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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF HAWAI'I

GRAHAM T. CHELIUS, M.D., *et al.*, Plaintiffs, vs. ALEX M. AZAR, II, M.D., M.P.H., *in his official capacity as* SECRETARY, U.S. D.H.H.S., *et al.*, Defendants.	CIV. NO. 1:17-cv-00493-DKW-KSC **MEMORANDUM IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT** Hearing scheduled for March 6, 2020, at 9am Judge Otake

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INTRODUCTION

Plaintiffs ask this Court to override the scientific judgment of the Food and Drug Administration ("FDA") and eliminate safeguards on the use of Mifeprex (mifepristone 200mg), the first FDA-approved drug product for non-surgical abortions. FDA approved Mifeprex in 2000 with certain restrictions related to the drug's prescribing and dispensing that were deemed essential by FDA and agreed to by the drug's sponsor. The restrictions are necessary given Mifeprex's risks, which include incomplete abortion and serious bleeding that require surgical intervention in about 2-7 out of every 100 women who take the drug. With these precautionary restrictions in place, millions of women in the United States have safely used Mifeprex for non-surgical abortions.

Notwithstanding this background, Plaintiffs seek in this suit to jettison the most recent iteration of the Mifeprex safeguards, which FDA approved in 2016 as part of a modified Risk Evaluation and Mitigation Strategy ("REMS") for the drug. FDA approved the 2016 REMS in response to a supplemental new drug application ("sNDA") submitted by Mifeprex's sponsor, Danco Laboratories, LLC ("Danco"). Consistent with Danco's sNDA (which did not seek to remove the REMS or lift certain prescribing and dispensing restrictions) and FDA's finding that Mifeprex's safety profile had "not substantially changed," FDA relaxed certain restrictions while retaining others. In particular, FDA modified the REMS to allow certain non-physicians to prescribe the drug, and allow patients to take the drug somewhere other than a "provider's office," but it maintained, among other things, the requirements that the drug be prescribed by a certified healthcare provider who is able to assess the duration of a pregnancy, diagnose an ectopic pregnancy, and ensure surgical intervention in cases of

incomplete abortion or severe bleeding. FDA also approved extension of the gestational period of approved use from 49 to 70 days.

Dissatisfied with the eased restrictions that Danco proposed and FDA approved, Plaintiffs contend that FDA should have eliminated the REMS entirely and allege both statutory and constitutional infirmities in FDA's action. Dr. Graham T. Chelius, an obstetrician, sues on behalf of himself and his patients. Three nonprofit organizations, Society of Family Planning ("SFP"), California Academy of Family Physicians ("CAFP"), and Pharmacists Planning Services, Inc. ("PPSI"), all sue on behalf of their members and their members' patients. Plaintiffs challenge the revised Mifeprex REMS under the Administrative Procedure Act ("APA") and also allege that it: (1) places undue burdens on access to abortion in violation of due-process doctrine; and (2) violates equal-protection doctrine by purportedly treating Plaintiffs and their members differently from other similarly situated parties without a sufficient state interest. The Court should reject these challenges.

Plaintiffs cannot establish any plausible violation of the APA. FDA's decision to retain the Mifeprex REMS in 2016 was a reasoned scientific judgment based on the agency's expert evaluation of the serious health risks associated with the drug and its mandate to protect patient safety. In arguing to the contrary, Plaintiffs urge the Court to override the determination of FDA experts that the REMS's limitations are necessary on the premise that Mifeprex is safe. That argument, however, proves too much, as a lack of serious patient harm is the very hallmark of an effective REMS. Mifeprex's record therefore counsels in favor of *retaining*, rather than eliminating, the REMS safeguards that FDA decided were necessary to mitigate the drug's serious risks.

Plaintiffs also cannot demonstrate that the REMS violates due-process or equal-protection doctrines. The REMS is necessary to ensure patient safety and does not impose a substantial obstacle to women seeking medical abortion. The Court should enter summary judgment for FDA.

BACKGROUND

A. Statutory and Regulatory Background

Under the Federal Food, Drug, and Cosmetic Act ("FDCA"), a sponsor must apply for and secure FDA approval to market a "new drug" in interstate commerce. 21 U.S.C. § 355(a); *see* 21 U.S.C. § 321(p) (defining "new drug"). FDA approves two general categories of such applications: a new drug application ("NDA") for what are commonly referred to as "brand-name drugs," and an abbreviated new drug application for what are commonly referred to as "generic" versions of brand-name drugs. *See* 21 U.S.C. §§ 355(a), (b), (j). In certain circumstances, FDA also may approve specified changes to a previously approved NDA, which a drug sponsor may request through an sNDA. *See generally* 21 C.F.R. § 314.70.

An NDA must include, among other things, the drug product's proposed indications for use; full reports of the clinical investigations of the drug product's safety and effectiveness for the proposed indications; and the drug product's proposed labeling. *See* 21 C.F.R. § 314.50(a)(1); 21 U.S.C. § 355(b)(1)(A), (F). FDA will approve an NDA only if it determines that the drug product is safe and effective for use in accordance with its proposed labeling. 21 U.S.C. § 355(d).

FDA is responsible for considering whether and how to approve new drugs for use. 21 U.S.C. § 355(a). For example, pursuant to the Food and Drug Administration

Amendments Act of 2007 ("FDAAA"), FDA may require a REMS for a drug product if the agency determines that the REMS "is necessary to ensure that the benefits of the drug outweigh the risks of the drug." *See* 21 U.S.C. § 355-1(a). A REMS may incorporate a specific labeling requirement, such as a Medication Guide, to explain a drug's risks and offer important instructions. *See* 21 U.S.C. § 355-1(e). A REMS may also include certain "elements to assure safe use" ("ETASU") if "the drug . . . has been shown to be effective, but is associated with a serious adverse drug experience" that makes approval of the product contingent on those elements to mitigate its serious risks. *See* 21 U.S.C. § 355-1(f)(1)(A). ETASU can include, among other things, requirements that a drug product's prescribers have particular training or experience, and that a drug product be dispensed only in certain healthcare settings and/or only after documentation of safe use conditions is provided. *See* 21 U.S.C. § 355-1(f)(3). In addition, a REMS may require an implementation system under which the sponsor must monitor and evaluate the operation and effectiveness of certain ETASU. *See* 21 U.S.C. § 355-1(f)(4). Once FDA approves a drug with a REMS, the drug sponsor later may seek to modify the REMS through submission of an sNDA. *See* 21 U.S.C. § 355-1(g)(4).

B. Factual Background

On September 28, 2000, FDA approved the NDA for Mifeprex, authorizing the drug's use in a 600-mg dose, in a regimen with another drug (misoprostol), to terminate intrauterine pregnancy through 49 days' gestation. JSF 8, 10, 14. Mifeprex was the first approved drug for non-surgical abortion. JSF 7-10.

FDA approved the Mifeprex application in accordance with 21 C.F.R. part 314, subpart H, "Accelerated Approval of New Drugs for Serious or Life-Threatening Illnesses" ("subpart

H"). Defs.' Ex. 2 at 0004. The agency concluded that pregnancy falls within the scope of subpart H because pregnancy can pose serious risks, particularly for certain patient populations or under certain circumstances. Defs.' Ex. 32 at 0858-60.

In approving Mifeprex under subpart H, FDA recognized that the drug carries serious risks to the patient using it, including incomplete abortion or serious bleeding that may require surgical intervention and can even cause maternal death. JSF Ex. A at 387-88. Thus, in accordance with section 314.520 of subpart H—which governs approvals of select drugs requiring post-marketing restrictions—and the details provided by Mifeprex's then-NDA sponsor, the Population Council, FDA placed certain restrictions on the distribution of Mifeprex. The restrictions, in relevant part, included a requirement that Mifeprex be provided by, or under the supervision of, a physician who can accurately assess the duration of a pregnancy, diagnose an ectopic pregnancy (for which Mifeprex is contraindicated), and provide surgical intervention in cases of incomplete abortion or severe bleeding (or have made plans to provide such care through others). Defs.' Ex. 2 at 004; Defs.' Ex. 12 at 0228. Moreover, the restrictions required a physician to dispense Mifeprex directly to a patient and for the patient to take the drug in the physician's office. Defs.' Ex. 3 at 0016. These provisions were similar to conditions of the U.S. clinical trial for the drug—without which the drug could not have been approved—and were critical to ensuring that Mifeprex would be prescribed only when consistent with protecting patient safety. Defs.' Ex. 12 at 0223, 0226-27.

The Mifeprex restrictions initially established as part of the drug's approval in 2000 have remained in place, largely unchanged, since that time. Defs.' Ex. 12 (2000 restrictions); JSF Ex. C (2016 restrictions); JSF Ex. I at 0679-0680 (REMS Modification Review); Defs.'

Exs. 30, 31 (Overview of 2016 REMS). In 2007, the restrictions were "deemed . . . an approved risk evaluation and mitigation strategy" (*i.e.*, a REMS) under Section 909(b)(1) of the newly enacted FDAAA, because FDA previously had approved the drug with the restrictions under 21 C.F.R. part 314, subpart H. In 2011, FDA affirmatively approved Mifeprex's REMS with certain ETASU, maintaining the originally approved restrictions. Defs.' Ex. 13 at 0231-36; JSF Ex. B. At that time, FDA specifically determined that the REMS with ETASU remained necessary because Mifeprex "was associated with serious adverse drug experiences, [and could] be approved only if, or would be withdrawn unless, such elements [were] required" as part of a strategy to mitigate the serious risks listed in its labeling. *See* 21 U.S.C. § 355-1(f)(1)(A).

In October 2013, FDA again conducted a full review of the Mifeprex REMS and determined that "[t]he Mifeprex REMS provides the foundation to ensure the implementation of safe use conditions with Mifeprex use. . . . It is not likely that the essential safe use conditions will be maintained to a similar extent if a REMS is no longer required and, as a consequence, we would expect a negative impact on the types, incidence, and severity of adverse events." JSF 55. Therefore, FDA concluded that "the existing elements of the REMS should be maintained." JSF 56. FDA also reviewed and maintained the Mifeprex REMS in 2012, and again in 2015. Defs.' Ex. 17 at 0331-0341; Defs.' Ex. 18 at 0361-0370.

In 2015, Danco (which took ownership of the Mifeprex NDA in November 2000), submitted an sNDA to FDA, seeking approval to alter Mifeprex's indication, labeling, and REMS to reflect a new evidence-based prescription regimen. Defs.' Exs. 19-28; JSF Exs. A, C, I. In particular, Danco requested, *inter alia*, that FDA approve: (1) an increase in the gestational age through which Mifeprex can be used from 49 days to 70 days; (2) a reduction

in the Mifeprex dosage from 600-mg to 200-mg; (3) making an in-person patient follow-up visit with a healthcare provider a recommended advisement rather than a requirement; (4) elimination of the instruction that patients take Mifeprex at their "provider's office"; (5) an expansion of the universe of healthcare providers who may prescribe Mifeprex to include all "healthcare providers who prescribe," rather than just "physicians"; and (6) modifying the Medication Guide's risk-expectation advisement to note that "about 2-7 out of 100," rather than "about 5-8 out of 100," women "taking Mifeprex will need a surgical procedure to end the pregnancy or to stop too much bleeding." Defs.' Ex. 20 at 0414-15, 435. Notably, Danco did not propose to eliminate or significantly modify the restricted distribution scheme for the drug in conjunction with its sNDA. Medical experts and organizations—including Plaintiff Society of Family Planning—also submitted materials to FDA following submission of Danco's sNDA.

After a careful review of the sNDA, FDA approved each of the changes that Danco proposed, with some modifications, concluding that the proposed alterations were supported by appropriate data and information. Defs.' Ex. 21 at 0464-70; JSF Ex. I at 0680-82. At the same time, FDA also determined that all of the REMS requirements that Danco did not seek to change remained necessary because the drug's safety profile had "not substantially changed." JSF Ex. I at 0681. This conclusion was based on the evidence FDA reviewed, including a clinical review of the drug that identified thousands of adverse events between 2000 and 2014, involving hundreds of hospitalizations, transfusions, and infections. Compl. Ex. A, at 83-84. It also reflected the agency's unchanged view that:

> the current safety profile [of Mifeprex] is reflective of an effective system in place with knowledgeable prescribers primarily using Mifeprex within that system guided by standard protocols. It is not likely that the current safe use conditions will persist to a similar extent if a REMS is no longer required and,

> as a consequence, we would expect a negative impact on the types, incidence, and severity of adverse events if the REMS was eliminated.

JSF Ex. H at 0354; *see also* JSF Ex. I at FDA 0681. More succinctly, FDA determined that the REMS remained necessary to address Mifeprex's risks.

On April 11, 2019, FDA maintained these critical REMS elements when it approved an abbreviated new drug application for a generic version of Mifeprex. *See* Defs.' Ex. 34. This approval offers the opportunity over time for expanded drug availability and potential cost savings to patients. *See generally* Drug Price Competition and Patent Term Restoration Act of 1984 P. L. No. 98-417 (1984) (the "Hatch-Waxman Act"). In conjunction with the generic approval, FDA established a single, shared system REMS called the Mifepristone REMS Program.

The Mifepristone REMS Program includes the following three elements, each of which is designed to mitigate the serious risks associated with mifepristone for non-surgical abortion: (1) the ETASU; (2) an implementation system; and (3) a timetable for submission of assessments. *See* JSF Ex. C at 0404-0407; Defs.' Ex. 33. The ETASU require that:

> (1) Healthcare providers who prescribe mifepristone be specially certified. To become specially certified, healthcare providers must review the prescribing information and complete a Prescriber Agreement Form.[1] By signing a Prescriber Agreement Form, prescribers agree that:
>
> a) They have the following qualifications:
>
> i. Ability to assess the duration of pregnancy accurately;
> ii. Ability to diagnose ectopic pregnancies;
> iii. Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding or to have made plans to provide such care through others, and to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary; and

[1] *See, e.g.*, Defs.' Ex. 37; JSF Ex. B at 0264; JSF Ex. C at 0408; JSF Ex. I at 0694.

b) They will follow the guidelines for the use of mifepristone described below:

i. Review the Patient Agreement Form,[2] fully explain the risks of the mifepristone treatment regimen, and answer any questions the patient may have;
ii. Sign the Patient Agreement Form and obtain the Patient's signature;
iii. Provide the patient with a copy of the Patient Agreement Form and Medication Guide;[3]
iv. Place the signed Patient Agreement Form in the patient's medical record;
v. Record in the patient's record the serial number of each mifepristone package dispensed; and
vi. Report any deaths to the company that provided the mifepristone.

(2) Mifepristone be dispensed to patients only in certain health care settings, specifically clinics, medical offices, and hospitals, by or under the supervision of a certified prescriber. Mifepristone sponsors must ensure compliance with this requirement and also that mifepristone is not distributed to or dispensed through retail pharmacies or other settings not described above.

(3) Mifepristone be dispensed to patients with evidence or other documentation of safe use conditions. The patient must sign the Patient Agreement Form indicating that she has:

i. Received, read, and been provided a copy of the Patient Agreement Form;
ii. Received counseling from the prescriber regarding the risk of serious complications associated with mifepristone.

Defs.' Ex. 33 at 1-2. The Mifepristone REMS Program requires mifepristone sponsors to ensure that mifepristone is only distributed to clinics, medical offices and hospitals by or under the supervision of a certified prescriber, and that distributors put certain processes and procedures in place. *See id.* at 2-3. The timetable for submission of assessments requires the

[2] *See, e.g.*, Defs.' Ex. 38; JSF Ex. B at 0266-267; JSF Ex. C at 0410; JSF Ex. I at 0696.

[3] *See, e.g.*, JSF Ex A at 0398-401; JSF Ex. B at 0261-263.

NDA sponsor to submit REMS assessments to FDA one year from the date of the initial REMS approval and every three years thereafter. *See id.* at 3.

C. Procedural Posture

In October 2017, Plaintiffs filed suit in this Court, challenging FDA's 2016 determination that the REMS remained necessary given Mifeprex's risks. Plaintiffs seek a declaration that the Mifeprex REMS, in its entirety, violates the Fifth Amendment and/or the APA, or that specific REMS requirements violate the Fifth Amendment and/or the APA; an injunction prohibiting Defendants from requiring a REMS for Mifeprex; a remand to FDA to remove the Mifeprex REMS; and costs and attorneys' fees.

STANDARD OF REVIEW

A court "shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "An issue is genuine only if there is sufficient evidentiary basis on which a reasonable fact finder could find for the nonmoving party, and a dispute is material only if it could affect the outcome of the suit under the governing law." *Chen-Li Sung v. Doyle*, 988 F. Supp. 2d 1195, 1203 (D. Haw. 2013) (internal quotation marks and citation omitted).

In reviewing an administrative decision of an agency, "there are no disputed facts that the district court must revolve" because the agency is the finder of fact. *Occidental Eng'g Co. v. Immigration & Naturalization Serv.*, 753 F.2d 766, 769-70 (9th Cir. 1985). As such, "the function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." *Id.* at 769; *see also Ringgold v. Johnson*, 40 F. Supp. 3d 1331, 1338 (D. Haw. 2014). Here, summary judgment is the "mechanism for deciding the legal question of whether the agency could

reasonably have found the facts as it did." *Id.* at 770; *see also City & Cty. of S.F. v. United States*, 130 F.3d 873, 877 (9th Cir. 1997).

ARGUMENT

A. FDA's Decisions Regarding the Mifeprex REMS Comport with the APA

When FDA approved Danco's sNDA in 2016, the agency concluded that the REMS remained "necessary to ensure that the benefits of [Mifeprex] outweigh [its] risks." *See* 21 U.S.C. § 355-1(g). Plaintiffs now challenge this determination, alleging that it was: (1) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (2) contrary to a constitutional right; and (3) in excess of statutory authority, in violation of the APA, 5 U.S.C. § 706(2). *See* Compl. ¶¶ 232, 235, 238-40. But as the administrative record in this case demonstrates, FDA has, since 2000, repeatedly and consistently determined that a restricted distribution system is, and remains, necessary to protect the safety of patients using Mifeprex. Those decisions were grounded on a thorough review of the underlying science and careful consideration of the regulatory and statutory requirements. They thus fall squarely within the agency's realm of expertise and are owed substantial deference.

A litigant challenging agency action as arbitrary and capricious bears a "heavy burden." *Managed Pharm. Care v. Sebelius*, 716 F.3d 1235, 1244 (9th Cir. 2013). "The scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of the agency." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983); *see also Ringgold*, 40 F. Supp. 3d at 1337 ("Review under the arbitrary and capricious standard is highly deferential, presuming the agency action to be valid and affirming the agency action if a reasonable basis exists for its decision.") (internal quotations and citations omitted). In an APA case, the court "must determine

whether the agency 'has considered the relevant factors and articulated a rational connection between the facts found and the choice made.'" *Pac. Coast Fed'n of Fishermen's Ass'ns v. Blank*, 693 F.3d 1084, 1091 (9th Cir. 2012) (quoting *Balt. Gas & Elec. Co. v. NRDC*, 462 U.S. 87, 105 (1983)).

Moreover, "deference to the agency's technical expertise and experience is particularly important with respect to questions involving scientific matters." *Aina Nui Corp. v. Jewell*, 52 F. Supp. 3d 1110, 1119 (D. Haw. 2014); *see also Ctr. for Biological Diversity v. Zinke*, 868 F.3d 1054, 1061 (9th Cir. 2017). FDA is charged with protecting the public health, and FDA's scientific mandate includes regulating all aspects of drug approvals. *See, e.g.*, 21 U.S.C. §§ 355, 393. In evaluating whether to approve a drug application, FDA must assess, based on the scientific evidence before the agency, whether a drug product is safe and effective under the conditions of use described in its labeling. *See* 21 U.S.C. § 355(d). "When examining this kind of scientific determination, as opposed to simple findings of fact, a reviewing court must generally be at its most deferential." *NRDC*, 462 U.S. at 103; *see also Helping Hand Tools v. EPA*, 848 F.3d 1185, 1199 (9th Cir. 2016).

Indeed, courts are rightfully loath to disturb an agency's scientific judgment and must generally "defer to an agency's determination in an area involving a high level of technical expertise." *Lands Council v. McNair*, 537 F.3d 981, 993 (9th Cir. 2008) (internal quotation marks and citation omitted); *see also Conservation Council for Haw. v. Nat'l Marine Fisheries Serv.*, 154 F. Supp. 3d 1006, 1039 (D. Haw. 2015). As the Ninth Circuit has made clear, "[d]eference to the informed discretion of the responsible federal agencies is especially appropriate, where, as here, the agency's decision involves a high level of technical

expertise." *Ranchers Cattlemen Action Legal Fund United Stockgrowers of Am. v. USDA*, 415 F.3d 1078, 1093 (9th Cir. 2005).

The decision Plaintiffs challenge in this case directly implicates FDA's undisputed technical expertise—the conditions necessary to address risks associated with a drug that will be taken by millions of American women. FDA's conclusion that the Mifeprex REMS remains necessary in light of the drug's risks is a quintessential scientific judgment that readily passes muster under the APA's deferential standard of review.

1. Safeguards Put in Place with the Initial Approval of Mifeprex Were Necessary for Patient Safety

The FDA, as noted, initially approved Mifeprex in September 2000 in accordance with subpart H, which applies, among other things, when FDA concludes that a drug can be used safely by the patient only if its distribution or use is restricted. *See* Defs.' Ex. 12 at 0223-30. Consistent with the substantial information before it, FDA determined that it was necessary, pursuant to subpart H to place certain restrictions on Mifeprex. Defs.' Ex. 2; Defs.' Ex. 12 at 0223-30. This determination was reasonable.

Among other things, the agency determined in 2000 that it was critical that Mifeprex be dispensed by or under the supervision of a qualified prescriber. This requirement ensured that distribution was limited to prescribers who were able to accurately date pregnancies and diagnose ectopic pregnancies. Mifeprex is contraindicated in ectopic pregnancies and use beyond the approved gestational age increases the risk of incomplete abortion and serious, or even fatal, bleeding. And requiring dispensing by or under the supervision of a qualified prescriber also ensured that patients have access to appropriate medical care to address incidents of severe bleeding or incomplete abortion, and that patients have access to medical facilities equipped to provide blood transfusions and resuscitation. Defs.' Ex. 12 at 0226-27.

In addition, when Mifeprex was first approved, FDA concluded that certain labeling and educational interventions were essential given the risks associated with the drug. *See id.* at 0226 ("Patient adherence to directions for use and [follow-up] visits is critical to the drug's effectiveness and safety."). As FDA noted in a memorandum documenting the approval of the initial NDA,

> Labeling is important to educate prescribers and patients about the safe and effective use of the drug and to inform health professionals about adverse event risks. The 1996 Advisory Committee strongly supported education of users of mifepristone. By coupling professional labeling with other educational interventions such as the Medication Guide, Patient Agreement, and Prescriber's Agreement, along with having physician qualification requirements of abilities to date pregnancies accurately and diagnose ectopic pregnancies (and other requirements), goals of safe and appropriate use may be achieved.

Id. at 0224.

More specifically, FDA determined that the Medication Guide helped "ensure dispensers provide important information to patients to enhance compliance with the regimen for safety and efficacy." *Id.* at 0224. Similarly, FDA found the Patient Agreement to "foster[] active patient education and participation in this regimen." *Id.* FDA further determined that patient education and participation were particularly important with Mifeprex, given the potential serious risks to the patient, such as bleeding and incomplete abortion, which can arise after taking the drug and require patients to independently seek emergency surgical intervention. *Id.* By requiring prescribing physicians to explain the medical abortion procedure and provide patients with the Medication Guide and Patient Agreement Form, FDA could help ensure that physicians would discuss the serious potential risks with the patient. *Id.*

Likewise, by limiting distribution of Mifeprex to specified healthcare settings, FDA and the sponsor could ensure that patients were "properly counseled [at the time of dispensing

Mifeprex] about the serious complications and what to do in the event that they experience an adverse event," which was considered vital to ensuring the safety of patients who use Mifeprex. JSF Ex. H at 0356.

At the time Mifeprex was initially approved, FDA also determined that both drugs in the approved Mifeprex regimen— Mifeprex, which was to be taken on Day 1, and misoprostol, which was to be taken on Day 3—must be obtained from, and taken in, the prescriber's office. Defs.' Ex. 3 at 0016. FDA deemed these safeguards necessary as part of the overall restricted distribution system implemented to minimize the risk of serious patient complications associated with Mifeprex. These constraints were similar to the conditions of the clinical studies on which FDA's approval of the drug was based. Defs.' Ex. 6 at 43, 49-50; Defs.' Ex. 12 at 0224-25. Mifeprex's sponsor proposed that patients have the option of taking the second drug in the regimen, misoprostol, on Day 3 of the regimen either at home (which was a departure from the conditions of use studied) or at the prescriber's office. Defs.' Ex. 12 at 0224-225. FDA did not approve this option at the time, however, because it found the data provided by the sponsor to support home use of misoprostol—which included "anecdotal off-label experience with a [different regimen], an observational study about home use in Guadeloupe, and a U.S. clinical study of home use of a different regimen"—did not provide substantial evidence for patient safety and efficacy. *Id.* Without evidence, FDA could not approve an application allowing for administration outside of the specialized healthcare setting. FDA concluded that retaining the requirement that the drug be administered at the prescriber's office "assures that the misoprostol is correctly administered," and has the "additional advantage of contact between the patient and health care provider to provide ongoing care and to reinforce the need to return on Day 14." *Id.* at 0225.

2. FDA Appropriately Retained Certain Safeguards When it Approved Modifications to the Mifeprex REMS in 2016

In 2015, when Mifeprex manufacturer Danco proposed modifications to the indication, labeling, and certain elements of the REMS to reflect a new prescription regimen for the drug, FDA thoroughly considered whether each element of the REMS remained necessary to mitigate Mifeprex's risks. *See* Defs.' Exs. 19-28; JSF Exs. A, C. This evaluation included a multidisciplinary, multi-layered review, as the administrative record demonstrates. *Id.* [4]

Based on this review, in 2016 FDA approved each of the changes the sponsor initially proposed, with some agreed-upon modifications, concluding that the proposed changes were supported by appropriate data and information. But consistent with the information submitted with the sNDA and FDA's finding that Mifeprex's safety profile "is essentially unchanged," FDA concluded that certain prescribing and dispensing restrictions remained necessary under the modified REMS, given Mifeprex's risks. Defs.' Ex. 20 at 0412-0439. FDA ultimately concluded, "[b]ased on the available data and information, . . . that a REMS [continues to be] necessary to ensure the benefits outweigh the risks." JSF Ex. I at 0702.

Plaintiffs' allegations do not warrant a different outcome. Plaintiffs argue that the Mifeprex REMS with ETASU violates 21 U.S.C. § 355-1(f)(2)(A) because the ETASU (requiring the Prescriber Agreement, the Patient Agreement, and the restricted distribution to

[4] The multiple memoranda in the record, *see generally* Defs.' Exs. 19-28; JSF Exs. A, C, H, include: a Summary Review (Defs.' Ex. 12), Cross Discipline Team Leader Review (Defs.' Ex. 21), Clinical Review (Defs.' Ex. 22), Chemistry Reviews (Defs.' Ex. 23), Pharmacology Review (Defs.' Ex. 24), Statistical Review (Defs.' Ex. 25), Clinical Pharmacology and Biopharmaceutics Reviews (Defs.' Ex. 26), Risk Assessment and Risk Mitigation Reviews, including a REMS Modification Review (JSF Ex. I), other reviews including Labeling (Defs.' Ex. 27), and other internal memoranda and correspondence with the sponsor (Defs.' Ex. 28).

certain healthcare settings) are not "commensurate with the specific serious risk[s] listed on Mifeprex's label." Compl. ¶ 116. Although the Mifeprex labeling warns that "[s]erious and sometimes fatal infections and bleeding occur very rarely following spontaneous, surgical, and medical abortions, including following MIFEPREX use," JSF Ex. A at 0383, Plaintiffs maintain that because these adverse events occur only "very rarely," the REMS is disproportionate to the risks associated with Mifeprex, Compl. ¶¶ 118-121. But in determining whether a REMS is necessary for any drug product, FDA reasonably takes into account not only the *frequency*, but also the *severity* of adverse events associated with the use of a drug product. While a high frequency of adverse events may necessitate a REMS to mitigate this risk, FDA may also require a REMS for an infrequent adverse event, if that event is particularly severe. *See generally* Defs.' Ex. 35. "Serious and sometimes fatal infections and bleeding" are precisely the sort of severe harms that justify a REMS of the sort at issue here, despite their low incidence.

Plaintiffs also contend that none of the six factors outlined in 21 U.S.C. § 355-1(a)(1) supported "reauthorization" of the REMS in 2016. Compl. ¶¶ 99-115. But when considering the necessity for a REMS, FDA engages in a complex, drug-specific inquiry, reflecting an analysis of multiple, interrelated factors, including those in section 355-1(a)(1). *See* Defs.' Ex. 35 at 4-5. Notably, the statutory factors FDA considers in determining whether a REMS "is necessary to ensure that the benefits of a drug outweigh [its] risks" include the "seriousness of any known or potential adverse events that may be related to the drug." *Id.* at 5-6; *see also* 21 U.S.C. § 355-1(a)(1). And there is no question that there are serious risks

associated with Mifeprex. The approved labeling currently includes a boxed warning,[5] *see* JSF Ex. A at 384, which is required when there are certain contraindications or serious warnings, particularly those that may lead to death or serious injury, associated with the use of the drug product. *See* 21 C.F.R. § 201.57(c)(1). The restrictions put in place by the REMS serve to mitigate Mifeprex's serious risks. As FDA has explained, "[i]t is not likely that the current safe use conditions w[ould] persist to a similar extent if a REMS is no longer required"; rather, based on its expertise and experience, FDA "would expect a negative impact on the types, incidence, and severity of adverse events if the REMS was eliminated." JSF Ex. H at 0354.

Although FDA reasonably concluded that it would not be appropriate to remove the REMS restrictions altogether, it approved most of Danco's proposed changes in its sNDA, thus significantly easing the prior restrictions on Mifeprex while continuing to account for serious risks. Defs.' Ex. 20. FDA agreed to Danco's proposals because the agency found them supported by data and information submitted in the sNDA. *Id.* at 0418-433. For instance, although FDA decided in 2000 not to approve Mifeprex's then-sponsor's proposal that patients be allowed to take misoprostol at their home because the evidence was "anecdotal" and off-label, FDA agreed to this modification in 2016, when the sponsor submitted new evidence supporting this change. *Id.* at 0429. FDA also approved: (1) an increase in the gestational age through which Mifeprex can be used; (2) a reduction in the Mifeprex dosage from 600-mg to 200-mg; (3) making an in-person patient follow-up visit with a healthcare provider a recommendation rather than a requirement; (4) an expansion of

[5] Boxed warnings are commonly referred to as "black-box" warnings. The boxed warning for Mifeprex is not being challenged as part of this lawsuit.

the universe of healthcare providers who may prescribe Mifeprex beyond just "physicians"; and (5) modifying the Medication Guide's risk-expectation advisement. *Id.* at 0418-29. All of these changes were adequately supported by data and information submitted by Danco, and most allow patients greater access to Mifeprex.

Plaintiffs' assertion that FDA acted arbitrarily because other drugs with similar or greater risks than Mifeprex are not subject to the same restrictions, Compl. ¶¶ 142-150, lacks merit. As noted above, FDA considers every drug on its own merits, and the necessity for a REMS in any particular instance turns on a variety of interrelated factors and how those factors apply in a particular case. In conducting its analysis, FDA considers whether, based on premarketing or postmarketing risk assessments, there is a particular risk or risks associated with the use of the drug that, on balance, outweigh its benefits, and whether additional interventions beyond FDA-approved labeling are necessary. Defs.' Ex. 35 at 4-5. As with all drug products, in determining whether a REMS is necessary, the agency takes into consideration information from a variety of sources, including internal experts with specialized expertise relevant to the potential risks and, after products are approved, available post-approval information (such as adverse event reports and post-approval studies). *Id.* Based on those analyses, FDA has not determined that REMS are necessary for the products cited by Plaintiffs. *See* Compl. ¶¶ 146-47. Just as it did with Mifeprex, the agency applied its scientific judgment and expertise to evaluate the risk/benefit profile of the drugs at issue and reached a considered conclusion specific to each drug. Plaintiffs' claim that the agency has treated Mifeprex differently without justification is thus meritless. *See also* B.2 *infra*.

As Plaintiffs repeatedly emphasize, Mifeprex has been used by millions of patients since it was approved with restrictions in 2000, and serious adverse events to patients are rare.

See, e.g., Compl. ¶¶ 1, 59, 118-19. But this just demonstrates *the effectiveness of the REMS* at mitigating Mifeprex's risks, not that the REMS should be eliminated. The REMS requirements ensure that only qualified practitioners will have access to Mifeprex, which reduces the likelihood of the drug product being improperly prescribed. And because prescribers must agree that they are able to provide surgical intervention (themselves or through others) in cases of incomplete abortion or severe bleeding and will assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, the REMS requirements further ensure that patients will have access to appropriate medical care in the event of a serious adverse event. Likewise, limiting distribution of the drug to specified healthcare settings "contributes to the patient's safe use of Mifeprex by making the prescriber responsible for giving the drug directly to the patient and counseling the patient at the time of dispensing." *See* JSF Ex. H at 0356-57. Dispensing the drug in broader settings, such as through retail pharmacies, might expose patients to unnecessary and increased risks because they would not receive counseling about the serious complications associated with Mifeprex or what to do if experiencing an adverse event when they receive the drug. *Id.* at 0356-57. Additionally, patients may delay picking up their Mifeprex prescription from the pharmacy, or may have difficulty finding a pharmacy that stocks the drug; initiating an abortion after such delay could result in increased complications. *See id.* at 0356.

Against this backdrop, the effectiveness of the Mifeprex REMS in mitigating the drug's undeniably serious potential risks is self-evident. Plaintiffs' suggestion that Mifeprex's record warrants eradicating the REMS "is like throwing away your umbrella in a rainstorm because you are not getting wet." *See Shelby Cty., Ala. v. Holder*, 570 U.S. 529, 590 (2013) (Ginsburg, J., dissenting).

FDA's determinations that the Mifeprex REMS was—and remains—necessary given the risks of the drug were reasoned scientific decisions based on robust analysis and thoughtful consideration of a complex body of scientific data and information. Consistent with its public health mission, FDA's paramount focus is on patient safety; its evaluation of Mifeprex's risks, like that of any drug, falls squarely within the agency's area of expertise and is owed substantial deference. The agency's well-considered actions fully comport with the APA.

B. The Mifeprex REMS Is Constitutional

1. The Mifeprex REMS Does Not Violate Due-Process Doctrine

Plaintiffs' constitutional claims fare no better. Plaintiffs first argue that the Mifeprex REMS violates substantive due process "by imposing significant burdens on abortion access that are not justified by the law's purported benefits." Compl. ¶ 227. The Supreme Court in *Casey* held that "laws regulating pre-viability abortions are unconstitutional if they impose an 'undue burden' on a woman's right to abortion." *Planned Parenthood Ariz. v. Humble*, 753 F.3d 905, 911-12 (9th Cir. 2014) (quoting *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 876 (1992)); *see also Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016). "A woman's right to terminate her pregnancy is not, however, absolute." *Isaacson v. Horne*, 716 F.3d 1213, 1222 (9th Cir. 2013). For example, "the State may enact regulations to further the health or safety of a woman seeking an abortion." *Casey*, 505 U.S. at 878. Only "unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion" may impose an undue burden in violation of substantive due process. *Hellerstedt*, 136 S. Ct. at 2309 (quoting *Casey*, 505 U.S. at 878) (internal quotation marks omitted).

The Ninth Circuit applies *Casey*'s undue burden test by comparing "the extent of the burden a law imposes on a woman's right to abortion with the strength of the state's justification for the law." *Humble*, 753 F.3d at 912-13 ("If a burden significantly exceeds what is necessary to advance the state's interests, it is 'undue.'"). To establish an undue burden, Plaintiffs must demonstrate that "in a large fraction of the cases in which the law is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Id.* at 914 (limiting inquiry to "the group for whom the law is a restriction, not the group for whom the law is irrelevant") (internal quotation marks and citations omitted). "The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Casey*, 505 U.S. at 874. Here, the Mifeprex REMS is necessary to address risks associated with the drug and does not have the purpose or effect of imposing a substantial obstacle on access to medical abortion. Accordingly, Plaintiffs' due process claim cannot survive summary judgment.

a. The Mifeprex REMS Is Necessary Given the Drug's Risks

The Mifeprex REMS is necessary because it serves a valid purpose of accounting for risks associated with the drug. Mifeprex is associated with potentially serious adverse events, including serious infection and hemorrhage sometimes resulting in transfusions, hospitalization, and even maternal death. *See* JSF Ex. H at 0354; Defs. Ex. 22 at 0610 (noting thousands of adverse events between 2000 and 2014, including hundreds of hospitalizations, transfusions, and infections). To mitigate these risks, FDA approved the drug with certain safeguards, including, *inter alia*, a Patient Agreement, Prescriber Agreement, and a requirement that Mifeprex be distributed in specified healthcare settings. *See* Defs.' Ex. 12 at

0224-28, 0230; JSF Ex. H at 0346-47; Defs.' Ex. 20 at 0415. Since the drug's approval, FDA has continued to approve the REMS with ETASU because the agency has concluded, in its expert opinion and following a thorough analysis, that such safeguards are *necessary* given the drug's risks.[6] *See supra* at 5-9, 12-17.

Each of these safeguards furthers the public health goal of protecting the safety of patients who use Mifeprex. For instance, the Prescriber Agreement Form helps ensure patient safety by requiring certified prescribers "to attest to having certain skills, agree to abide by the program requirements including reporting of serious adverse events, and complete an additional step (e.g., the enrollment form) in the usual drug procurement process." JSF Ex. H at 0356. As discussed *supra*, in signing the Prescriber Agreement Form, prescribers agree that they have the ability to: (1) provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others; (2) date pregnancies accurately; and (3) diagnose ectopic pregnancies. *See* Defs. Ex. 37. The latter two requirements ensure that prescribers dispensing Mifeprex "are very familiar with managing early pregnancies," further mitigating risks. *See* Defs.' Ex. 12 at 0227. Without the Prescriber Agreement, prescribers unfamiliar with Mifeprex could prescribe it, potentially increasing the risk of serious complications in patients using the drug. *See* JSF Ex. H at 0356. Moreover, medical abortions comprise a minority of abortions in the United States, resulting in limited training opportunities on this subset of abortions. *See id.* at 0357-58. Consequently, restricting distribution of Mifeprex to certified prescribers who have skills in

[6] Although there are other elements of the REMS, Plaintiffs specifically allege that the ETASU impose an unconstitutional undue burden on abortion. Compl. ¶¶ 9-12, 15-20.

medical abortion and can provide counseling and follow up "is necessary to assuring safe use of Mifeprex." *Id.*

Similarly, limiting distribution of the drug to specified healthcare settings "contributes to the patient's safe use of Mifeprex by making the prescriber responsible for giving the drug directly to the patient and counseling the patient at the time of dispensing." *Id.* at 0357. As noted above, dispensing the drug in broader settings, such as through retail pharmacies, could expose patients to unnecessary and increased risks. *See id.* at 0356. Patients might not, for example, receive proper counseling about the serious complications associated with Mifeprex or what to do if experiencing an adverse event. *See id.* Patients might also delay picking up their Mifeprex prescription and initiating an abortion, resulting in increased complications. *See id.* Patients who have a hard time finding a pharmacy that stocks Mifeprex may similarly experience a delay with potential complications. *See id.*

The Patient Agreement also addresses risks by informing patients about "the indication of the drug and how it is given," and by helping patients "understand the type of regimen they are about to commit to and its risks and benefits." Defs.' Ex. 12 at 0225. It also allows active patient participation in the process, and ensures "women are completely informed about the process and make a commitment to follow through." *Id.* at 0225, 0230. Although FDA reviewers initially recommended removal of the Patient Agreement form, FDA ultimately retained the form because it "would not interfere with access and would provide additional assurance that the patient is aware of the nature of the procedure, its risks, and the need for appropriate follow-up care." Compl. Ex. D, at 1.

It is undisputed that, in the years since approval, with these sensible safeguards in place, millions of women in the United States have used Mifeprex and serious complications

are rare. *See, e.g.*, Defs.' Ex. 22 at 0539, 0574-76; Compl. ¶¶ 1, 3. But this fact simply illustrates the success of the REMS—not its lack of justification. That Mifeprex has proven to have an acceptable safety profile is "likely reflective of the use of Mifeprex within a system of knowledgeable healthcare providers, safe use protocols, proper patient counseling, and follow up procedures." JSF Ex. H at 0357. No longer requiring the REMS would "negative[ly] impact . . . the types, incidence, and severity of adverse events," result in "treatment delays which are problematic given the importance of gestational timing on the safe and effective use," and lead to "inappropriate prescribing (e.g., ectopic pregnancy) by less experienced practitioners." *Id.* at 0354-55. As FDA has reasonably determined, "[a]ccurate gestation dating, patient education, dispensing Mifeprex directly to the patient during the office visit, and timely access to medical care remain important to maintain the current safety profile of Mifeprex." *Id.* at 0358.

b. The Mifeprex REMS Does Not Impose a Substantial Obstacle to Medical Abortion

Plaintiffs cannot show that "in a large fraction of the cases in which [the REMS] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Humble*, 753 F.3d at 914; *see also Hellerstedt*, 136 S. Ct. at 2320. Plaintiffs assert that, as a result of the Mifeprex REMS, fewer providers are willing to stock Mifeprex, thereby significantly increasing the financial and logistical burdens for patients who wish to obtain Mifeprex. *See, e.g.*, Compl. ¶¶ 83, 152-53, 176-77, 179, 202, 214. But these incidental effects of the REMS, which serves a valid purpose of addressing the risks associated with Mifeprex, "cannot be enough to invalidate it." *Casey*, 505 U.S. at 874; *see, e.g.*, *Karlin v. Foust*, 188 F.3d 446, 481 (7th Cir. 1999) (noting that "inconvenience, even severe inconvenience, is not an undue burden"); *Rust v. Sullivan*, 500 U.S. 173, 202 (1991) ("The

difficulty that a woman encounters when a Title X project does not provide abortion counseling or referral leaves her in no different position than she would have been if the Government had not enacted Title X."); *Maher v. Roe*, 432 U.S. 464, 474 (1977) ("The indigency that may make it difficult and in some cases, perhaps, impossible for some women to have abortions is neither created nor in any way affected by the Connecticut regulation.").

Plaintiffs also allege that the Mifeprex REMS unduly burdens abortion access because it affects a woman's ability to keep her abortion decision confidential. Compl. ¶¶ 19, 184, 188, 202, 211, 227. Plaintiff Chelius, for example, alleges that, because he cannot stock Mifeprex at his healthcare facility, he must refer patients seeking medical abortion to a certified prescriber. Compl. ¶¶ 174, 175. According to Plaintiff Chelius, it "is especially difficult for a patient to keep her abortion decision confidential" when referred to a second health care provider. Compl. ¶ 184. But "disclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice," *Whalen v. Roe*, 429 U.S. 589, 602 (1977), and Plaintiffs have identified no authority for the remarkable proposition that any regulation that has the effect of causing some doctors to provide referrals for a particular type of abortion creates an undue burden. In any event, nothing in the record demonstrates that, in the rare instances where patients are referred to a second healthcare provider, they are unable to keep their abortion decision confidential.

In fact, the requirement that certified healthcare providers only distribute Mifeprex in specified healthcare settings ensures greater, not less confidentiality. JSF Ex. H at 0357 (the requirement of distribution in specified healthcare settings is "probably the most critical element for maintaining confidentiality and privacy for both patients and prescribers"). If

available in retail pharmacies, pharmacists would "need to write and fill a prescription," necessarily introducing other people in the distribution process and increasing the risk to patient confidentiality. *Id.* at 0355. That risk only grows larger for patients who contact multiple pharmacies to find one that stocks Mifeprex. *See id.*

Notwithstanding the restrictions imposed by the REMS and any resulting difficulties in accessing Mifeprex, the REMS is not a substantial obstacle to women seeking a medical abortion—as demonstrated by the millions who have used the drug since 2000. Indeed, since initial approval of Mifeprex, FDA has made it *less* burdensome for patients to obtain a medical abortion. FDA, for example, has extended the gestational period of approved use from 49 to 70 days. Defs.' Ex. 20 at 0426-29. It has allowed certain nonphysicians to prescribe the drug. *Id.* It has allowed patients to take the second drug in the regimen, misoprostol, somewhere other than a provider's office. *Id.* And it has changed the process for follow-up after administration of the Mifeprex regimen. *Id.*

Even if the REMS has had the "incidental effect of making it more difficult or more expensive to procure" a medical abortion, Plaintiffs cannot show that the REMS is a substantial obstacle to a "large fraction" of women seeking medical abortion. *Casey*, 505 U.S. at 874, 895. Thus, any minimal burdens imposed by the REMS on abortion access are outweighed by FDA's interest in addressing the serious risks associated with Mifeprex.

In addition, Plaintiffs ask the court to do something no court has ever done—apply the *Casey* undue burden analysis in the context of a routine drug approval by the FDA, an agency that unquestionably brings a wealth of knowledge and experience to bear in the realms of science and public health. *Cf. Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016) (disapproving of uncritical deference to state legislature's scientific judgments).

Especially in an area quintessentially within FDA's expert scientific judgment—considering a drug's risks to determine the appropriate restrictions necessary for its use—this Court should not supplant its own judgment for the agency's, even in the context of a constitutional question. *See, e.g.*, *Abigail All. v. Eschenbach*, 495 F.3d 695, 709 (D.C. Cir. 2007) (expressing skepticism at "a constitutional right to override the collective judgment of the scientific and medical communities expressed through the FDA's clinical testing process"); *see also All. for Nat'l Health U.S. v. Sebelius*, 786 F. Supp. 2d 1, 12 (D.D.C. 2011) ("While the Court is obligated to conduct an independent review of the record and must do so without reliance on the FDA's determinations as to constitutional questions, it must also give deference to an agency's assessment of scientific or technical data within its area of expertise.") (internal quotation marks and citation omitted). For this reason too, Plaintiffs' due process challenge should be rejected.

2. The Mifeprex REMS Does Not Violate Equal-Protection Doctrine

Plaintiffs next argue that the Mifeprex REMS violates equal-protection doctrine by treating Plaintiffs, their members, and their patients differently from "other similarly situated parties without a sufficient state interest." Compl. ¶ 229. To establish an equal protection violation, "a plaintiff must show that the defendants acted with an intent or purpose to discriminate against the plaintiff based upon membership in a protected class." *Lee v. City of Los Angeles*, 250 F.3d 668, 686 (9th Cir. 2001) (internal quotation marks and citation omitted). "Where the challenged governmental policy is facially neutral, proof of its disproportionate impact on an identifiable group can satisfy the intent requirement only if it tends to show that some invidious or discriminatory purpose underlies the policy." *Id.* at 686-87 (internal quotation marks and citation omitted).

Laws that "discriminate against a suspect class," such as race, or "impact a fundamental right" are subject to strict scrutiny. *See Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 543 (9th Cir. 2004). Laws that discriminate "based on certain other suspect classifications, such as gender," are subject to intermediate scrutiny. *Id.* All other classifications are subject to rational basis review, and will be upheld if "rationally related to a legitimate state interest." *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432, 440 (1985). A classification subject to rational basis review is "presumed to be valid," *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 314 (1976), and must be upheld "if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." *Heller v. Doe by Doe*, 509 U.S. 312, 320 (1993). The burden is on the challenger to show that no rational basis exists for the law. *Id.* at 320-21.

Where a law affects abortion or women seeking abortions, however, and the government can establish that the law's purpose is maternal health (as opposed to some invidious purpose), the *Casey* undue burden analysis applies. *Eden*, 379 F.3d at 544-45, 549. It is therefore unnecessary in the abortion context to assess whether a classification is gender-neutral. *Id.* at 549 (using undue burden analysis for gender classifications in abortion context because the burden on women "arises entirely out of the burden on abortion, as a service only women seek"). The equal protection claim "collapses" with the due process claim and is not "judicially cognizable" apart from it. *Id.* at 544-45, 549.

Here, Plaintiffs have not alleged any facts demonstrating an equal protection violation. Indeed, Plaintiffs have failed to identify a manner in which the Mifeprex REMS discriminates between similarly situated parties. *See Thornton v. City of St. Helens*, 425 F.3d 1158, 1166-67 (9th Cir. 2005) (noting that the first step in equal protection analysis is identification of

asserted "classification of groups"). Thus, it is unclear whether Plaintiffs claim that the Mifeprex REMS disproportionately impacts women, women seeking abortion, women with limited financial means, or drug products approved for medical abortion with assertedly similar risks as other non-abortion drug products. Even if Plaintiffs were able to identify a manner in which the Mifeprex REMS discriminates against them, Plaintiffs cannot show that FDA acted with discriminatory intent in approving the REMS, which is necessary to support an equal protection challenge to a facially neutral law. *See Lee*, 250 F.3d at 686-87. Plaintiffs have also not identified a manner in which the Mifeprex REMS discriminates against a suspect class. And to the extent Plaintiffs contend that the Mifeprex REMS disproportionately impacts a right to abortion, their equal protection claim fails for the same reasons their substantive due process claim fails.

First, Plaintiffs have failed to identify a manner in which the Mifeprex REMS discriminates between similarly-situated parties. For example, contrary to Plaintiffs' assertion, the Mifeprex REMS does not discriminate between low-income patients and those with greater financial means. *See* Compl ¶¶ 176-78, 202. As discussed *supra*, FDA approved Mifeprex with certain safeguards, which were subsequently incorporated into the REMS, to mitigate the risks associated with the drug's use. *See* JSF Ex. H at 0354. However, the REMS safeguards apply to all patients who use Mifeprex and do not discriminate on the basis of income or some other criteria unrelated to health and safety. Moreover, even assuming *arguendo* that the Mifeprex REMS disproportionately impacts low-income patients, Plaintiffs have not shown, and cannot show, discriminatory intent behind FDA's imposition of the REMS. *See Lee*, 250 F.3d at 686-87 (noting requirement of discriminatory intent for facially neutral laws).

Second, Plaintiffs have not shown that the Mifeprex REMS discriminates against a suspect class. The Supreme Court has never held that "financial need alone identifies a suspect class for purposes of equal protection analysis." *Maher v. Roe*, 432 U.S. 464, 470-71 (1977); *see also Harris v. McRae*, 448 U.S. 297, 323 (1980) ("this Court has held repeatedly that poverty, standing alone is not a suspect classification."). Moreover, the fact that FDA imposed a REMS on Mifeprex, a product approved for medical abortion, and did not impose a REMS on drug products with assertedly similar risks for uses other than abortion, is not a distinction based on a suspect class. *See CareToLive v. von Eschenbach*, 525 F. Supp. 2d 952, 967-68 (S.D. Ohio 2007) (using rational basis review to analyze classification that FDA evaluated each drug and biologic application individually). Similarly, that FDA imposed a REMS on a drug taken only by women does not, in and of itself, constitute a gender-based classification. *See Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 272-73 (1993). Assuming Plaintiffs eventually assert these classifications, rational basis review will apply, and the Mifeprex REMS should be upheld because "it bears a rational relation to some legitimate end." *Eden*, 379 F.3d at 543 (internal quotation marks and citation omitted). That is, as explained above, its purpose is mitigate the potential risks associated with the drug's use.

Third, to the extent Plaintiffs assert that the Mifeprex REMS impinges on abortion access or classifies based on women seeking abortion, their equal protection claim is "not judicially cognizable" and "collapses with the undue burden claim." *Eden*, 379 F.3d at 544-45, 549. As discussed *supra*, the government's interest in ensuring the safety of women using Mifeprex outweighs any minimal burden on access to abortion. And in any event, Plaintiffs have not shown any discriminatory intent or animus behind the law. *See id.* at 549 (holding

that undue burden analysis applies where no evidence of invidious purpose). Accordingly, for the same reasons that Plaintiffs' substantive due process claim cannot survive summary judgment, their equal protection claim cannot survive either.

Because Plaintiffs' constitutional claims lack merit, judgment should be entered on those claims as a matter of law in favor of FDA.

CONCLUSION

For the reasons discussed above, the Court should grant judgment in favor of Defendants.

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Respectfully submitted,

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CERTIFICATION

I certify using the word count feature of Microsoft Word, that the above memorandum in support of Defendants' cross-motion for summary judgment consists of 9768 words, below the 10,000-word limit requested by the parties (Dkt. No. 79) (granted in part by Dkt. No. 82).

__/s/ Roger Gural_____
ROGER GURAL