nevada
14 clinicians and patients. The REMS Patient Agreement Form must be signed by
15 both a patient and a certified provider before a prescription can be filled by a
16 qualified pharmacy. This imposes a significant burden for telehealth patients or
17 patients without access to smartphones or scanning apps.

18 202. A pharmacy can only become qualified by undergoing the REMS
19 certification process which further limits the availability of mifepristone in
20 Nevada.

21
22

1 203. The barriers created by the REMS program disproportionately
2 burden people of color, low-income families, and communities within Nevada’s
3 large rural regions whose residents would have to travel long distances to seek
4 alternative reproductive healthcare services.

5 204. These barriers interfere with Nevada’s inherent authority to provide
6 for the health and welfare of its residents.

7 **New Mexico**

8 205. New Mexico's injuries are exemplified in the sections discussing
9 Washington’s and the other Plaintiff States’ injuries.

10 206. New Mexico repealed its antiquated prohibition of abortion in
11 2021.⁹⁸

12 207. Nonetheless, many communities in New Mexico—particularly the
13 rural communities—do not currently have adequate access to reproductive health
14 care services.

15 208. New Mexico’s injuries are exacerbated by various local cities and
16 counties in the State of New Mexico enacting ordinances attempting to regulate
17 abortion, declaring unlawful the delivery of abortion medications, and creating a
18 private cause of action against abortion clinics. New Mexico residents in these
19 cities and counties, as well as in other rural communities in the State, are
20 particularly subject to the harms described in this Complaint.

21 _____
22 ⁹⁸NMSA 1978, §§ 30-5-1 to -3 (repealed 2021).

1 **Rhode Island**

2 209. In Rhode Island, mifepristone is a critical medicine for providing
3 safe and effective abortion care as well as for supporting miscarriage
4 management.

5 210. The mifepristone REMS requirements impede drug availability for
6 Rhode Islanders by limiting the providers that can prescribe and the pharmacies
7 that can dispense the medication, while creating additional barriers to patient
8 access through the Patient Agreement Form requirement.

9 211. Limited access to abortion and miscarriage management medication
10 increases other health care utilization costs, including emergency care, resulting
11 from complications due to unwanted pregnancies, childbirth, and miscarriage. A
12 significant proportion of this cost is borne by the state, in which over 30% of
13 Rhode Islanders are enrolled in Medicaid.

14 212. Rhode Islanders are harmed when access to mifepristone is limited,
15 including the emotional, financial, and social harms that individuals experience
16 by having to carry an unwanted pregnancy to term or not having access to the
17 benefit of miscarriage management medication.

1 **Vermont**

2 213. Medication abortion is critically important for Vermonters. In 2019,
3 59% of abortions in Vermont were medication abortions; in 2020, that number
4 rose to 75%.⁹⁹

5 214. The harms that the REMS cause are particularly acute in Vermont
6 because the state’s rurality makes it difficult for many Vermonters to access
7 providers. Less than a third of Vermont counties have abortion providers—
8 meaning that 43% of women of reproductive age live in a county without an
9 abortion provider.¹⁰⁰

12 ⁹⁹Agency of Human Services, *Vermont 2019 Vital Statistics: 135th Report*
13 *Relating to the Registry and Return of Births, Deaths, Marriages, Divorces, and*
14 *Dissolutions* at 139, Vermont Department of Health (June 2021),
15 [https://www.healthvermont.gov/sites/default/files/documents/pdf/HS-VR-](https://www.healthvermont.gov/sites/default/files/documents/pdf/HS-VR-2019VSB_final.pdf)
16 [2019VSB_final.pdf](https://www.healthvermont.gov/sites/default/files/documents/pdf/HS-VR-2019VSB_final.pdf); Agency of Human Services, *Vermont 2020 Vital Statistics:*
17 *136th Report Relating to the Registry and Return of Births, Deaths, Marriages,*
18 *Divorces, and Dissolutions* at 142, Vermont Department of Health (July 2022)
19 [https://www.healthvermont.gov/sites/default/files/documents/pdf/Vital%20Stati](https://www.healthvermont.gov/sites/default/files/documents/pdf/Vital%20Statistics%20Bulletin%202020.pdf)
20 [stics%20Bulletin%202020.pdf](https://www.healthvermont.gov/sites/default/files/documents/pdf/Vital%20Statistics%20Bulletin%202020.pdf).

21 ¹⁰⁰Jesse Philbin, et al., *10 US States Would Be Hit Especially Hard by a*
22 *Nationwide Ban on Medication Abortion Using Mifepristone*, GUTTMACHER

1 **V. FIRST CAUSE OF ACTION**
2 **(Administrative Procedure Act—Agency Action in Excess of Statutory**
3 **Authority and Contrary to Law)**

4 215. The Plaintiff States reallege and incorporate by reference the
5 allegations set forth in each of the preceding paragraphs of this Complaint.

6 216. FDA’s promulgation of the mifepristone 2023 REMS was a final
7 agency action that is causing the Plaintiff States irreparable harm for which the
8 States have no other adequate remedy under 5 U.S.C. § 704.

9 217. This Court must “hold unlawful and set aside agency action” that is,
10 *inter alia*, “not in accordance with law,” “in excess of statutory jurisdiction,
11 authority, or limitations,” or “without observance of procedure required by
12 law[.]” 5 U.S.C. § 706(2).

13 218. Through their actions described above, Defendants violated
14 5 U.S.C. § 706(2)(C) by acting in excess of statutory jurisdiction, authority,
15 limitations, and short of statutory right in promulgating the mifepristone
16 2023 REMS.

17
18
19
20
21 _____
22 INSTITUTE (Feb. 7, 2023), <https://www.guttmacher.org/2023/02/10-us-states-would-be-hit-especially-hard-nationwide-ban-medication-abortion-using>.

1 **VI. SECOND CAUSE OF ACTION**
2 **(Administrative Procedure Act—Arbitrary and Capricious Agency Action)**

3 219. The Plaintiff States reallege and incorporate by reference the
4 allegations set forth in each of the preceding paragraphs of this Complaint.

5 220. FDA’s promulgation of the mifepristone 2023 REMS was a final
6 agency action that is causing the Plaintiff States irreparable harm for which the
7 States have no other adequate remedy under 5 U.S.C. § 704.

8 221. FDA’s promulgation of the mifepristone 2023 REMS was arbitrary,
9 capricious, an abuse of discretion, and otherwise not in accordance with law in
10 violation of 5 U.S.C. § 706(2)(A).

11 **VII. THIRD CAUSE OF ACTION**
12 **(Administrative Procedure Act—Action Contrary to Constitutional Right)**

13 222. The Plaintiff States reallege and incorporate by reference the
14 allegations set forth in each of the preceding paragraphs of this Complaint.

15 223. FDA’s promulgation of the mifepristone 2023 REMS was a final
16 agency action that is causing the Plaintiff States irreparable harm for which the
17 States have no other adequate remedy under 5 U.S.C. § 704.

18 224. FDA’s promulgation of the mifepristone 2023 REMS treated
19 similarly situated parties differently without adequate justification, and therefore
20 violates the constitutional guarantee of equal protection in violation of
21 5 U.S.C. § 706(2)(B).

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

**VIII. FOURTH CAUSE OF ACTION
(Equal Protection)**

225. The Plaintiff States reallege and incorporate by reference the allegations set forth in each of the preceding paragraphs of this Complaint.

226. Through their actions described above, Defendants violate the equal protection guarantee of the Due Process Clause of the Fifth Amendment to the United States Constitution.

227. Through the 2023 REMS, FDA reduces access to a critical and time-sensitive health care service needed by pregnant people. And FDA treats providers, pharmacists, and patients who prescribe, dispense, or use mifepristone worse than providers, pharmacists, and patients who prescribe, dispense, or use nearly every other medication. FDA’s actions are irrational and violate the Fifth Amendment under any standard of review.

IX. PRAYER FOR RELIEF

WHEREFORE, Washington, Oregon, Arizona, Colorado, Connecticut, Delaware, Illinois, Attorney General of Michigan, Nevada, New Mexico, Rhode Island, and Vermont pray that the Court:

- a. Declare, pursuant to 28 U.S.C. § 2201, that mifepristone is safe and effective and that Defendants’ approval of mifepristone is lawful and valid;
- b. Declare, pursuant to 28 U.S.C. § 2201, that the mifepristone REMS violates the Administrative Procedure Act;

1 c. Declare, pursuant to 28 U.S.C. § 2201, that the mifepristone REMS
2 violates the United States Constitution;

3 d. Enjoin Defendants, pursuant to 28 U.S.C. § 2202, from enforcing or
4 applying the mifepristone REMS;

5 e. Enjoin Defendants, pursuant to 28 U.S.C. § 2202, from taking any
6 action to remove mifepristone from the market or reduce its availability; and

7 f. Award such additional relief as the interests of justice may require.

8 DATED this 23rd day of February 2023.

9 ROBERT W. FERGUSON
10 Attorney General of Washington

11 /s/ Kristin Beneski

NOAH GUZZO PURCELL, WSBA #43492
Solicitor General

12 KRISTIN BENESKI, WSBA #45478
First Assistant Attorney General

13 COLLEEN M. MELODY, WSBA #42275
Civil Rights Division Chief

14 ANDREW R.W. HUGHES, WSBA #49515
LAURYN K. FRAAS, WSBA #53238

15 Assistant Attorneys General

16 TERA M. HEINTZ, WSBA #54921

(application for admission forthcoming)

Deputy Solicitor General

17 800 Fifth Avenue, Suite 2000

18 Seattle, WA 98104-3188

(206) 464-7744

19 *Attorneys for Plaintiff State of Washington*

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

ELLEN F. ROSENBLUM
Attorney General of Oregon

/s/ Marc Hull

SANDER MARCUS HULL WSBA #35986
Senior Assistant Attorney General
YOUNGWOON JOHNSON OSB #164105*
Assistant Attorney General
Trial Attorneys
Tel (971) 673-1880
Fax (971) 673-5000
marcus.hull@doj.state.or.us
youngwoon.joh@doj.state.or.us
Attorneys for State of Oregon

**Application for pro hac vice admission
forthcoming*

KRIS MAYES
Attorney General of Arizona

/s/ Daniel C. Barr

Daniel C. Barr (Arizona No. 010149)*
Chief Deputy Attorney General
Office of the Attorney General of Arizona
2005 N. Central Ave.
Phoenix, AZ 85004-1592
Phone: (602) 542-8080
Email: Daniel.Barr@azag.gov
Attorney for Plaintiff State of Arizona

**Application for pro hac vice admission
forthcoming*

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

PHILIP J. WEISER
Attorney General of Colorado

/s/ Eric Olson

ERIC OLSON, CO #36414*
Solicitor General
MICHAEL MCMASTER, CO #42368*
Assistant Solicitor General
Office of the Attorney General
Colorado Department of Law
1300 Broadway, 10th Floor
Denver, CO 80203
Phone: (720) 508-6000
Attorneys for Plaintiff State of Colorado

**Applications for pro hac vice admission
forthcoming*

WILLIAM TONG
Attorney General of Connecticut

/s/ Joshua Perry

Joshua Perry*
Solicitor General
Office of the Connecticut Attorney General
165 Capitol Ave, Hartford, CT 06106
Joshua.perry@ct.gov
(860) 808-5372
Fax: (860) 808-5387
Attorney for Plaintiff State of Connecticut

**Application for pro hac vice admission
forthcoming*

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

KATHLEEN JENNINGS
Attorney General of Delaware

/s/ Vanessa L. Kassab

VANESSA L. KASSAB*

Deputy Attorney General
Delaware Department of Justice
820 N. French Street
Wilmington, DE 19801
302-683-8899

vanessa.kassab@delaware.gov
Attorney for Plaintiff State of Delaware

**Application for pro hac vice admission
forthcoming*

KWAME RAOUL
Attorney General of Illinois

/s/ Liza Roberson-Young

Liza Roberson-Young*

Public Interest Counsel
Office of the Illinois Attorney General
100 West Randolph Street
Chicago, IL 60601
Phone: (872) 272-0788

E.RobersonYoung@ilag.gov
Attorney for Plaintiff State of Illinois

**Application for pro hac vice admission
forthcoming*

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

DANA NESSEL
Attorney General of Michigan

/s/ Stephanie M. Service

Stephanie M. Service (P73305)*
Assistant Attorney General
Michigan Department of Attorney General
Health, Education & Family
Services Division
P.O. Box 30758
Lansing, MI 48909
(517) 335-7603
ServiceS3@michigan.gov
*Attorney for Plaintiff Attorney General of
Michigan*

**Application for pro hac vice admission
forthcoming*

AARON D. FORD
Attorney General of Nevada

/s/ Heidi Parry Stern

Heidi Parry Stern (Bar. No. 8873)*
Solicitor General
Office of the Nevada Attorney General
555 E. Washington Ave., Ste. 3900
Las Vegas, NV 89101
HStern@ag.nv.gov
Attorney for Plaintiff State of Nevada

**Application for pro hac vice admission
forthcoming*

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

RAÚL TORREZ
Attorney General of New Mexico

/s/ Aletheia Allen
Aletheia Allen*
Solicitor General
New Mexico Office of the Attorney General
201 Third St. NW, Suite 300
Albuquerque, NM 87102
AAllen@nmag.gov
Attorney for Plaintiff State of New Mexico

**Application for pro hac vice admission
forthcoming*

PETER F. NERONHA
Attorney General of Rhode Island

/s/ Julia C. Harvey
JULIA C. HARVEY #10529*
Special Assistant Attorney General
150 S. Main Street
Providence, RI 02903
(401) 274-4400 x2103
Attorney for Plaintiff State of Rhode Island

**Application for pro hac vice admission
forthcoming*

CHARITY R. CLARK
Attorney General of Vermont

/s/ Eleanor L.P. Spottswood
ELEANOR L.P. SPOTTSWOOD*
Solicitor General
109 State Street
Montpelier, VT 05609-1001
(802)793-1646
eleanor.spottswood@vermont.gov
Attorney for Plaintiff State of Vermont

**Application for pro hac vice admission
forthcoming*