EXHIBIT 51

Center for Drug Evaluation and Research, Application Numbers: 020687 and 91178 Rationale Review
(Dec. 16, 2021)
("FDA 2021 Rationale Review")

Center for Drug Evaluation and Research (CDER)

(b) (6)

Application Type	NDA and ANDA
Application Number	020687 and 91178
Reviewer Names	(b) (6)
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Review Completion Date	December 16, 2021

Subject	REMS Modification Rationale Review
Established Name	Mifepristone REMS
Name of Applicants	Danco Laboratories, LLC and GenBioPro, Inc.
Therapeutic Class	Progestin antagonist
Formulation	Oral tablets

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EXECUTIVE SUMMARY

This review provides the [redacted] rationale and conclusions regarding modifications to the single, shared system Risk Evaluation and Mitigation Strategy (REMS) for mifepristone 200 mg (Mifepristone REMS Program) for new drug application (NDA) 20687 and abbreviated new drug application (ANDA) 91178.

ANDA 91178 was approved with the approval of the Mifepristone REMS Program on April 11, 2019 to mitigate the risk of serious complications associated with mifepristone 200 mg. The most recent REMS modification was approved on May 14, 2021. The REMS consists of elements to assure safe use (ETASU) under ETASU A, C and D, an implementation system, and a timetable for submission of assessments. To determine whether a modification to the REMS was warranted, FDA undertook a comprehensive review of the published literature; safety information collected during the COVID-19 public health emergency (PHE); the one-year REMS assessment report of the Mifepristone REMS Program; adverse event data; and information provided by advocacy groups, individuals and the Applicants. Our review also included an examination of literature references provided by plaintiffs in the *Chelius v. Becerra* litigation discussed below.

The modifications to the REMS will consist of:

- Removing the requirement under ETASU C that mifepristone be dispensed only in certain healthcare settings, specifically clinics, medical offices, and hospitals (referred to here as the "in-person dispensing requirement" for brevity)
- Adding a requirement under ETASU B that pharmacies that dispense the drug be specially certified

A REMS Modification Notification letter will be sent to both Applicants in the Single Shared System.

1. Introduction

In connection with the *Chelius v. Becerra* litigation, FDA agreed to undertake a full review of the Mifepristone REMS Program, in accordance with the REMS assessment provisions of the Federal Food, Drug, and Cosmetic Act (FD&C Act).[a] This review provides the analysis of the (b) (6) ((b) (6) and the (b) (6) ((b) (6) regarding whether any changes are warranted to the single, shared system Risk Evaluation and Mitigation Strategy (REMS) for mifepristone (hereafter referred to as the Mifepristone REMS Program) for new drug application (NDA) 20687 and abbreviated new drug application (ANDA) 91178. The Mifeprex REMS was initially approved in 2011; the single, shared system REMS for mifepristone 200 mg, known as the Mifepristone REMS Program, was approved in 2019.

The last time the existing REMS elements to assure safe use (under ETASU A, C and D) were reviewed was in the context of our review of supplement S-020 to NDA 20687; these ETASU were updated following review and approval of supplement S-020 on March 29, 2016. The key changes approved in 2016 are summarized below.

Changes to labeling included:

- Changing the dosing of Mifeprex to 200 mg orally x 1
- Extension of maximum gestational age through 70 days
- Inclusion of misoprostol in the indication statement
- Replacing the term “physician” with “licensed healthcare provider”
- Removal of the phrase “Under Federal Law”

The Mifeprex REMS and REMS materials were updated to reflect the changes above, and additional changes were made including:

- Removing the Medication Guide as part of the REMS but retaining it as part of labeling.

2. Background

2.1. PRODUCT AND REMS INFORMATION

[a] Section 505-1(g)(2) of the FD&C Act (21 U.S.C. § 355-1(g)(2)).

Mifepristone is a progestin antagonist indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy (IUP) through 70 days gestation. Mifepristone is available as 200 mg tablets for oral use.

Mifeprex (mifepristone) was approved on September 28, 2000 with a restricted distribution program under 21 CFR 314.520 (subpart H)[b] to ensure that the benefits of the drug outweighed the risk of serious complications associated with mifepristone when used for medical abortion. Mifeprex was deemed to have a REMS under section 505-1 of the Federal Food, Drug, and Cosmetic Act with the passage of the Food and Drug Administration Amendments Act (FDAAA) of 2007, and the Mifeprex REMS was approved on June 8, 2011. On March 29, 2016, as noted above, a supplemental application and REMS modification was approved for Mifeprex. On April 11, 2019, ANDA 091178 was approved, and the Mifepristone REMS Program was approved. The Mifepristone REMS Program is a single, shared system REMS that includes NDA 020687 and ANDA 91178.

The goal of the REMS for mifepristone is to mitigate the risk of serious complications associated with mifepristone by:

a. Requiring healthcare providers who prescribe mifepristone to be certified in the Mifepristone REMS Program (under ETASU A).
b. Ensuring that mifepristone is only dispensed in certain healthcare settings, by or under the supervision of a certified prescriber (under ETASU C).
c. Informing patients about the risk of serious complications associated with mifepristone (under ETASU D).

Under ETASU A, to become specially certified to prescribe mifepristone, a healthcare provider must review the prescribing information, complete and sign the *Prescriber Agreement Form,* and follow the guidelines for use of mifepristone. Under ETASU C, mifepristone must be dispensed to patients only in certain healthcare settings, specifically clinics, medical offices, and hospitals, by or under the supervision of a certified prescriber. Under ETASU D, mifepristone must be dispensed to patients with evidence or other documentation of safe use conditions (i.e., the patient must sign a *Patient Agreement Form*). The Mifepristone REMS Program also includes an implementation system, and a timetable for assessments (one year from the date of the initial approval of the REMS on April 11, 2019, and every three years thereafter).

[b] NDA approval letter Mifeprex (NDA 020687) dated September 28, 2000.

2.2. REGULATORY HISTORY AND EVENTS RELEVANT TO THIS REMS MODIFICATION RATIONALE REVIEW

The following is a summary of significant regulatory history since approval of the REMS modification on March 29, 2016:

- 03/29/2016: FDA approved an efficacy supplement (S-020) that, among other things, provided a new dosing regimen (200 mg mifepristone, followed in 24 to 48 hours by 800 mcg buccal misoprostol), increased the gestational age (GA) to which mifepristone may be used (through 70 days gestation), and modified the REMS.

- 03/29/2019: A Citizen Petition was received requesting that FDA revise the product labeling to reflect pre-2016 provisions (including limiting GA to 49 days and requiring patients to make 3 office visits) and that FDA maintain the REMS.

- 04/11/2019: ANDA 91178 was approved along with the Single Shared System REMS for Mifepristone 200 mg (Mifepristone REMS Program) for NDA 20687 and ANDA 91178.

- 01/31/2020: the COVID-19 public health emergency (PHE) was declared by the Secretary of Health and Human Services (HHS) as having existed since January 27, 2020.[c]

- 7/13/2020: The United States (US) District Court of Maryland granted a preliminary injunction in the *ACOG v. FDA* litigation to temporarily bar enforcement of the Mifepristone REMS Program in-person dispensing requirement during the COVID-19 PHE.

- 1/12/2021: US Supreme Court granted a stay of that injunction.

- 04/12/2021: FDA issued a General Advice Letter to both the NDA and ANDA Applicants, stating that provided that all other requirements of the Mifepristone REMS Program are met, and given that in-person dispensing of mifepristone for medical termination of early pregnancy may present additional COVID-related risks to patients and healthcare

[c] *See* Secretary of Health and Human Services, Determination that a Public Health Emergency Exists (originally issued January 31, 2020, and subsequently renewed), available at https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

personnel because it may involve a clinical visit solely for this purpose, FDA intends to exercise enforcement discretion during the COVID-19 PHE with respect to the in-person dispensing requirement in the Mifepristone REMS Program, including any in-person requirements that may be related to the *Patient Agreement Form.* FDA further stated that to the extent all of the other requirements of the Mifepristone REMS Program are met, FDA intends to exercise enforcement discretion during the COVID-19 PHE with respect to the dispensing of mifepristone through the mail, either by or under the supervision of a certified prescriber, or through a mail-order pharmacy when such dispensing is done under the supervision of a certified prescriber.

- 05/07/2021: FDA stated that it would be reviewing the elements of the Mifepristone REMS Program in accordance with the REMS assessment provisions of section 505-1 of the FD&C Act.

- 05/14/2021: A modification was approved for the Mifepristone REMS Program. This modification was to revise the *Patient Agreement Form* to include gender-neutral language.

- 06/30/2021: An Information Request (IR) was sent to the Applicants for additional information on shipments and any program deviations, adverse events, or noncompliance with the REMS that occurred during the period from April 1, 2021 through September 30, 2021.

- 7/15/2021: An IR was sent to the Applicants to provide the total number of shipments during the period from April 1, 2021 to September 30, 2021 and details on whether any of those shipments were involved in any program deviation or non-compliance.

- 8/5/2021: An IR was sent to the Applicants for additional clinical and other information (e.g., adverse events and units of mifepristone shipped) for the period of March 29, 2016 through June 30, 2021, to be provided by August 31, 2021. This IR also requested information covering the period of July 1, 2021 through September 30, 2021 and an

aggregate summary (for the period of March 29, 2016 through September 30, 2021), to be provided by October 12, 2021.[d]

- 8/26/2021: The ANDA Applicant submitted a response to the IR issued on 8/5/2021.
- 08/27/2021: The NDA Applicant submitted a response to the IR issued on 8/5/2021.
- 10/08/2021: The NDA Applicant submitted a response to the June 30 and July 15, 2021 IRs as well as an aggregate summary for the period March 29, 2016 through September 30, 2021 in response to the August 5, 2021 IR. The NDA Applicant also included a follow-up to their initial response provided on August 27, 2021 to the August 5, 2021 IR.
- 10/12/2021: The ANDA Applicant submitted a response to the June 30 and July 15, 2021 IRs as well as an aggregate summary for the period March 29, 2016 through September 30, 2021 in response to the August 5, 2021 IR.
- 10/16/2021: The ANDA Applicant revised their Oct 12, 2012 response to provide a correction to the number of mifepristone tablets.
- (b) (4)
- 11/02/2021: A (b) (6) ((b) (6) meeting was convened to obtain CDER concurrence on the removal of the in-person dispensing requirement and the addition of a certification requirement for pharmacies. The (b) (6) (b) (6) and senior CDER leadership concurred with removing the in-person dispensing and adding pharmacy certification.

3. Rationale for Proposed REMS Modification

[d] Multiple Information Requests were issued to obtain additional information on drug shipments, any program deviations or noncompliance, and use of alternative methods for drug distribution during the COVID-19 PHE. These IRs are referenced as appropriate in this document and the one-year REMS Assessment Review of the Mifepristone REMS Program, December 16, 2021.

3.1. CURRENT REQUIREMENTS FOR THE APPROVED REMS

The Mifepristone REMS Program includes elements to assure safe use (ETASU), an implementation system, and a timetable for submission of assessments. Elements to assure safe use in the current REMS include a prescriber certification requirement (ETASU A), a requirement that mifepristone be dispensed only in certain healthcare settings by or under the supervision of a certified prescriber (ETASU C), and a requirement that mifepristone be dispensed only with documentation of safe use conditions (ETASU D). Documentation of safe use conditions under ETASU D consists of a *Patient Agreement Form* between the prescriber and the patient indicating that the patient has received counseling from the prescriber regarding the risk of serious complications associated with mifepristone 200 mg for medical termination of early pregnancy.

3.2. EVALUATION OF THE EVIDENCE

We reviewed multiple different sources of information, including published literature, safety information submitted to the Agency during the COVID-19 PHE, FDA Adverse Event Reporting System (FAERS) reports, the first REMS assessment report for the Mifepristone REMS Program, and information provided by advocacy groups, individuals, and the Applicants. Our review also included an examination of literature references provided by plaintiffs in the *Chelius v. Becerra* litigation. Below is an overview of how information relevant to the current Mifepristone REMS Program was retrieved, analyzed, and applied to each of the individual ETASUs to determine if further changes should be considered.

Methods for the literature search

(b) (6) conducted a literature search in PubMed and Embase to retrieve publications relevant to this review. The time period used for this literature search was between March 29, 2016 (when the Mifeprex labeling and REMS were last substantially revised) through July 26, 2021. The search terms used were “medical abortion” and “mifepristone” and “pregnancy termination and mifepristone.”

The search retrieved 306 publications from PubMed and 613 from Embase, respectively; the search yielded 646 unique publications after eliminating duplications between the two databases. The result of our literature search was also supplemented by an examination of literature references provided by advocacy groups, individuals, plaintiffs in the *Chelius* litigation, and the Applicants, as well as letters from healthcare providers and researchers.

References included in these letters were considered for inclusion in this review using identical selection criteria to the (b) (6) literature search (outlined below).

For this review of the REMS, (b) (6) focused on publications containing safety data related to outcomes of medical abortion (objective safety data) obtained from our literature search and from the references provided to us relevant to the REMS ETASUs. We excluded systematic reviews and meta-analyses because these publications did not include original safety data related to the outcomes of medical abortion. The following are examples of materials that were excluded from our literature search:

- Information from survey studies or qualitative studies that evaluated perspectives on and/or satisfaction with medical abortion procedures from patients, pharmacists, clinic staff, or providers, even if the study assessed REMS ETASUs. These surveys or qualitative studies did not include objective safety data related to outcomes of medical abortion.

- Opinions, commentaries, or policy/advocacy statements. These publications did not include objective safety data related to outcomes of medical abortion.

- Safety data related to mifepristone use for second trimester medical abortion. These publications reported data not applicable to the approved indication for medical abortion up to 70 days gestation.

- Safety data related to mifepristone use for spontaneous first trimester abortion (i.e., miscarriages). These publications reported data not applicable to the approved indication for medical abortion up to 70 days gestation.

- Safety data that pertained only to surgical abortion or did not separate out medical abortion from surgical abortion.

- Other safety information unrelated to the REMS elements (e.g., articles limited to case reports or those discussing unrelated gynecologic or medical issues)

- Publications for which it was not possible to conduct a full review of the methods or results, i.e., the references were limited to an abstract of the study methods and results.

- Publications that provided only general statistics on abortion care in the United States.

- Information pertinent to molecular or other basic science aspects of mifepristone.

- Data on the logistics of accessing abortion care in general, such as time to appointment or the distance traveled to obtain care.

- Publications that provided data not related specifically to abortion care or the REMS (e.g., references focused on federal poverty guidelines, poverty data, or the financial impact of the COVID-19 pandemic).

One exception to the above literature search criteria was the inclusion in Section 3.2.2 of this review, which discusses the *Patient Agreement Form*, of publications that discussed changes in provider volume. The data discussed in relation to provider volume was obtained from surveys. This data was included because changes in provider volume could only be obtained from well-conducted survey studies.

Regarding medical/scientific references submitted with letters from the plaintiffs in the *Chelius* litigation, we applied the same criteria as for the literature search, as described above.

Letters from the plaintiffs in the *Chelius* litigation included several references that preceded our 2016 review of the REMS. Two of those pre-2016 studies were not captured in our 2016 literature search. These two studies were assessed as part of our current review; their results are consistent with the existing safety profile of the approved medical abortion regimen, and therefore, support our current conclusions regarding the REMS. See Appendix A.

3.2.1. Evaluation of the requirement for healthcare providers who prescribe the drug to be specially certified (ETASU A)

In order to become specially certified, prescribers must: 1) review the prescribing information for mifepristone and 2) complete the *Prescriber Agreement Form*. In signing the *Prescriber Agreement Form*, prescribers agree they meet the qualifications listed below:

- Ability to assess the duration of pregnancy accurately
- Ability to diagnose ectopic pregnancies
- 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 ability to

ensure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
- Has read and understood the Prescribing Information of mifepristone (which the provider can access by phone or online).

In addition to meeting these qualifications, as a condition of certification the healthcare provider also agrees to follow the guidelines for use below:

- Review the *Patient Agreement Form* with the patient and fully explain the risks of the mifepristone treatment regimen. Answer any questions the patient may have prior to receiving mifepristone.
- Sign and obtain the patient's signature on the *Patient Agreement Form*.
- Provide the patient with a copy of the *Patient Agreement Form* and the Medication Guide.
- Place the signed *Patient Agreement Form* in the patient's medical record.
- Record the serial number from each package of mifepristone in each patient's record.
- Report deaths to the Applicant, identifying the patient by a non-identifiable patient reference and the serial number from each package of mifepristone.

The literature review was the primary source of information that contributed to our reassessment of ETASU A.

We continue to be concerned that absent these provider qualifications, serious and potentially fatal complications associated with medical abortion, including missed ectopic pregnancy and heavy bleeding from incomplete abortion, would not be detected or appropriately managed. Our review of the literature did not identify any studies comparing providers who met these qualifications with providers who did not. In the absence of such studies, there is no evidence to contradict our previous finding that prescribers' ability to accurately date pregnancies, diagnose ectopic pregnancies, and provide surgical intervention or arrange for such care through others if needed, is necessary to mitigate the serious risks associated with the use of mifepristone in a regimen with misoprostol. Therefore, our review continues to support the conclusion that a healthcare provider who prescribes mifepristone should meet the above qualifications. We conclude it is reasonable to maintain the requirement for a one-time prescriber certification where prescribers attest to having the ability to diagnose an intrauterine

pregnancy, to diagnose an ectopic pregnancy,[e] and to either manage serious complications themselves or arrange for other providers to provide the needed care in a timely manner.

In addition, in signing the *Prescriber Agreement Form* and placing it in the patient's medical record, the prescribers acknowledge the requirement to report patient deaths associated with mifepristone to the manufacturer. Such a requirement ensures that the manufacturer receives all reports of patient deaths and, in turn, fulfills its regulatory obligations to report those deaths to the FDA.

As discussed in Section 3.2.2 below, there is a potential for doubling of the number of prescribers of mifepristone if the in-person dispensing requirement in ETASU C is removed from the Mifepristone REMS Program. Given the potential addition of new prescribers, in addition to the considerations described above, we conclude that we should maintain the requirement for prescriber certification, to ensure that providers meet the necessary qualifications and adhere to the guidelines for use. Our literature review supports that these requirements are still necessary, and the potential increase in new prescribers under the REMS is a further reason to maintain prescriber certification. Healthcare provider certification continues to be a necessary component of the REMS to ensure the benefits of mifepristone for medical abortion outweigh the risks. The burden of prescriber certification has been minimized to the extent possible by requiring prescribers to certify only one time for each applicant.

3.2.2. Evaluation of the requirement for the drug to be dispensed with evidence or other documentation of safe-use conditions (ETASU D)

In order to receive mifepristone for medical termination of pregnancy through 70 days gestation, the patient must sign a *Patient Agreement Form* indicating that the patient has received, read, and been provided a copy of the *Patient Agreement Form* and received counseling from the prescriber regarding the risk of serious complications associated with mifepristone for this indication. The *Patient Agreement Form* ensures that patients are informed of the risks of serious complications associated with mifepristone for this indication.

[e] American College of Obstetricians and Gynecologists (ACOG) Practice Bulleting Number 191, February 2018. Tubal Ectopic Pregnancy. https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/03/tubal-ectopic-pregnancy. Mifepristone is not effective for terminating ectopic pregnancy. Some of the expected symptoms experienced with a medical abortion (abdominal pain, uterine bleeding) may be similar to those of a ruptured ectopic pregnancy. A missed ectopic pregnancy that ruptures is a medical emergency that requires immediate surgical intervention.

In a number of approved REMS, *Patient Agreement Forms* or *Patient Enrollment Forms* ensure that patients are counseled about the risks of the product and/or informed of appropriate safe use conditions.[f]

As a condition of certification under the Mifepristone REMS Program, healthcare providers must follow the guidelines for use of mifepristone, including reviewing the *Patient Agreement Form* with the patient, fully explaining the risks of the treatment regimen, and answering any questions the patient may have before receiving the medication. With this form, the patient acknowledges that they have received and read the form, and that they have received the counseling regarding when to take mifepristone, the risk of serious complications associated with mifepristone and what to do if they experience adverse events (e.g., fever, heavy bleeding). Both the healthcare provider and patient must sign the document and the patient must receive a copy of the signed form. In addition to the counseling described in the *Patient Agreement Form*, patients also receive a copy of the Medication Guide for mifepristone. Ultimately, the *Patient Agreement Form* serves as an important counseling component, and documentation that the safe use conditions of the Mifepristone REMS Program have been satisfied, as the prescriber is required to place the signed *Patient Agreement Form* in the patient's medical record.

Prior to the March 29, 2016 approval of the S-020 efficacy supplement for Mifeprex, FDA undertook a review of all elements of the REMS. At that time, the (b) (6) ((b) (6)), along with the (b) (6) ((b) (6)), recommended removal of the *Patient Agreement Form* (ETASU D). This recommendation received concurrence from the (b) (6) on February 23, 2016. The rationale for this recommendation in the 2016 review[g] is summarized here as follows:

- The safety profile of Mifeprex is well-characterized over 15 years of experience, with known risks occurring rarely; the safety profile has not changed over the period of surveillance.
- Established clinical practice includes patient counseling and documentation of informed consent and evidence shows that practitioners are providing appropriate patient

[f] REMS@FDA, https://www.accessdata.fda.gov/scripts/cder/rems/index.cfm, Accessed November 15, 2021.
[g] (b) (6) Clinical Review, NDA 020687/S20, dated March 29, 2016. https://darrts.fda.gov/darrts/faces/ViewDocument?documentId=090140af803dc7bd&_afrRedirect=386175573203745

counseling and education; the *Patient Agreement Form* is duplicative of these established practices.

- Medical abortion with Mifeprex is provided by a small group of organizations and their associated providers. Their documents and guidelines are duplicated in the *Patient Agreement Form*.
- ETASUs A and C remain in place: The *Prescriber Agreement Form* and the requirement that Mifeprex be dispensed to patients only in certain healthcare settings, specifically, clinics, medical offices, and hospitals under the supervision of a certified prescriber, remain in place.

In light of a memorandum from the Director of the Center for Drug Evaluation and Research, an addendum to the (b) (6) March 29, 2016 review and a memorandum from the signatory authority in (b) (6) indicated that the *Patient Agreement Form* would be retained in the REMS.[h,i]

The current review of literature from March 29, 2016 to July 26, 2021, is relevant to our assessment of the necessity of the *Patient Agreement Form* as part of the REMS. While our literature search yielded no publications which directly addressed this element of the REMS, we identified the following literature that focused on the informed consent process. These studies were reviewed for their potential relevance on this topic, though the articles do not directly assess the need for the *Patient Agreement Form* as a condition necessary to assure safe use of Mifepristone under ETASU D.

- Two studies[1,2] (both authored by Dr. Grossman in 2021) used the *Patient Agreement Form* and additional clinic-specific written informed consent forms as part of the study methodology. One study evaluated medical abortion with pharmacist dispensing of mifepristone and another evaluated mail-order pharmacy dispensing. Safety and efficacy outcomes were not assessed regarding the element of consent in isolation or the *Patient Agreement Form*.
- Several studies included use of electronic or verbal consent. Two studies were conducted using signed electronic consent (Chong[3], Kerestes[4]). Aiken[5] reported that patients had the option of providing consent verbally and the discussion had to be recorded in the notes. Rocca[6] described obtaining verbal informed consent from patients seeking medical abortion provided in pharmacies or government-certified

h (b) (6) Review of proposed REMS modifications to Mifeprex. March 29, 2106.
i (b) (6) Summary of Regulatory Action for Mifeprex. March 29, 2016.

public health facilities by auxiliary nurse midwives (ANMs) in Nepal. Outcomes were not assessed regarding the single element of consent and its role in the efficacy of medical abortion.

- A retrospective chart review (Wiebe[7]) was conducted in Canada. This study included telemedicine abortions between January 31, 2017 and January 31, 2019 and a similar group of controls seen in the clinic during the same time frame, matched by date of initial appointment. As part of the telemedicine process, patients read a consent form (not specified whether they could view an electronic version) and gave verbal consent "witnessed by the counselor". Again, outcomes were not assessed regarding the single element of consent and its role in the efficacy of medical abortion.

After review, we conclude that there are no outcome data from these studies that address the need for the *Patient Agreement Form* as a condition necessary to assure safe use of mifepristone. Nor do any of these studies provide evidence of whether the patient's informed consent has been adequately documented under the process set out in the study protocol. Therefore, these studies do not provide evidence that would support removing ETASU D.

Although (b) (6) agrees that informed consent in medicine is an established practice, the National Abortion Federation's 2020 Clinical Policy Guidelines for Abortion Care[8] continue to include a detailed section on patient education, counseling, and informed consent. The guidelines state that these steps are essential parts of the abortion process; that they should be conducted by appropriate personnel, with accurate information, including about alternatives and potential risks and benefits; and that the patients must have an opportunity to have any questions answered to their satisfaction prior to any intervention. Under these guidelines, documentation must show that the patient affirms that they understand all the information provided and that the decision to undergo an abortion is voluntary. The guidelines specifically list the risks that must be addressed at a minimum, including those pertinent to medical abortion: hemorrhage, infection, continuing pregnancy, and death. Additionally, Practice Bulletins from ACOG[9] and the Society of Family Planning also support detailed patient counseling.

In addition, trends in US clinical practice are developing which could negatively impact adequate patient counseling about the risks of medical abortion. One survey by Jones 2017[10] of abortion providers in the United States and Canada prior to the COVID-19 pandemic did reveal strong adherence to evidence-based guidelines. However, this same survey noted continued increasing uptake of medical abortion by US providers. Grossman[11] conducted a US survey in

2019 which suggested that the number of obstetrician/gynecologists providing medical abortion care may be increasing and that uptake might increase if mifepristone were dispensed by pharmacies instead of being dispensed in-person. A subsequent survey of US obstetricians/ gynecologists by Daniel in 2021[12] evaluated a subsample (n = 868) from a prior national survey of providers and found that 164 (19%) reported providing medical abortion in the previous year. Of those obstetrician/gynecologists not providing medical abortion, 171 (24%) said they would offer the method to their patients if the in-person dispensing requirement for mifepristone were removed. This indicates a potential doubling of providers (+ 104%, 95% confidence interval (CI): 97% −112%). There were geographical variations, with the largest potential increases being in the Midwest (+ 189%, 95% CI: 172% −207%) and the South (+ 118%, 95% CI: 103% −134%).

Based on the articles discussed above, removal of the in-person dispensing requirement from the Mifepristone REMS Program (as discussed below in section 3.2.3) could significantly increase the number of providers to a larger group of practitioners. The *Patient Agreement Form* is an important part of standardizing the medication information on the use of mifepristone that prescribers communicate to their patients, and also provides the information in a brief and understandable format for patients. The requirement to counsel the patient, to provide the patient with the *Patient Agreement Form*, and to have the healthcare provider and patient sign the *Patient Agreement Form*, ensures that each provider, including new providers, informs each patient of the appropriate use of mifepristone, risks associated with treatment, and what to do if the patient experiences symptoms that may require emergency care. The single-page *Patient Agreement Form* is in line with other elements of this REMS, in that it supports the requirement that certified prescribers be able to accurately assess a patient, counsel a patient appropriately and recognize and manage potential complications. The form is placed in the patient's medical record to document the patient's acknowledgment of receiving the information from the prescriber and a copy is provided to the patient. We determined, consistent with section 505-1(f)(2) of the FD&C Act, that this does not impose an unreasonable burden on providers or patients, and that the *Patient Agreement Form* remains necessary to assure the safe use of Mifepristone.

After considering potential burden on healthcare providers and patients and considering the available data discussed above, including the potential for increased prescribing of mifepristone if in-patient dispensing is removed from the REMS, we conclude that the *Patient Agreement Form* should remain a safe use condition in the REMS.

3.2.3. Evaluation of the requirement for drug to be dispensed only in certain healthcare settings (ETASU C)

Mifepristone applicants must ensure that mifepristone is available to be dispensed to patients only in clinics, medical offices, and hospitals by or under the supervision of a certified prescriber. This creates what we refer to in this document as an in-person dispensing requirement under the REMS; i.e., the patient must be present in person in the clinic, medical office or hospital when the drug is dispensed. The mifepristone REMS document states that mifepristone may not be distributed to or dispensed through retail pharmacies or settings other than these.

The following information contributed to our analysis of this requirement: Mifepristone REMS Program year-one assessment data, postmarketing safety information and literature review.

REMS Assessment Data

Reporting period for the Mifepristone REMS Program - April 11, 2019 through February 29, 2020

We evaluated information included in the one-year (1st)[j] REMS assessment reports for the Mifepristone REMS Program, which included healthcare provider certification data, program utilization data, compliance data, audit results and patient exposure data.[13] The assessment reports were submitted on April 10, 2020 by the NDA Applicant and April 15, 2020 by the ANDA Applicant and cover a reporting period from April 11, 2019 through February 29, 2020. During this reporting period, the NDA Applicant reported (b) (4) newly certified healthcare providers, and the ANDA Applicant reported (b) (4) newly certified healthcare providers in the Mifepristone REMS Program. The NDA Applicant reported a total of (b) (4) certified healthcare providers (includes new and previously certified) ordered mifepristone during the assessment reporting period, and the ANDA Applicant reported a total of (b) (4) certified healthcare providers ordered mifepristone during the assessment reporting period. The NDA Applicant estimated that a total of (b) (4) patients were exposed to mifepristone during the assessment reporting period. The ANDA Applicant reported an estimated total of (b) (4) patients were exposed to mifepristone during the reporting period.

During the reporting period, a small number of non-compliance events were reported. The authorized distributor for the NDA applicant reported to the NDA Applicant that they experienced deviations with scanning of the product serial numbers which were confirmed during the February 2020 audit. The authorized distributor conducted a root cause analysis and developed a corrective and preventive action (CAPA) on February 12, 2020. The CAPA was

[j] This REMS assessment report was the first to be submitted following the approval of the single, shared system REMS for mifepristone.

validated and deployed with monitoring of the system through April 10, 2020. The corrective action will prevent similar events from occurring in the future.

January 27, 2020 through September 30, 2021

During the timeframe from January 27, 2020 through September 30, 2021, there were periods when the in-person dispensing requirement was not being enforced.

- On July 13, 2020, the United States District Court for the District of Maryland granted a preliminary injunction in the *ACOG* case to temporarily bar enforcement of the in-person dispensing requirement during the COVID-19 PHE.
- On January 12, 2021, the United States Supreme Court issued a stay of the injunction.
- On April 12, 2021, the FDA issued a General Advice Letter informing the applicants of the Agency's intent to exercise enforcement discretion during the COVID-19 public health emergency regarding the in-person dispensing requirement in the Mifepristone REMS Program.[k,l]

To better understand whether there was any impact on safety or noncompliance during the periods when the in-person dispensing requirement was not being enforced, we requested additional information from the Applicants to provide for more comprehensive assessment of the REMS for the time period from January 27, 2020 (the effective date of the COVID-19 PHE) to September 30, 2021. We requested the Applicants provide a summary and analysis of any program deviation or noncompliance events from the REMS requirements and any adverse events that occurred during this time period that had not already been submitted to FDA. As part of an additional request for information for the REMS assessment report, the Applicants were also asked to submit the adverse events to FAERS and to notify FDA that the reports were submitted.

Between January 27, 2020 and September 30, 2021, the NDA Applicant distributed (b) (4) shipments representing (b) (4) tablets. The NDA Applicant reported that there were (b) (4) shipments representing a total of (b) (4) tablets sent to (b) (4) non-certified healthcare providers.[m,n] (b) (4) of these healthcare providers subsequently became certified while (b) (4) did not. Of the (b) (4) healthcare providers who were not subsequently certified, (b) (4) returned a total of 12 of the 13

[k] FDA General Advice Letter for NDA 20687, April 12, 2021.
[l] FDA General Advice Letter for ANDA 091178, April 12, 2021.

[m] NDA 020687 September 9, 2021 response to the FDA's September 2, 2021 Information Request.
[n] NDA 020687 October 8, 2021 response to the FDA's June 30, 2021 Information Request.

Mifeprex tablets to the distributor. (b) (4) non-certified healthcare provider dispensed one tablet to a patient; no adverse events were reported. The NDA Applicant attributed the non-compliance observed to the authorized distributor's transition to a new platform. The NDA Applicant implemented a corrective and preventative action to address this issue, which we found to be acceptable.

The ANDA Applicant distributed (b) (4) shipments representing (b) (4) tablets of mifepristone from January 27, 2020 to September 30, 2021 and reported no instances of shipments to non-certified healthcare providers during this timeframe.

The NDA and the ANDA applicants reported a total of eight cases reporting adverse events between January 27, 2020 and September 30, 2021. These eight cases were also identified in the FAERS database and are described in the section below.

The number of adverse events reported to FDA during the COVID-19 PHE with mifepristone use for medical termination of pregnancy is small, and the data provide no indication that any program deviation or noncompliance with the Mifepristone REMS Program contributed to these reported adverse events. Further analysis of the adverse events is included below in the section on Pharmacovigilance Data.

Pharmacovigilance Data

The (b) (6) ((b) (6) conducted a search of the FAERS database and the published medical literature to identify U.S. postmarketing adverse events that reportedly occurred from January 27, 2020 through September 30, 2021 with mifepristone use for medical termination of pregnancy.[o,p]

The data for this time period were then further divided into date ranges when the in-person dispensing requirement was being enforced per the REMS (January 27, 2020 - July 12, 2020 & January 13, 2021 - April 12, 2021) versus when the in-person dispensing requirement was not being enforced (July 13, 2020 - January 12, 2021 (in-person dispensing requirement was temporarily enjoined) & April 13, 2021 - September 30, 2021 (in-person dispensing requirement was not being enforced because of the COVID-19 PHE)).

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[o] (b) (6). Pharmacovigilance Memorandum: Mifepristone and All Adverse Events. NDA 020687 and ANDA 091178. (b) (6) # 2007-525. Finalized April 12, 2021.

[p] (b) (6) Pharmacovigilance Memorandum: Mifepristone and All Adverse Events. NDA 020687 and ANDA 091178. (b) (6) # 2007-525. Finalized December 16, 2021.

A total of eight cases that met the search criteria were identified in FAERS and no additional case reports were identified in the medical literature. Two of the eight cases reported adverse events that occurred when the in-person dispensing requirement in the REMS was being enforced (i.e., January 27, 2020 - July 12, 2020 & January 13, 2021 - April 12, 2021). These two cases reported the occurrence of uterine/vaginal bleeding (case 1) and uterine/vaginal bleeding and sepsis (case 2). Of note, uterine/vaginal bleeding and sepsis are labeled adverse events. Five of the eight cases reported adverse events that occurred when the in-person dispensing requirement was not being enforced (i.e., July 13, 2020 - January 12, 2021 & April 13, 2021 - September 30, 2021). These five cases reported the occurrence of ongoing pregnancy (case 3), drug intoxication and death approximately 5 months after ingestion of mifepristone (case 4), death [cause of death is currently unknown] (case 5), sepsis and death (case 6), and pulmonary embolism (case 7). Although these adverse events occurred during the period when the in-person dispensing requirement was not being enforced, the narratives provided in the FAERS reports for cases 5, 6, and 7 explicitly stated that mifepristone was dispensed in-person. Of note, ongoing pregnancy, and sepsis, including the possibility of fatal septic shock, are labeled adverse events. The remaining case from July 2021 reported the occurrence of oral pain/soreness (case 8) but did not provide sufficient information to determine the exact date of the adverse event. Based upon the U.S. postmarketing data reviewed, no new safety concerns were identified by (b) (6)

In addition to the FAERS data provided above, (b) (6) routinely monitors adverse events reported to FAERS and published in the medical literature for mifepristone for medical termination of pregnancy. (b) (6) has not identified any new safety concerns with the use of mifepristone for medical termination of pregnancy.

To enable additional review of adverse events, the Applicants were requested[q] to provide a summary and analysis of adverse events reported with incomplete medical abortion requiring surgical intervention to complete abortion, blood transfusion following heavy bleeding or hemorrhage, ectopic pregnancies, sepsis, infection without sepsis, hospitalization related to medical abortion, and emergency department (ED)/urgent care encounter related to medical abortion. The Applicant for Mifeprex provided a summary of postmarketing safety information from March 29, 2016, when S-020 was approved, through September 30, 2021, on August 27 and October 8, 2021. During the time period in question, (b) (4) tablets were shipped, and

[q] On August 5, 2021, an IR was sent to the Applicants requesting a summary and analysis of adverse events from March 29, 2016 through June 30, 2021 and from July 1, 2021 through September 30, 2021.

48 adverse events were received. The 48 adverse events included 4 deaths (one of which occurred in 2010 but was reported in 2017), 25 incomplete abortions requiring surgical intervention, 17 blood transfusions following heavy vaginal bleeding, 2 ectopic pregnancies, 7 infections (1 sepsis and 6 infection without sepsis), 13 hospitalizations, and 43 ED or urgent care visits related to medical abortion. For the period between January 27, 2020 and September 30, 2021, a time frame that includes the entire period when the COVID-19 public health emergency (PHE) has been in effect, there were three adverse events reported corresponding to the above cases from FAERS identified by (b) (6) case 1 (uterine/vaginal bleeding), case 2 (uterine/vaginal bleeding and sepsis), and case 4 (drug intoxication and death).

The ANDA Applicant provided a summary of postmarketing safety information from April 11, 2019 (date of ANDA approval) through September 30, 2021. On August 26, 2021, the Applicant provided distribution and adverse event information from April 11, 2019 through June 30, 2021. During this time period, a total of (b) (4) tablets were shipped. There were 7 adverse events including 3 deaths (1 from sepsis, 1 from bilateral pulmonary artery thromboemboli, 1 in a patient who complained of not being able to breathe), 1 ongoing pregnancy treated with uterine aspiration, 2 blood transfusions, 1 sepsis (with death), 1 hospitalization, and 3 ED or urgent care visits related to medical abortion. On October 12, 2021 the Applicant provided information from July 1, 2021 to September 30, 2021; there were no additional adverse events. For the period between January 27, 2020 and September 30, 2021, there were four adverse events reported corresponding to the above cases from FAERS identified by (b) (6) case 3 (ongoing pregnancy), case 5 (death unknown cause), case 6 (sepsis and death), and case 7 (pulmonary embolism).[r]

The postmarketing data from FAERS were analyzed by (b) (6) to determine if there was a difference in adverse events between periods when the in-person dispensing requirement was being enforced and periods when the in-person dispensing requirement was not being enforced. Based on this review, we conclude that there does not appear to be a difference in adverse events between periods when the in-person dispensing requirement was being enforced and periods when the in-person dispensing requirement was not being enforced. This suggests that mifepristone may be safely used without an in-person dispensing requirement.

[r] The eighth FAERS case, oral pain/soreness, was not within the scope of the August 5, 2021 IR and was not considered for this review of postmarketing safety information submitted by the Applicants in response to the IRs.

(b) (6) review of the Applicants' IR responses, which included the same cases identified by (b) (6) from FAERS, did not change our conclusion.[s]

Literature Review

Published studies have described alternatives in location and method for dispensing mifepristone by a certified prescriber (or an equivalent healthcare provider in countries other than the US). Some studies have examined replacing in-person dispensing in certain health care settings with dispensing at retail pharmacies (Grossman[2], Wiebe[7], Rocca[6]) and dispensing mifepristone from pharmacies by mail (Grossman[1], Upadhyay[14], Hyland[15]). Other studies have evaluated two modes of dispensing by prescribers: (1) prescribers mailing the medications to women (Gynuity study [Raymond[16], Chong[3], Anger[17]], Kerestes[4], Aiken[5] (2021)) and (2) prescribers using couriered delivery of medications (Reynolds-Wright[18]). Other studies have evaluated dispensing mifepristone by mail by an entity described as "a partner organization" (Aiken[19] (2017), Norton[20], Endler[21]). For ease of review, in the sections below that describe these studies, we have separated relevant references by the methodology used to dispense mifepristone.

Retail pharmacy dispensing

Three studies report medical abortion outcomes for retail pharmacy dispensing of mifepristone after clinical evaluation. Grossman[2] conducted a US-based study in which mifepristone and misoprostol were dispensed from a pharmacy partnered with the clinic where the participant had an evaluation by ultrasound and counseling. Of the 266 participants enrolled, 260 had known abortion outcomes. Complete abortion without additional procedure occurred in 243 participants (93.5% of those with known outcomes). Seventeen participants (6.5% of those with known outcomes) were diagnosed with incomplete abortion and underwent uterine aspiration. The reported proportion of complete abortion is within the range described in the approved mifepristone labeling. However, the finding represents a lower-than-expected efficacy based on the cohort's GA (84% of participants were at ≤ 56 days GA, a cohort for which the labeled success rate is 96.8%). No participants experienced a serious adverse event, were hospitalized, or required transfusion. Three participants had ED visits with treatment (intravenous hydration, pain medication, pelvic infection after uterine aspiration for incomplete abortion). The study's

[s] The reporting period of (b) (6) assessment of the adverse events in FAERS is not identical to the time period for summaries of adverse events in the IRs to the Applicants. Therefore, the numbers of cases and adverse events summarized in (b) (6) assessment may differ from the numbers of cases and adverse events summarized by the Applicants in their responses to IRs (note that each case report may include more than one adverse event).

safety and efficacy outcomes are consistent with labeled frequencies. The majority of participants (65%) were very satisfied with the experience. There were some complaints from participants about not receiving all prescribed medications at the initial pharmacy visit, privacy not being adequately maintained, and perceived negative pharmacist attitude.

Overall, we conclude that this study has limited generalizability because it was conducted in two US states and involved partnered pharmacies, some of which were in the same building as the clinic. Additionally, all participating pharmacies in this study were required to have a pharmacist on duty during clinic hours who had been trained in the study protocol and was willing to dispense mifepristone. The study conditions may not be generalizable to US retail pharmacies; there is insufficient information to assess this. Rocca[6] conducted an observational study evaluating 605 participants at ≤63 days GA who obtained medical abortions in Nepal by comparing the provision of medical abortion service by newly trained nurse midwives in pharmacies to medical abortion provided in government-certified clinics. Participants who presented to pharmacy study sites underwent clinical screening including a pelvic exam by trained nurse midwives at the pharmacy (which was equipped with an examination room) and if eligible for medical abortion, were dispensed mifepristone and misoprostol in the pharmacy at the time of their visit. Participants who presented to public health facilities underwent clinical screening including pelvic examination by abortion providers including trained nurse midwives and if eligible for medical abortion were dispensed mifepristone and misoprostol in the clinic at the time of their visit. The authors reported that, with respect to complete abortion (>97%) and complications (no hospitalizations or transfusions), evaluation and dispensing in pharmacy was non-inferior to in-clinic evaluation and dispensing.

Wiebe,[7] in a retrospective, chart review study conducted in Canada, compared abortion outcomes of 182 women at ≤ 70 days GA who underwent medical abortion with telemedicine consult, and either received medications by courier or picked them up at a local pharmacy, with outcomes of a matched control cohort of 199 women who received the medications at a pharmacy after an in-clinic visit. The groups had similar documented complete medical abortion outcomes (90%, calculated maintaining subjects with unknown outcomes in the denominator; ≥ 95% calculated with known outcomes only). The telemedicine group had one case of hemorrhage (0.5%) and one case of infection requiring antibiotics (0.5%) compared with no cases of hemorrhage or infection requiring antibiotics in the in-clinic cohort. The telemedicine group had more ED visits (3.3% compared to 1.5% in-clinic cohort). Both models of dispensing mifepristone resulted in efficacy and safety outcomes within labeled frequency.

None of the three studies described above allow a determination regarding differences in safety between in-person dispensing by a certified prescriber in a health care setting and dispensing through a retail pharmacy, due to limitations on the generalizability of the studies to the current retail pharmacy environment in the US. The outcome findings from the one US study (Grossman[2]), in which the pharmacies were partnered with prescribers, may not be generalizable to much of the US as they do not reflect typical prescription medication availability with use of retail pharmacy dispensing. Although retail pharmacy dispensing of mifepristone and misoprostol in Canada has been described in the literature, there are important differences in healthcare systems between Canada and the US that render the findings from studies in Canada (Wiebe[7]) not generalizable to the US. In the Wiebe study, timely provision of medication from the retail pharmacy was accomplished by either courier to the woman or faxed prescription to the woman's pharmacy. It is unknown whether conditions that allow timely access to medications for medical abortion would occur in retail pharmacies throughout the US. Canada's federal government has reaffirmed that abortion is an essential health service[t] which may have implications affecting access to medical abortion from retail pharmacies in Canada. The Rocca[6] study evaluated medical abortion provided in Nepali pharmacies and essentially moved the abortion provider and clinical examination into the pharmacy, a scenario that is not, at this time, applicable to the US retail setting.

Mail order pharmacy

Grossman[1] published an interim analysis of an ongoing prospective cohort study evaluating medical abortion with mifepristone and misoprostol dispensed by mail-order pharmacy after in-person clinical assessment. All participants were evaluated for eligibility during a clinic visit with GA up to 63 days confirmed with either an ultrasound or examination; instead of receiving medication at the clinic visit, participants received medications from a mail-order pharmacy. A total of 240 participants have been enrolled; three participants did not take either medication. A total of 227 (94.6%) provided some outcome information, of whom 224 provided abortion outcome information. Complete abortion without additional procedures occurred in 217 participants (96.9% of those with known outcomes). Two (0.9%) participants experienced serious adverse events (SAE); one received a blood transfusion, and one was hospitalized overnight. Nine (4%) participants attended 10 ED visits. In this interim analysis, the outcomes are consistent with labeled frequencies. With respect to the time interval between a

[t] As noted in Mark[23] and Martin[24], most provincial and federal health insurance programs in Canada cover medical abortion, and covered services are free at the point of care.

participant's clinic visit and receipt of medications, of the 224 participants with known abortion outcomes, 184 (82.1%) received medication within 3 days. However, 17% received between 4-7 days and one participant waited over 7 days for receipt. Seven of 216 (3.2%) participants who completed the day-3 survey reported compromised confidentiality (e.g., someone found their medication, privacy concerns).

Upadhyay[14] reports findings from a retrospective cohort study of 141 women undergoing medical abortion in the US without a consultation or visit. Eligibility was assessed based on a participant-completed online form collecting pregnancy and medical history. Participants who were considered eligible received medication delivered by a mail-order pharmacy. Three interactions via text, messaging or telephone occurred to confirm medication administration, assessment of expulsion and pregnancy symptoms, and results of a 4-week home pregnancy test. Abortion outcome was determined by either the day 3 assessment or the 4-week pregnancy test. The investigators reported a complete abortion rate without additional procedures of 95% (105 participants out of 110 for whom outcomes were known) and stated that no participants had any major adverse events. The proportion of abortion outcomes assessed at 3 days versus 4 weeks is not reported. Regardless, determining outcomes at 3 days is insufficient to determine outcome rates or safety findings because a 3-day follow-up period is too short. Additionally, a substantial number of participants (31) provided no outcomes information. Among the 141 participants enrolled, 128 had any follow-up contact with the study staff, and 110 provided outcomes information. Excluding outcomes of 22% of the cohort is a limitation of this study. This study used a model with numerous deviations from standard provision of medical abortion in the US, such as no synchronous interaction with the prescriber during informed consent or prior to prescribing medication, no confirmation of self-reported medical, surgical, and menstrual history. Further, follow-up information based on a 3-day period is insufficient to determine outcome rates or safety findings. These deviations, limited follow-up information, and small sample size limit the usefulness of this study.

Hyland[15] describes findings from a cohort study in Australia evaluating medical abortion outcomes utilizing telemedicine and a central mail order pharmacy. All participants obtained screening tests including ultrasound confirmation of GA. A total of 1010 participants completed the screening process and were provided mifepristone and misoprostol. Abortion outcomes were determined for 754 (75%) of the 1010. Outcomes for the remaining 256 participants (25%) were not included because 31 provided no relevant information after shipment, 14 reported not taking misoprostol, and 211 did not have "full follow up" (i.e., known outcome of either complete medical abortion, uterine evacuation, or ongoing pregnancy with plan to continue).

Complete abortions without additional procedures occurred in 727 participants (96% of those with definitively documented outcomes) and is consistent with labeled efficacy. Of the 754 participants included in the analysis 717 (95%) had no face-to-face clinical encounters after medications were mailed while 21 (3%) were admitted to the hospital and 16 (2%) had an outpatient encounter. One participant who was hospitalized and underwent a surgical uterine evacuation received a transfusion. Not included in the findings are 7 hospitalizations occurring in 7 participants who did not have "full follow up". The authors do not report any other adverse events and conclude use of the telemedicine medical abortion service is safe. The reasons for hospitalization are not discussed by the authors; therefore, it is unknown why the patients were hospitalized. Although the reported number of hospitalizations (3%) is higher than the less than 1% in the FDA-approved mifepristone labeling, conclusions regarding the safety findings in this study cannot be made in the absence of information about the reasons for hospitalization. Other limitations of this study include incomplete information about outcomes with face-to-face encounters, and not reporting outcomes of 25% of the enrolled cohort.

Overall, the three studies evaluating mail order pharmacy dispensing suggest that the efficacy of medical abortion is maintained with mail order pharmacy dispensing. In the Grossman[1] study, the interim analysis, although small, does not raise serious safety concerns. We note that 18% of participants did not receive medications within 3 days; the potential for delay in receiving medication by mail could limit the GA eligible for medical abortion through mail order pharmacy dispensing, because women at GA closer to 70 days might not receive medication in time. A small proportion (3%) of participants raised concerns regarding the issues of confidentiality and privacy. Safety findings from the Hyland[15] study are difficult to interpret. Although only one transfusion is reported, and the authors state the findings demonstrate safety, the higher hospitalization rates, and lack of information on the reasons for hospitalization do not allow any conclusions about safety findings. Lastly, the Upadhyay[14] study had no reported adverse events, but the findings are less useful because of the limited follow-up, and because medical abortions were provided using a model with numerous deviations from standard provision of medical abortion in the US.

Clinic dispensing by mail

A total of five studies evaluated clinic dispensing by mail.[3,4,5,16,17] Gynuity Health Projects conducted a prospective cohort study (the "TelAbortion" study) evaluating use of telemedicine for remote visits and mifepristone being dispensed from clinics via overnight or regular tracked mail. Three publications reviewed have reported outcomes for the Gynuity population

exclusively: Raymond[16] from May 2016 to December 2018, Chong[3] from May 2016 to September 2020 and Anger[17] from March 2020 to September 2020. Due to the pandemic, the Gynuity study deviated from the protocol requirement of confirmation of GA by examination or ultrasound for many participants treated from March 2020 onward (although none of the three publications reported on the single element of dispensing mifepristone from the healthcare setting by mail). A fourth study, Kerestes,[4] reports outcomes of medical abortion at the University of Hawai'i from April 2020 to November 2020: seventy-five (of whom 71 were enrolled in the Gynuity study) of the 334 participants in Kerestes were dispensed mifepristone by mail after a telemedicine consult. The section below discusses these four studies from the US as well as a large UK study by Aiken[5] (2021).

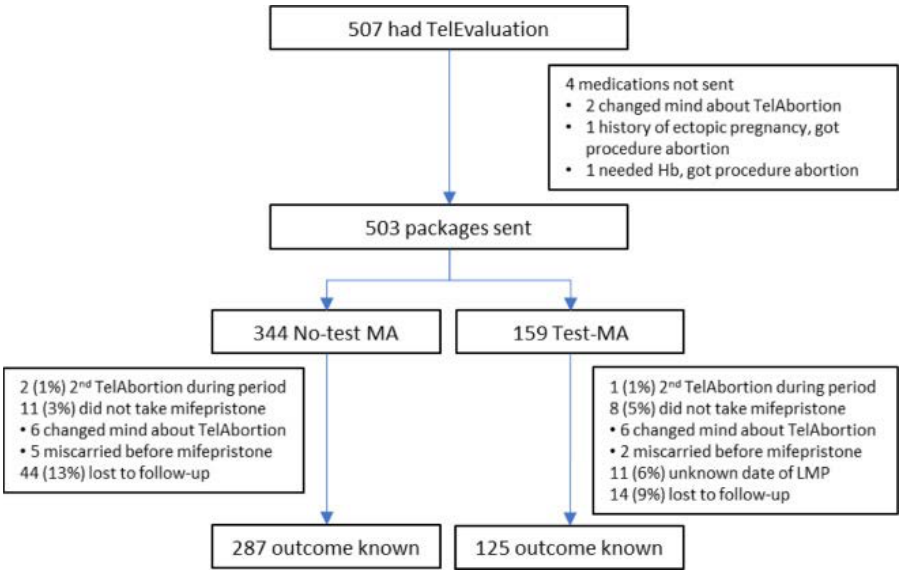
Raymond [16] (2019) reported outcomes from the Gynuity study prior to the pandemic. In the TelAbortion study, participants were not required to have an in-person clinic visit; rather, they obtained screening tests at laboratories and radiology offices and then communicated with the abortion provider by videoconference. If the participant was eligible for treatment, the provider dispensed the medications by mail. Of 433 women screened, 165 (38%) either declined to schedule the videoconference or did not keep the videoconference appointment. Among the 268 participants evaluated via videoconference, medication packages were sent to 248. Abortion outcomes were determined for 190 (77%) of the 248; outcomes for 58 (23%) participants were unknown. Complete abortion without additional procedures occurred in 177 participants (93% of those with known outcomes). The investigators obtained follow-up information from 217 participants after package shipment; there were two hospitalizations (one received a transfusion for severe anemia despite having had a complete abortion), and 16 other participants (7%) had clinical encounters in ED and urgent care centers. The reported outcomes in Raymond[16] (2019) are similar to outcomes described in approved labeling except the combined ED/urgent care center encounters (7%) exceeded the ED visits in approved labeling (2.9-4.6%). The authors note that half of the ED/urgent care visits did not entail any medical treatment and opine that the increased number of visits may have been due to the study participants living farther from the abortion providers.[16] All participants received medications within 8 days.

Chong[3] updated the findings from the Gynuity study described in Raymond[16] and reported on 1157 medical abortion outcomes, of which approximately 50% occurred during the period of the COVID-19 PHE. Although a screening ultrasound was required per the protocol, sites determined in 52% (346/669) of abortions that occurred during the period of the COVID-19 PHE that, in order to avoid potential exposure to COVID-19 at a health care facility, those

participants were not required to obtain a screening ultrasound. Use of urine pregnancy test to confirm abortion completion also increased from 67% (144/214) in the 6 months prior to the pandemic to 90% (602/669) in the 6 months during the pandemic. Of the 1390 participants to whom medicine packages (containing both mifepristone and misoprostol) were mailed, 1157 (83.2%) had known abortion outcomes. Complete abortion without a procedure occurred in 1103 participants (95% of the those with a known outcome). Ten women experienced an SAE (5 transfusions (0.4%) and 7 hospitalizations (0.7%)) and 70 (6%) participants had unplanned clinical encounters in ED/urgent care. Surgical interventions were required in 47 participants (4.1% of 1390) to complete abortion. The reported outcomes in this study are similar to outcomes described in approved labeling, except that the combined ED/urgent care center encounters (6%) exceeded the ED visits in approved labeling (2.9-4.6%).

Anger[17] compared outcomes among participants enrolled in the Gynuity study who did versus did not have confirmation of GA/intrauterine location with an examination or ultrasound from 10 jurisdictions across the US. These participants were screened for enrollment from March 25 through September 15, 2020. All participants had a telemedicine consultation and received mifepristone and misoprostol by mail from the healthcare facility. Determination of which participants did not require confirmation of GA by examination or ultrasound to be eligible depended on the study clinician's assessment of eligibility for "no-test medication abortion"[u] based on a sample protocol published by Raymond[22] (2020). There were two key differences between the two groups. Participants for whom the study clinician determined a pre-abortion ultrasound was required were more likely than the participants who had no ultrasound or examination to live further than 150 miles from the clinic (51.2% vs. 31.7%) and were more likely to have a GA above 63 days (12.0% vs. 1.7%). The study sites shipped 503 medication packages during the analysis period; 344 packages went to the "no test" group while 159 went to the "test" medical abortion cohort (see figure below). However, because the two cohorts were not randomized in this study, they had different baseline characteristics. Consequently, findings based on the comparisons between the two cohorts should be interpreted carefully.

[u] "No-test medication abortion" refers to medical abortion provided without a pretreatment ultrasound, pelvic examination, or laboratory tests when, in the judgment of the provider, doing so is medically appropriate (appropriateness based on history and symptoms); "no-test medication abortion" does include post-abortion follow up. A sample protocol is described by Raymond et al.[22]



Source: Figure 1 in this publication. MA= medical abortion.

The investigators' analyses excluded 91 (18% of 503; 57 in the no-test group and 34 in the test group) participants because they did not provide a date of the last menstrual period (LMP), did not take mifepristone, or did not have a recorded abortion outcome. Overall, 410 participants (81.5% of 503) provided outcomes data. There were no reported ectopic pregnancies in either group. The number of ED/urgent care visits and the proportion of unplanned clinical encounters that led to medical treatment were not reported. In the no-test group, complete medical abortion was confirmed in 271 participants who took medications (94% among those with known outcome). In the no-test cohort, two participants were "hospitalized and/or blood transfusion," and 36 (12.5%) had an unplanned clinical encounter (participant sought in-person medical care related to abortion and the visit was not planned prior to abortion).

In the test medical abortion group, complete abortion was confirmed in 123 participants (of 125 with known outcomes); the completion rate was 98% among those with known outcomes. In the test medical abortion group, one participant was "hospitalized and/or blood transfusion," and 10 (8.0%) had an unplanned clinical encounter. The authors concluded that, compared to participants who had an ultrasound prior to medical abortion, those without an examination prior to medical abortion were more likely to require procedural interventions and had more unplanned clinical encounters.

Kerestes[4] was the only publication that linked outcomes of medical abortion with different delivery models. Participants included in the report had GA up to 77 days and received

medications in Hawaii between April 2020 and January 2020. A total of 334 medication packages (to 330 unique participants) were dispensed containing mifepristone and misoprostol; three different delivery models were used concurrently: 110 (32.9%) had traditional in-person visits, 149 (44.6%) had telemedicine consultation with in-person pick-up of medications, and 75 (22.5%) were sent medications by mail (71 of these were enrolled through Gynuity's TelAbortion study). Seven participants of the 330 participants who received 334 medication packages reported that they did not take them and were excluded from analysis of the outcomes. Among participants with follow-up data, the rates of successful medical abortion without surgery were 93.6%, 96.8%, and 97.1% in the in-clinic group, telemedicine + in-person pickup group, and telemedicine + mail group, respectively; these were consistent with outcomes in approved labeling. Blood transfusion was given to two participants (both in the telemedicine + in-person pickup group). Eleven participants went to an ED. Although ED visits occurred the most frequently in the telemedicine + mail group (four participants or 5.8%) and the least in the in-person group (two participants or 2.1%), the study reported no increases in other serious adverse events.

Taken together, the three Gynuity study reports[3,16,17] and Kerestes[4] support dispensing mifepristone and misoprostol by mail after a telemedicine visit. Efficacy was maintained in all four studies. All of the studies reported SAEs frequencies comparable to labeled rates, except two of the Gynuity study reports (Raymond[16], Chong[3]) and Kerestes[4] report a higher frequency of ED/urgent care visits than the labeled frequency of ED visits. We do not know whether the reporting of combined ED and urgent care visits represents an increased rate of ED visits compared to the labeled rate of ED visits (2.9-4.6%). Other labeled SAEs (e.g., transfusion) occur infrequently (< 1%).

Aiken[5] (2021) reports outcomes of medical abortion up to 70 days GA in the UK before and during the pandemic in a retrospective cohort study. In the UK, prior to the COVID-19 pandemic, all patients attended an in-clinic visit where they received an ultrasound, were administered mifepristone in the clinic, and given misoprostol in-clinic for use at home (traditional model). During the pandemic, medical abortion consultations were performed remotely by telephone or video. Based on the consultation and questionnaire (including date of last menstrual period; menstrual, contraceptive and medical history; symptoms; risk for ectopic pregnancy), an assessment of eligibility for treatment via telemedicine was made. If eligible, medications were delivered to participants via mail or were made available for collection from the clinic for use at home. If the participant was assessed to be ineligible for treatment via

telemedicine, an in-person assessment with ultrasound was performed and medications were provided from the clinic for home use (hybrid model).

The study compared the two cohorts: 22,158 obtained medical abortion before the pandemic and had in-person visits and dispensing (traditional model) and 29,984 obtained medical abortion during the pandemic with either in-person visit and in-person dispensing, or a telemedicine visit and dispensing by mail or picked up from the clinic (hybrid model). Outcomes were obtained from electronic records and incident databases. Outcomes of all hospitalizations related to abortion, ED visits, infection without sepsis, and hemorrhage without transfusion were not reported. The investigators' analysis for non-inferiority determined the efficacy and safety were comparable between both cohorts. Complete abortion occurred in > 98% in both cohorts. Hemorrhage requiring transfusion was reported in 0.04% and 0.02% of the traditional and hybrid cohorts, respectively; this is lower than the labeled 0.5% transfusion rate. There were no severe infections requiring hospitalization, major surgery or deaths reported.

A secondary analysis of the hybrid cohort was reported. Within the 29,984-person hybrid model cohort, 11,549 (39%) abortions were conducted in-person (in-person assessment with ultrasound was performed and medications provided from the clinic for home use) and 18,435 (61%) abortions were provided by telemedicine visit, without tests or confirmation of GA/intrauterine position by ultrasound, and medications either mailed or picked up from the clinic. Outcomes stratified by type of mifepristone dispensing were not reported. The rate of complete abortion was slightly higher in the telemedicine group (99.2%) than that in the in-person group (98.1%). There were no significant differences in the rates of reported SAEs. Adjustments for clinical and demographic characteristics were made because the two groups differed in baseline characteristics, including a higher proportion of pregnancies with GA over 6 weeks in the in-person group (68.2% compared with 55.1%). The authors conclude a hybrid model for medical abortion that includes no-test medical abortion[u] (no ultrasound, no pelvic exam, no pregnancy test) is effective and safe.

We conclude that although the Aiken[5] (2021) study has a large sample size and includes 85% of all medical abortions performed in England and Wales during the study period, the study has limitations. The authors acknowledge the main limitation of their study was that analysis was based on deidentified information in the NHS database and the investigators were unable to verify the outcomes extracted. Other limitations included that their search only captured

outcomes in electronic records and incident databases that met the authors' defined threshold for SAE reporting, and that the labeled abortion outcomes considered serious, such as hospitalizations related to abortion, infection without sepsis, hemorrhage without transfusion, or ED/urgent care visits, were not all included in the authors' definition of serious adverse event.

Data from the mail order dispensing studies with telemedicine visits from Gynuity (Raymond, Chong and Anger),[3,16,17] Kerestes[4], and Aiken[5] (2021) support that efficacy of medical abortion was maintained. The Aiken[5] study appears to be of sufficient sample size to determine whether safety outcomes with mail dispensing differ from in-person dispensing; however, the study's design did not capture all serious safety outcomes, thus limiting the certainty of the findings. Study reports of Raymond[16] Chong[3], and Kerestes[4] all suggest there may be an increase in ED/urgent care visits with telemedicine visits and dispensing by mail without increases in other adverse events. Anger's[17] comparative analysis suggests a pre-abortion examination may decrease the occurrence of procedural intervention and decrease the number of unplanned visits for postabortion care. Overall, despite the limitations noted, these studies support that dispensing by mail is safe and effective. Although the literature suggests there may be more frequent ED/urgent care visits related to the use of mifepristone when dispensed by mail from the clinic, there are no apparent increases in other SAEs related to mifepristone use. One reason for the increase in frequent ED/urgent care visits in the Raymond[16] publication, according to its authors, may have been that a substantial proportion of participants lived significant distances from their providers and increased distances have been associated with higher use of ED following treatment. Raymond[16] reported that half of the participants who had an ED/urgent care visit did not require medical treatment.

Clinic dispensing by courier

Reynolds-Wright[18] reported findings from a prospective cohort study of 663 women at less than 12 weeks' GA in Scotland undergoing medical abortion at home with use of telemedicine during the pandemic (from April 1 to July 9, 2020). The majority of medical abortions (78.7%) used telemedicine visits, eliminated pre-abortion ultrasound, and provided mifepristone for pick up at the service or by couriered delivery to woman's home. The number of couriered deliveries was not reported; thus, this study does not provide abortion outcomes separately for couriered delivery of mifepristone and misoprostol. With access to NHS regional hospital databases, the investigators were able to verify pregnancy outcomes and complications. Of the 663 participants, 642 (98.2%) were under 10 weeks GA, 21 (1.8%) were between 10 and 12 weeks

GA, and one participant was never pregnant. A total of 650 participants had complete abortion without requiring surgical intervention (98%), 5 (0.8%) an ongoing pregnancy and 4 (0.6%) an incomplete abortion. The outcomes from this study in Scotland are consistent with labeled mifepristone outcomes. The study shares the same limitations as the Aiken[5] (2021) study.

Partner organization dispensing by mail

Women on Web (WoW), an internet group, connects patients and providers outside of the US and provides medical abortion globally, dispensing mifepristone through "a partner organization" by mail.[v] Medical abortion eligibility is determined using an online questionnaire with asynchronous physician review. If eligible, medications are mailed to the women. WoW provides help and support by email or instant messaging.

Aiken[19] (2017) conducted a population-based study analyzing findings from 1,636 women in the Republic of Ireland and Northern Ireland who were sent medications between 2010 and 2012. Receipt of medications was confirmed for 1,181 women, among whom 1,023 confirmed use of mifepristone and misoprostol; outcome information was available for 1,000 (61% of women sent medications). Of the 1,000 women, the majority (781, 78%) were less than 7 weeks GA and 219 (22%) were at 7-9 weeks. Complete abortion without surgical intervention occurred in 947 (94.7% of 1,000 with known outcome); 7 (0.7%) women received a blood transfusion, 26 (2.6%) received antibiotics (route of administration undetermined) and 87 (8.7%) sought medical care at a hospital or clinic for symptoms related to medical abortion. Hospitalizations related to abortion were not reported. The reported proportion of complete abortion is within the range labeled for medical abortion up to 70 days (92.7-98.1%). However, the finding of 94.7% complete abortion represents a lower-than-expected efficacy based on the cohort's GA (almost 80% less than 7 weeks, labeled success for medical abortion ≤ 49 days is 98.1%). This study has limitations, including outcomes based on self-report without validation of completed abortion by examination or laboratory testing, and no known outcomes for 39% of study cohort. Additionally, the authors noted medical abortion was provided in a legally-restrictive setting, where the law provided a maximum penalty of life imprisonment for the woman undergoing the abortion, which may affect participants' self-reporting.

[v] In March 2019, FDA sent a WL to Aidaccess.org, a group affiliated with WoW. Aidaccess.org received this WL because it was introducing misbranded and unapproved new drugs into the U.S. In the context of this REMS review, studies involving WoW are included solely for purposes of evaluating of data regarding the methods of dispensing mifepristone.

Endler[21] and Norten[20] have reported outcomes from WoW cohorts but do not provide relevant information on mifepristone dispensing by mail, because neither provide meaningful outcomes data for consideration. Endler[21] compared the outcomes of self-reported heavy bleeding and clinical visits occurring during the "first or second day of abortion" that occurred in women undergoing medical abortion at 9 weeks GA or less, with outcomes from women at more than 9 weeks GA. Outcome data from day 1 or 2 is of limited usefulness. Norten[20] describes findings from a survey of women who were sent medical abortion medication through WoW and provided self-reported outcomes. Results were based on surveys returned from only 37% of participants, a return rate that is too low for the study to be considered valid.

WoW uses a model with numerous deviations from the standard provision of medical abortion in the US. For example, this model has no synchronous interaction with the prescriber during informed consent or prior to prescribing medication and no confirmation of self-reported medical, surgical, and menstrual history or confirmed pregnancy testing. Further, although Aiken[19] (2017) is a large cohort study, the outcomes are self-reported with no verification of complete abortion by laboratory or clinical evaluation and 39% of outcomes are unaccounted for. These limitations in the Aiken study result in the data being insufficient to determine the safety of dispensing mifepristone by mail through a partner organization.

4. Discussion

After review of the published literature, safety information collected during the COVID-19 PHE, postmarketing data, information from the first Mifepristone REMS Program assessment report, responses to information requests to the Applicants, and information provided by advocacy groups, individuals and the plaintiffs in the *Chelius v. Becerra* litigation, we conclude that the REMS can be modified to reduce burden without compromising patient safety.

Prescriber Certification

None of the publications we reviewed would support a conclusion that a healthcare provider who prescribes mifepristone does not need to meet the qualifications included in the Mifepristone REMS Program as described above in section 3.2.1. Absent these provider qualifications, serious complications associated with medical abortion, including missed ectopic pregnancy and heavy bleeding from incomplete abortion, would not be detected or appropriately managed.

We conclude that prescriber certification (ETASU A) should be maintained. The current process requires the prescriber to agree to the requirements of the Mifepristone REMS Program and to attest that they meet the qualifications described in section 3.2.1 above. The REMS has been structured to minimize burden to prescribers by requiring only a one-time certification by the prescriber for each Applicant. We have determined that healthcare provider certification continues to be necessary to ensure the benefits outweigh the risks, especially considering that, if the in-person dispensing requirement is removed from the Mifepristone REMS Program, the number of new providers may increase (see discussion in section 3.2.2 above).

Drug to be dispensed with evidence or other documentation of safe use conditions

The requirement to counsel the patient and provide them with the *Patient Agreement Form* ensures that each patient is informed of the appropriate use of mifepristone, the risks associated with treatment, and what to do if they experience symptoms that may require emergency care.

In 2016, we initially recommended eliminating the *Patient Agreement Form* (see section 3.2.2), though the form was ultimately maintained as part of the REMS. As discussed above, our current literature review has indicated that there is no basis to remove the *Patient Agreement Form* from the REMS. In addition, surveys we reviewed suggest that if the in-person dispensing requirement for mifepristone is removed, there could be a potential doubling of medical abortion providers. This potential doubling of medical abortion providers supports the continued need to ensure that patients are consistently provided patient education under the Mifepristone REMS Program regarding the use and risks of mifepristone. The *Patient Agreement Form* is an important part of standardizing the medication information that prescribers communicate to their patients, including new prescribers, and also provides the information in a brief and understandable format to patients. We determined, in accordance with section 505-1(f)(2) of the FD&C Act, that this does not impose an unreasonable burden on providers or patients.[w]

Given the likelihood of a potential increase in new prescribers if the in-person dispensing requirement is removed from the Mifepristone REMS Program, we conclude that maintaining the *Patient Agreement Form* remains necessary to assure safe use at this time.

[w] *The Patient Agreement Form* can be signed in person or through other means.

Drug to be dispensed only in certain healthcare settings

As discussed above in section 3.2.3, our evaluation of information submitted by the applicants in the one-year (1st) REMS assessment report for the Mifepristone REMS Program and in response to follow-up requests from the Agency indicates that the number of adverse events reported to FDA during the COVID-19 PHE with mifepristone use is small, and the data provide no indication that any program deviation or noncompliance with the Mifepristone REMS Program contributed to these adverse events. We further conclude, based our review of the postmarketing safety data from FAERS during the COVID-19 PHE and information submitted by the applicants for the timeframe of January 27, 2020 through September 30, 2021, that there does not appear to be a difference in adverse events between periods during the COVID-19 PHE when the in-person dispensing requirement was being enforced and periods when the in-person dispensing requirement was not being enforced; nor have we identified any new safety concerns with the use of mifepristone for medical termination of early pregnancy.

Alternatives to in-person dispensing of mifepristone have been investigated in several studies and countries. The literature review identified 15 publications[x] that assessed safety outcomes from various medication delivery models (US, UK, Canada, Ireland, Australia, Nepal), including dispensing by retail and mail order pharmacies, prescribers mailing medications or using couriered service to deliver medications, and dispensing by "partner organizations". The ability to generalize the results of these studies to the US population is hampered by differences in pre-abortion care (e.g., telemedicine versus in-person, testing), and the usefulness of the studies is limited in some instances by small sample sizes and lack of follow-up information on outcomes with regard to both safety and efficacy.

In addition, there are factors which complicate the analysis of the dispensing element alone. Some of these factors are: (1) only a few studies have evaluated alternatives for in-person dispensing of mifepristone in isolation; for example, most studies on mail dispensing of mifepristone also include telemedicine consultation, and (2) because most SAEs with medical abortion are infrequent, though they can be life threatening, further evaluation of changes in dispensing would require studies with larger numbers of participants. We did not find any large clinical studies that were designed to collect safety outcomes in healthcare systems similar to the US.

[x] The 15 publications correspond to endnote numbers: 1-7, 14-21.

Based on the literature identified by our review, dispensing mifepristone by mail from the clinic or from a mail order pharmacy does not appear to jeopardize the efficacy of medical abortion. The studies we reviewed are not adequate on their own to establish the safety of the model of dispensing mifepristone by mail, although the safety and efficacy outcomes reported in these studies remain within the ranges described in mifepristone labeling except for increased numbers of ED/urgent care visits and hospitalizations.

Four publications (Raymond[16], Chong[3], Anger[17] and Kerestes[4]), describe a relevant US cohort where dispensing mifepristone from the clinic by mail was paired with telemedicine visits. These studies showed that efficacy was maintained and there was no increased frequency of SAEs except for higher ED/urgent care visits. The increased ED/urgent care visits were not associated with increases of other SAEs, and in the view of one study's authors (Raymond[16]), may be associated with participants being located significant distances from their providers. The Aiken[5] (2021) study of a large UK cohort where the clinics mailed mifepristone report small (lower than labeled) occurrences of transfusion and no significant infections requiring hospitalization. In Grossman[1] and Hyland[15], where the pharmacies mailed mifepristone after prescribers confirmed GA, efficacy is maintained. Grossman's[1] interim analysis found no increases in SAEs. Hyland[15] reported higher numbers of hospitalizations but did not report increases of other SAEs. Overall, while the studies assessing mifepristone dispensing by mail suggest more frequent encounters with healthcare providers, they generally support a conclusion that dispensing by mail is safe. Despite the limitations of the studies we reviewed, we conclude that overall, the outcomes of these studies are not inconsistent with our conclusion that, based on the 1st year REMS assessment report and postmarketing safety data, mifepristone will remain safe, and efficacy will be maintained if the in-person dispensing requirement is removed from the Mifepristone REMS Program.

Based on the REMS assessment data, FAERS data from the time period when the in-person dispensing requirement was not being enforced, our review of the literature, and information provided by advocacy groups, individuals, the Applicants, and the plaintiffs in the *Chelius v. Becerra* litigation, we conclude that mifepristone will remain safe and effective for medical abortion if the in-person dispensing requirement is removed, provided all the other requirements of the REMS are met, and pharmacy certification is added as described below.

Removing the in-person dispensing requirement will render the REMS less burdensome to healthcare providers and patients and provided all other requirements of the REMS are met, including the additional requirement for pharmacy certification, the REMS will continue to

ensure that the benefits of mifepristone for medical abortion outweigh the risks. Therefore, to reduce the burden imposed by the REMS, the Mifepristone REMS Program should be modified to remove the in-person dispensing requirement, which would allow, for example, dispensing of mifepristone by mail via certified prescribers or pharmacies, in addition to in-person dispensing in clinics, medical offices and hospitals as currently outlined in ETASU C.

New requirement to be added for pharmacy certification

The current distribution model requires the certified prescriber to dispense mifepristone directly to the patient in a clinic, medical office, or hospital. During the periods when the in-person dispensing requirement was not being enforced, both applicants used mail order pharmacies to receive and hold mifepristone on behalf of the certified healthcare providers who had purchased the product.[j,y,z] Pursuant to a prescription for mifepristone, the mail order pharmacy would ship the product to a named patient.

The Mifepristone REMS Program continues to require that mifepristone be prescribed only by certified prescribers. With the removal of the in-person dispensing requirement, however, the drug is no longer required to be dispensed only in a clinic, medical office or hospital. Under the REMS as modified, mifepristone can be dispensed through a pharmacy, provided the product is prescribed by a certified prescriber and all other requirements of the REMS are met. Given this modification to the dispensing requirements in the REMS, it is necessary to add a requirement for certification of pharmacies under ETASU B. Adding the pharmacy certification requirement incorporates pharmacies into the REMS, ensures that pharmacies are aware of and agree to follow applicable REMS requirements, and ensures that mifepristone is only dispensed pursuant to prescriptions that are written by certified prescribers. Without pharmacy certification, a pharmacy might dispense product that was not prescribed by a certified prescriber. Adding pharmacy certification ensures that ETASU A is met prior to dispensing the product to a patient; certified prescribers, in turn, have agreed to meet all the conditions of the REMS, including ensuring that the *Patient Agreement Form* (ETASU D) is completed. In addition, wholesalers and distributors can only ship to certified pharmacies. Based on our review of the safety data and our consideration of the distribution model implemented by the Applicants during the periods

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y ANDA 091178: September 23, 2021 response to the September 15, 2021 information request; October 11 and 16, 2021 responses to the June 30, 2021 and July 15, 2021 information requests; October 26, 2021 response to the October 22, 2021 information request; October 29, 2021 response to the October 27 information request.
z NDA 020687: September 20, 2021 response to the September 15, 2021 information request; October 26, 2021 response to the October 22 information request.

when the in-person dispensing requirement was not being enforced, as well as REMS assessment data and published literature, we conclude that provided all other requirements of the REMS are met, the REMS program, with the removal of the in-person dispensing requirement and the addition of a requirement for pharmacy certification, will continue to ensure the benefits of mifepristone for medical abortion outweigh the risks while minimizing the burden imposed by the REMS on healthcare providers and patients. As modified, the REMS would allow, for example, dispensing by mail order or specialty pharmacies, similar to the distribution model used by applicants during the periods when the in-person dispensing requirement was not being enforced.[aa]

The above recommendations were discussed with the (b) (6) ((b) (6) and senior leadership from CDER on November 2, 2021. The (b) (6) (b) (6) along with senior CDER leadership, concurred with removing the in-person dispensing requirement provided that all of the remaining REMS requirements are met, including but not limited to prescriber certification where prescribers need to attest to having certain qualifications, and maintaining the *Patient Agreement Form*. The (b) (6) (b) (6) and senior leadership from CDER were also in favor of adding pharmacy certification to assure the safe use of mifepristone.

5. Conclusions and Recommendations

Based on the results of REMS assessments; our review of safety data collected during the PHE as well as data from FAERS; our literature search; and information provided by advocacy groups, individuals, the Applicants, and the plaintiffs in the *Chelius v. Becerra* litigation, (b) (6) and (b) (6) have concluded that a REMS modification is necessary and should include the following changes:

- Removing the requirement under ETASU C that mifepristone be dispensed only in certain healthcare settings, specifically clinics, medical offices, and hospitals.
- Adding a requirement under ETASU B that pharmacies that dispense the drug be specially certified.

[aa] Our current conclusion that the REMS would allow dispensing by mail order or specialty pharmacies is based on data received from Applicants relating to the periods when the in-person dispensing requirement was not enforced and mail-order pharmacies were used to dispense the product, as well as our analysis of postmarketing safety data and available literature. At this time we do not have data (from the Applicants or from other sources) to assess the certification of retail pharmacies under the REMS. We have not yet determined the details of pharmacy certification requirements, including whether any limitations on the types of pharmacies that may dispense the product are necessary.

(b) (6) and (b) (6) recommend the Applicants be issued a REMS Modification Notification Letter that requests submission within 120 days from the date of the letter.

6. References

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7. Appendix A

References Cited in Letters from Plaintiffs

References cited in letter from *Chelius v. Becerra* Plaintiffs (September 29, 2021)	
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Aiken A et al. BJOG 2021: 128 (9): 1464-1474	
Chong, et al. Contraception 2021; 104(1) 43-48	
Daniel S. et al. Contraception 2021; 104(1): 73-76	
References excluded from the REMS review	**Rationale for Exclusion**
Am. Coll. of Obstetricians & Gynecologists, *Position Statement: Improving Access to Mifepristone for Reproductive Health Indications* (June 2018), https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/improving-access-to-mifepristone-for-reproductive-health-indications	Policy/advocacy statement
House of Delegates, Am. Med. Ass'n., *Memorial Resolutions Adopted Unanimously No. 504 (2018)* https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/a18-resolutions.pdf	Policy/advocacy statement
Cong. Of Delegates, Am. Acad. Of Fam. Physicians, *Resolution No. 506 (CoSponsored C) Removing Risk Evaluation and Mitigation Strategy (REMS) Categorization of Mifepristone* (May 24, 2018) https://www.reproductiveaccess.org/wp-content/uploads/2019/02/Resolution-No.-506-REMS.pdf	Policy/advocacy statement
Schummers L et al, Contraception 2020; 102(4): 273	Abstract
Upadhyay UD et al.) Obstet & Gynecol 2015; 125: 175	Published prior to March 29, 2016-July 26, 2021 timeframe for current literature review. We note that the extensive literature review conducted as part of the 2016 review, which was consistent with the division's standard approach for reviewing an efficacy supplement

	and encompassed 90 references, did not capture this publication. However, the authors' conclusion in this publication is consistent with our review of the safety data in 2016.
Kapp N et al. Best Pract Clin Obstet Gynaecol. 2020;63:37-44	Abstract. Also outside the scope of first trimester medical abortion.
Fuentes L et al. J Women's Health 2019; 28 (12): 1623, 1625 Bearak JM, Lancet Pub Health 2017 Nov;2(11): e493, e495-96 Cartwright A et al 20 J Med Internet Res 2018 20(5):e10235 Barr-Walker J, et al PLoS One 2019;14(4): e0209991 Grossman et al JAMA Network 2017;317(4):437, 437-438 Dobie S et al 31 Fam Plan Persp 1999; 31(5): 241-244 Shelton JD 8 Fam Plan Persp 1976; 8(6):260, 260-262 Norris AH et al Am J Pub Health 2020; 110 (8): 1228,1232 Upadhyay UD et al Am J Pub Health 2014; 104(9):1687, 1689	Focused on the logistics of accessing abortion care.
CDC MMWR Abortion Surveillance – United States, 2018 https://www.cdc.gov/mmwr/volumes/69/ss/ss6907a1.htm#T5_down	Contains primarily general statistics on abortion care by state.

References cited in appendix from *Chelius v. Becerra* Plaintiffs (September 29, 2021)
References included in the REMS review
None

References excluded from the REMS review	Rationale for Exclusion
Jones RK et al Guttmacher Institute Abortion Incidence and Service Availability in the United States, 2017 (2019) Guttmacher Inst, Induced Abortion in the United States (2019)	Contains primarily general statistics on abortion care and logistics of accessing abortion care.
University of Minnesota Healthy Youth Dev. Prevention Rsch Ctr, 2019 Minnesota Adolescent Sexual Health Report 3 (2019)	Not related specifically to abortion care.
Jerman J et al Guttmacher Inst, Characteristics of U.S. Abortion Patients in 2014 and Changes since 2008 (2016)	Contains figures on patient characteristics from 2008-2014.
Roberts CM et al Women's Health Issues 2014; 24:e211, e215	Focused on cost of abortion.
CDC MMWR Abortion Surveillance 2018 https://www.cdc.gov/mmwr/volumes/69/ss/ss6907a1.htm#T7 down (last updated Nov. 7, 2020)	Contains primarily statistics on number of abortions in the US.
Jones RK Persp on Sexual & Reprod Health 2017; 49:17, 20	Focused on abortion incidence and service availability.
Fuentes L et al (as above) Bearak JM et al (as above) Cartwright A et al (as above) Johns NE et al. BMC Health Serv Res 2017; 17: 287, 294	Focused on logistics of accessing abortion care.

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Grossman D et al. Obstet Gynecol 2021; 137 (4): 613-622.	
Winikoff B et al. Obstet Gynecol 2012; 120: 1070-1076 reviewed in 2016 clinical memo	
Chen MJ et al. Obstet Gynecol 2015;126(1):12-21 reviewed in 2016 memo	
Chong et al. Contraception 2021;104(1): 43-48	
Aiken A et al. BJOG 2021; 128 (9): 1464 -1474	
Hyland 2018 et al. Aust New Zeal J Obstet Gynaecol 2018; 58 (3): 335-340	
References excluded from the REMS review	**Rationale for Exclusion**
Schummers L et al. BMJ Sex Reprod Heal 2021;47(e1)	Abstract
Kapp et al. 2020 (as above)	Abstract
Upadhyay et al. 2015 (as above)	(See rationale above)
Srinivasulu et al. Contraception 2021; 104(1):92-97	Survey on clinician perspectives on access to mifepristone.
Calloway D et al. Contraception 2021; 104(1): 24-28	Primarily addresses provider stigma around abortion care.
Rasmussen et al. Contraception; 104(1): 98-103	Opinion/commentary
Cleland et al. Obstet Gynecol 2013;121(1):166-171	Published prior to March 29, 2016 - July 26, 2021 timeframe for current literature review. We note that the extensive literature search conducted as part of the 2016 clinical review, which was consistent with the division's standard approach for reviewing an efficacy supplement and encompassed 90 references, did not capture this publication. However, the authors' conclusion in this publication is consistent with our review of the safety data in 2016.
National Academy of Sciences, Engineering, and Medicine. Safety and Quality of Abortion Care in the US 2018	General information about abortion care in the US. Did not provide safety data relevant to the elements of the REMS
Raymond EG. Obstet Gynecol 2012: 119(2): 215-219	Does not separate out medical and surgical abortion.

Bartlett LA et al. Obstet Gynecol 2004; 103(4): 729-737	Focused on surgical abortion.
Jones RK, Jerman J. Time to appointment and delays in accessing care among U.S. abortion patients, Guttmacher 2016	Focused on logistics of accessing abortion care.
Foster DG et al. Perspect Sex Reprod Health 2013; 45(4):210-218	Focused on second trimester abortion.
Ely G et al. Heal Soc Work 2019;44(1):13-21	Focused on logistics of accessing abortion care.
Munro S et al. Ann Fam Med 2020; 18(5):413-421.	Survey on physician perspectives on implementing medical abortion with mifepristone.

EXHIBIT 52

FDA Adverse Events Reporting System
(FAERS) Public Dashboard

U.S. Department of Health and Human Services
Food and Drug Administration

FDA Adverse Events Reporting System (FAERS) Public Dashboard

The FAERS public dashboard is a new, user-friendly and interactive web-based tool that was created to give the public the ability to query the FDA FAERS database and improve transparency. The data presented in the FAERS public dashboard has several key limitations. The existence of adverse event reports for a drug or biologic in FAERS does not mean that the drug or biologic caused the adverse event. Importantly, the FAERS data is not an indicator of the safety profile of the drug or biologic. For more information, please refer to the question What points should I consider while viewing the dashboard content?

Frequently Asked Questions (FAQs)

Expand all | Collapse all

General Questions

− What is FAERS?

The FDA Adverse Event Reporting System (FAERS) is a database that contains adverse event reports, medication error reports and product quality complaints resulting in adverse events that were submitted to FDA. The database is designed to support the FDA's post-marketing safety surveillance program for drug and therapeutic biologic products. The informatic structure of the FAERS database adheres to the international safety reporting guidance issued by the International Conference on Harmonisation (ICH E2B). Adverse events and medication errors are coded using terms in the Medical Dictionary for Regulatory Activities (MedDRA) terminology.

− How does FDA use the information in FAERS?

FAERS is a useful tool for FDA for activities such as looking for new safety concerns that might be related to a marketed product, evaluating a manufacturer's compliance to reporting regulations and responding to outside requests for information. The reports in FAERS are evaluated by clinical reviewers, in the Center for Drug Evaluation and Research (CDER) and the Center for Biologics Evaluation and Research (CBER), to monitor the safety of products after they are approved by FDA.

If a potential safety concern is identified in FAERS, further evaluation is performed. Further evaluation might include conducting studies using other large databases, such as those available in the Sentinel System. Based on an evaluation of the potential safety concern, FDA may take regulatory action(s) to improve product safety and protect the public health, such as updating a product's labeling information, restricting the use of the drug, communicating new safety information to the public, or, in rare cases, removing a product from the market.

− Who sends reports to FAERS?

Healthcare professionals, consumers, and manufacturers submit reports to FAERS. FDA receives voluntary reports directly from healthcare professionals (such as physicians, pharmacists, nurses and others) and consumers (such as patients, family members, lawyers and others). Healthcare professionals and consumers may also report to the products' manufacturers. If a manufacturer receives a report from a healthcare professional or consumer, it is required to send the report to FDA as specified by regulations.

− How can I report an adverse event or medication error to FDA?

The MedWatch website provides information about voluntary and mandatory reporting.

− Can mandatory reporters submit adverse events electronically?

Yes, the FDA Adverse Events Reporting System (FAERS) Electronic Submissions website provides drug and therapeutic biological product manufacturers, distributors, packers, and other interested parties with information about FDA Adverse Event Reporting System (FAERS) electronic submissions and instructions on how to electronically submit post-marketing individual case safety reports (ICSRs), with and without attachments.

− Does FAERS data have limitations?

Yes, FAERS data does have limitations. First, there is no certainty that the reported event (adverse event or medication error) was due to the product. FDA does not require that a causal relationship between a product and event be proven, and reports do not always contain enough detail to properly evaluate an event. Furthermore, FDA does not receive reports for every adverse event or medication error that occurs with a product. Many factors can influence whether an event will be reported, such as the time a product has been marketed and publicity about an event. There are also duplicate reports where the same report was submitted by a consumer and by the sponsor. Therefore, FAERS data cannot be used to calculate the incidence of an adverse event or medication error in the U.S. population. For more information, please refer to the question What points should I consider while viewing the dashboard content?

− Is FAERS data available to the public?

FAERS data is available to the public in the following ways:

- FAERS dashboard: a highly interactive web-based tool that allows for the querying of FAERS data in a user friendly fashion.
- FAERS data files: provides raw data consisting of individual case safety reports extracted from the FAERS database. A simple search of FAERS data cannot be performed with these files by persons who are not familiar with the creation of relational databases.
- Individual case safety reports from the FAERS database can also be obtained by sending a Freedom of Information (FOI) request to FDA.

– How do I find or confirm my report is in FAERS?

To confirm that your report is in FAERS, please send a Freedom of Information (FOI) request to FDA.

– What are the benefits of the FAERS public dashboard?

This tool makes the data easier to query and produces user-friendly information and charts. For example, users can view a summary of adverse event reports received from 1968 to the present or for a specific timeframe. In addition, users can search for products or reactions of interest within a specific timeframe.

– Will there be a tutorial so I can learn how to use this database?

Yes, a recorded webinar is available which reviews the capabilities, and limitations, of the FAERS public dashboard.

Please note that a new webinar addressing the version 2.0 updates to the FAERS Public dashboard will be available soon.

– Is the FAERS public dashboard accessible on an Android™ or iPhone®?

Yes, but the user interface layout may not be very user friendly. FDA will continue to work on the dashboard to make the user interface Android and iPhone friendly.

– Can I download my search results from the dashboard?

Yes, you will be able to export a limited set of search data to an Excel® spreadsheet and then download it. FDA will still continue to provide the FAERS Latest Quarterly Data Files online.

– Where else can I find safety information?

- Potential Signals of Serious Risks/New Safety Information Identified from the FDA Adverse Event Reporting System (FAERS): quarterly reports on potential serious side effects identified by FAERS.
- Post-marketing Drug and Biologic Safety Evaluations: provides summary information about ongoing and completed post-marketing safety evaluations of adverse experience reports made to FDA for New Drug Applications (NDAs) and Biologic License Applications (BLAs) approved since September 27, 2007.
- Center for Drug Evaluation and Research (CDER): Drug Safety and Availability
- Post-market Drug Safety Information for Patients and Providers
- MedWatch: The FDA Safety Information and Adverse Event Reporting Program

– How are versions of a case in FAERS handled?

Each unique submission of a case received is assigned a version number (for example, Case #1234567, version 1). The initial version received will be version 1. If a follow up is received on a previously submitted case, then that version of the case will be version 2, and so on. The latest version of a case represents the most current information about that case.

– How frequently is the data in the FAERS public dashboard updated?

The data is updated quarterly. Dates for upcoming dashboard updates are shown below:

Quarter	Estimated data update
Q1 – 2019 (January – March)	*Updated on 8-May-2019*
Q2 – 2019 (April – June)	*Updated on 1-Aug-2019*
Q3 – 2019 (July – September)	*Updated on 7-Nov-2019*
Q4 – 2019 (October – December)	*Updated on 5-Feb-2019*
Q1 – 2020 (January – March)	*Updated on 30-Apr-2020*
Q2 – 2020 (April – June)	*Updated on 4-Aug-2020*
Q3 – 2020 (July – September)	*Updated on 17-Nov-2020*
Q4 – 2020 (October – December)	*Updated on 29-Jan-2021*
Q1 – 2021 (January – March)	*Updated on 10-May-2021*
Q2 – 2021 (April – June)	*Updated on 3-Aug-2021*
Q3 – 2021 (July – September)	*Updated on 4-Nov-2021*
Q4 – 2021 (October – December)	*Updated on 15-Feb-2022*
Q1 – 2022 (January – March)	*Updated on 2-May-2022*
Q2 – 2022 (April – June)	*Updated on 1-Aug-2022*
Q3 – 2022 (July – September)	*Updated on 4-Nov-2022*
Q4 – 2022 (October – December)	*Updated on 30-Jan-2023*
Q1 – 2023 (January – March)	*Updated on 27-Jan-2023*
Q2 – 2023 (April – June)	*Updated on 1-Aug-2023*
Q3 – 2023 (July – September)	*Updated on 2-Nov-2023*
Q4 – 2023 (October – December)	*Updated on 23-Jan-2024*
Q1 – 2024 (January – March)	*Updated on 22-Apr-2024*
Q2 – 2024 (April – June)	*Updated on 30-Jul-2024*
Q3 – 2024 (July – September)	*Updated on 30-Oct-2024*

Q4 – 2024 (October – December)	*Updated on 28-Jan-2025*
Q1 – 2025 (January – March)	*Updated on 28-Apr-2025*
Q2 – 2025 (April – June)	30-July-2025

– What points should I consider while viewing the dashboard content?

When you view the website output of reported reactions (side effects or adverse drug reactions) for a drug product, it is important to consider the following points:

- **Data Quality:** There are many instances of duplicative reports and some reports do not contain all the necessary information. Duplicate reporting occurs when the same report is submitted by the consumer and the sponsor. The information in FAERS evolves daily and the number of individual cases may increase or decrease. It is therefore possible that the information on this website may change over time.
- **Existence of a report does not establish causation:** For any given report, there is no certainty that a suspected drug caused the reaction. While consumers and healthcare professionals are encouraged to report adverse events, the reaction may have been related to the underlying disease being treated, or caused by some other drug being taken concurrently, or occurred for other reasons. The information in these reports reflects only the reporter's observations and opinions.
- **Information in reports has not been verified:** Submission of a report does not mean that the information included in it has been medically confirmed nor is it necessarily a conclusion from the reporter that the drug caused or contributed to the event.
- **Rates of occurrence cannot be established with reports:** The number of suspected reactions in FAERS should not be used to determine the likelihood of a side effect occurring. The FDA does not receive reports for every adverse event or medication error that occurs with a product. Many factors can influence whether an event will be reported, such as the time a product has been marketed and publicity about an event. Therefore, information in these reports cannot be used to estimate the incidence (occurrence rates) of the reactions reported.
- **Patients should talk to their doctor** before stopping or changing how they take their medications.
- **Patient Outcomes received in FAERS**: These data describe the outcome of the patient as defined in U.S. reporting regulations (21 CFR 310.305, 314.80, 314.98, 600.80). Serious means that one or more of the following outcomes were documented in the report: death, hospitalization, life-threatening, disability, congenital anomaly, and/or other serious outcome. Documenting one or more of these outcomes in a report does not necessarily mean that the suspect product(s) named in the report was the cause of the outcomes.

Importantly, the FAERS data by themselves are not an indicator of the safety profile of the drug.

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Data Questions

– How do I know if a side effect I saw on the dashboard is related to the drug I was taking?

The best sources of information for the known side effects of a drug are the FDA approved product information (also known as full prescribing information or US package insert) and your health care provider. This dashboard tells you what was reported to the FDA, but it is difficult to know what caused a particular event in a particular patient from the information on the dashboard. Even if a symptom is a known side effect for a drug, it can be difficult to know if the symptom that a patient had was caused by a particular drug, since there may be other possible causes as well. For example, some medications cause headaches, but many people have headaches even when they aren't on any medications.

– If an adverse event wasn't caused by a drug, what could have caused it?

Although some adverse events can be caused by a drug, there are also other possible explanations for symptoms that appear while a patient is taking a drug. For example, the adverse event could be related to a disease that a patient already has, something in the environment, diet, or sleep habits, to name a few, could cause symptoms that could be misinterpreted as adverse events caused by a drug.

– Is every adverse event reported with a drug on the dashboard caused by the drug?

Although it is difficult to generalize, it is unlikely that every adverse event reported for a given drug was caused by that drug.

– Are drugs with fewer side effects reported to the dashboard safer than those that have a higher number of side effects reported?

The FAERS dashboard should not be used to determine the safety profile of one drug compared to another. Even identical drug products can have widely differing levels of adverse event reporting due to the voluntary nature of the reporting system.

– How should reports of death be interpreted?

The same caution that applies to all of the FAERS reports, should be applied to death reports. The existence of a death report in the FAERS dashboard does not mean that the drug caused the person to die. Fatal outcome could be from the natural progression of the disease being treated.

– Does the FAERS Dashboard have all the side effects that have occurred with a drug?

No. The FAERS database contains only a small fraction of the side effects that occur with a drug. This is due to a variety of reasons. Most importantly, there is no requirement for healthcare professionals and consumers to report side effects to either the FDA or to the manufacturer. Even for side effects that have been reported to the manufacturer, only certain categories of adverse events are required to be submitted to the FDA. Lastly, there are a variety of factors that can cause more or less reporting to both the FDA and manufacturers, including whether a particular side effect is known for a drug, how long a drug has been on the market and even whether there have been recent news reports about possible side effects for a given drug or a group of drugs.

– What is the difference between an adverse event, a side effect, and an adverse drug reaction?

An adverse event (AE) is any symptom that occurs while taking a drug, which may or may not have been caused by the drug. This is different from an adverse drug reaction (ADR), where there is specific evidence that the AE is related to the drug. A side effect is the same as an ADR. As a result, ADR is always an AE, but an AE may or may not be an ADR.

– Should I discontinue a prescription drug I'm taking if I think that it's causing an adverse event?

You should always check with your healthcare provider before discontinuing any medication that you have been prescribed.

– I looked up a drug that I am taking on the FAERS dashboard and the list of adverse events includes deaths. What should I do?

You should check with your healthcare provider if you have any concerns about a medication that you are taking. You and your healthcare provider should decide if the potential benefits of you taking a particular drug outweigh its potential risks as well as the risks of an illness being left untreated.

– Where can I find the safety profile of the drug?

Please consult with your health care provider to discuss the safety profile and the overall benefit-safety balance of the drug.

– After the data refresh for Q4 2021, why do I now see reduced counts in the Home page for previous time periods (Q3 2021 and older)?

The **Home** page displays the count of reports received each year and quarter by the FDA. This includes both initial and follow-ups reports submitted in FAERS.
In Q4 2021, the FAERS system was modernized and the data was migrated to a new database. The new database handles deletion of report submissions slightly differently compared to the previous system. Whenever a case is deleted, the previous system deleted only the latest follow-up report for the case and left the older reports in the case untouched. As a result, the counts displayed in the **Home** page included older reports for deleted cases. However, in the new FAERS database currently in use, all reports (initial and follow-ups) for a case are deleted upon the deletion of a case. Because of this, the counts of reports displayed in the **Home** page are now reduced compared to previous iterations of the FAERS Public Dashboard.

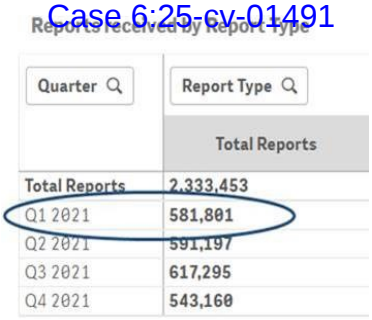
As an example, the comparison below highlights the difference in counts of reports for Q1 2021 before and after the data refresh for Q4 2021.

Q1 2021 report count before the data refresh for Q4 2021:

Reports received by Report Type

Quarter	Report Type Total Reports
Total Reports	1,801,429
Q1 2021	587,876
Q2 2021	593,598
Q3 2021	619,955

Q1 2021 report count after the data refresh for Q4 2021:



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Technical Questions

− Which internet browsers can I use to access the dashboard?

You can use any of the following internet browsers to access and view the dashboard:
Microsoft Internet Explorer 11, Microsoft Edge, Google Chrome, Mozilla Firefox, Apple Safari.

− What is the recommended screen resolution for viewing the dashboard?

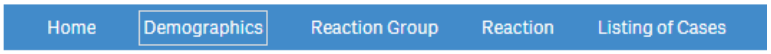
For the best dashboard viewing experience, the recommended screen resolution for your desktop or laptop is 1920x1080.

− How do I navigate through different sheets of the dashboard?

You may use the navigation bar on the top of the dashboard to navigate through different sheets. Depending on the sheet you are currently viewing, you may see different options to select in the navigation bar.

When viewing the “Home” or “Search” sheets, you will see the options shown below in the navigation bar.

When viewing any other page in the dashboard after searching for a product, you will see the options shown below.

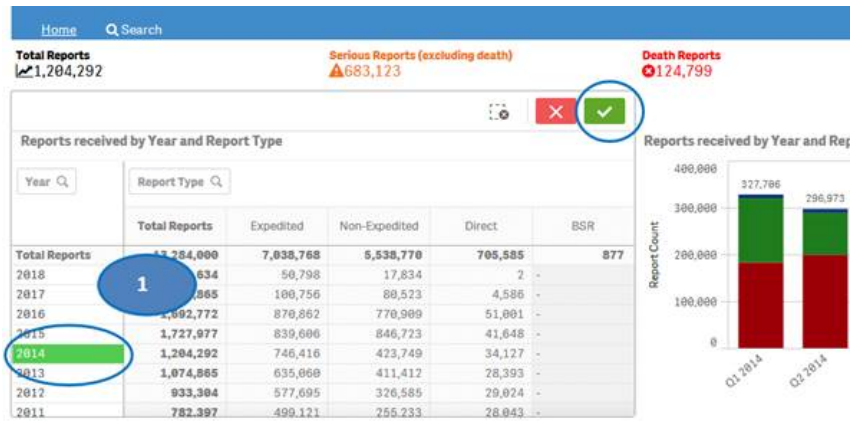


− How can I view report statistics for quarters and months of a specific year?

The “Home” sheet displays report statistics for all the years by default. But you may view report statistics for quarters and months of any specific year. You can view statistics for quarters of only one year at time. You can view statistics for months of only one quarter at a time.

1. Click on any year in the table or chart and confirm selection to view statistics for the year by quarters.
2. Then select any quarter by clicking on it to view statistics for the months of the selected quarter.
3. Clear the selected quarter to go back to view statistics by quarters.
4. Clear the year selection to go back to view statistics for all year.

Note: If a year has just one quarter of data, selecting the year will directly display months for the year without displaying quarters.

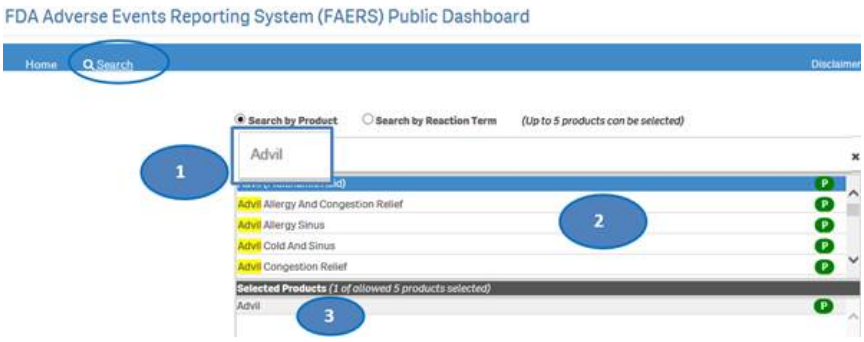


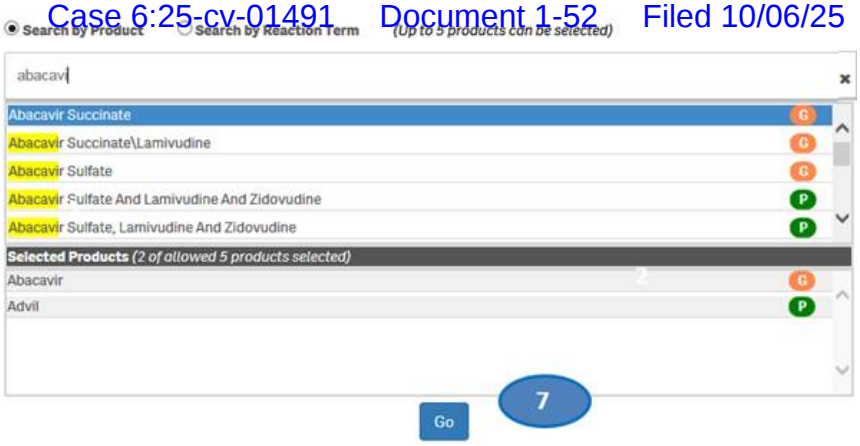
[–] How do I search for cases for a product or products?

After accepting the disclaimer, click on the “Search” option and then:

1. Type a product value in the search bar.
2. Click or double-click on a desired value from the list of values to select it.
3. The selected product will be displayed under the list “Selected Products”.
4. To clear the search text, click on the ‘X’ button in the right corner of the search bar.
5. If you want to add more products to your search, repeat the steps above for the products you are interested in. You may select up to five products for your search.
6. If you want to deselect a product you have already selected, click or double-click on the product you want to deselect from the list “Selected Products”.
7. Once you have selected all the products you want to search for, click on the “Go” button.

Please note that you can select no more than five products at a time for your search.





– Can I search for generic products as well as specific trade names?

es. You can search for a generic product or a specific trade name by simply typing the name in the search bar. The search box pop-p includes icons to indicate whether a suggested product is a trade name or a generic product based on FDA's internal product ctionary.

- P indicates that the suggested value is a product name or trade name.
- G indicates that the suggested value is a generic product.

– How can I change my product search?

f you have already done a product search, the navigation bar will display a search box where you can type in and select new products or your search.

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– Does FAERS include over-the-counter (OTC) or just prescription drugs?

FAERS includes both OTC and prescription drugs.

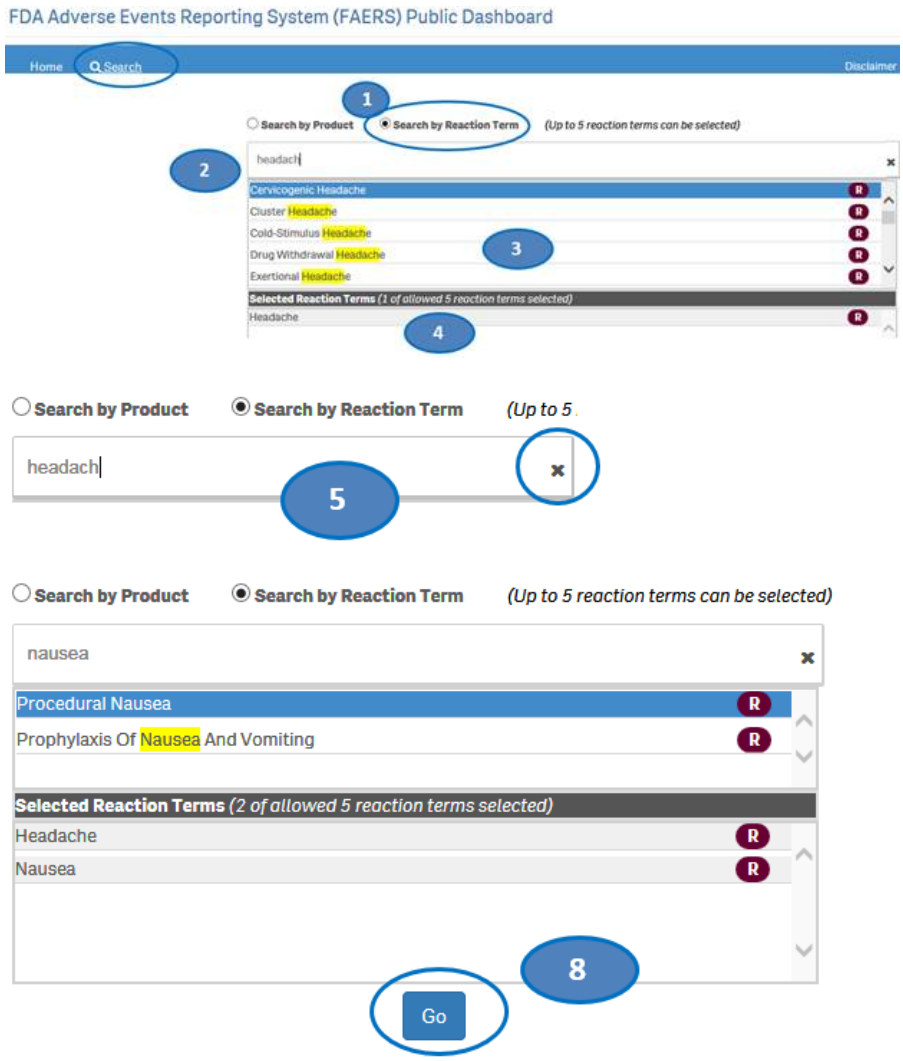
– How can I search for cases for specific side effects/reactions?

From the "Home" sheet, click on the "Search" option and then:

1. Select option "Search by Reaction Term".
2. Type a reaction term value in the search bar.
3. Click or double-click on a desired value from the list of values to select it.
4. The selected reaction term will be displayed under the list "Selected Reactions".
5. To clear the search text, click on the 'X' button in the right corner of the search bar.
6. If you want to add more reactions to your search, repeat the steps above for the reactions you are interested in. You may select up to five reactions for your search.

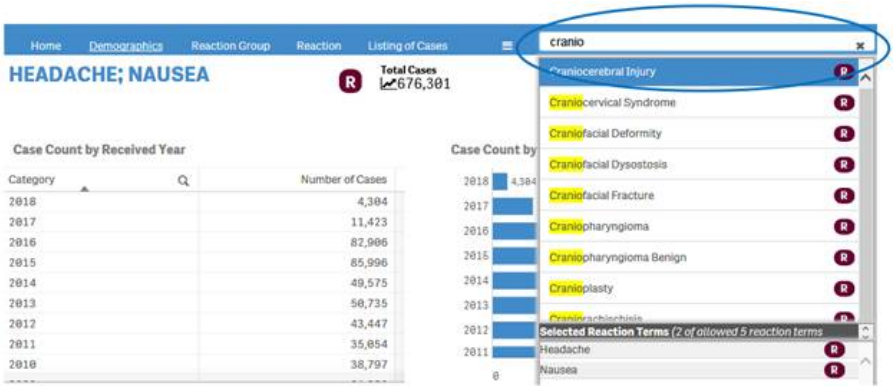
7. If you want to deselect a reaction you have already selected, click or double-click on the reaction you want to deselect from the list “Selected Reactions”.
8. Once you have selected all the reactions you want to search for, click on the “Go” button.

Please note that you can select no more than five reaction terms at a time for your search.



[–] How can I change my reaction search?

If you have already done a reaction search, the navigation bar will display a search box where you can type in and select new reactions for your search.



[–] What can I search for using the search box in the navigation bar?

Depending on your initial search, you can use the search box in the navigation to search for either products or reactions terms.

If your initial search in the “Search” sheet was based on product(s), you can only search for products in the search box of the navigation bar.

If your initial search in the "Search" sheet was based on reaction term(s) you can only search for reaction terms in the search box of the navigation bar.

− How many products or reactions can I search for at a time?

You can select up to five products or reactions at a time for a search.

Note: This restriction is applicable for products and reactions only. Multiple value selections can be made for all other data elements such as sex, country, and outcomes.

− Does the "Search" sheet allow selecting products and reactions for the same search?

No, the search sheet allows you to select either products or reactions for your search but not both. For example, if you select specific products using the "Search by Product" option and then choose the "Search by Reaction Term" option, the products you have selected will be removed from the search.

You may, however, filter for products and reactions after your initial search in subsequent sheets.

− How can I view the distribution of report or case counts for different parameters?

To view distribution of counts for different parameters, click on the drop-down menu on the top right corner of a sheet and select the desired option.

− Can I view charts and tables in full screen mode? How do I exit from full screen mode?

When you hover over any chart or table, a symbol is displayed on the right top corner of the chart or table. Clicking on this icon will enable you to view the chart or table in full screen mode. To exit the full screen mode, click the X on the top right corner of the chart or table.

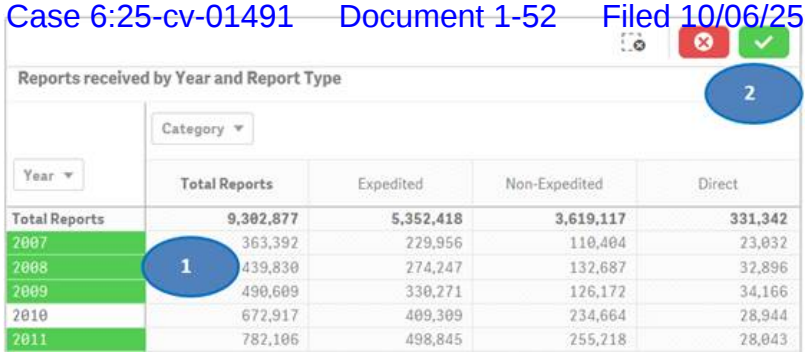
− Can I filter data in charts and tables?

Yes, the dashboard provides extensive filtering capabilities on both charts and tables.

Note: When you apply filters on a table or chart within the "Home" sheet, the filters will be applied only on charts and tables in this sheet. Conversely, when you apply filters on tables or charts in any other sheet, after searching for a product, the filters will be applied on all sheets except for the "Home" sheet.

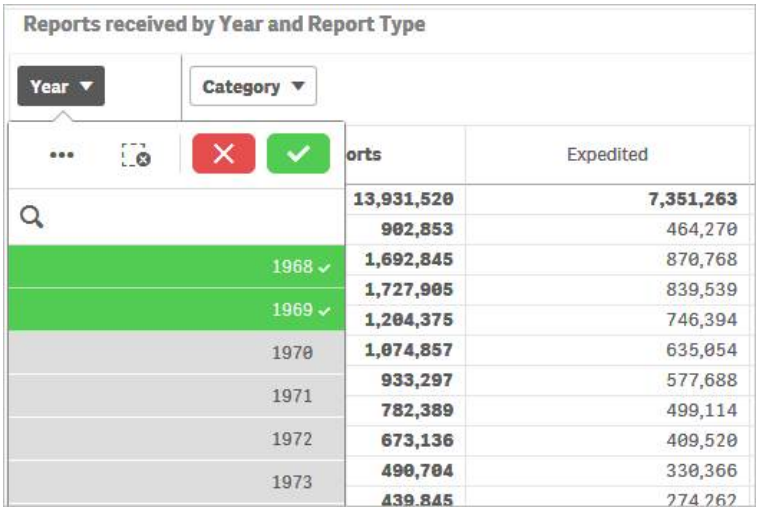
To filter data in a table, for example, filtering by year, there are two options:
Option 1:

1. Click on one or multiple columns or rows. You may also click and drag multiple rows or columns to select them for filtering data.
2. Click on the icon to confirm your selection.



Option 2:

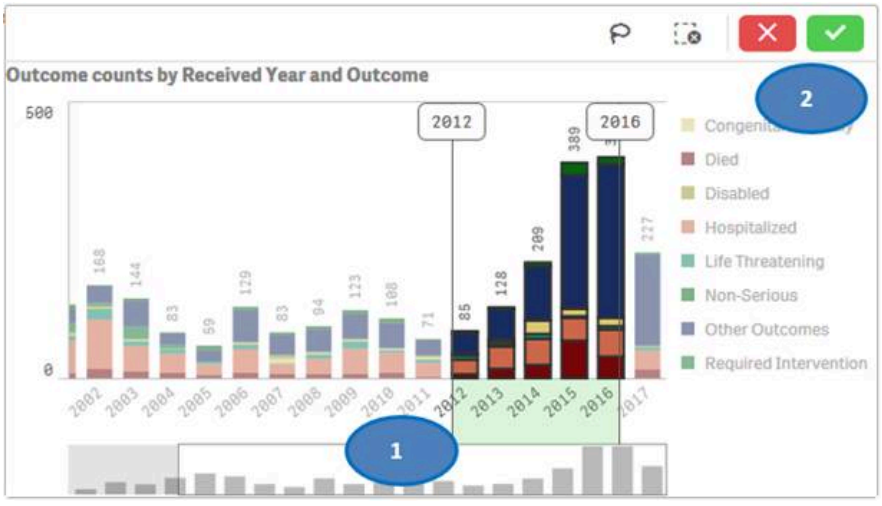
You may also use drop-downs (also known as filter panes) displayed on top of the rows or columns to choose your values for filtering. Please see screenshot below which shows how to select specific years for filtering.



To filter data in a chart, for example, filtering by year, there are two options:

Option 1:

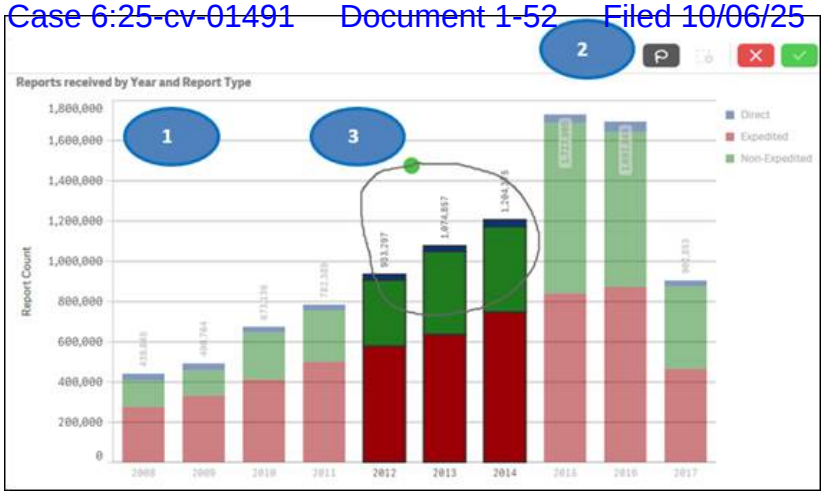
1. Click on one or multiple bars in the chart or items in the chart legend. You may also click and drag multiple bars to select them for filtering data.
2. Click on the ✓ button to confirm your selection.



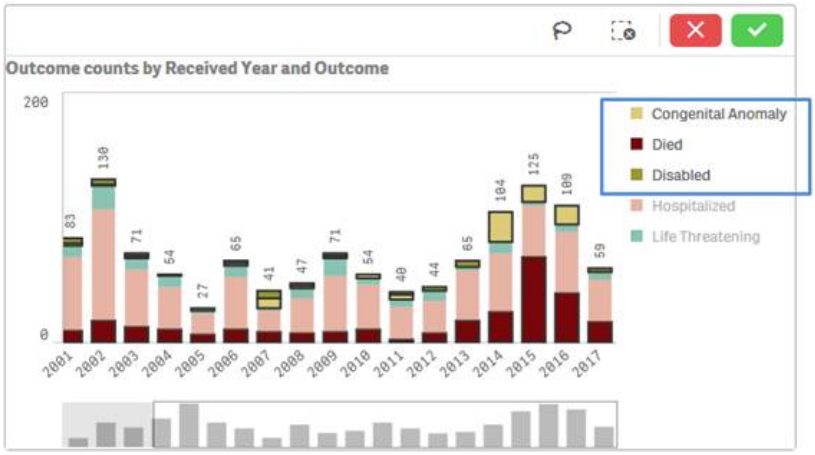
Option 2:

You may also use “lasso selection tool” to select multiple values from the chart. To use this feature:

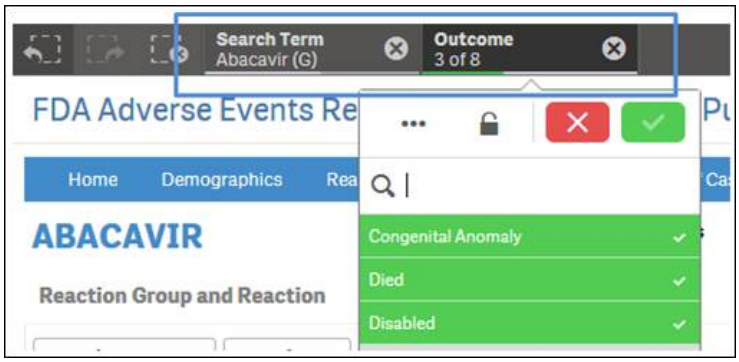
1. Click anywhere on the chart.
2. Click on the lasso icon.
3. Click and drag to draw on the chart and select the bars you want to use for filtering.



You may also select values from a chart's legend for filtering by clicking on the values.

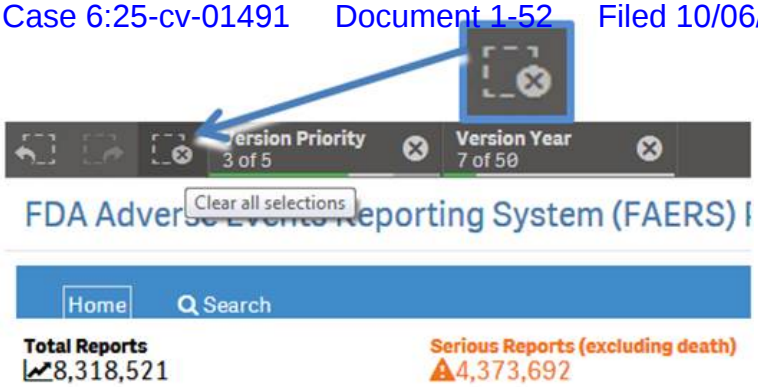


Note that the applied filters show up on the top selection bar.



– How do I reset selected search criteria and remove all filters?

On the top left side of every sheet, you can see the icon shown below, with a dotted lined square with an "X" on it. Click the icon to clear any product you have selected for searching and all selected values used for filtering.



[−] Can I extract or download dashboard data?

Yes, you may export or download dashboard data. Right-click on any table or chart in the dashboard and click on the “Export” option. You may choose from the following three options for exporting and downloading data:

1. Export as an image: This option will export a snapshot of the table or chart that you are viewing to an image file.
2. Export to PDF: This option will export a snapshot of the table or chart that you are viewing to a PDF file.
3. Export data: This option will export the underlying data of the table or chart that you are viewing to a Microsoft Excel (.xlsx) file. This option is explained in more detail in the final question of the FAQs below.

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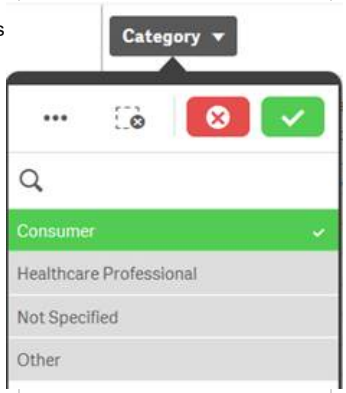
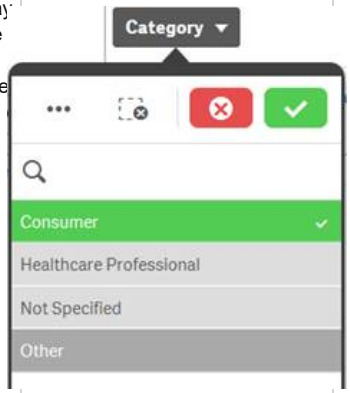
[−] When using filter panes (or drop-downs) for filtering, I have noticed that different colors are used to highlight different values. What do these colors indicate?

Action	Color Code	Description	Screenshot
Selected	Green, with a check mark as a selection indicator	When you select one or more values in a filter pane and the values turn green, they are in the selected state. In the example screenshot, the value “Consumer” has been selected.	
Possible	White	In the screenshot of the “Category” filter pane for “Reporter Region”, the values “Domestic” and “Foreign” are white (possible), because selecting these values will return data. You could refine your data set by selecting one or more of these possible values.	

Action	Color Code	Description	Screenshot
Alternative	Light gray	Selecting a light gray value will add to the previously selected value to broaden the filtering.	
Excluded	Dark gray	Dark gray value indicates that there is no data for the specific value based on other filters that have already been applied to the data. Caution: Selecting a dark gray value: • May clear some or all other existing filters and apply that value as the new filter. • May cause the selected product to be removed. If that happens, restart your search using the Search for Product option in the navigation bar.	

– Can I use the dashboard without accepting the disclaimer?

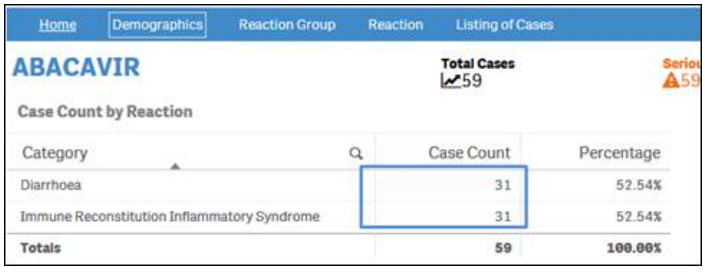
No. You will not be able to view any data in the dashboard without accepting the disclaimer.

– How recent is the data in the dashboard?

Data in the FAERS Public Dashboard is as of March 31, 2025. Data is updated quarterly.

– Why does the sum of case counts for individual reactions not add up to the overall case count for the product?

Each case might have more than one reaction term. Therefore, the sum of the case counts for individual reactions may be same or more than the total count of distinct cases.



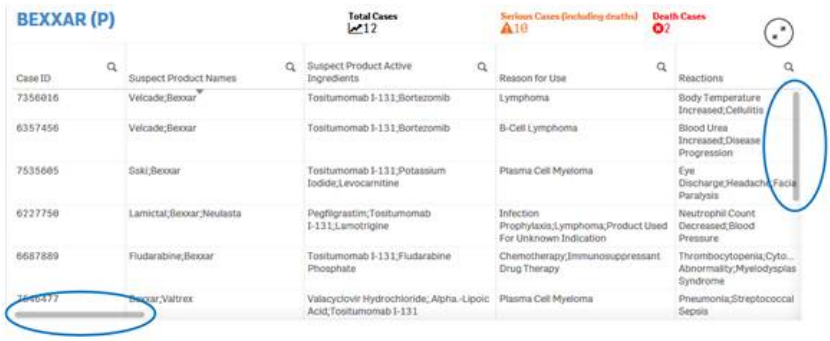
– Why does the sum of individual outcome counts not add up to the overall count for the product?

Each case might have more than one outcome. Therefore, the sum of counts for individual outcomes may not match the total count of distinct cases.

– How do I scroll in the “Listing of Cases” table?

The “Listing of Cases” table allows you to scroll vertically or horizontally using vertical and horizontal scroll bars respectively. To view the scroll bars, hover over the listing of cases table.

- Scroll up or down in the Listing of Cases table using the vertical scroll bar on the right side of the table. This will allow you to see all the rows in the table.
- Scroll to the left or right in the Listing of Cases table using the horizontal scroll bar on the bottom of the table. This will allow you to see all the columns in the table.



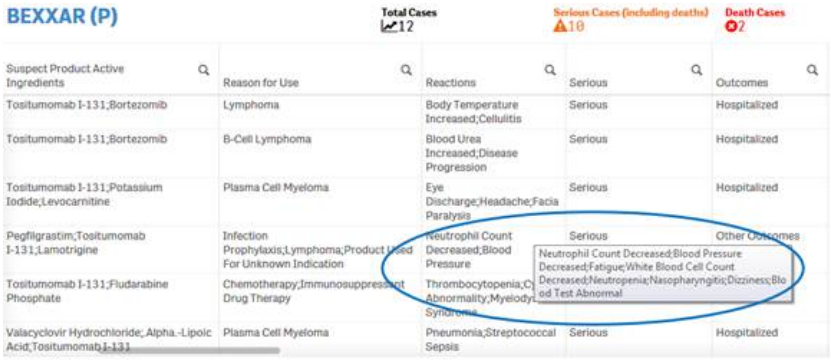
– Can I rearrange columns in the “Listing of Cases” table?

Yes, you may rearrange columns by dragging and dropping column headers anywhere in the table. To move a particular column:

1. Click and hold on the column header.
2. Drag it next to a column you want to move it to and release the click.

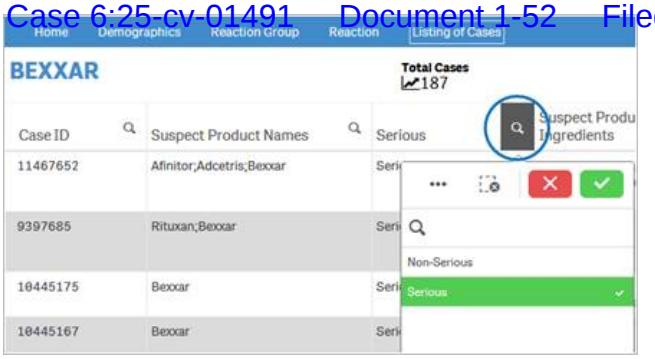
– Some of the cells seem to be showing only partial data. How can I see the entire content of such cells?

Due to space constraints, some cells display only partial data. To view the entire content of any cell, simply hover over the cell with your mouse. The entire content of the cell appears in a pop-up.



– How do I filter and sort data in the “Listing of Cases” table?

You can filter and sort data in the table using any column or any value in a cell. To filter using a value in cell, simply click on the cell. The table is refreshed with the filtered data. To filter using a column, click on the 🔍 icon next to the column header, and then select from the list of values for that column.



To sort data using a specific column, simply click on the column header. Click once on the column header to view data in ascending order. Click again on the column heading to sort the values in descending order.

– How do I download data from the “Listing of Cases” table?

You can download data from the “Listing of Cases” table to a Microsoft Excel (.xlsx) file by using the “Export data” option.

Note: The “Listing of Cases” table provides a limited set of columns for case data. If you require a more comprehensive data set for download, you may download FAERS (FDA Adverse Events Reporting System) Quarterly Data files.

The data displayed in the FAERS Public Dashboard may not be identical to the data in the FAERS Quarterly Data files due to several reasons. Please refer to the Data Questions section for more information.

To download data from the “Listing of Cases” table:

1. Right-click anywhere on the “Listing of Cases” table and click on “Export”.
2. Select “Export data” option.
3. Then click on “Click here to download your data file” to save the file to your machine.

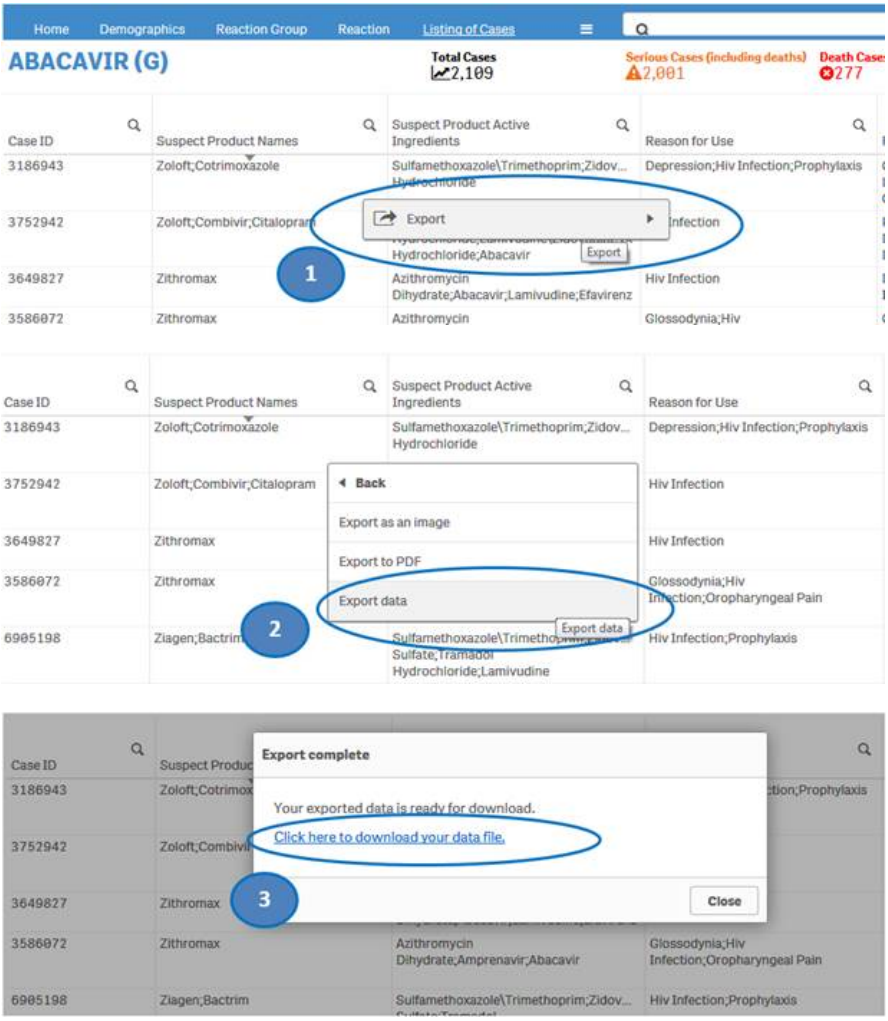


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EXHIBIT 53

Kathi A. Aultman et al.,
Deaths and Severe Adverse Events After the Use of Mifepristone as an Abortifacient from September 2000 to February 2019,
26 Issues in L. & Med., no. 1,
Nov. 1, 2021

Deaths and Severe Adverse Events after the use of Mifepristone as an Abortifacient from September 2000 to February 2019

Kathi A. Aultman M.D.,[*] Christina A. Cirucci M.D., Donna J. Harrison M.D.,[**] Benjamin D. Beran M.D.,[***] Michael D. Lockwood D.O.,[****] Sigmund Seiler M.D.[*****]

ABSTRACT: *Objectives:* Primary: Analyze the Adverse Events (AEs) reported to the Food and Drug Administration (FDA) after use of mifepristone as an abortifacient. Secondary: Analyze maternal intent after ongoing pregnancy and investigate hemorrhage after mifepristone alone.

***Methods*: Adverse Event Reports (AERs) for mifepristone used as an abortifacient, submitted to the FDA from September 2000 to February 2019, were analyzed using the National Cancer Institute's Common Terminology Criteria for Adverse Events (CTCAEv3).**

***Results*: The FDA provided 6158 pages of AERs. Duplicates, non-US, or AERs previously published (Gary, 2006) were excluded. Of the remaining, there were 3197 unique, US-only AERs of which there were 537 (16.80%) with insufficient information to determine clinical severity, leaving 2660 (83.20%) Codable US AERs (Figure 1). Of these, 20 were Deaths, 529 were Life-threatening, 1957 were Severe, 151 were Moderate, and 3 were Mild.**

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[***] Department of Obstetrics and Gynecology, Medical College of Wisconsin, Milwaukee, WI.

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[*****] Associate Professor of Family Medicine, Liberty University College of Osteopathic Medicine.

The deaths included: 9 (45.00%) sepsis, 4 (20.00%) drug toxicity/ overdose, 1 (5.00%) ruptured ectopic pregnancy, 1 (5.00%) hemorrhage, 3 (15.00%) possible homicides, 1 (5.00%) suicide, 1 (5.00%) unknown (Table 1).

Retained products of conception and hemorrhage caused most morbidity. There were 75 ectopic pregnancies, including 26 ruptured ectopics (includes one death).

There were 2243 surgeries including 2146 (95.68%) D&Cs of which only 853 (39.75%) were performed by abortion providers.

Of 452 patients with ongoing pregnancies, 102 (22.57%) chose to keep their baby, 148 (32.74%) had terminations, 1 (0.22%) miscarried, and 201 (44.47%) had unknown outcomes.

Hemorrhage occurred more often in those who took mifepristone and misoprostol (51.44%) than in those who took mifepristone alone (22.41%).

***Conclusions*: Significant morbidity and mortality have occurred following the use of mifepristone as an abortifacient. A pre-abortion ultrasound should be required to rule out ectopic pregnancy and confirm gestational age. The FDA AER system is inadequate and significantly underestimates the adverse events from mifepristone.**

A mandatory registry of ongoing pregnancies is essential considering the number of ongoing pregnancies especially considering the known teratogenicity of misoprostol.

At the very least, the FDA should reinstate the original 2011 REMS and strengthen the reporting requirements.

***Conflict of Interest Statement*: The authors did not report any potential conflicts of interest. Authors note that although Dr. Harrison is an associate editor for Issues in Law and Medicine, she recused herself from any involvement in the peer review process for this manuscript.**

***Keywords*: Mifepristone, Mifeprex, RU-486, Misoprostol, Abortifacient, Medical Abortion, Abortion Pill, Medical Abortion Complications, No touch abortion, DIY Abortion, Self-Administered Abortion, Adverse Events, Adverse Event Reports, Post-marketing Surveillance, FAERS, Drug Safety, Emergency Medicine, FDA, REMS, Risk Evaluation Mitigation Strategy.**

Introduction

The application for mifepristone (RU-486, RU-38486, Mifeprex) as an abortifacient was submitted to the Food and Drug Administration (FDA) in 1996 by the Population Council, which was given the manufacturing and distribution rights from Roussel Uclaf. [1] The Population Council partnered with Danco Laboratories, newly created in 1995, and gave them the manufacturing, marketing, and distribution rights. The FDA approved mifepristone in September 2000 under restricted distribution regulations (Subpart H) due to the FDA's conclusion that restrictions "on the distribution and use of mifepristone are needed to ensure safe use of this product."[2]

Included in these restrictions was the requirement that all serious Adverse Events (AEs), after the use of mifepristone as an abortifacient, be reported to the FDA by Danco as part of post-marketing surveillance. According to the FDA,[3] the purpose of such post-marketing surveillance includes identification of potential risks recognized after the time of approval, identification of unexpected deaths, causal attribution of AEs based on the product's known pharmacological action, and AEs for which a Risk Evaluation Mitigation Strategy (REMS) is intended to mitigate the risk.

In 2006, in response to the deaths of 4 women from a rare bacterial sepsis from *Clostridium sordellii (C. sordellii)*, the FDA and CDC convened a workshop, during which mifepristone alteration of the immune system was detailed, and they concluded that such alteration could lead to impaired ability to respond to *C. sordellii* toxin.[4]

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[1] Citizen petition re: Request for Stay and Repeal of the Approval of Mifeprex (mifepristone) for the Medical Termination of Intrauterine Pregnancy through 49 Day's Gestation Final. Before the Department of Health and Human Services: Food and Drug Administration. AAPLOG. 2002. 7-10. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/Documents/2002%20Aug%2020%20Citizen%20Petition_Mifeprex.pdf

[2] Center for Drug Evaluation and Research. Approval Letter for Mifeprex NDA 20-687. February 18, 2000. Food and Drug Administration. p 5. Accessed November 16, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2000/20687approvable00.pdf

[3] US Department of Health and Human Services, Food and Drug Administration Center for Drug Evaluation and Research, Center for Biologics Evaluation and Research. Best Practices in Drug and Biological Product Postmarket Safety Surveillance for FDA Staff. November 2019. p 7-8. Accessed Jan 16 2021. https://www.fda.gov/media/130216/download p7-8

[4] Emerging Clostridial Disease Workshop: May 11, 2006, Atlanta, GA. Department of Health and Human Services, Centers for Disease Control and Prevention, Food and Drug Administration, National Institutes of Health. 2006. p. 109,110. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/2006%20CDC%20FDA%20Clostridial%20Disease%20Transcript.pdf

There is evidence that both mifepristone[5,6,7] and misoprostol[8] can suppress immune response to *C. sordellii* in animal models.

In response to the septic deaths, Planned Parenthood changed their off-label protocol from vaginal administration of misoprostol to buccal in 2006.[9,10] Yet, as we found in our analysis, sepsis deaths from *C. sordellii* and other bacteria continued to occur after 2007. All sepsis deaths occurred with either vaginal or buccal misoprostol, which were both off label routes of administration until the buccal route was authorized in 2016.[11]

In 2011, the FDA approved a Risk Evaluation and Mitigation Strategy (REMS) for Mifepristone incorporating the original restrictions.[12] In May 2015, Mifepristone's sponsor submitted a supplemental new drug application to the FDA to obtain approval to revise the drug's labeling, which the FDA approved in 2016.[13,14] The 2016 changes in the Regimen and Prescriber Agreement extended the original gestational age limit from 49 days to 70 days, changed the mifepristone dose from 600 mg to 200 mg orally, changed the misoprostol dose from 400 mcg orally on Day 3 to 800 mcg buccally on Day 2 or 3, allowed non-physicians to become prescribers, reduced the number of required office visits from 3 to just one initial office visit, and allowed a repeat dose of misoprostol if complete expulsion did not occur.[15] The prescriber agreement was changed so

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[5] Emerging Clostridial Disease Workshop: May 11, 2006, Atlanta, GA. Department of Health and Human Services, Centers for Disease Control and Prevention, Food and Drug Administration, National Institutes of Health. 2006. p. 109, 110 Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/2006%20CDC%20FDA%20Clostridial%20Disease%20Transcript.pdf

[6] Webster JI, Sternberg EM. Role of the hypothalamic-pituitary-adrenal axis, glucocorticoids and glucocorticoid receptors in toxic sequelae of exposure to bacterial and viral products. J Endocrinol. 2004;181(2):212, 213, 216, 217. doi.org/10.1677/joe.0.1810207

[7] Hawes AS, Rock CS, Keogh CV, Lowry SF, Calvano SE. In vivo effects of the antiglucocorticoid RU 486 on glucocorticoid and cytokine responses to Escherichia coli endotoxin. Infect Immun. 1992;60(7):2645, 2646. doi:10.1128/IAI.60.7.2641-2647.1992

[8] Aronoff DM, Hao Y, Chung J, et al. Misoprostol impairs female reproductive tract innate immunity against Clostridium sordellii. J Immunol. 2008;180(12):8227-8229. https://doi.org/10.4049/jimmunol.180.12.8222

[9] Trussell, J, Nucatola, D, Fjerstad, M, Lichtenberg, ES. Reduction in infection-related mortality since modifications in the regimen of medical abortion. Contraception, 2014;89(3):193-196. https://doi.org/10.1016/j.contraception.2013.11.020

[10] Fjerstad M, Trussell, J, Sivin, I, Lichtenberg, ES, Rates of Serious Infection after Changes in Regimens for Medical Abortion. N Engl J Med. 2009 July 9;361(2):148-149. July 9, 2009 N Engl J Med 2009; 361:145-151. doi:10.1056/NEJMoa0809146

[11] GAO-18-292 Revised Mifeprex Labeling: Food and Drug Administration Information on Mifeprex Labeling Changes and Ongoing Monitoring Efforts. Report to Congressional Requesters. Food and Drug Administration. 2018. p. 7. Published March 2018. Accessed November 13, 2020. https://www.gao.gov/assets/700/690914.pdf

[12] NDA 20-687 MIFEPREX (mifepristone) Tablets, 200 mg: Risk Evaluation and Mitigation Strategy (REMS). Food and Drug Administration. 2011. 1-11. Reference ID: 2957855. Published June 8, 2011. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifeprex_2011-06-08_Full.pdf

[13] GAO-18-292 Revised Mifeprex Labeling: Food and Drug Administration Information on Mifeprex Labeling Changes and Ongoing Monitoring Efforts. Report to Congressional Requesters. Food and Drug Administration. 2018. p. 1. Published March 2018. Accessed November 13, 2020. https://www.gao.gov/assets/700/690914.pdf

[14] NDA 20-687 MIFEPREX (mifepristone) Tablets, 200 mg: Risk Evaluation and Mitigation Strategy (REMS). Food and Drug Administration. 2016. 1-8. Reference ID: 3909592. Published March 29, 2016. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020RemsR.pdf

[15] GAO-18-292 Revised Mifeprex Labeling: Food and Drug Administration Information on Mifeprex Labeling Changes and Ongoing Monitoring Efforts. Report to Congressional Requesters. Food and Drug Administration. 2018. p.7. Published March 2018. Accessed November 13, 2020. https://www.gao.gov/assets/700/690914.pdf

that instead of being required to "report any hospitalization, transfusion or other serious event to Danco Laboratories,"[16] providers were only required to report deaths.[17] The requirement to report ongoing pregnancies that are not terminated was also eliminated. "The FDA approved GenBioPro, Inc.'s abbreviated new drug application (ANDA) for generic Mifeprex on April 11, 2019" and "established a single, shared system REMS for mifepristone products" without substantially changing the REMS.[18]

During the COVID-19 pandemic the Maryland District Court issued a preliminary injunction prohibiting the FDA from enforcing the in-person dispensing and signature requirements contained in the mifepristone REMS.[19] This decision eliminated the need for an initial office visit for dispensing the medication and opened the door for dispensing of the drug via telehealth with no actual clinician contact. On January 12, 2021, the Supreme Court enabled the FDA to enforce the mifepristone REMS.[20] These requirements are essential for the safety of women and must be kept in place.

The first systematic analysis of these Adverse Event Reports (AERs) obtained by the Freedom of Information Act (FOIA), was published by Gary and Harrison in 2006.[21] This paper extends that analysis to AERs not previously published and augments the scant published literature on mifepristone safety.

Objectives

Primary: To analyze and codify the significant adverse events and their treatment after the use of mifepristone as an abortifacient, extending the previously published analysis by Gary in 2006.[22] Secondary: To examine maternal decisions in the case of ongoing pregnancy after attempted mifepristone termination, and to determine if failing to take misoprostol after mifepristone increased the risk of hemorrhage.

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[16] NDA 20-687 MIFEPREX (mifepristone) Tablets, 200 mg: Risk Evaluation and Mitigation Strategy (REMS). Food and Drug Administration. 2011. p. 7. Reference ID: 2957855. Published June 8, 2011. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifeprex_2011-06-08_Full.pdf

[17] NDA 20-687 MIFEPREX (mifepristone) Tablets, 200 mg: Risk Evaluation and Mitigation Strategy (REMS). Food and Drug Administration. 2016. p. 6. Reference ID: 3909592. Published March 29, 2016. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020RemsR.pdf

[18] Questions and Answers on Mifeprex. Food and Drug Administration. March 28, 2018. Updated 4-12-2019. Accessed November 13, 2020. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex

[19] American College of Obstetricians and Gynecologists, et al., v. Food and Drug Administration, et al., No. 20-1320, 2020 WL 3960625 (D. Md. July 13, 2020). Accessed November 16th, 2020. https://www.courthousenews.com/wp-content/uploads/2020/07/093111166803.pdf

[20] FDA v ACOG. SCOTUS. 20a34_3f14. Accessed January 20, 2021. https://www.supremecourt.gov/opinions/20pdf/20a34_3f14.pdf

[21] Gary M, Harrison D. Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient. Ann Pharmacother. 2006 Feb 40(2):191-7. https://doi.org/10.1345/aph.1G481

[22] Gary M, Harrison D. Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient. Ann Pharmacother. 2006 Feb 40(2):191-7. https://doi.org/10.1345/aph.1G481

Materials and Methods

FDA AERs related to the use of mifepristone from September 2000 to February 2019 were obtained through the Freedom of Information Act (FOIA) from the FDA, and a comparison was made with FDA reports available online on the FDA Adverse Events Reporting System (FAERS) Dashboard.[23] Duplicate AERs were identified by comparing FDA case identification numbers, manufacturer identification numbers, dates of treatment, patient age, and descriptions of case scenarios to ensure that each case was included only once in this analysis. The authors excluded duplicates, cases originating outside of the United States, and cases previously published in the Gary analysis[24] (Figure 1).

One of the concerns in looking at AEs is the risk of falsely assigning causality. The FDA does not give guidance for determining causality for AEs in the AERs but does give guidance for selecting AEs for inclusion in the Adverse Reaction section of the Drug Label.[25] They recommend that, "Decisions on whether there is some basis to believe there is a causal relationship are a matter of judgment and are based on factors such as" the "frequency of reporting," "the extent to which the adverse event is consistent with the pharmacology of the drug," "the timing of the event relative to the time of drug exposure," and other factors. Although a causal relationship cannot be attributed with certainty to all reported AEs for a drug, a causal relationship seems probable for each of the categories of AEs we chose to analyze based on these factors, except for ectopic pregnancies and some of the deaths. Ectopic pregnancies were included in our analysis not because there is a causal relationship, but because ectopic pregnancy is a contraindication to the use of mifepristone and the diagnosis was missed, putting women's lives at risk. The deaths must be evaluated individually to determine causality.

Because reporting is often voluntary and sporadic, there is no denominator for how many mifepristone abortions are performed in the U.S. It was therefore impossible to calculate complication rates for mifepristone and misoprostol abortions based on AER data. For clarity, we specified the denominator used in each case. Coding for severity was done using the National Cancer Institute's Common Terminology Criteria for Adverse Events (CTCAEv3),[26] since this was

[23] FDA Adverse Events Reporting System (FAERS) Public Dashboard. Food and Drug Administration. Accessed November 13, 2020. https://fis.fda.gov/sense/app/d10be6bb-494e-4cd2-82e4-0135608ddc13/sheet/33a0f68e-845c-48e2-bc81-8141c6aaf772/state/analysis

[24] Gary M, Harrison D. Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient. Ann Pharmacother. 2006 Feb 40(2):191-7. https://doi.org/10.1345/aph.1G481

[25] Guidance for Industry Adverse Reactions Section of Labeling for Human Prescription Drug and Biological Products — Content and Format. U.S. Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research (CDER), Center for Biologics Evaluation and Research (CBER); January 2006. P. 8. Accessed January 8, 2021. https://www.fda.gov/media/72139/download

[26] Common Terminology Criteria for Adverse Events v3.0 (CTCAE). Cancer Center Therapy Evaluation Program (CTEP); 2003. 1-77. Published December 12, 2003. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/CTCAEv3.pdf

the methodology used in the original analysis of the first 607 Adverse Events.[27] The five levels of coding are: Mild, Moderate, Severe, Life-threatening, and Death.

Overall severity (Figure 1) for each unique AER was determined independently by two board-certified physicians (Obstetrics and Gynecology or Family Medicine). Since within each AER, a patient may have experienced several Adverse Events (AEs), the overall severity of the AER was based on the highest severity of its AEs. For the diagnoses we analyzed (Table 1), each AE was coded in the same manner and stratified according to type, severity, and treatment. Disagreements were resolved by discussion or review by a third board-certified Obstetrician-Gynecologist who also reviewed coding for uniformity. Surgeries, transfusions, providers, and location of treatment were analyzed and tabulated.

Ruptured ectopic pregnancies were coded as Life-threatening and unruptured ectopic pregnancies as Severe.

Infections were coded as Life-threatening when evidence of sepsis was present, or ICU-level treatment was required. They were coded as Severe if parenteral/IV antibiotics were given and Moderate if oral antibiotics were prescribed.

Life-threatening hemorrhage was defined, as in the previous analysis, to be transfusion of two or more units of packed red blood cells (PRBCs), hemoglobin less than 7, or documented large volume, rapid blood loss with clinical symptomatology of acute blood loss anemia (e.g., syncope, tachycardia, hypotension). Severe hemorrhage was defined as requiring surgical intervention and/or less than 2 U PRBCs. Moderate hemorrhage was defined as management with fluids/medication alone.

Retained Products of Conception (RPOC) was coded as Severe if a dilatation and curettage/evacuation (D&C) was performed. Ongoing viable intrauterine pregnancy was considered equivalent in severity to RPOC requiring curettage and thus Severe. When the ultimate outcome was unknown, the pregnancy was considered ongoing if "ongoing pregnancy" was noted or ultrasound showed cardiac motion or significant growth.

AEs which did not contain sufficient information to assign an accurate severity code were deemed "Uncodable." AERs lacking any codable information were deemed overall Uncodable.

The percent of women with significant hemorrhage after mifepristone alone was compared to those who took both mifepristone and misoprostol, to investigate the validity of the assertion that lack of subsequent misoprostol administration was a causative factor in hemorrhage after mifepristone use.[28]

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[27] Gary M, Harrison D. Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient. Ann Pharmacother. 2006 Feb 40(2):191-7. https://doi.org/10.1345/aph.1G481

[28] Creinin MD, Hou MY, Dalton L, Steward R, Chen MJ. Mifepristone Antagonization With Progester-one to Prevent Medical Abortion: A Randomized Controlled Trial. Obstet Gynecol. 2020;135(1):158-165. doi:10.1097/AOG.0000000000003620

Results

Adverse Event Report Overall Severity

Figure 1 summarizes the handling of the AERs provided by the FDA and their severity coding. The FDA provided 6158 pages of AERs. Of these, any duplicates, non-US, or AERs previously published in the Gary paper were excluded from the analysis. There were 3197 unique, US-only AERs of which 537 had insufficient information to determine clinical severity, leaving 2660 Codable US-only AERs. Of these, 20 were Deaths, 529 were Life-threatening, 1957 were Severe, 151 were Moderate, and 3 were Mild.

Deaths (Table 1)

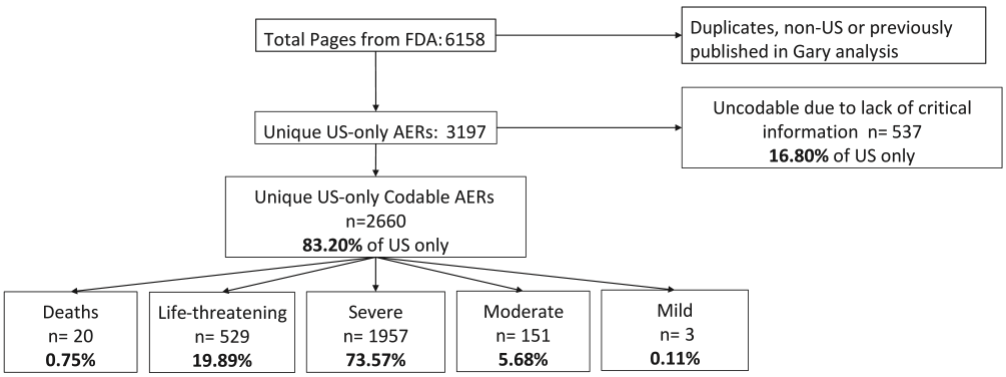
Our analysis identified 23 of the 24 deaths reported by the FDA as of 2018.[29] Three of those deaths were previously published in the Gary paper[30] leaving 20 deaths (Table 1). Our analysis yielded a total of 7 sepsis deaths. These included five cases of *C. sordellii* and one case of *Clostridium perfringens*, all consistent with those reported by the FDA. There was an additional death which we categorized as a sepsis death whereas the FDA labeled this case as "delayed onset toxic shock-like syndrome" but did not include it as a sepsis death. The patient had an exploratory laparotomy revealing green pus, which was culture positive for *prevotella* and *peptostreptococcus,* and she died intraoperatively.[31]

[29] RCM # 2007-525 NDA 20-687 Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018. FDA. 1-2. Reference ID: 4401215. Accessed November 13, 2020. https://www.fda.gov/media/112118/download

[30] Gary M, Harrison D. Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient. Ann Pharmacother. 2006 Feb 40(2):191-7. https://doi.org/10.1345/aph.1G481

[31] Individual Case Safety Report number 4734082-4-00-01. Danco Laboratories, LLC. Office of Post-marketing Drug Risk Assessment, Food and Drug Administration. Received August 4, 2005. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/Peptostreptococcus%20death%209.10277-8.pdf

Figure 1. AER Distribution



Note: From 2000 to 2016 FDA only required the manufacturer to report AEs which were severe, life-threatening or had fatal outcomes. Since 2016, FDA only requires the manufacturer to report fatal outcomes.

We categorized two deaths as suspicious for infectious death. One case was labeled by the FDA as "undetermined natural causes," however, the AER reported the cause of death as "acute visceral and pulmonary (1420 grams) congestion and edema," [32] which is consistent with the clinical findings for sepsis/Acute Respiratory Distress Syndrome (ARDS). This patient had autopsy-proven retained products of conception and blood cultures which grew *Strep viridans* isolated at less than 24 hours incubation. One additional case which the FDA labeled "methadone overdose"[33,34] we considered suspicious for sepsis. Prior to her death, this patient had fever and chills and was treated by an outside physician with cephalexin, which would have been ineffective against infections from *C. sordellii* or anaerobic gram-negative bacilli. There was no autopsy report or toxicology report in the AER.

Non-infectious deaths include one death that the FDA listed as "natural," caused by "pulmonary emphysema."[35] This patient was a 40-year-old chronic smoker who died within hours of misoprostol ingestion and had a contusion on her head consistent with a fall, a scenario possibly related to a cardiac event or acute respiratory reaction to misoprostol. She had an intact fetus at the time of

[32] Individual Case Safety Report number 9587011-03-00-01. Danco Laboratories, LLC. Office of Post-marketing Drug Risk Assessment, Food and Drug Administration. Received May 21, 2014. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/death%20Visc%20pul%20cong.pdf

[33] Individual Case Safety Report number 4970303-0-00-01. Danco Laboratories, LLC. Office of Post-marketing Drug Risk Assessment, Food and Drug Administration. Received April 21, 2014. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/death%2023%20yo%20meth%20overdose%20fever%20and%20chills.pdf

[34] Individual Case Safety Report number 5063156-8-00-01. Danco Laboratories, LLC. Office of Post-marketing Drug Risk Assessment, Food and Drug Administration. Received July 27, 2006. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/methadone%20AER%20(1).pdf

[35] Individual Case Safety Report number 11283049-02-00-01. Danco Laboratories, LLC. Office of Post-marketing Drug Risk Assessment, Food and Drug Administration. Received December 8, 2015. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/emphysema.pdf

autopsy. Other non-infectious deaths included one death from a ruptured ectopic pregnancy, one from hemorrhage, 3 possible homicides, one suicide, and 4 deaths from drug toxicity/overdose. It is unknown whether the 8 women who died by homicide, suicide, or drug toxicity/overdose were screened for domestic violence, drug addiction, or depression prior to the abortion.

Infection (Table 1)

Infection was the leading cause of mortality. There were 502 cases of infection, which included 9 Deaths, 39 had Life-threatening sepsis, 249 were Severe infections, 132 Moderate infections, and 73 infections which were Uncodable.

Ectopic Pregnancy (Table 1)

There were 75 ectopic pregnancies. Of these, 26 were ruptured, including 1 death. Twenty-four were unruptured, and there were 25 for which the rupture status was not given. Fifty-six ectopic pregnancies were treated surgically and 11 were treated with methotrexate. The management was not documented in 7 cases. The patient who died received no treatment as she died on the way to the hospital.

Retained Products of Conception (RPOC) (Tables 1 and 2)

RPOC was the leading cause of morbidity. There were 977 confirmed cases of RPOC, including 2 molar pregnancies, and 1506 likely cases of RPOC (documentation was inadequate for confirmation). Of the 2146 total D&Cs, most were for RPOC, including 897 for confirmed RPOC, 1058 for bleeding or presumed RPOC, but no pathology was provided, and 2 for molar pregnancy. A small percentage of RPOC had medical treatment or no treatment.

Hemorrhage/Bleeding (Table 1)

There were 1639 bleeding events including one death. These included 466 Life-threatening and 642 Severe events. There were also 106 events coded as Moderate, while 424 reports of bleeding were Uncodable given the information in the database.

Ongoing Pregnancy (Table 1)

There were 452 ongoing pregnancies. Of these 102 chose to keep their baby, 148 chose termination, 1 miscarried, and 201 had an unknown outcome. Of those with an unknown outcome, there were 44 patients referred or scheduled for termination, who did not follow through (39 no-showed, 3 canceled, 2 did not schedule).

Surgeries (Table 2)

There were 2243 surgeries including 2146 D&Cs, 76 laparoscopies/laparotomies without hysterectomy, 7 hysterectomies, and 14 other surgeries. Of the hysterectomies, 3 were performed for sepsis, 2 for hemorrhage, 1 for a cervical ectopic, and 1 for placenta accreta. There were 1291 surgeries performed in the hospital or ER and 952 in an outpatient setting. Of the 2146 D&Cs, 1194 were performed in the hospital or ER, and 952 in an outpatient setting. Of the 2146 D&Cs, 1194 were provided by the Hospital or ER, 853 by the abortion provider, and 99 by another outpatient provider.

Transfusions (Table 2)

Four hundred and eighty-one patients required blood transfusion following medical abortions. Of these, 365 received 1 to 10 units packed red blood cells (PRBCs) alone, 1 received fresh frozen plasma (FFP) alone, 8 received a combination of PRBCs and FFP, and 107 received an unknown amount of blood product.

Relationship of Misoprostol Use to Hemorrhage (Table 3)

The use of mifepristone with misoprostol was associated with a higher incidence of hemorrhage than the use of mifepristone alone. Of the 3056 women who took both mifepristone and misoprostol, 1572 (51.44%) hemorrhaged, whereas, among the 58 women who did not take misoprostol, only 13 (22.41%) hemorrhaged. It was unclear whether 84 patients took misoprostol or not. Fifty-four (64.29%) of them hemorrhaged. The hemorrhage rate was higher for the mifepristone with misoprostol group as compared to the mifepristone alone group even if all the unknowns were assigned to the mifepristone alone group or vice versa.

Table 1 - Diagnoses[a]

Deaths	Deaths (n)	Deaths (%)	Deaths: % of (3197) Unique US AERs (%)	Organism (%)
Sepsis	9	45.00%	0.28%	
Sepsis confirmed	7	35.00%	0.22%	100%
Clostridium sordellii	*5*	*25.00%*	*0.16%*	*71.43%*
Clostridium perfringens / Peptostreptococcus	*1*	*5.00%*	*0.03%*	*14.29%*
Peptostreptococcus	*1*	*5.00%*	*0.03%*	*14.29%*
Sepsis Likely, Unknown Organism	2	10.00%	0.06%	
Visceral and Pulmonary Congestion consistent with ARDS / sepsis	1	5.00%	0.03%	
Fever / chills treated with cephalexin, found dead[b]	1	5.00%	0.03%	
Ruptured Ectopic Pregnancy	1	5.00%	0.03%	
Hemorrhage	1	5.00%	0.03%	
Possible Homicide	3	15.00%	0.09%	
Suicide	1	5.00%	0.03%	
Drug Toxicity/Overdose	4	20.00%	0.13%	
Unknown[c]	1	5.00%	0.03%	
Total Deaths	**20**	**100%**	**0.63%**	
Infections, Level of Severity	**Infections (n)**	**Infections (%)**	**Infections: % of (3197) Unique US AERs (%)**	
Death	9	1.79%	0.28%	
Life threatening infection/sepsis	39	7.77%	1.22%	
Severe infection (IV anitbiotics)	249	49.60%	7.79%	
Moderate infection (oral antibiotics)	132	26.29%	4.13%	
Uncodable[d]	73	14.54%	2.28%	
Total Infections	**502**	**100%**	**15.70%**	

Table 1 – Diagnoses (Continued)

Ectopic Pregnancies, Rupture Status	Ectopic Pregnancies (n)	Ectopic Pregnancies (%)	Ectopic Pregnancies: % of (3197) Unique US AERs (%)
Ruptured[e]	26	34.67%	0.81%
Unruptured[f]	24	32.00%	0.75%
Surgical Treatment	13	17.33%	0.41%
Methotrexate Treatment	11	14.67%	0.34%
Unknown Rupture Status[g]	25	33.33%	0.78%
Surgical Treatment	18	24.00%	0.56%
Unknown Treatment	7	9.33%	0.22%
Total Ectopic Pregnancies	**75**	**100%**	**2.35%**
Ectopic Pregnancies, Level of Severity	**Ectopic Pregnancies (n)**	**Ectopic Pregnancies (%)**	**Ectopic Pregnancies: % of (3197) Unique US AERs**
Death	1	1.33%	0.03%
Life Threatening (Ruptured, survived)	25	33.33%	0.78%
Severe (Not Ruptured)	24	32.00%	0.75%
Uncodable	25	33.33%	0.78%
Total Ectopic Pregnancies	**75**	**100%**	**2.35%**

Table 1 – Diagnoses (Continued)

Retained Products of Conception (RPOC)	RPOC (n)	RPOC (%)	RPOC: % of (3197) Unique US AERs (%)
RPOC confirmed	977	39.35%	30.56%
RPOC confirmed (by pathology or ultrasound); Had D&C	891	35.88%	27.87%
RPOC confirmed by U/S but D&C not documented	29	1.17%	0.91%
RPOC treated medically	27	1.09%	0.84%
Tissue at os (no D&C)[h]	27	1.09%	0.84%
Molar Pregnancy	2	0.08%	0.06%
No Treatment, RPOC on autopsy	1	0.04%	0.03%
RPOC Likely	1506	60.65%	47.11%
Had D&C, no pathology provided	1056	42.53%	33.03%
Unknown[i]	450	18.12%	14.08%
Total RPOCs	**2483**	**100%**	**77.67%**
Bleeding Events, Level of Severity	**Bleeding Events (n)**	**Bleeding Events (%)**	**Bleeding Events: % of (3197) Unique US AERs**
Death	1	0.06%	0.03%
Life threatening or Disabling: 2U or more transfusion or Hgb<7 or witnessed massive blood loss	466	28.43%	14.58%
Severe: surgical intervention and/or 1 U transfusion	642	39.17%	20.08%
Moderate: medical intervention	106	6.47%	3.32%
Uncodable[j]	424	25.87%	13.26%
Total Bleeding Events	**1639**	**100%**	**51.27%**

Table 1 – Diagnoses (Continued)

Ongoing Pregnancies, Outcome	Ongoing Pregnancies (n)	Ongoing Pregnancies	Ongoing Pregnancies: % of (3197) Unique US AERs (%)	Ongoing Pregnancies with Unknown Outcome (%)
Desired to Keep Pregnancy	102	22.57%	3.19%	
Kept Pregnancy	101	22.35%	3.16%	
Kept Pregnancy but baby died in-utero	1	0.22%	0.03%	
Terminated Pregnancy	148	32.74%	4.63%	
Surgical Termination[k]	139	30.75%	4.35%	
Medical Termination	9	1.99%	0.28%	
Unknown Intent, miscarried[l]	1	0.22%	0.03%	
Unknown Outcome	201	44.47%	6.29%	100%
Referred D&C but did not show	39	8.63%	1.22%	19.40%
Referred D&C but cancelled	3	0.66%	0.09%	1.49%
Told to schedule/referred D&C did not go	2	0.44%	0.06%	1.00%
Unknown outcome, no other information[m]	157	34.73%	4.91%	78.11%
Total	**452**	**100%**	**14.14%**	

[a] Because of rounding, percentages may not appear to add up exactly.
[b] FDA attributed to methadone overdose.
[c] 40 year old smoker died within hours of misoprostol ingestion. Per FDA, "natural causes due to severe pulmonary emphysema."
[d] Patients with documented infection but inadequate information to determine severity.
[e] One of the ruptured ectopics died on the way to the hospital. The other 25 were treated surgically.
[f] The unruptured ectopics include two cornual ectopics, one treated surgically and one treated medically.
[g] Includes two cervical ectopics, one treated with D&C/Hysterectomy/massive transfusion and one with unknown treatment.
[h] Either with path provided, or described as RPOC, placental fragments, fetus, or tissue.
[i] Suspected RPOC indicating D&C needed, but not documented as being done.
[j] Patients with documented bleeding but inadequate information to determine severity.
[k] Includes one hysterotomy for pregnancy in non-communicating horn.
[l] After no show for surgical termination.
[m] Includes 10 with known gestational age 20-29 weeks.

Table 2 – Treatment[a]

Type of Surgery	Type of surgery (n)	Type of surgery (%)	Surgery: % of (3197) Unique US AERs (%)
D&C[b]	**2146**	**95.68%**	**67.13%**
Hysterectomy	**7**	**0.31%**	**0.22%**
Sepsis (includes 2 deaths)	3	0.13%	0.09%
Hemorrhage after uterine perforation	2	0.09%	0.06%
Hemorrhage - Cervical Ectopic	1	0.04%	0.03%
Placenta accreta	1	0.04%	0.03%
Laparoscopy/Laparotomy without hysterectomy	**76**	**3.39%**	**2.38%**
Ectopic (Actual or Suspected)	66	2.94%	2.06%
Infection	7	0.31%	0.22%
Uterine Perforation	1	0.04%	0.03%
Salpingo oophorectomy for Torsion	1	0.04%	0.03%
Hysterotomy for pregnancy in non-communicating horn	1	0.04%	0.03%
Other Surgeries	**14**	**0.62%**	**0.44%**
Uterine Artery Embolization	1	0.04%	0.03%
Vaginal sutures (after 15 week surgical termination for ongoing pregnancy)	1	0.04%	0.03%
Paracenteses (multiple, same patient, death)	1	0.04%	0.03%
Necrotozing fasciitis debridement and below knee amputation	1	0.04%	0.03%
Upper and lower endoscopy for bright red bleeding	1	0.04%	0.03%
Unknown surgery for deep venous thrombosis	1	0.04%	0.03%
Angioplasty	1	0.04%	0.03%
Cholecystectomy	2	0.09%	0.06%
Appendectomy	1	0.04%	0.03%
Laceration repair (scalp, chin)	2	0.09%	0.06%
Unknown Surgery	2	0.09%	0.06%
Total	**2243**	**100%**	**70.16%**

Table 2 – Treatment (Continued)

Location of Surgery	Location of Surgery (n)	Location of Surgery (%)
All Surgeries	**2243**	**100.00%**
Hospital or ER	1291	57.56%
Outpatient	952	42.44%
D&C	**2146**	**100.00%**
Hospital or ER	1194	55.64%
Outpatient	952	44.36%
Surgical Provider for D&C	**Surgical Provider (n)**	**Surgical Provider (%)**
Hospital/ER	1194	55.64%
Abortion Provider	853	39.75%
Other Provider	99	4.61%
Total	**2146**	**100%**
Indication for D&Cs	**Indication for D&C (n)**	**Indication for D&C (%)**
Confirmed D&C[c]	**2146**	**100%**
RPOC (confirmed by pathology or ultrasound)	897	41.80%
RPOC/Bleeding (no pathology provided)	1058	49.30%
Ongoing pregnancy, surgical termination by D&C	139	6.48%
RPOC ruled out	34	1.58%
Ectopic evaluation	12	0.56%
Molar pregnancy	2	0.09%
Not able to take misoprostol	4	0.19%
Possible D&C	**680**	
Possible RPOC, unknown treatment, possible D&C	450	
RPOC confirmed by U/S but D&C not documented	29	
Ongoing pregnancy Unknown outcome, possible D&C	201	
TOTAL (Confirmed and Possible)	**2826**	

Table 2 – Treatment (Continued)

Transfusions	Transfusions (n)	Transfusions (%)	Transfusion: % of (3197) Unique US AERs (%)
PRBC alone	**365**	**75.88%**	**11.42%**
1U	32	6.65%	1.00%
1-2U	1	0.21%	0.03%
2U	246	51.14%	7.69%
2.5U	1	0.21%	0.03%
3U	45	9.36%	1.41%
4U	27	5.61%	0.84%
5U	5	1.04%	0.16%
6U	5	1.04%	0.16%
7U	2	0.42%	0.06%
10U	1	0.21%	0.03%
Other Blood products	**9**	**1.87%**	**0.28%**
1 U FFP	1	0.21%	0.03%
2 U PRBC/1 U FFP	1	0.21%	0.03%
2 U PRBC/ 4 U FFP	1	0.21%	0.03%
3 U PRBC/ 1 U FFP	1	0.21%	0.03%
4 U PRBC/ 1 U FFP	1	0.21%	0.03%
4 U PRBC/ 2 U FFP	1	0.21%	0.03%
5 U PRBC/ 4 U FFP	1	0.21%	0.03%
6 U PRBC/ 2 U FFP	1	0.21%	0.03%
7 U PRBC/ FFP and Platelets unknown amount	1	0.21%	0.03%
Unknown amount (documented as given, units not recorded)	**107**	**22.25%**	**3.35%**
Total[d]	**481**	**100%**	**15.05%**

[a] Because of rounding, percentages may not appear to add up exactly.
[b] With or without suction, one with hysteroscopy.
[c] There were 8 patients who had 2 D&Cs and one who required uterine artery embolization. There were 4 perforations: two had resultant hysterectomies, one had a laparoscopy, and one received 2 U PRBCs but no documented surgery.
[d] Additionally there were 7 patients who likely received transfusion, but was not recorded, 3 patients who refused transfusion, and 1 patient for whom transfusion was considered but not given.

Table 3 – Relationship of Misoprostol to Hemorrhage[a]

	Mifepristone + Misoprostol		Mifepristone alone		Unknown		Mifepristone + Misoprostol + unknown [b]		Mifepristone alone + unknown [c]	
	n	%	n	%	n	%	n	%	n	%
No Hemorrhage	**1484**	**48.56%**	**45**	**77.59%**	**30**	**35.71%**	**1514**	**48.23%**	**75**	**52.82%**
Hemorrhage	**1572**	**51.44%**	**13**	**22.41%**	**54**	**64.29%**	**1625**	**51.77%**	**67**	**47.18%**
Death	1	0.03%	0	0.00%	0	0.00%	1	0.03%	0	0.00%
Life threatening	441	14.43%	5	8.62%	20	23.81%	461	14.69%	25	17.61%
Severe	633	20.71%	3	5.17%	6	7.14%	639	20.36%	9	6.34%
Moderate	101	3.30%	1	1.72%	4	4.76%	105	3.35%	5	3.52%
Uncodable	396	12.96%	4	6.90%	24	28.57%	420	13.38%	28	19.72%
Total US AERs	**3056**	**100%**	**58**	**100%**	**84**	**100%**	**3139**	**100%**	**142**	**100%**

[a] Because of rounding, percentages may not appear to add up exactly.
[b] Assumes all unknowns took both mifepristone and misoprostol.
[c] Assumes all unknowns took mifepristone, but not misoprostol.

Discussion

This article is critically important considering the paucity of published literature on mifepristone safety and the minimal analysis done on the AERs by the FDA.

Ectopic Pregnancies

Although reported as AEs, ectopic pregnancies are not a direct adverse event from the medication, but rather a contraindication to its administration. They were reported as adverse events because the ectopic pregnancies were missed.

The American College of Obstetricians and Gynecologists (ACOG) notes that "According to the Centers for Disease Control and Prevention, ectopic pregnancy accounts for approximately 2% of all reported pregnancies. However, the true current incidence of ectopic pregnancy is difficult to estimate because many patients are treated in an outpatient setting where events are not tracked, and national surveillance data on ectopic pregnancy have not been updated since 1992. Despite improvements in diagnosis and management, ruptured ectopic pregnancy continues to be a significant cause of pregnancy-related mortality and morbidity. In 2011–2013, ruptured ectopic pregnancy accounted for 2.7% of all pregnancy-related deaths and was the leading cause of hemorrhage-related mortality."[36]

[36] ACOG Practice Bulletin No. 193: Tubal Ectopic Pregnancy, Obstet Gynecol: March 2018; 131(3): e91-e103. doi:10.1097/AOG.0000000000002560

Confirmed/suspected ectopic pregnancy and undiagnosed adnexal mass are contraindications to mifepristone use under current prescribing requirements. The label warnings state: "Ectopic pregnancy: exclude before treatment." [37] Unfortunately, it is difficult to rule out ectopic pregnancy by history alone because, "half of all women who receive a diagnosis of an ectopic pregnancy do not have any known risk factors."[38] According to ACOG Practice Bulletin No. 193, "The minimum diagnostic evaluation of a suspected ectopic pregnancy is a transvaginal ultrasound evaluation and confirmation of pregnancy." Of the 75 reported ectopic pregnancies in the FDA AERs we analyzed, over a third were known to be ruptured including one death. Clearly, an ultrasound should be required prior to the administration of mifepristone to document that the pregnancy is located within the uterus. Although not 100% effective, this will screen for ectopic pregnancy, confirm gestational age, which can be inaccurate based on menstrual history alone,[39] and screen for adnexal masses, another contraindication to mifepristone use.[40]

Ongoing pregnancies

Of the women with an ongoing pregnancy, less than a third were known to have proceeded with termination of the pregnancy, and almost a quarter were known to have kept their pregnancy; in almost half, the outcome was unknown. The significant percentage of women with ongoing pregnancy who changed their mind and chose to keep their pregnancy, after initially choosing termination, raises concerns regarding the pre-abortion counseling and informed consent they received. Women undergoing abortion should receive the same quality of informed consent and pre-procedural counseling that is standard of care prior to other medical treatment or surgery. It is imperative that women considering abortion be provided adequate and complete information and counseling on risks, advantages, disadvantages, and alternative options.

Additionally, the high percentage of women with ongoing pregnancies for whom there is no follow up or known outcome is concerning. As health care providers we are to continue to care for our patients and manage any complications, yet in the AERs we reviewed this was not typically the case for the abortion provider. Furthermore, a federal registry of known outcomes and birth defects is imperative. One of the initial FDA post-marketing requirements for

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[37] MIFEPREX. Package insert. Danco; 2016. Approved March 2016. p. 1. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf

[38] ACOG Practice Bulletin No. 193: Tubal Ectopic Pregnancy, Obstet Gynecol: March 2018; 131(3): e91-e103. doi: 10.1097/AOG.0000000000002560

[39] Shipp, Thomas D. 2020. Overview of ultrasound examination in obstetrics and gynecology. Lit Rev current through Dec 2020. UpToDate. Edited by Barss A Vanessa. Wolters Kluwer. June 10, 2020. Accessed January 11, 2021. https://www.uptodate.com/contents/ectopic-pregnancy-clinical-manifestations-and-diagnosis/print?source=history_widget.

[40] MIFEPREX. Package insert. Danco; 2016. Approved March 2016. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf

Danco was a surveillance study of outcomes of ongoing pregnancies.[41] The FDA released them from this post-marketing commitment in January 2008 because Danco reported that only one or two ongoing pregnancies per year were followed for final outcomes in part because of consent requirements.[42] This is disturbing in light of the percentage of women in our analysis who kept their pregnancies, as well as those with ongoing pregnancy and unknown outcomes, all of whom could have been followed for final outcomes. The significant lack of follow-up of ongoing pregnancies (44.47% with unknown outcomes) and the very minimal information on those who chose to keep the pregnancy, highlights the need for a national registry especially considering the teratogenicity of misoprostol.[43]

Relationship of Misoprostol to Hemorrhage

The Creinin study of abortion pill reversal was stopped for safety concerns due to hemorrhage in 3 of the 12 study participants.[44] One of the conclusions of that study was that "Patients who use mifepristone for a medical abortion should be advised that not using misoprostol could result in severe hemorrhage, even with progesterone treatment."[45] The authors hypothesized that the absence of misoprostol caused these women to hemorrhage. The women who had documented use of misoprostol in our database hemorrhaged at a higher rate than those documented not to have taken misoprostol.

Reporting of Adverse Events

Although not the initial goal of this study, the analysis of the AERs revealed glaring deficiencies in the AE reporting system making it difficult to properly evaluate adverse events. When mifepristone was approved in 2000, FDA required that providers "must report any hospitalization, transfusion or other serious event to Danco Laboratories."[46] This created an inherent conflict of interest as it is not in the best interest of the entities or providers to report adverse events to those regulating them. Because only severe events were reportable, this requirement likely resulted in an underestimation of moderate and mild AEs. It

[41] Center for Drug Evaluation and Research. NDA 20-687. Approval Letter for MIFEPREX (mifepristone) Tablets, 200 mg to Population Council. Food and Drug Administration. Written September 28, 2000. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2000/20687appltr.htm

[42] 2016 03 20 FDA resp to Cit Pet.pdf. Docket No. FDA-2002-P-0364. FDA. March 29, 2016. p. 31. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/2016%2003%2020%20%20FDA%20resp%20to%20Cit%20Pet.pdf

[43] Cytotec (misoprostol tablets). Package insert. G.D. Searle; Revised November 2012. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/019268s047lbl.pdf

[44] Creinin MD, Hou MY, Dalton L, Steward R, Chen MJ. Mifepristone Antagonization With Progesterone to Prevent Medical Abortion: A Randomized Controlled Trial. Obstet Gynecol. 2020;135(1):158-165. doi:10.1097/AOG.0000000000003620

[45] Creinin MD, Hou MY, Dalton L, Steward R, Chen MJ. Mifepristone Antagonization With Progesterone to Prevent Medical Abortion: A Randomized Controlled Trial. Obstet Gynecol. 2020;135(1):5. doi:10.1097/AOG.0000000000003620

[46] M I F E P R E X™(Mifepristone) Tablets, 200 mg Prescriber's agreement. Food and Drug Administration. September 28, 2000, 1-2. Accessed November 16, 2020. http://wayback.archive-it.org/7993/20170113112742/http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111364.pdf

is also likely that some of the AEs that we coded as Mild or Moderate were actually Severe but there was not enough information in the AER for us to justify coding them as Severe. In March 2016, the FDA substantially reduced the prescribing requirements and changed the drug protocol [47] and yet at the same time eliminated reporting requirements except for deaths.[48] With the relaxation of reporting requirements, the ability to perform any relevant post-marketing evaluation of mifepristone was lost. It is imperative for the safety of women that the FDA restore and strengthen the 2011 REMS requirements.

The information in the AERs is almost exclusively obtained from abortion providers, rather than the physician treating the complication, yet in this analysis, abortion providers managed only 39.75% of surgical complications (a number which is likely much lower since these are only the cases which are known to the abortion provider). Throughout the reports, there was also a lack of detail and many patients who were simply "lost to follow-up." This resulted in 16.80% of the AERs being Uncodable as to severity and likely under-coding of many AERs and AEs, as coding could only be assigned based on the scant information provided. Many of the AEs experienced by women were unknown to the abortion provider until the follow-up examination, which is troubling considering the poor follow-up rate and elimination of the requirement for an in-office follow up visit. Some of the patient deaths were not known to the abortion provider until they saw the death in an obituary or were contacted by an outside source. Because of this, in addition to abortion providers, hospitals, emergency departments, and private practitioners should be required to report AEs.

Complications occur in the best of hands in all areas of medicine, but as physicians, we are responsible to manage those complications and follow our patients through to resolution. The findings that: 1. the most common outcome of ongoing pregnancy was unknown outcome, 2. abortion providers performed less than half the D&Cs done for complications, and 3. a third of ectopic pregnancies (missed prior to administering the abortifacient) had unknown rupture status, leave us deeply concerned regarding the care these women received. A post-marketing requirement was that there be a "cohort-based study of safety outcomes of patients having medical abortion under the care of physicians with surgical intervention skills compared to physicians who refer their patients for surgical intervention."[49] The applicant was released from this requirement because they stated that because there were so few providers

[47] GAO-18-292 Revised Mifeprex Labeling: Food and Drug Administration Information on Mifeprex Labeling Changes and Ongoing Monitoring Efforts. Report to Congressional Requesters. Food and Drug Administration. 2018. p. 7. Published March 2018. Accessed November 13, 2020. https://www.gao.gov/assets/700/690914.pdf

[48] NDA 20-687 MIFEPREX (mifepristone) Tablets, 200 mg: Risk Evaluation and Mitigation Strategy (REMS). Food and Drug Administration. 2016. p. 3, 6. Reference ID: 3909592. Published March 29, 2016. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020RemsR.pdf

[49] Center for Drug Evaluation and Research. NDA 20-687. Approval Letter for MIFEPREX (mifepristone) Tablets, 200 mg to Population Council. Food and Drug Administration. Written September 28, 2000. Accessed November 13, 2020. https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2000/20687appltr.htm

without surgical intervention skills, no meaningful study could be done.[50] Yet, that same year the FDA changed the provider agreement to allow non-physicians to become prescribers.[51] These findings highlight the importance of follow-up and management of complications by the abortion provider. Allowing any further relaxation of mifepristone prescribing requirements will put women at an even higher risk of adverse events

Limitations and Strengths

It was not possible to calculate complication rates for mifepristone and misoprostol abortions based on AER data because there is no denominator for how many mifepristone abortions are performed in the U.S. since reporting is often voluntary and sporadic. For clarity, we specified the denominators we used.

Our analysis was limited by the fact that the number of AEs for which we received reports is likely a gross underestimation of the actual number of AEs that occurred. In our analysis, the surgical management of over half the complications was performed by someone other than the abortion provider, yet treating physicians are not required to report complications. Few reports were generated by those in Emergency Departments and hospitals who treated the complications.

Our analysis was also limited by the lack of information in the AERs, including redaction of critical dates, a paucity of diagnosis and treatment information, and lack of follow up.

Our study has several strengths. Our data comes from information provided to the FDA and is the largest analysis of AERs for mifepristone abortions. This data is publicly available under the Freedom of Information Act so that anyone can verify the data for themselves. This analysis reviews all AERs not reported in the first study by Gary.[52] Although heavily redacted, there was sufficient information in over 80% of the AERs to evaluate severity. An objective standardized system, CTCAEv3, was used to code for severity, and each AER was coded by at least two board-certified obstetrician-gynecologists or family medicine physicians.

Conclusions and Relevance

This article is important because it augments the scant published literature on mifepristone safety.

Due to the lack of adequate reporting of adverse events, especially by those treating them, these unique AERs represent a fraction of the actual adverse events occurring in American women.

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[50] 2016 03 20 FDA resp to Cit Pet.pdf. Docket No. FDA-2002-P-0364. FDA. March 29, 2016. p. 31. Accessed November 13, 2020. https://aaplog.wildapricot.org/resources/2016%2003%2020%20%20FDA%20resp%20to%20Cit%20Pet.pdf

[51] GAO-18-292 Revised Mifeprex Labeling: Food and Drug Administration Information on Mifeprex Labeling Changes and Ongoing Monitoring Efforts. Report to Congressional Requesters. Food and Drug Administration. 2018. p. 7. Published March 2018. Accessed November 13, 2020. https://www.gao.gov/assets/700/690914.pdf

[52] Gary M, Harrison D. Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient. Ann Pharmacother. 2006 Feb 40(2):191-7. https://doi.org/10.1345/aph.1G481

Significant morbidity and mortality have occurred with the use of mifepristone as an abortifacient, including at least 24 US deaths reported by the FDA from September 2000 to December 2018. Because of this and the significant morbidity associated with this drug, the FDA should consider at a minimum reinstating the original 2011 REMS and strengthening the reporting requirements. The reporting of transfusions, hospitalizations, and other serious adverse events are essential.

Given the morbidity and mortality of undiagnosed ectopic pregnancy, a clear contraindication to the use of mifepristone, an ultrasound to confirm pregnancy location is essential before mifepristone is dispensed.

Considering the significant percentage of women with ongoing pregnancies who chose to continue their pregnancy, there must be reasonable waiting periods, parental involvement, and adequate pre-abortion counseling on all pregnancy options. It is also critical that a pregnancy registry be established.

In our analysis, the patients who used mifepristone alone had a lower rate of hemorrhage than those using mifepristone followed by misoprostol.

The FDA Adverse Event Reporting System is woefully inadequate to determine the post-marketing safety of mifepristone due to its inability to adequately assess the frequency or severity of adverse events. The reliance solely on interested parties to report, the large percentage of uncodable events, the redaction of critical clinical information unrelated to personally identifiable information, and the inadequacy of the reports highlight the need to overhaul the current AER System.

This analysis evaluated 3197 adverse events resulting from the use of mifepristone as an abortifacient and brought to light serious concerns about the safety requirements and care of women undergoing mifepristone abortion. Although complications may occur in the best of hands, and no medical procedure is without risks, safety measures must be employed to minimize these adverse outcomes. Women undergoing abortion should receive the same quality of informed consent and pre-procedural counseling that is standard of care prior to other medical treatment or surgery. It is imperative that women considering abortion be provided adequate and complete information and counseling on risks, advantages, disadvantages, and alternative options. Although there may be disagreements about the ethics of abortion, there must be total agreement that our patients—whether undergoing a medical abortion or otherwise—deserve the highest standard of medical care.

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EXHIBIT 54

Specifications for Preparing and Submitting Electronic ICSRs and ICSR Attachments

(Apr. 2021)

Specifications for Preparing and Submitting Electronic ICSRs and ICSR Attachments

Technical Specifications Document

Associated Guidance Documents and Conformance Guide:

Draft Guidance for Industry: Providing Submissions in Electronic Format – Postmarketing Safety Reports (June 2014)

Guidance for Industry and FDA Staff: Postmarketing Safety Reporting for Combination Products (July 2019)

Draft Guidance for Industry: Providing Regulatory Submissions in Electronic Format: IND Safety Reports (October 2019)

Electronic Submissions of IND Safety Reports Technical Conformance Guide (October 2019)

For questions regarding this technical specifications document, contact the Office of Surveillance and Epidemiology, Center for Drug Evaluation and Research, Food and Drug Administration, at FAERSESUB@fda.hhs.gov; or Office of Communication, Outreach and Development, Center for Biologics Evaluation and Research, Food and Drug Administration, at CBERICSRSubmissions@fda.hhs.gov.

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)
Center for Biologics Evaluation and Research (CBER)

April 2021

Specifications for Preparing and Submitting Electronic ICSRs and ICSR Attachments

Revision History Table

Date	Version	Summary of Changes
2008-06-11	1.0	Initial Version
2008-08-06	1.1	Added Filename format information
2008-10-10	1.2	Updated UTF-8 to ISO-8859-1 encoding; indicated simultaneous acceptance of ICSR and ICSR attachments; provided another acceptable file extension for SGML files; and clarified use of abbreviations (NDA, ANDA, and STN)
2008-10-22	1.3	Provided clarification in Section II; updated footnote 3; and added new paragraph to Section V.C.
2013-07-05	1.4	Updated AERS to FAERS migration changes, removed references to SGML file formatting, incorporated updates from CBER
2018-02-06	1.5	Added a new section to highlight data fields for reporting ICSRs on Combination Products
2019-09-30	1.6	Added two new sections to provide regional data elements for electronic submissions of certain IND safety reports (section I) and IND-exempt Bioavailability (BA)/Bioequivalence (BE) studies (section J). Added an appendix (II) highlighting various case scenarios for electronic submissions of IND safety reports to FAERS.

2020-02-11	1.7	Added a new value to the data element B.4.k.1 for drug characterization to accommodate a similar device. Updated the data element B.4.k.18.2 to specify values. Updated the data element B.4.k.18.3 to use default value.
2020-12-18	1.8	Added a new regional data element A.1.FDA.16 (FDA Safety Report Type) in Table 2 Detailed Description of Administrative Tags Added section Submission Rules Added a new value to the data element B.4.k.1 and B.4.k.19 in section J. IND-exempt BA/BE Studies
2021-03-26	1.9	Updated section XML Header to include DTD 3.0 for premarketing reporting Updated the reference description to data element A.1.FDA.16 in Table 2 Detailed Description of Administrative Tags Updated section ICSR Message Header Information to include information in premarketing reporting Updated section AS2 Headers and Routing IDs for Premarketing Safety Report Submissions Updated section Submission Rules

Specifications for Preparing and Submitting Electronic ICSRs and ICSR Attachments

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Specifications for Preparing and Submitting Electronic ICSRs and ICSR Attachments

This document provides current specifications for submitting individual case safety reports (ICSRs) and ICSR attachments in electronic form. The specifications apply to electronic submission of ICSRs for drug and biological products studied under an investigational new drug application (IND) (including bioequivalence studies conducted under IND), ICSRs from IND-exempt bioavailability (BA)/bioequivalence (BE) studies, and ICSRs for marketed drug and biological products and combination products to the FDA Adverse Event Reporting System (FAERS). The specifications do not apply to the following marketed biological products: prophylactic vaccines, whole blood or components of whole blood, human cells, tissues, and cellular and tissue-based products (HCT/Ps) regulated by FDA.

This document discusses the technical specifications for electronic submission of ICSRs and ICSR attachments through the FDA Electronic Submissions Gateway (ESG).[1] ICSRs (and any ICSR attachments) are to be prepared in accordance with the International Council for Harmonisation (ICH) E2B(R2) data elements in extensible markup language (XML) file format for compatibility with the FAERS database. ICSRs for marketed products should not be submitted to the electronic Common Technical Document (eCTD).[2]

If you have not previously submitted an ICSR in electronic format to FAERS, you should contact the FAERS electronic submission coordinator at faersesub@fda.hhs.gov and they will assist you with submission of a test file.

I. ELECTRONIC SUBMISSIONS OF ICSRS AND ICSR ATTACHMENTS

Each initial ICSR or follow-up ICSR may consist of structured information and non-structured information, such as ICSR attachments.

For the FDA to process, review, and archive the ICSRs, prepare your ICSRs for electronic submission by following these steps:

- Provide a unique filename for the submission; see section II of this document.
- Add a file header and file extension; see section IV of this document.
- Populate the elements of the ICSR file; see section V of this document.

[1] For information on providing submissions using the ESG, refer to https://www.fda.gov/ForIndustry/ElectronicSubmissionsGateway/default.htm.

[2] See FAERS Electronic Submissions at https://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Surveillance/AdverseDrugEffects/ucm115894.htm.

- If applicable, add ICSR attachments to ICSRs; see section VI of this document.

II. SUBMISSION FILE NAME

Each electronic submission of ICSRs or attachments to ICSRs must have a unique filename (e.g., your named file + date and time stamp down to the second: filenameYYYYMMDDHHMMSS). You may choose your own format to maintain uniqueness.

III. ICSR ACKNOWLEDGEMENTS

A. ESG Acknowledgement

After submitting an ICSR or ICSR attachment, you should receive an ESG message delivery notice (MDN) notifying the sender of the receipt of their submission, but not acknowledging the acceptance of the submission. If the MDN is not received within 2 hours, go to the ESG System Status web page. If the ESG web page is non-operational, go to the ESG Home Page for further information.

B. FAERS Acknowledgment

The MDN is then followed by a FAERS acknowledgment within 2 hours of the ESG acknowledgement. The FAERS acknowledgement notifies the sender whether their submission has been processed. If you do not receive the FAERS acknowledgement, resubmit the ICSRs without changing the filename.

If you receive a report acknowledgement code 02, indicating that your submission did not process due to file error/s that are specified in the acknowledgment, then proceed as follows:

- For submission with a single ICSR, resubmit the corrected ICSR with a new unique filename.

- For a submission consisting of multiple ICSRs, if one or more ICSRs in the submission failed to process, separate those ICSRs from the processed ICSRs, correct them and resubmit only the corrected ICSRs as a new submission with a unique filename. For example, if there were 50 ICSRs in an original submission and 15 of them failed to process, then only those 15 ICSRs must be separated, corrected appropriately, and resubmitted with a new unique filename. The resubmission should not contain any of the previously processed ICSRs.

IV. ELECTRONIC TRANSPORT FORMAT: XML FILES

FDA accepts the data elements defined in the "Guidance for Industry E2BM Data Elements for

Transmission of Individual Case Safety Reports (April 2002)."[3] The ICH E2B(R2) guidance provides additional information and clarification of the previously issued guidances.[4]

The electronic transport format also known as the Document Type Definition (DTD) for XML files is described in the associated document "XML Formatted DTD" (DTD Version 2.1, DTD Version 2.2 and DTD Version 3.0) (see links to the documents below in section C).

A. AS2 Headers and Routing IDs for Postmarketing Safety Report Submissions

For postmarketing safety report submissions, the sponsors should include the unique AS2 headers or routing IDs for safety reports and attachments in one of the two ways listed below.

- AS2 Headers
  - Destination: "CDER"
  - XML files: AERS
  - PDF's: AERS_ATTACHMENTS

or

- Routing IDs
  - XML files: FDA_AERS
  - PDF's: FDA_AERS_ATTACHMENTS

B. AS2 Headers and Routing IDs for Premarketing[5] Safety Report Submissions

For premarketing safety report submissions, the sponsors should include the unique AS2 headers or routing IDs for premarketing safety reports and attachments, as listed below, to differentiate these reports between CDER and CBER, and from postmarketing ICSRs.

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[3] For information on Guidance for Industry on E2BM Data Elements for Transmission of Individual Case Safety Reports, please refer to the following:

https://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM073092.pdf.

[4] See the guidance for industry entitled *E2B Data Elements for Transmission of Individual Case Safety Reports* (January 1998) (E2B). FDA currently supports use of E2B data elements in addition to the E2BM data elements. However, it is preferred that ICSRs be submitted with E2BM data elements to allow for the most efficient processing of the submissions. For those who wish to use E2B data elements and the corresponding electronic transport format (ICH M2 Electronic Transmission of Individual Case Safety Reports Message Specification Final Version 2.3 Document Revision February 1, 2001 (ICH ICSR DTD Version 2.1)), please refer to documentation provided at https://www.fda.gov/downloads/drugs/ucm149932.pdf

[5] The term premarketing safety report refers to IND safety reports and IND-exempt BA/BE studies safety reports.

1. Submitting premarketing safety reports for CDER IND and IND-Exempt BA/BE

- AS2 Headers
  - Destination: "CDER"
  - XML files: AERS_PREMKT_CDER
  - PDF's: AERS_ATTACHMENTS_PREMKT_CDER

or

- Routing IDs
  - XML files: FDA_AERS_PREMKT_CDER
  - PDF's: FDA_AERS_ATTACHMENTS_PREMKT_CDER

2. Submitting premarketing safety reports for CBER IND

- AS2 Headers
  - Destination: "CBER"
  - XML files: AERS_PREMKT_CBER
  - PDF's: AERS_ATTACHMENTS_PREMKT_CBER

or

- Routing IDs
  - XML files: FDA_AERS_PREMKT_CBER
  - PDF's: FDA_AERS_ATTACHMENTS_PREMKT_CBER

C. XML Header

The addition of an XML header enables FDA to process ICSRs in an XML format successfully. FDA supports only the ISO-8859-1 character set for encoding the submissions.

1. For submissions of postmarketing safety reports for drug and biological products, add the following XML header to the ICSR file:

<?xml version="1.0" encoding="ISO-8859-1"?>

<!DOCTYPE ichicsr SYSTEM "https://www.accessdata.fda.gov/xml/icsr-xml-v2.1.dtd">

2. For submissions of postmarketing safety reports for combination products, add the following XML header to the ICSR file:

<?xml version="1.0" encoding="ISO-8859-1"?>

<!DOCTYPE ichicsr SYSTEM "https://www.accessdata.fda.gov/xml/icsr-xml-

v2.2.dtd">

3. For submissions of premarketing safety reports, add the following XML header to the ICSR file:

<?xml version="1.0" encoding="ISO-8859-1"?>

<!DOCTYPE ichicsr SYSTEM "https://www.accessdata.fda.gov/xml/icsr-xml-v3.0.dtd">

D. ICSR Message Header Information

1. For submissions of postmarketing drug and biological product safety reports, use the value "2.1" for the DTD Descriptor <messageformatversion>:

<messageformatversion>2.1</messageformatversion>

2. For submissions of postmarketing combination product safety reports, use the value "2.2" for the DTD Descriptor <messageformatversion>:

<messageformatversion>2.2</messageformatversion>

3. For submissions of premarketing safety reports, use the value "3.0" for the DTD Descriptor <messageformatversion>:

<messageformatversion>3.0</messageformatversion>

E. ICSR File Extension

Use "xml" as the file extension for ICSRs in XML format. The name of the file should be 200 characters or less, excluding the three-digit extension. FDA does not support file names with multiple periods "." or the use of any special or foreign characters except underscore "_" and dash "-".

V. DATA ELEMENTS FOR ELECTRONIC SUBMISSIONS

A. Minimum Data Elements Requirements

For a submission to be successfully processed, submit an ICSR with the minimum data elements for reporting that are appropriate for the product type. If a sponsor submits an ICSR without the minimum data elements, they will receive a FAERS acknowledgement code 02 stating that the submission was not processed (see section III.B above). The minimum data elements for reporting are provided in Table 1 and the bullets that follow list the data elements to include in an ICSR by product type.

Table 1. Minimum Data Elements

Element	Data
B.1	Identifiable Patient
A.2	Identifiable Reporter
B.2	Reaction or Event
B.4	Suspect Drug Product

- Adverse event reports submitted for unapproved prescription drug products, unapproved nonprescription drug products and products approved for marketing under an abbreviated new drug application (ANDA), biologics license application (BLA), or new drug application (NDA), including combination products should have, at a minimum, the four data elements listed in Table 1.

- Adverse event reports for compounded drugs submitted by registered outsourcing facilities should have at a minimum, a suspect product and an adverse event.

- IND safety reports should include, at a minimum, the four data elements listed in Table 1 and the IND number under which the clinical trial where the event occurred is conducted.

- Serious adverse event reports from IND-exempt BA/BE studies should include, at a minimum, the four data elements listed in Table 1 and the pre-assigned ANDA number (hereafter referred as, Pre-ANDA number).

B. Administrative and Identification Elements

For FDA to successfully process your electronic ICSR submissions, populate the administrative and identification elements as indicated in Table 2.

Table 2. Detailed Description of Administrative Tags*

Element	DTD Descriptor 2.1	Length	Element Values for DTD 2.1
A.1.9	<fulfillexpeditecriteria>	1N	1= Yes (15-Day expedited) 2= No (non-expedited) 4= 5-Day 5= 30-Day 6= 7-Day expedited
A.1.0.1	<safetyreportid>	100AN	Sender's (Case) Safety Report Unique Identifier†
A.1.10.1	<authoritynumb>	100AN	Regulatory authority's case report number
A.1.10.2	<companynumb>	100AN	Other sender's case report number
A.3.1.2	<senderorganization>	60AN	Sender identifier
A.2.3.2^	<sponsorstudynumb>	35AN	IND or Pre-ANDA number under which the clinical trial where the event occurred is conducted
A.1.FDA.16††	<fdasafetyreporttype>	1N	1=IND Safety Report 2=IND-Exempt BA/BE Safety Report 3=Postmarketing Safety Report

* Include either <companynumb> or <authoritynumb> values. FDA cannot process the ICSR without one of these element values.
† The Sender's Safety Report Unique Identifier is comparable to the Manufacturer Report Number (also referred to as the Manufacturer Control Number (MCN)) provided on paper in FDA Form 3500A. This number is the company's unique case identification number, which is used for the life of the case.
^ For IND and IND-exempt BA/BE study safety reports only. An IND-exempt BA/BE study refers to a BA/BE study not conducted under IND.
†† The FDA Safety Report Type data element distinguishes premarketing (IND and IND-Exempt BA/BE) safety reports from postmarketing safety reports and is used to determine which reports are posted publicly. The FDA Safety Report Type data element is optional when using DTD 2.1 and 2.2 for postmarketing safety report submission but is mandatory when using DTD 3.0 for premarketing safety report submission.

C. Authorization/ Application Number Format

In the section designated for drug and biological products information, use the following format for the "Authorization/ Application Number" element (B.4.k.4.1) <drugauthorizationnumb> as indicated in Table 3 and described below.

- For approved drug and biological products marketed under an approved application, include the acronym "NDA" or "ANDA," followed by a space and then the number for the application (e.g., NDA 012345, ANDA 012345). For prescription drug products marketed without an approved application (Rx No Application), use "000000." For a nonprescription drug product marketed without an approved application (Non-Rx No

Application), use "999999." For adverse event reports for compounded drug products submitted by registered outsourcing facilities, use "COMP99."

- For marketed biological products, include the appropriate acronym "BLA," "STN," or "PLA" followed by a space and the primary six-digit number (e.g., STN 123456).

Table 3. Detailed Description of Application Number Formats

Type of Application	Recommended Format
NDA/ ANDA	NDA, ANDA 012345
STN/ BLA/ PLA	STN or BLA or PLA 123456
Rx No Application	000000
Non-Rx No Application	999999
Compounded Products	COMP99

D. Unique Case Identification Numbers for Initial and Follow-Up ICSRs

For the follow-up ICSR safety reports to be correctly linked to your initial ICSR report, follow these steps:

- Use the same <safetyreportid> for the E2BM elements in section A.1.0.1 for the initial ICSR and any of its follow-up ICSRs; this allows the follow-up report to be linked to the initial report in the FAERS database.

- If the initial ICSR was submitted on paper but its follow-up ICSR is submitted electronically, include the Manufacturer Control Number (MCN) listed in Box G9 of the FDA paper Form 3500A from the initial report in both A.1.0.1 <safetyreportid> and in A.1.10.2 <companynumb> field in the follow-up electronic submission.

- Always use the <safetyreportid> that was assigned to the initial ICSR when submitting follow-up reports. If you need to change the <safetyreportid> internally, note the internally reassigned <safetyreportid> in the narrative section of the follow-up report (i.e., element B.5.1) (e.g., "This ICSR has been reassigned to the Company ID number COA12345"). Do not use the internally reassigned <safetyreportid> for any follow-up reports.

- In the event that an incorrect <safetyreportid> has been used in a follow-up report, contact the FAERS electronic submission coordinator at faersesub@fda.hhs.gov so that the follow-up ICSR can be matched to the initial ICSR.

E. MedDRA Specific Elements

Use the ICH Medical Dictionary for Regulatory Activities (MedDRA) to code medical

terminology.[6] When possible, use the Lowest Level Term (LLT), and record the LLT as the MedDRA numeric code rather than the LLT name (e.g., the LLT name is Rash; the MedDRA numeric code for LLT Rash is 10378444).

1. Reaction/Event

a) Reaction/Event as reported by the primary source field

Record the original reporter's words verbatim and/or use short phrases to describe the reaction/event in element (B.2.i.0).

b) Reaction/Event MedDRA Term LLT numeric code or text field

Record the MedDRA LLT that most closely corresponds to the term reported by the original reporter in element (B.2.i.1).

c) Reaction/Event MedDRA Preferred Term (PT) numeric code or text field

Record the MedDRA PT that most closely corresponds to the term reported by the original reporter in element (B.2.i.2).

2. Other E2B Elements

For the E2B elements listed in Table 4, use either MedDRA text or, preferably, the corresponding numeric code.

Table 4. Additional E2B Elements for Preferred MedDRA Coding

Element	DTD Descriptor 2.1	Length
B.1.7.1a.2	<patientepisodename>	250 AN
B.1.8f.2	<patientdrugindication>	250 AN
B.1.8g.2	<patientdrugreaction>	250 AN
B.1.9.2b	<patientdeathreport>	250 AN
B.1.9.4b	<patientdetermineautopsy>	250 AN
B.1.10.7.1a.2	<parentmedicalepisodename>	250 AN
B.1.10.8f.2	<parentdrugindication>	250 AN
B.1.10.8g.2	<parentdrugreaction>	250 AN
B.3.1c	<testname>	100 AN
B.4.k.11b	<drugindication>	250 AN
B.4.k.17.2b	<drugrecuraction>	250 AN
B.4.k.18.1b	<drugreactionasses>	250 AN
B.5.3b	<senderdiagnosis>	250 AN

[6] Companies can license MedDRA from an international maintenance and support services organization (MSSO) (toll free number 877-258-8280; Direct 571-313-2574; fax 571-313-2345; e-mail MSSOhelp@mssotools.com).

F. Drug Description and Case Narrative Elements

To ensure the successful processing of your electronic ICSR submission, applicants are advised to populate the drug description and narrative elements as indicated in Table 5.

Table 5. Detailed Description of Drug(s) and Narrative Elements*†

Element	DTD Descriptor 2.1	Length	Element Values for DTD 2.1
B.4.k.1	<drugcharacterization>	1N	1=Suspect 2=Concomitant 3=Interacting 4=Drug not administered
B.4.k.2.1	<medicinalproduct>	70AN	Proprietary Medicinal Product Name
B.4.k.2.2	<activesubstancename>	100AN	Drug Substance Name
B.5.1	<narrativeincludeclinical>	20000AN	Case Narrative

*Include <medicinalproduct> and/or <activesubstancename>. FDA cannot process the ICSR without at least one of these elements.
†Appendix I lists various examples of correct drug element formats.

1. Recording Multiple Drugs

If you are submitting safety reports for products containing multiple drugs, you should follow these steps:

- List the proprietary drug product name in element (B.4.k.2.1) and/or list the drug substance name in element (B.4.k.2.2).
- List the characterization of each reported drug's role, such as suspect, concomitant, interacting, drug not administered, or similar device in element (B.4.k.1).

2. Medicinal Product Name and Active Drug Substance Name

FDA validates medicinal product names to the available Structured Product Labeling (SPL)[7], the submitted label (as ICSR attachment), and the Substance Registration System (SRS). These are further described below:

- When the product has an SPL, use the same naming convention as it appears in the SPL when submitting the ICSR.

[7] The SPL is a document markup standard approved by Health Level Seven (HL7) and adopted by FDA as a mechanism for exchanging product and facility information. See https://www.fda.gov/ForIndustry/DataStandards/StructuredProductLabeling/default.htm.

- When submitting a product label as an attachment to an ICSR, use the name as it appears on the submitted product label.

- If no medicinal product is named and only the active substance is named, use the name of the active substance as it appears in the SRS.[8]

3. Case Narrative

a) Initial ICSR

Record all case narrative information including clinical course, therapeutic measures, outcome, and all additional relevant information in element (B.5.1). If the information exceeds the field length, consider describing the information using fewer words. Although the use of only the most widely used medical abbreviations is permissible if necessary, their use should be limited when possible.

b) Follow-up ICSR

Record both new information and corrections to previously submitted ICSRs in element (B.5.1).

G. Other Data Elements

1. Dosage Information Field

If dosage information cannot be captured in the structured fields in B.4.k.5, then use the element (B.4.k.6) <drugdosagetext>.

2. Pharmaceutical Form Field

Record the pharmaceutical form in element (B.4.k.7) <drugdosageform>. FDA accepts the European Medicines Agency (EMA) dosage codes or text.[9]

3. Route of Administration Field

Code the route of administration in element (B.4.k.8) <drugadministrationroute> as described in the ICH E2B(R2) guidance.

4. Receiver Field (A.3.2)

Complete the receiver using the code or text listed in Table 6.

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[8] https://www.fda.gov/ForIndustry/DataStandards/SubstanceRegistrationSystem-UniqueIngredientIdentifierUNII/default.htm.

[9] For a complete list of EMA dosage form codes and text, please refer to https://www.ema.europa.eu/documents/other/list-pharmaceutical-dosage-forms_en.xls

Table 6. Receiver Information

Element	DTD Descriptor 2.1	Code or Text
A.3.2.1	<receivertype>	2
A.3.2.2a	<receiverorganization>	FDA
A.3.2.2b	<receiverdepartment>	Office of Surveillance and Epidemiology
A.3.2.2d	<receivergivename>	FAERS
A.3.2.3a	<receiverstreetaddress>	10903 New Hampshire Avenue
A.3.2.3b	<receivercity>	Silver Spring
A.3.2.3c	<receiverstate>	MD
A.3.2.3d	<receiverpostcode>	20993
A.3.2.3e	<receivercountrycode>	US
A.3.2.3l	<receiveremailaddress>	faersesub@fda.hhs.gov

5. Message Receiver Field (M.1.6)

The following two message receiver identifiers are used by FDA to distinguish between test and production submissions:

- Test ICSRs: <messagereceiveridentifier>ZZFDATST</messagereceiveridentifier>
- Production ICSRs: <messagereceiveridentifier>ZZFDA</messagereceiveridentifier>

H. Data Elements for Electronic Submissions of Safety Reports for Postmarketing Combination Products

To ensure the successful processing of your electronic ICSR submission for a marketed drug- or therapeutic biologic led- combination product (e.g., a combination product containing a drug/biologic and device and marketed under an NDA or a BLA), you should populate the data elements indicated in Table 7.

Note: Some of the DTD descriptors listed in Table 7 are under existing E2B(R2) header elements, and some DTD descriptors are under new data elements. Those data element numbers that are new, have the word "FDA" incorporated into the number and are U.S.-specific regional elements related to reporting on combination products.

Table 7. Combination Product Data Elements

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
M.1.2	<messageformatversion>	Message Format Version	Version number of Message Format	3AN	2.2	Use value 2.2 if using icsr-xml-v2.2.dtd Use value 2.1 if using icsr-xml-v2.1.dtd
A.1	<safetyreport>	Header/ Entity	Identification of the case safety report			
A.1.9	<fulfillexpeditecriteria>	Does this case fulfill the local criteria for an expedited report		1N	1=Yes 2=No 4=5-Day 5=30-Day	Element values= 1 for 15-Day Expedited* and 2 for periodic non-expedited† Element value= 4 for remedial action to prevent an unreasonable risk of substantial harm to the public health Element value= 5 for malfunction with no associated adverse event Do not use element value of 3.
A.1.FDA.15	<combinationproductreport>	Combination Product Report Flag	Combination Product Report Flag	1N	1=Yes 2=No	
A.2	<primarysource>	Primary source(s) of information	Header/ Entity		Area below should be a repeatable block	

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
A.2.1		Primary source(s)	Header			
A.2.1.3.FDA.4	<reporteremailaddress>	Reporter's Email Address		100AN		
B.1.1	<patientinitial>	Patient	Patient Identifier	10AN		If a single report is reported for a malfunction with no adverse event, the element value should be "NONE." If there are multiple malfunction reports with no adverse event, then the element value should be "SUMMARY."
B.4	<drug>	Drug(s) Information	Header/ Entity		Area below should be a repeatable block	
B.4.k.1	<drugcharacterization>	Characterization of drug role		1N	1=Suspect 2=Concomitant 3=Interacting 5=Similar Device	If the product in the report is about a similar device, the element value should be 5=Similar Device.
B.4.k.2		Drug Identification	Header			
B.4.k.2.4.FDA.1a	<expirationdateformat>	Expiration date format	Product Expiration date	3N	102=CCYYMMDD 610=CCYYMM 602=CCYY	
B.4.k.2.4.FDA.1b	<expirationdate>	Expiration date	Product Expiration date	8N		

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
B.4.k.2.FDA.5	<productavailableforevaluation>	Product available for evaluation	Indicate whether product is available for evaluation	1N	1=Yes 2=No 3=Return	
B.4.k.2.6.FDA.1a	<productreturndateformat>	Product return date format	Date Format	3N	102=CCYYMMDD 610=CCYYMM 602=CCYY	
B.4.k.2.6.FDA.1b	<productreturndate>	Product return date	Date when Product was returned	8N		
B.4.k.20.FDA.1	<brandname>	Brand Name	The trade or proprietary name of the device constituent part of the suspect combination product as used in product labeling or in the catalog	80AN		At least one of the 3 must be reported <brandname> or <commondevicename> or <productcode> for the device constituent part
B.4.k.20.FDA.2	<commondevicename>	Common Device Name	Generic or common name of the device constituent part of the suspect combination product or a generally descriptive name	80AN		At least one of the 3 must be reported <brandname> or <commondevicename> or <productcode> for device constituent part
B.4.k.20.FDA.3	<productcode>	Product Code	Product code	3AN	http://www.acce	At least one of the 3 must be

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
			assigned to the device constituent part based upon the medical device product classification		ssdata.fda.gov/premarket/ftparea/foiclass.zip	reported <brandname> or <commondevicename> or <productcode> for device constituent part
B.4.k.20.FDA.4	<manufacturer>	Manufacturer	Header/ Entity			
B.4.k.20.FDA.4a	<manufacturername>	Device Manufacturer Name	Manufacturer name of the device constituent part of the suspect combination product	100AN		
B.4.k.20.FDA.4b	<manufactureraddress>	Manufacturer Address	Manufacturer address of the device constituent part of the suspect combination product	100AN		
B.4.k.20.FDA.4c	<manufacturercity>	Manufacturer City	Manufacturer city of the device constituent part of the suspect combination product	35AN		
B.4.k.20.FDA.4d	<manufacturerstate>	Manufacturer State	Manufacturer state of the device	40AN		

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
			constituent part of the suspect combination product			
B.4.k.20.FDA.4e	<manufacturercountry>	Manufacturer Country	Manufacturer country of the device constituent part of the suspect combination product	2AN	ISO3166	
B.4.k.20.FDA.5	<modelnumber>	Model Number	Model number of the device constituent part	30AN		
B.4.k.20.FDA.6	<catalognumber>	Catalog Number	Catalog number of the device constituent part	30AN		
B.4.k.20.FDA.7	<serialnumber>	Serial Number	Serial number of the device constituent part	30AN		
B.4.k.20.FDA.8	<udinumber>	Unique Identifier UDI#	Unique identifier of the device constituent part	50AN		
B.4.k.20.FDA.9a	<dateimplantedformat>	Device Implant Date Format	Date format of device implant in the patient	3N	102=CCYYMMDD 610=CCYYMM 602=CCYY	For medical devices that are implanted in the patient, provide the implant date or best estimate. If day is unknown, month and year are acceptable. If month and day are unknown, year is acceptable

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
B.4.k.20.FDA.9b	<dateimplanted>	Device Implant Date	Date of device implant in the patient	8N		For medical devices that are implanted in the patient, provide the implant date or best estimate. If day is unknown, month and year are acceptable. If month and day are unknown, year is acceptable
B.4.k.20.FDA.10a	<dateexplantedformat>	Device Explant Date Format	Date format of device explant from the patient	3N	102=CCYYMMDD 610=CCYYMM 602=CCYY	If an implanted device was removed from the patient, provide the explant date or best estimate. If day is unknown, month and year are acceptable. If month and day are unknown, year is acceptable
B.4.k.20.FDA.10b	<dateexplanted>	Device Explant Date	Date of device explant from the patient	8N		If an implanted device was removed from the patient, provide the explant date or best estimate. If day is unknown, month and year are acceptable. If month and day are unknown, year is acceptable
B.4.k.20.FDA.11a	<deviceage>	Approximate age of device/ product	Age of device constituent part	5N		
B.4.k.20.FDA.11b	<deviceageunit>	Approximate age unit of device/	Age unit of device constituent part	3N	800=Decade 801=Year 802=Month	

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
		product			803=Week 804=Day 805=Hour	
B.4.k.20.FDA.12	<labeledsingleusedevice>	Single Use Device	Indicate whether the device constituent part was labeled for single use or not	1N	1=Yes 2=No	
B.4.k.20.FDA.13a	<devicemanufacturedateformat>	Device Manufacture Date Format	Device Manufacture Date format	3N	102=CCYYMMDD 610=CCYYMM 602=CCYY	
B.4.k.20.FDA.13b	<devicemanufacturedate>	Device Manufacture Date	Device Manufacture Date	8N		
B.4.k.20.FDA.14		Remedial action initiated/ Remedial action taken for the product	Header			
B.4.k.20.FDA.14.1a	<remedialactionrecall>	Recall	Recall initiated	1N	1=Yes 2=No	
B.4.k.20.FDA.14.1b	<remedialactionrepair>	Repair	Repair initiated	1N	1=Yes 2=No	
B.4.k.20.FDA.14.1c	<remedialactionreplace>	Replace	Replace initiated	1N	1=Yes 2=No	
B.4.k.20.FDA.14.1d	<remedialactionrelabel>	Relabeling	Relabeling initiated	1N	1=Yes 2=No	
B.4.k.20.FDA.14.1	<remedialactionnotify>	Notification	Notification	1N	1=Yes	

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
e			initiated		2=No	
B.4.k.20.FDA.14.1f	<remedialactioninspection>	Inspection	Inspection initiated	1N	1=Yes 2=No	
B.4.k.20.FDA.14.1g	<remedialactionpatientmonitor>	Patient monitoring	Patient monitoring	1N	1=Yes 2=No	
B.4.k.20.FDA.14.1h	<remedialactionmodifyadjust>	Modification/ Adjustment	Modification/ Adjustment initiated	1N	1=Yes 2=No	
B.4.k.20.FDA.14.1i	<remedialactionother>	Other	Other Remedial Action initiated	75AN		
B.4.k.20.FDA.15	<deviceusage>	Device Usage	Indicate the use of the device constituent part of the suspect combination product	1N	1=Initial Use of Device 2=Reuse 3=Unknown	
B.4.k.20.FDA.16	<devicelotnumber>	Device Lot Number	Lot number of the device constituent part of the suspect combination product	35AN		
B.4.k.20.FDA.17	<malfunction>	Malfunction	Malfunction of product	1N	1=Yes 2=No	
B.4.k.20.FDA.18		Follow-up type	Header			
B.4.k.20.FDA.18.1a	<followupcorrection>	Correction	Correction	1N	1=Yes 2=No	
B.4.k.20.FDA.18.1b	<followupadditionalinfo>	Additional information	Additional information	1N	1=Yes 2=No	
B.4.k.20.FDA.18.1	<followupresponsetoFDA>	Response to	Response to FDA	1N	1=Yes	

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
c		FDA request	request		2=No	
B.4.k.20.FDA.18.1d	<followupdeviceevaluation>	Device Evaluation	Device Evaluation	1N	1=Yes 2=No	
B.4.k.20.FDA.19	<deviceproblemandevaluation>	Device Problem and evaluation codes	Header/ Entity		Area Below Should be a Repeatable Block	
B.4.k.20.FDA.19.1a	<evaluationtype>	Evaluation Type	Type of problem and/or the evaluation	2N	01=Device Problem 02=Method 03=Result 04=Conclusion	
B.4.k.20.FDA.19.1b	<evaluationvalue>	Evaluation Value	The FDA code value based on the respective evaluation type	6N		The value depends on the respective <evaluationtype> If <evaluationtype> = 01 --> https://www.fda.gov/media/146825/download If <evaluationtype> = 02 --> https://www.fda.gov/media/146827/download If <evaluationtype> = 03 --> https://www.fda.gov/media/146828/download If <evaluationtype> = 04 --> https://www.fda.gov/media/146829/download
B.4.k.20.FDA.20	<operatorofdevice>	Operator of	Operator of the	100AN		Use the value “Health

Data Element	DTD Descriptor 2.2	Title	Description	Length	Element Values for DTD 2.2	Notes
		the Device	Device			Professional" or "Lay User/Patient." If none applicable, then specify the "Other" value

* 21 CFR 314.80(c)(1) and 600.80(c)(1) use the term "15-day Alert reports." In the combination product PMSR final rule (21 CFR 4.101), these reports are defined as "Fifteen-day reports."

† Periodic non-expedited ICSRs are the reports required under 21 CFR 314.80(c)(2)(ii)(B) and 21 CFR 600.80(c)(2)(ii)(B) for serious, expected and nonserious adverse drug experiences.

I. Data Elements for Electronic Submissions of IND Safety Reports

To ensure the successful processing of your electronic IND ICSR submission, you should populate the following data elements as described in Table 8.

Table 8. Investigational New Drug Clinical Data Elements

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
A.1.4	<reporttype>	Type of Report		1N	1=Spontaneous 2=Report from Study 3=Other 4=Not Available to Sender (unknown)	Element value= 2 for Report from Study
A.1.9	<fulfillexpeditecriteria>	Does this case fulfill the local criteria for an expedited report?		1N	1=Yes 2=No 4=5-Day 5=30-Day 6=7-Day	Element value=1 for 15-Day Expedited Element value= 6 for 7-Day Expedited
A.1.12	<linkreportnumb>	Identification Number of the report which is linked to this report		100AN		Used to link all individual cases (safetyreportid) that make up an IND Safety Report submitted as a result of an Aggregate Analysis as per 312.32(c)(1)(i)(C) or for several events

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
						submitted as per (312.32(c)(1)(i)(B)) when a Narrative Summary Report is provided, this field should be populated in the IND Safety Report that contains the Narrative Summary Report.
A.2.3.1	<studyname>	Study Name		100AN	Study ID_$Abbreviated Trial Name	The Study ID should be the same value used in the study tagging file format of the eCTD submission.
A.2.3.2	<sponsorstudynumb>	Sponsor Study Number		35AN	IND number under which the clinical trial where the event occurred is conducted Use the "Parent" IND number* for reports submitted from an Aggregate Analysis as per (312.32(c)(1)(i)(C)) or for several events	Populate this field with the Primary IND in the first block and repeat block A.2 with elements A.2.3.2 and A.2.3.3.as noted below with element value= 5 for sponsor's other INDs evaluating suspect product (where applicable) Include the acronym "IND" followed by a space and then the IND

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
					submitted as per (312.32(c)(1)(i)(B)), from trials conducted under more than one IND	number for the application (e.g. IND 123456) See Appendix II (Case Scenarios) for additional information on how to submit reports from sponsor's other INDs (Cross-reporting).
A.2.3.3	<observestudytype>	Study type in which the Reaction(s)/ Event(s) were observed		1N	1= Clinical Trials 2= Individual Patient Use (e.g., 'Compassionate Use' or 'Named Patient Basis') 3= Other Studies (e.g., Pharmacoepidemiology, Pharmacoeconomics, Intensive Monitoring) 4= Report from	Required if element value for A.1.4 is 2=Report from Study Repeat this field as needed with element value= 5 for each Cross-reported IND. The first block of this element in the report must not be 5. If element value 4 is chosen, then A.1.9= 1. See Appendix II (Case

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
					Aggregate Analysis as per 312.32(c)(1)(i)(C) or for several events submitted as per 312.32(c)(1)(i)(B) if a Narrative Summary Report is provided 5= Cross-reported IND Safety Report	Scenarios) for additional information on how to submit reports from an Aggregate Analysis.
B.1.1	<patientinitial>	Patient Identifier		10AN		For a report from an Aggregate Analysis as per 312.32(c)(1)(i)(C) or for several events submitted as per 312.32(c)(1)(i)(B) if a Narrative Summary Report is provided, the element value should be "AGGREGATE"
B.4.k.2.1	<medicinalproduct>	Proprietary Medicinal Product Name		70AN		For investigational drug and biological products without an established name (i.e. INN or USAN

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
						name), prior to submitting IND safety reports to FAERS, the sponsor should submit a clinical information amendment to the IND, listing the names of the active drug substance/s and the medicinal product as they will be reported in E2B file submissions. The names should fit within the established E2B character length limits. Use company product code if no established name, for multi-ingredient products, or if name exceeds character length
B.4.k.2.2	<activesubstancename>	Active Drug Substance Names		100AN		
B.4.k.18	<drugreactionrelatedness>	Relatedness of Drug to				For IND Safety Reports, at least one suspect

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
		Reaction/ Event				product should have relatedness of drug to reaction/ event
B.4.k.18.1a	<drugreactionassesmeddra version>	MedDRA Version for Reaction Assessed		8AN		
B.4.k.18.1b	<drugreactionasses>	Reaction Assessed		250AN		
B.4.k.18.2	<drugassessmentsource>	Source of Assessment		60AN		Use the value "Sponsor" or "Investigator". Include sponsor and investigator assessment when reporting both in separate blocks
B.4.k.18.3	<drugassessmentmethod>	Method of Assessment		35AN		Use the value "FDA".
B.4.k.18.4	<drugresult>	Result		35AN	1=Suspected 2=Not suspected	For IND Safety Reports, at least one suspect product should have relatedness of drug to reaction/ event
B.5.1	<narrativeincludeclinical>	Case Narrative Including Clinical		20,000 AN		FDA strongly encourages sponsors to construct narratives that fit within the ICH E2B character

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
		Course, Therapeutic Measures, Outcome, and Additional Relevant Information				limit of 20,000 AN. If your narrative exceeds this limit, sponsors should include as much of the narrative as possible in this field and submit an ICSR attachment for any text that exceeds the character limit. Sponsors should not submit an ICSR attachment containing the entire narrative and leave the case narrative field empty. For reports from Aggregate Analysis as per 312.32(c)(1)(i)(C) or for several events submitted as per 312.32(c)(1)(i)(B) where PDF is attached, put "see attached Narrative Summary Report" in this field.

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
B.5.4	<sendercomment>	Sender's Comments		2000 AN		Identification and analysis of previously submitted events (as required by 312.32(c)(1)) should be reported in this field.

* The "parent IND" is the IND under which clinical investigations were initiated in the United States. (If the drug is being evaluated in multiple INDs, this is generally the IND with the lowest number.) NOTE: This may not be the same as the first A.2.3.2 block if the drug is being evaluated under multiple INDs.

NOTE: See FAERS Webpage for case scenario examples for reporting IND safety reports (e.g., IND safety reports where the sponsor is evaluating suspect product under more than one IND, IND safety reports that are a result of an aggregate analysis, and IND safety reports with unapproved and approved drugs listed as suspect products).

J. Data Elements for Electronic Submissions of ICSRs from IND-Exempt Bioavailability (BA)/ Bioequivalence (BE) Studies

For successful processing of your electronic ICSRs submissions for a BA/BE study not conducted under an IND, you should populate the following data elements as described in Table 9.

Table 9. Data Elements for IND-Exempt BA/BE Studies

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
A.1.4	<reporttype>	Type of Report		1N	1=Spontaneous 2=Report from Study 3=Other 4=Not Available to Sender (unknown)	Element value= 2 for Report from Study

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
A.1.9	<fulfillexpeditecriteria>	Does this Case Fulfill the Local Criteria for an Expedited Report?		1N	1=Yes 2=No 4=5-Day 5=30-Day 6=7-Day	Element value=1 for 15-Day Expedited Or Element value= 6 for 7-Day Expedited
A.2.3.1	<studyname>	Study Name		100AN	Abbreviated Trial Name	
A.2.3.2	<sponsorstudynumb>	Sponsor Study Number		35AN	Pre-ANDA number for the IND-Exempt BA/BE Studies	Include the acronym "Pre-ANDA" followed by a space and then the Pre-ANDA number for the application (e.g. Pre-ANDA 123456)
A.2.3.3	<observestudytype>	Study Type in Which the Reaction(s)/ Event(s) were Observed		1N	1= Clinical Trials 2= Individual Patient Use (*e.g., 'Compassionate Use' or 'Named Patient Basis'*) 3= Other Studies (*e.g., Pharmacoepidemiology, Pharmacoeconomics, Intensive Monitoring*) 4= Report from Aggregate Analysis as per 312.32(c)(1)(i)(C) or for	Element value="1" for Clinical Trials.

Data Element	DTD Descriptor 3.0	Title	Description	Field Length	Element Values for DTD 3.0	Notes
					Several Events Submitted as per 312.32(c)(1)(i)(B) if a Narrative Summary Report is Provided 5= Cross-Reported IND Safety Report	
B.4.k.2.1	<medicinalproduct>	Proprietary Medicinal Product Name		70AN		
B.4.k.1	<drugcharacterization>	Characterization of drug role		1N	1 = Suspect 2 = Concomitant 3 = Interacting 4 = Drug not administered	For no exposure to a study drug use 4=Drug not administered
B.4.k.2.2	<activesubstancename>	Active Drug Substance Name		100AN		
B.4.k.19	<drugadditional>	Additional Information on Drug		100AN	1 = Test drug 2 = Reference drug 3 = Placebo/Vehicle 4 = Control (negative or positive) 5 = Other drug	Specify whether the product exposed is the Test drug, Reference drug, Placebo, Vehicle, Control or Other drug

VI. ELECTRONIC FORMAT FOR ICSR ATTACHMENTS

FDA can accept and archive ICSR attachments in PDF format. Currently approved formats for the non-structured component of an ICSR, such as ICSR attachments, are PDF versions 1.4 (current ICH standard) or 1.6 (current version in use at FDA). An ICSR attachment should be electronically submitted to FAERS after the associated ICSR has been submitted and accepted by FAERS.

A. Converting the ICSR Attachment to PDF

Applicants should provide an individual PDF file for each ICSR attachment. If you are submitting multiple ICSR attachments for a particular ICSR, include each attachment in the same PDF file and provide a PDF bookmark to distinguish each attachment. For example, if you are submitting a hospital discharge summary and an autopsy report for a single ICSR, include both in a single PDF file with a bookmark to the hospital discharge summary and a bookmark to the autopsy report.

B. Identification Information in the PDF Document Information Fields

Each PDF file contains fields to be completed by the author of the document. FAERS uses these fields to locate and retrieve the attachments to specific ICSRs. To enable FDA to match the attachment(s) to the correct ICSR, applicants should fill in the PDF document information fields with the appropriate E2B(R2) data elements for the ICSR as indicated in Table 10.

Table 10. Document Information Fields in ICSR Attachments

PDF Document Information Field	Include/ Optional	Document Information*	Length
Title	Include	A.1.0.1 <safetyreportid> Sender's (Case) Safety Report Unique Identifier	100AN
Subject	Include	A.1.10.1 <authoritynumb> Regulatory Authority's Case Report Number OR A.1.10.2 <companynumb> Other Sender's Case Report Number	100AN
Author	Optional	A.1.11.2 <duplicatenumb> Other Identification Number	100AN
Keywords	Optional	A.1.7b <receiptdate> Date of Receipt of the Most Recent Information for this ICSR	8N

* The information refers to the data elements in E2B(R2)

In addition:

- Use the ISO-8859-1 character set for the information fields.
- Do not exceed the character length indicated above for each information field.
- Avoid creating any custom fields with names identical to the information fields listed in Table 10.

If you need assistance, you can contact the FAERS electronic submission coordinator at faersesub@fda.hhs.gov.

VII. SUBMISSION RULES

The submission rules define the condition that shall result in a negative acknowledgement and not be accepted by FAERS.

Table 111. Submission Rules and Acknowledgement Status

Data Element	DTD Descriptor 2.1/2.2/3.0	Rejection Rule Description	Acknowledgement
NA	NA	ICSR submitted via AS2 Header where XML file: AERS or Routing ID where XML file: FDA_AERS and using DTD 3.0	reportacknowledgmentcode (B.1.8) = 02
NA	NA	ICSR submitted via AS2 Header where XML file: AERS_PREMKT or Routing ID where XML file: FDA_AERS_PREMKT and using DTD 2.1 or 2.2	reportacknowledgmentcode (B.1.8) = 02
A.1.FDA.16	<fdasafetyreporttype>	ICSR submitted via AS2 Header where XML file: AERS_PREMKT or Routing ID where XML file: FDA_AERS_PREMKT using DTD 3.0 and data value is empty	reportacknowledgmentcode (B.1.8) = 02
A.2.3.2	<sponsorstudynumb>	ICSR submitted via AS2 Header where XML file: AERS_PREMKT or Routing ID where XML file: FDA_AERS_PREMKT using DTD 3.0 and data value is empty or not prefixed with 'IND' or 'Pre-ANDA'	reportacknowledgmentcode (B.1.8) = 02

APPENDIX I. EXAMPLES OF CORRECT AND INCORRECT APPLICATION NUMBER AND DRUG ELEMENT FORMATS

Table 122. Examples of Application Number Formats and Drug Element Formats

Examples of Application Number Format		Comment
Correct	<drugauthorizationnumb>NDA 012345</drugauthorizationnumb>	
Correct	<drugauthorizationnumb>BLA 123456</drugauthorizationnumb>	
Correct	<drugauthorizationnumb>NDA 012345</drugauthorizationnumb> <drugauthorizationholder>COMPANYX</drugauthorizationholder>	
Incorrect	<drugauthorizationnumb>123456/**10300**</drugauthorizationnumb>	Use the appropriate prefix for the NDA/ ANDA/ STN/ BLA/ PLA. Do not include additional data after the application number
Incorrect	<drugauthorizationnumb>NDA **12-345;IND12,345** </drugauthorizationnumb>	Omit hyphens and commas in the application number. Do not populate the tag with two application numbers
Incorrect	<drugauthorizationnumb>**OTC Product**</drugauthorizationnumb>	For a non-prescription drug product marketed without an approved application (Non-Rx No Application), use “999999"
Incorrect	<drugauthorizationnumb>NDA 012345**(COMPANYX)**</drugauthorizationnumb> <drugauthorizationholder></></drugauthorizationholder>	Do not populate the company name in the <drugauthorizationnumb> tag

Examples of Application Number Format		Comment
Correct	<medicinalproduct>TYLENOL</medicinalproduct> <activesubstancename>ACETAMINOPHEN</activesubstancename>	
Correct	<medicinalproduct>MIRACLE WONDER DRUG</medicinalproduct> <activesubstancename>ACETAMINOPHEN</activesubstancename>	
Incorrect	<medicinalproduct>AMAZING DRUG **OTC®**</medicinalproduct> <activesubstancename>ACETAMINOPHEN **500 mg**</activesubstancename>	
Incorrect	<medicinalproduct>NEW DRUG **40 mcg/mL**</medicinalproduct> <activesubstancename>NEWSUBSTANCE **Inj** </activesubstancename>	
Incorrect	<medicinalproduct>**MWD**</medicinalproduct> <activesubstancename>**APAP**</activesubstancename>	Do not use abbreviations for the brand name or active substance in the <medicinalproduct> and <activesubstance> tags

APPENDIX II. CASE SCENARIOS FOR IND SAFETY REPORTS SUBMITTED TO FAERS

The following case scenarios are intended to provide examples to sponsors on the use of ICH E2B data standard elements for submission of IND safety reports to FAERS that may differ from postmarketing safety reports.

1. For any IND safety report where the sponsor is evaluating the suspect product under more than one IND (i.e. "Cross-reporting")
    a. Repeat block A.2 for each IND
        i. Use first block A.2 to designate IND where the event occurred = "primary IND"
            1. A.2.3.2 = primary IND
            2. A.2.3.3 = data value could either be 1, 2, 3, or 4
            3. Other relevant information for the report to be populated in block A.2
        ii. Repeat block A.2 as many times as needed with only the following data elements for each IND that the sponsor holds where that suspect product is being evaluated:
            1. A.2.3.2 = IND number for each cross-reported IND

            and

            2. A.2.3.3 = 5

Table 133. Case Scenario 1. For IND Safety Reports Submitted to FAERS

Data Element	DTD Descriptor 3.0	Title	Element Values for DTD
A.2.3.2	<sponsorstudynumb>	Sponsor Study Number	IND number under which the Clinical Trial where the event occurred is conducted

Data Element	DTD Descriptor 3.0	Title	Element Values for DTD
A.2.3.3	<observestudytype>	Study Type in Which the Reaction(s) were observed	1= Clinical Trial 2= Individual Patient Use (*e.g. 'Compassionate Use' or 'Named Patient Basis'*) 3= Other Studies (*e.g. Pharmacoepidemiology, Pharmacoeconomics, Intensive Monitoring*) 4= Report from Aggregate Analysis 312.32(c)(1)(i)(C) or for several events submitted as per 312.32(c)(1)(i)(B) if a Narrative Summary report is provided. 5=Cross-reported IND safety report

2. For an IND safety report that is a result of an aggregate analysis as per 312.32(c)(1)(i)(C) or for several events submitted as per 312.32(c)(1)(i)(B) if a narrative summary report is provided:

    a. Submit one IND safety report with the IND where the event occurred in A.2.3.2 <sponsorstudynumb> (or the "parent" IND if the events occurred in multiple INDs).

    For this IND safety report, populate the data elements below in addition to other relevant information regarding the event and suspect product.

        i. Use data element = 4 in A.2.3.3<observestudytype>

        ii. Use the term "AGGREGATE" in B.1.1 <patientinitial>

    b. Section VII.A.2. of the *FDA Guidance for Industry – "Safety Reporting Requirements for INDs and BA/BE Studies" (December 2012)* discusses several submission requirements for IND safety reports that are a result of an aggregate analysis. The following two sections describe these submission elements and how they are accomplished with electronic submission to FAERS.

        1. The guidance states that IND safety reports that are a result of an aggregate analysis should contain a narrative description of the event and the results of the analysis (hereafter referred to as a "narrative

summary report"). For IND reports submitted to FAERS, attach the narrative summary report to the IND safety report as a PDF attachment (do not put the narrative summary report in the E2B narrative field).

a. These instructions also apply to several events submitted as per 312.32(c)(1)(i)(B) if a narrative summary report is provided.

2. The guidance states that all the individual cases that were analyzed in the aggregate analysis should be submitted. Use the repeatable block A.1.12 to link all the safety report numbers for the individual supportive ICSRs (i.e. the numbers in A.1.0.1 for all the individual cases that are summarized in the narrative summary report).

a. These instructions also apply to several events submitted as per 312.32(c)(1)(i)(B) if a narrative summary report is provided.

b. IND safety reports previously submitted as ICSRs to FAERS do not have to be resubmitted (place the safety report numbers for these previously submitted reports in A.1.12).

c. For IND safety reports previously submitted in eCTD format, the sponsor should list the eCTD sequence number and date of submission in the narrative summary report. (The eCTD sequence number is the unique four-digit number for each IND submission the sponsor submits in the us-regional.xml file for the eCTD submission.)

d. IND safety reports previously submitted on paper should be attached to the IND safety report as PDF attachments.

Table 144. Case Scenario 2. For IND Safety Reports Submitted to FAERS

Data Element	DTD Descriptor 3.0	Title	Element Values for DTD
A.1.12	<linkreportnumb>	Identification number of the report(s) which are linked to this report	Used to link all individual cases (safetyreportid) that make up an IND Safety Report submitted as a result of an Aggregate Analysis as per 312.32(c)(1)(i)(C) or for several events submitted as per 312.32(c)(1)(i)(B) if a narrative summary report is provided
A.2.3.2	<sponsorstudynumb>	Sponsor Study Number	IND number under which the Clinical Trial where the event occurred is conducted

Data Element	DTD Descriptor 3.0	Title	Element Values for DTD
A.2.3.3	<observestudytype>	Study Type in Which the Reaction(s) were Observed	1= Clinical Trials 2= Individual Patient Use (*e.g. 'Compassionate Use' or 'Named Patient Basis'*) 3= Other Studies (*e.g. Pharmacoepidemiology, Pharmacoeconomics, Intensive Monitoring*) 4= Report from Aggregate Analysis 312.32(c)(1)(i)(C) 5=Cross-reported IND safety report
B.1.1	<patientinitial>	Patient Identifier	For a Report from an Aggregate Analysis, the element value should be "AGGREGATE"

3. For adverse events that occur with a marketed drug being evaluated under an IND that meets both IND and post-marketing safety reporting requirements (21 CFR 312.32 and 314.80, 600.80, or 310.305), sponsors must submit two separate ICSRs:

    a. for the marketed drug for the NDA/BLA

    and

    b. for the study drug for the IND (IND number in A.2.3.2)

APPENDIX III. CASE SCENARIOS FOR SAFETY REPORTS FROM IND-EXEMPT BA/BE STUDIES TO FAERS

Table 15 illustrates the ICH E2B data elements and element values for each IND-exempt BA/BE study exposure scenario described below:

Scenario 1: Exposure to a *study drug*:

This scenario applies to all drugs specified in the study protocol. For example, if a BA/BE study protocol for a generic opiate includes administration of naltrexone to each study subject prior to administration of a test or reference drug, naltrexone is a *study drug*, although it is not the test or reference drug. Similarly, a selective 5-HT3 receptor antagonist to prevent nausea and vomiting is considered a *study drug* if the BA/BE study protocol states that the drug is administered to each study subject prior to administration of a test or reference drug.

Scenario 2: Exposure to an *other drug*:

Other drugs are drugs taken by or administered to a subject that are not part of study conduct per protocol. For example, a subject with a diagnosis of hypertension has normal blood pressure while treated with a beta blocker. The subject meets study enrollment criteria and continues to take his beta blocker during study participation. In this situation, the beta blocker is an *other drug*. Similarly, if a subject develops symptoms of heartburn during participation in a BA/BE study and is permitted, by the investigator, to use a nonprescription antacid or H2 blocker for symptomatic relief, the nonprescription drug taken by the subject is an *other drug*.

Scenario 3: No exposure to a study drug:

A serious adverse event a subject experiences after enrollment to the study, but prior to exposure to a study drug, is subject to the expedited safety reporting requirement. To report a serious adverse event with no study drug exposure, the submitter should select values as shown in the Table 15, Scenario 3.

Table 155. ICH E2B Data Element & Value Selections for IND-Exempt BA/BE Study Exposures

Drug Exposure Scenario	Data Element	Element Values
Scenario 1: Exposure to a *study drug*	B.4.k.1	Select one element value
	B.4.k.2.1	Proprietary medicinal product name
	B.4.k.2.2	Drug substance name
	B.4.k.19	Select one from the following: 1 = Test drug 2 = Reference drug 3 = Placebo/Vehicle 4 = Control (negative or positive)
Scenario 2: Exposure to an *other drug*	B.4.k.1	Select one element value
	B.4.k.2.1	Proprietary medicinal product name
	B.4.k.2.2	Drug substance name
	B.4.k.19	5 = Other drug
Scenario 3: No exposure to a *study drug*	B.4.k.1	4 = Drug not administered
	B.4.k.2.1	Proprietary medicinal product name
	B.4.k.2.2	Drug substance name
	B.4.k.19	1 = Test drug

EXHIBIT 55

Christiana A. Cirucci et al.,
Mifepristone Adverse Events Identified by Planned Parenthood in 2009 and 2010 Compared to Those in the FDA Adverse Event Reporting System and Those Obtained Through the Freedom of Information Act,
8 Health Servs. Rsch & Managerial Epidemiology 1, 1 (2021)

Research Letter

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Mifepristone Adverse Events Identified by Planned Parenthood in 2009 and 2010 Compared to Those in the FDA Adverse Event Reporting System and Those Obtained Through the Freedom of Information Act

Christina A. Cirucci[1], Kathi A. Aultman[2], and Donna J. Harrison[3]

Abstract

Background: As part of the accelerated approval of mifepristone as an abortifacient in 2000, the Food and Drug Administration (FDA) required prescribers to report all serious adverse events (AEs) to the manufacturer who was required to report them to the FDA. This information is included in the FDA Adverse Event Reporting System (FAERS) and is available to the public online. The actual Adverse Event Reports (AERs) can be obtained through the Freedom of Information Act (FOIA).

Methods: We compared the number of specific AEs and total AERs for mifepristone abortions from January 1, 2009 to December 31, 2010 from 1. Planned Parenthood abortion data published by Cleland et al. 2. FAERS online dashboard, and 3. AERs provided through FOIA and analyzed by Aultman et al.

Results: Cleland identified 1530 Planned Parenthood mifepristone cases with specific AEs for 2009 and 2010. For this period, FAERS online dashboard includes a total (from all providers) of only 664, and the FDA released only 330 AERs through FOIA. Cleland identified 1158 ongoing pregnancies in 2009 and 2010. FAERs dashboard contains only 95, and only 39 were released via FOIA.

Conclusions: There are significant discrepancies in the total number of AERs and specific AEs for 2009 and 2010 mifepristone abortions reported in 1. Cleland's documentation of Planned Parenthood AEs, 2. FAERS dashboard, and 3. AERs provided through FOIA. These discrepancies render the FAERS inadequate to evaluate the safety of mifepristone abortions.

Keywords

mifepristone, misoprostol, adverse drug reaction reporting systems, drug-related side effects and adverse reactions, postmarketing product surveillance, induced abortion, steroidal abortifacient agents, United States food and drug administration

Introduction

The accelerated approval of mifepristone in the United States (US) in 2000 included post-marketing restrictions to monitor safety. Prescribers were required to report any ongoing pregnancies, hospitalizations, transfusions, and other serious events to the manufacturer, who was required to submit them to the Food and Drug Administration (FDA).[1] Adverse events (AEs) are documented in the FDA Adverse Event Reporting System (FAERS), available online.[2] Copies of the actual Adverse Event Reports (AERs) can be obtained via the Freedom of Information Act (FOIA).[3]

A paper published by Cleland et al. analyzed eight adverse events/outcomes (AEs) from mifepristone abortions at 63 days and less performed by Planned Parenthood in 2009 and 2010. They analyzed hospital admissions, blood transfusions, emergency department (ED) treatments, intravenous (IV)

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antibiotics, infections requiring IV antibiotics or hospitalization, deaths, ongoing pregnancies, and ectopic pregnancies. Cleland explained that Planned Parenthood reports all significant AEs to Danco Laboratories, which submits them to the FDA, per the mifepristone prescribing information. Their analysis for these specific AEs led them to conclude that, "Among the 233 805 medical abortions provided at Planned Parenthood health centers in 2009 and 2010, significant adverse events or outcomes were reported in 1530 (0.65%) cases."[4] Unless associated with another AE, they did not include data on incomplete abortion managed at Planned Parenthood or hemorrhage without transfusion, two of the most common AEs resulting from mifepristone abortion. They also admit that "we cannot exclude the possibility that some clinically significant adverse events or outcomes were not included. Some patients may have experienced a significant adverse event or outcome but did not follow up after their medical abortion."[4] Cleland did not provide the loss to follow-up rate.

In 2021, Aultman et al. published an analysis of the AERs for mifepristone abortion from September 2000 to February 2019 (excluding those published by Gary in 2006) utilizing AERs obtained through FOIA.[5,6]

The objective of this paper was to compare the total number of AERs/cases (which may include more than one AE) and the individual AEs identified by Cleland for 2009 and 2010 mifepristone abortions from three sources: those identified by Planned Parenthood as published by Cleland, those currently posted on the FAERS dashboard, and those provided by the FDA in response to FOIA and analyzed by Aultman.

Methods

We searched the FAERS dashboard for any US AERs related to mifepristone abortion occurring from January 1, 2009 through December 31, 2010 and tabulated the total number of AERs, hospital admissions, deaths, ongoing pregnancies, and ectopic pregnancies. The FAERS did not have enough information to evaluate for transfusion, ED visits, IV antibiotics, or infections requiring IV antibiotics or hospital admission. Since FAERS does not provide the "abortion date," we used the "event date"; in cases where there was no "event date," we used the "latest manufacturer received date." We evaluated Aultman's AERs for the events in Cleland and confirmed any missing reports by searching the 6158 pages of AERs related to mifepristone abortion obtained by FOIA. In analyzing FOIA data, Aultman accounted for duplicates. In the FAERS data, we accounted for duplicates for deaths and ectopic pregnancies, but FAERS did not provide sufficient detail to do so for hospital admissions and ongoing pregnancies. We then compared the total number of reports, as well as hospitalizations, ongoing pregnancies, ectopic pregnancies, and deaths from Cleland, FAERS, and FOIA AERs for 2009 and 2010. Adverse events not reported by Cleland were not evaluated. The FAERS and FOIA total AERs include reports from all sources, not just from Planned Parenthood, and include all reports for those years, not just those with the eight AEs evaluated by Cleland.

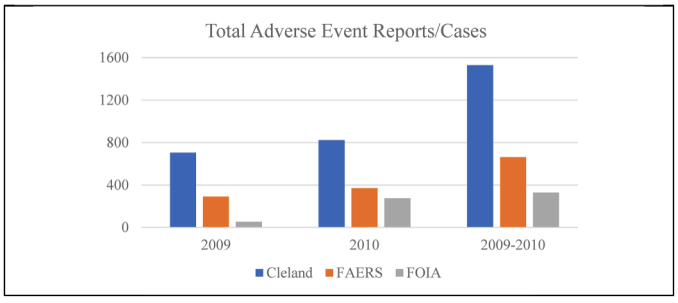

Figure 1. Comparison of total adverse event reports from three sources.

Results

Our analysis shows significant discrepancies between the number of AERs identified by Planned Parenthood as reported in Cleland, the number in the FAERS database, and the number received under FOIA. There are also discrepancies in the number of hospitalizations, ectopic pregnancies, and ongoing pregnancies.

Total Reports (Figure 1)

Cleland identified 1530 cases involving eight specific AEs after Planned Parenthood mifepristone abortion in 2009 and 2010. The FAERS dashboard contains only 664 AERs for this period, and only 330 were provided through FOIA. Both include AERS with other types of adverse events not included by Cleland and include reports from all sources, not just Planned Parenthood.

Specific Adverse Events/Outcomes (Table 1)

Cleland identified 548 ongoing pregnancies after mifepristone abortion in 2009, the FAERS dashboard includes just 56, and only seven were received via FOIA. For 2010, Cleland identified 610 ongoing pregnancies, FAERS contains just 39, and only 32 were obtained via FOIA. Cleland identified 70 hospital admissions in 2009 and 65 in 2010. FAERS includes 87 and 125, respectively, but the FDA only provided 14 and 94 via FOIA. Ectopic pregnancy, although not caused by mifepristone, is a contraindication to its use. Cleland reported eight ectopic pregnancies in 2009 and eight in 2010. FAERS includes eight for 2009 and nine for 2010. The FOIA AERs have only one ectopic for 2009 and eight for 2010. Cleland reported no deaths in 2009 and one in 2010. FAERS and FOIA were consistent with one death in 2009 and two in 2010.

Discussion

The total number of AEs published in Cleland is significantly higher than the number in the FAERs database, even though Cleland did not evaluate all AEs, including

Table 1. Comparison of Number of Specific Adverse Events[a] from Three Sources.

	2009			2010			Total 2009 to 2010		
	Cleland	FAERS[b]	FOIA	Cleland	FAERS[b]	FOIA	Cleland	FAERS[b]	FOIA
Hospital Admission	70	87	14	65	125	94	135	212	108
Transfusion	42		10	72		59	114		69
ED Treatment	87		27	151		105	238		132
IV Antibiotics	23		5	34		27	57		32
Infection requiring IV Antibiotics or Admission	14		4	23		21	37		25
Death	0	1	1	1	2	2	1	3	3
Ongoing Pregnancy	548	56	7	610	39	32	1158	95	39
Ectopic Pregnancy	8	8	1	8	9	8	16	17	9

[a]Events are not mutually exclusive.
[b]If blank, FAERS dashboard does not provide this detail.

failed abortions treated at Planned Parenthood.[4] The discrepancy is particularly concerning because the total number of AEs and AERs in the FAERS should be significantly higher than Cleland since Planned Parenthood performs only 37% of US abortions.[7] It is unclear why so many cases identified by Planned Parenthood in Cleland do not appear in FAERS. Cleland states, "In accordance with the mifepristone prescribing information, Planned Parenthood Federation of America reports all significant adverse events and outcomes to Danco Laboratories, the US distributor of mifepristone, which in turn reports them to the FDA."[4] If this claim is true, then either Danco did not report a significant number of adverse events to the FDA, or the FDA did not include them in FAERS. It also raises the question of whether FAERS includes all complications reported by the other 63% of abortion providers.

We are concerned that FDA and others will continue to rely on Cleland's statement, "significant adverse events or outcomes were reported in 1530 (0.65%) cases"[4] to claim that the complication rate for the abortion pill regimen is low. Although Cleland's paper is a study of over 200 000 abortions and is cited extensively in support of the safety of medical abortion[8–11] the analysis excludes the most common adverse events (retained products of conception and hemorrhage not requiring transfusion). Additionally, Cleland's reported complication rate of 0.65% is only a report of the complications known to Planned Parenthood. Cleland does not report the percent of patients lost to follow-up.[4]

There is also concern that the FDA will continue to rely on the FAERS to make decisions about removing mifepristone REMS, despite the findings herein that FAERS does not include all the events even known to the abortion provider. To compound this problem, in 2016, the FDA eliminated the requirement to report adverse events resulting from mifepristone other than death.[12] Nevertheless, in her April 12, 2021 letter to the American College of Obstetricians and Gynecologists, FDA Commissioner Janet Woodcock stated that, based on a review of post-marketing AEs from January 27, 2020, to January 12, 2021, the in-person dispensing requirements in the mifepristone REMS would not be enforced.[13] It is alarming that policy decisions that affect women's safety are based on a lack of information in the FAERS. Whether the inaccuracy of FAERS extends to required reporting for other medications is unknown to us, but the findings in this paper have significant implications for drug safety evaluation in general.

The ability of the FAERS to accurately identify complications from mifepristone abortion depends on 1. the abortion provider being aware of the adverse event, 2. the provider reporting the adverse event to the manufacturer, 3. the manufacturer reporting to the FDA, and 4. the FDA including the event in the FAERS. One problem inherent in this system is that adverse events unknown to the abortion provider or occurring in patients lost to follow-up will be missed. In addition, ED physicians or treating physicians other than the abortion provider were never obligated to report and may not even be aware of the system. For those events known to Planned Parenthood, it is unclear whether the error occurred in the abortion provider reporting to the manufacturer, the manufacturer reporting to the FDA, or the FDA uploading to the database.

FDA compliance in response to FOIA requests is required by law.[3] The number of AERs supplied under FOIA is much lower than the number in the FAERS database and known to the FDA at the time. Although there may be extenuating circumstances requiring that some information be withheld, withholding information, especially to this extent, interferes with independent, scientific analysis necessary to validate claims of safety and efficacy.

Strengths and Limitations

One of the limitations of this study is that Cleland only reported on a limited number of possible AEs. Because of the scant information included in the FAERS, we could not even compare all AEs reported by Cleland. Since we do not have

access to the Planned Parenthood records, reports cannot be evaluated on a patient-by-patient basis but only as a composite.

One of the strengths of this study is that it is the first known study comparing FAERS data with an outside report of mifepristone complications.

Conclusions

There are significant discrepancies in the number of AEs and total AERs reported for 2009 and 2010 mifepristone abortions identified by Planned Parenthood as reported by Cleland, those in FAERS, and those provided by FOIA, impugning the reliability of FAERS to evaluate the safety or efficacy of mifepristone abortions at a time when the FDA is under pressure to eliminate REMS on mifepristone.[14,15] The FDA used their review of post-marketing adverse events that occurred in 2020 and 2021 as a rationale for removing the in-person dispensing requirements for mifepristone during COVID, even though reporting requirements (other than death) were eliminated in 2016.[13] Whether Planned Parenthood did not submit all the AEs to Danco, Danco did not submit all to the FDA, or the FDA did not include all is unknown. By withholding a significant number of AERs, the FDA did not adequately comply with the FOIA request by the authors of the Aultman paper, hampering their ability to analyze the data. These discrepancies, and the fact that since 2016, reporting AEs other than deaths is no longer required,[12] demonstrate that the FAERS is inadequate to evaluate the safety of mifepristone.

Declaration of Conflicting Interests

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ORCID iDs

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Author biographies

Christina A. Cirucci, MD received her Bachelor of Science in Mechanical Engineering from Virginia Tech in Blacksburg, VA and her MD from Thomas Jefferson University, Philadelphia, PA. She completed her residency in obstetrics and gynecology at the Medical College of Virginia in Richmond, VA. She is a diplomate of the American Board of Obstetrics and Gynecology and a life Fellow of the American College of Obstetricians and Gynecologists. She is a member of the Christian Medical and Dental Associations, the North American Menopause Society, the Pennsylvania Medical Society, and the Allegheny County Medical Society. She is a board member of the American Association of Pro-Life Obstetricians and Gynecologists. She worked in private practice for twenty years in Pittsburgh, PA.

Kathi A. Aultman, MD received her B.A. from Drew University in 1972, earned her MD at the University of Florida College of Medicine in 1977, and completed her OB/GYN Residency at the University of Florida affiliated Jacksonville Health Education Program in 1981. She is a diplomate of the American Board of Obstetrics and Gynecology and is currently an Associate Scholar with the Charlotte Lozier Institute. She is a member of the American Association of Prolife Obstetricians and Gynecologists, the Christian Medical and Dental Associations, the Florida Medical Association, and is a Life Fellow of the American College of Obstetricians and Gynecologists. She practiced medicine from 1981-2014 in Orange Park, Florida. Dr. Aultman was the co-founder and co-director of the first Rape Treatment Center in Jacksonville, Florida and performed sexual assault exams on women and children as a medical examiner for Duval and Clay Counties. She performed 1st trimester D&C with suction abortions and 2nd trimester D&Es. She also served as the Medical Director for Planned Parenthood of Northeast Florida, Inc. from 1981 to 1983.

Donna J. Harrison, MD received her MD from the University of Michigan and completed her OBGYN residency at a University of Michigan affiliate hospital (St. Joseph Mercy Hospital). She is a diplomate of the American Board of Obstetrics and Gynecology. She is currently CEO of the American Association of Pro-Life Obstetricians and Gynecologists.

EXHIBIT 56

Pam Belluck,
CVS and Walgreens Will Begin Selling Abortion Pills this Month,
N.Y. Times (Mar. 1, 2024)

The New York Times https://www.nytimes.com/2024/03/01/health/abortion-pills-cvs-walgreens.html

CVS and Walgreens Will Begin Selling Abortion Pills This Month

The pill mifepristone will be available with a prescription at pharmacy counters in a few states to start.

By Pam Belluck

March 1, 2024

The two largest pharmacy chains in the United States will start dispensing the abortion pill mifepristone this month, a step that could make access easier for some patients.

Officials at CVS and Walgreens said in interviews on Friday that they had received certification to dispense mifepristone under guidelines that the Food and Drug Administration issued last year. The chains plan to make the medication available in stores in a handful of states at first. They will not be providing the medication by mail.

Both chains said they would gradually expand to all other states where abortion was legal and where pharmacies were legally able to dispense abortion pills — about half of the states.

President Biden said in a statement on Friday that the availability of the pill at pharmacies was “an important milestone in ensuring access to mifepristone, a drug that has been approved by the Food and Drug Administration as safe and effective for more than 20 years.”

“I encourage all pharmacies that want to pursue this option to seek certification,” he added.

Walgreens will start providing the pill within the next week in a small number of its pharmacies in New York, Pennsylvania, Massachusetts, California and Illinois, said Fraser Engerman, a spokesman for the chain. “We are beginning a phased rollout in select locations to allow us to ensure quality, safety and privacy for our patients, providers and team members,” he said.

CVS will begin dispensing in all of its pharmacies in Massachusetts and Rhode Island “in the weeks ahead,” Amy Thibault, a spokeswoman for the company, said.

The chains will be monitoring the prospects in a few states, including Kansas, Montana and Wyoming, where abortion bans or strict limitations have been enacted but are enjoined because of legal challenges.

Mr. Engerman said that Walgreens was “not going to dispense in states where the laws are unclear” to protect its pharmacists and staff members.

As for CVS, “we continually monitor and evaluate changes in state laws and will dispense mifepristone in any state where it is or becomes legally permissible to do so,” Ms. Thibault said. In some states where abortion is legal, she said, pharmacists are prohibited from dispensing mifepristone because laws require that to be done by doctors or in a hospital or clinic.

It is uncertain how much initial demand there will be for the service at brick-and-mortar pharmacies. In the states where the chains will begin dispensing, abortion pills are already available in clinics or easily prescribed through telemedicine and sent through the mail. But some women prefer to visit doctors, many of whom do not have the medication on hand. The new development will allow doctors and other eligible providers to send a prescription to a pharmacy for the patient to pick up.

“Now that doctors no longer have to stock the medicine themselves and dispense it, it increases the likelihood that a patient can go to their own doctor, the person with whom they already have a relationship, and say, ‘I’m pregnant — I don’t want to be,’” said Kirsten Moore, the director of the Expanding Medication Abortion Access Project.

She said it might also motivate more doctors and other health providers to obtain the special certification that the F.D.A. requires for prescribers of mifepristone. The steps to becoming a certified prescriber are simple, but some doctors have been deterred because of the paperwork and logistics of having to order and stock the pills.

As the availability in retail pharmacies expands, they may become a more popular alternative, and depending on the outcome of a case the Supreme Court will hear later this month, the pharmacy option could take on more importance.

In that case, abortion opponents have sued the F.D.A., seeking to remove mifepristone from the market in the United States. An appeals court ruling in that case did not go that far but effectively banned the mailing of mifepristone and required in-person doctor visits. If the Supreme Court upholds that ruling, it could mean that patients would have to obtain mifepristone by visiting a clinic or doctor. If such a ruling allowed pharmacies to continue dispensing, more patients might obtain the medication there.

Abortion opponents criticized the pharmacy chains' decision. "As two of the world's largest, most trusted 'health' brands, the decision by CVS and Walgreens to sell dangerous abortion drugs is shameful, and the harm to unborn babies and their mothers incalculable," Katie Daniel, the state policy director of Susan B. Anthony Pro-Life America, said in a statement.

In order to obtain certification, the pharmacy chains had to take specific steps, including ensuring that their computerized systems protected the privacy of prescribers, who are certified under a special program that the F.D.A. applies to mifepristone and several dozen other medications.

Pharmacy certification is granted by manufacturers of mifepristone. Walgreens was certified by the brand name manufacturer Danco Laboratories, and is seeking certification from the generic manufacturer GenBioPro, Mr. Engerman said. CVS was certified by GenBioPro.

Medication abortion is a two-drug regimen that is now the most common method of terminating pregnancies in the United States and is typically used through 12 weeks of pregnancy. Mifepristone, which blocks a hormone necessary for pregnancy development, is taken first, followed 24 to 48 hours later by misoprostol, which causes contractions that expel pregnancy tissue.

The same regimen is also used for miscarriages, and those patients can now also obtain mifepristone from the pharmacy chains.

Mifepristone has been tightly regulated by the F.D.A. since its approval in 2000. It had previously been available primarily from the prescribers or from clinics or telemedicine abortion services, in which the pills were generally shipped from one of two mail-order pharmacies that were authorized. Misoprostol has never been as tightly restricted as mifepristone and is used for many different medical conditions. It is easily obtained at pharmacies through a typical prescription process.

The American Pharmacists Association urged the F.D.A. to allow retail pharmacies to distribute mifepristone, even though the medication is unlikely to generate significant revenue. In a statement last year, the association said that it wanted the agency “to level the playing field by permitting any pharmacy that chooses to dispense this product to become certified.”

Shortly after the F.D.A. policy change was announced in January 2023, Walgreens and CVS said they planned to become certified and offer mifepristone in states where laws would allow pharmacies to dispense it.

Walgreens later became the focus of a consumer and political firestorm after it responded to threatening letters from Republican attorneys general in 21 states, confirming that it would not dispense the medication in those states.

Both chains have had protests outside their stores, mostly from anti-abortion advocates, and similar protesters interrupted a meeting of shareholders at Walgreens Boots Alliance, the chain’s parent company.

CVS is the nation's largest chain with over 9,000 stores in all 50 states. Walgreens has about 8,500 stores in all states except North Dakota. Neither chain would discuss the price of the medication, but both noted that some insurance policies would cover it in some states.

A handful of small independent pharmacies began dispensing mifepristone last year.

Pam Belluck is a health and science reporter, covering a range of subjects, including reproductive health, long Covid, brain science, neurological disorders, mental health and genetics.

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: 2 Major Chains Prepare to Sell Abortion Pills

EXHIBIT 57

2019 REMS Single Shared System for
Mifepristone 200MG
(Apr. 2019)

Initial Shared System REMS approval: 04/2019

Mifepristone Tablets, 200 mg

Progestin Antagonist

RISK EVALUATION AND MITIGATION STRATEGY (REMS)

SINGLE SHARED SYSTEM FOR MIFEPRISTONE 200MG

I. GOAL

The goal of the REMS for mifepristone is to mitigate the risk of serious complications associated with mifepristone by:

a) Requiring healthcare providers who prescribe mifepristone to be certified in the Mifepristone REMS Program.

b) Ensuring that mifepristone is only dispensed in certain healthcare settings by or under the supervision of a certified prescriber.

c) Informing patients about the risk of serious complications associated with mifepristone.

II. REMS ELEMENTS

A. Elements to Assure Safe Use

1. Healthcare providers who prescribe mifepristone must be specially certified.
   a. To become specially certified to prescribe mifepristone, healthcare providers must:
      i. Review the Prescribing Information for mifepristone.
      ii. Complete a *Prescriber Agreement Form*. By signing a *Prescriber Agreement Form*, prescribers agree that:
         1) They have the following qualifications:
            a) Ability to assess the duration of pregnancy accurately
            b) Ability to diagnose ectopic pregnancies
            c) 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 ability to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
         2) They will follow the guidelines for use of mifepristone (see b.i-v below).
   b. As a condition of certification, healthcare providers must follow the guidelines for use of mifepristone described below:
      i. Review the *Patient Agreement Form* with the patient and fully explain the risks of the mifepristone treatment regimen. Answer any questions the patient may have prior to receiving mifepristone.

ii. Sign the *Patient Agreement Form* and obtain the Patient's signature on the *Form*

iii. Provide the patient with a copy of the *Patient Agreement Form* and Medication Guide.

iv. Place the signed *Patient Agreement Form* in the patient's medical record.

v. Record the serial number from each package of mifepristone in each patient's record.

vi. Report any deaths to the Mifepristone Sponsor that provided the mifepristone, identifying the patient by a non- identifiable reference and the serial number from each package of mifepristone.

c. Mifepristone Sponsors must:

i. Ensure that healthcare providers who prescribe their mifepristone are specially certified in accordance with the requirements described above and de-certify healthcare providers who do not maintain compliance with certification requirements

ii. Provide the Prescribing Information and their *Prescriber Agreement Form* to healthcare providers who inquire about how to become certified.

The following materials are part of the REMS and are appended:

- *Prescriber Agreement Form for Danco Laboratories, LLC*
- *Prescriber Agreement Form for GenBioPro, Inc.*
- *Patient Agreement Form*

2. Mifepristone must be dispensed to patients only in certain healthcare settings, specifically clinics, medical offices, and hospitals, by or under the supervision of a certified prescriber.

a. Mifepristone Sponsors must:

i. Ensure that their mifepristone is available to be dispensed to patients only in clinics, medical offices and hospitals by or under the supervision of a certified prescriber.

ii. Ensure that their mifepristone is not distributed to or dispensed through retail pharmacies or other settings not described above.

3. Mifepristone must be dispensed to patients with evidence or other documentation of safe use conditions.

a. The patient must sign a *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.

B. Implementation System

1. Mifepristone Sponsors must ensure that their mifepristone is only distributed to clinics, medical offices and hospitals by or under the supervision of a certified prescriber by:

a. Ensuring that distributors who distribute their mifepristone comply with the program requirements for distributors. The distributors must:

i. Put processes and procedures in place to:

a. Complete the healthcare provider certification process upon receipt of a Prescriber Agreement Form.

b. Notify healthcare providers when they have been certified by the Mifepristone REMS Program.

c. Ship mifepristone only to clinics, medical offices, and hospitals identified by certified prescribers in their signed *Prescriber Agreement Form*.

d. Not ship mifepristone to prescribers who become de-certified from the Mifepristone REMS Program.

e. Provide the Prescribing Information and their Prescriber Agreement Form to healthcare providers who (1) attempt to order mifepristone and are not yet certified, or (2) inquire about how to become certified.

ii. Put processes and procedures in place to maintain a distribution system that is secure, confidential and follows all processes and procedures, including those for storage, handling, shipping, tracking package serial numbers, proof of delivery and controlled returns of mifepristone.

iii. Train all relevant staff on the Mifepristone REMS Program requirements.

iv. Comply with audits by Mifepristone Sponsors, FDA or a third party acting on behalf of Mifepristone Sponsors or FDA to ensure that all processes and procedures are in place and are being followed for the Mifepristone REMS Program. In addition, distributors must maintain appropriate documentation and make it available for audits.

b. Ensuring that distributors maintain secure and confidential distribution records of all shipments of mifepristone.

2. Mifepristone Sponsors must monitor their distribution data to ensure compliance with the REMS Program.

3. Mifepristone Sponsors must audit their new distributors within 90 calendar days after the distributor is authorized to ensure that all processes and procedures are in place and functioning to support the requirements of the Mifepristone REMS Program. Mifepristone Sponsors will take steps to address their distributor compliance if noncompliance is identified.

4. Mifepristone Sponsors must take reasonable steps to improve implementation of and compliance with the requirements of the Mifepristone REMS Program based on monitoring and assessment of the Mifepristone REMS Program.

5. Mifepristone Sponsors must report to FDA any death associated with mifepristone whether or not considered drug-related, as soon as possible but no later than 15 calendar days from the initial receipt of the information by the applicant. This requirement does not affect the applicants other reporting and follow-up requirements under FDA regulations.

C. Timetable for Submission of Assessments

The NDA Sponsor must submit REMS assessments to FDA one year from the date of the initial approval of the REMS (04/11/2019) and every three years thereafter. To facilitate inclusion of as much information as possible while allowing reasonable time to prepare the submission, the reporting interval covered by each assessment should conclude no earlier than 60 calendar days before the submission date for that assessment. The NDA Sponsor must submit each assessment so that it will be received by the FDA on or before the due date.

Mifeprex* (Mifepristone) Tablets, 200 mg, is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation. Please see Prescribing Information and Medication Guide for complete safety information.

To set up your account to receive Mifeprex, you must:
1. complete, 2. sign, and 3. fax page 2 of this form to the distributor.

If you will be ordering for more than one facility, you will need to list each facility on your order form before the first order will be shipped to the facility.

Prescriber Agreement: By signing page 2 of this form, you agree that you meet the qualifications below and will follow the guidelines for use. You also understand that if you do not follow the guidelines, the distributor may stop shipping Mifeprex to you.

Mifeprex must be provided by or under the supervision of a healthcare provider who prescribes and meets the following qualifications:

- Ability to assess the duration of pregnancy accurately.
- Ability to diagnose ectopic pregnancies.
- 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 ability to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
- Has read and understood the Prescribing Information of Mifeprex. The Prescribing Information is available by calling our toll free number, 1-877-4 Early Option (1-877-432-7596), or logging on to our website, www.earlyoptionpill.com.

In addition to meeting these qualifications, you also agree to follow these guidelines for use:

- Review the Patient Agreement Form with the patient and fully explain the risks of the Mifeprex treatment regimen. Answer any questions the patient may have prior to receiving Mifeprex.
- Sign and obtain the patient's signature on the Patient Agreement Form.
- Provide the patient with a copy of the Patient Agreement Form and the Medication Guide.
- Place the signed Patient Agreement Form in the patient's medical record.
- Record the serial number from each package of Mifeprex in each patient's record.
- Report deaths to Danco Laboratories, identifying the patient by a non-identifiable patient reference and the serial number from each package of Mifeprex.

TO SET UP YOUR ACCOUNT:

1. Read the Prescriber Agreement on page 1 of this form.
2. Complete and sign this form.
3. Fax this page to the Danco distributor at 1-866-227-3343. Your account information will be kept strictly confidential.
4. The distributor will call to finalize your account setup and take your initial order.
5. Subsequent orders may be phoned or faxed and are usually shipped within 24 hours.

Mifeprex® (Mifepristone) Tablets, 200 mg
THE ORIGINAL EARLY OPTION PILL

ACCOUNT SETUP MIFEPREX® (Mifepristone) Tablets, 200 mg; NDC 64875-001-01

BILLING INFORMATION

Bill to Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Attention _____

SHIPPING INFORMATION ☐ *Check if same as above*

Ship to Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Attention _____

ADDITIONAL SITE LOCATIONS *I will also be prescribing Mifeprex* at these additional locations:*

Name _____ Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Name _____ Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

(Any additional sites may be listed on an attached sheet of paper.)

REQUEST ADDITIONAL MATERIALS

☐ **Medication Guides** ☐ **State Abortion Guides** ☐ **Patient Brochures** ☐ **Patient Agreement Form**

ESTABLISHING YOUR ACCOUNT ***(required only with first order)***

Each facility purchasing Mifeprex must be included on this form (*see additional site locations box above*) before the distributor can ship the product to the facility.

By signing below, you agree that you meet the qualifications and that you will follow the guidelines for use on page 1 of the Prescriber Agreement.

Print Name _____ Signature _____

Medical License # _____ Date _____

FAX THIS COMPLETED FORM TO THE AUTHORIZED DISTRIBUTOR. FAX: 1-866-227-3343

Please fax any questions to the above number or call 1-800-848-6142.

*MIFEPREX is a registered trademark of Danco Laboratories, LLC.

Reference ID: 3909592
Reference ID: 4499499

PRESCRIBER AGREEMENT FORM Mifepristone Tablets, 200 mg

Mifepristone Tablets, 200 mg, is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation. Please see Prescribing Information and Medication Guide for complete safety information.

To set up your account to receive mifepristone, you must:
1. complete, 2. sign and 3. fax page 2 of this form to the distributor.

If you will be ordering for more than one facility, you will need to list each facility on your order form before the first order will be shipped to the facility.

Prescriber Agreement: By signing page 2 of this form, you agree that you meet the qualifications below and will follow the guidelines for use. You also understand that if you do not follow the guidelines, the distributor may stop shipping mifepristone to you.

Mifepristone must be provided by or under the supervision of a healthcare provider who prescribes and meets the following qualifications:

- Ability to assess the duration of pregnancy accurately.
- Ability to diagnose ectopic pregnancies.
- 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 ability to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
- Has read and understood the Prescribing Information for mifepristone. The Prescribing Information is available by calling our toll free number, 1-855-MIFE-INFO (1-855-643-3463), or logging on to our website, www.MifeInfo.com.

In addition to having these qualifications, you also agree to follow these guidelines for use:

- Review the Patient Agreement Form with the patient and fully explain the risks of the mifepristone treatment regimen. Answer any questions the patient may have prior to receiving mifepristone.
- Sign and obtain the patient’s signature on the Patient Agreement Form.
- Provide the patient with a copy of the Patient Agreement Form and the Medication Guide.
- Place the signed Patient Agreement Form in the patient's medical record.
- Record the serial number from each package of mifepristone in each patient’s record.
- Report deaths to GenBioPro, identifying the patient by a non-identifiable patient reference and the serial number from each package of mifepristone.

ACCOUNT SETUP

Mifepristone Tablets, 200 mg; NDC 43393-001-01

TO SET UP YOUR ACCOUNT:

1. **Read the Prescriber Agreement on Page 1 of this form.**
2. **Complete and sign this form.**
3. **Fax this page to the GenBioPro distributor at 1-877-239-8036.**

Your account information will be kept strictly confidential.

4. **The distributor will call to finalize your account setup and take your initial order.**
5. **Subsequent orders may be phoned or faxed and are usually shipped within 24 hours**

BILLING INFORMATION

Bill to Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Attention _____

SHIPPING INFORMATION ☐ *Check if same as above*

Ship to Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Attention _____

ADDITIONAL SITE LOCATIONS *I will also be prescribing mifepristone at these additional locations:*

Name _____ Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Name _____ Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

(Any additional sites may be listed on an attached sheet of paper)

REQUEST ADDITIONAL MATERIALS

☐ **Medication Guides** ☐ **State Abortion Guides** ☐ **Patient Brochures** ☐ **Patient Agreement Form**

ESTABLISHING YOUR ACCOUNT *(required only with first order)*

Each facility purchasing mifepristone tablets must be included on this form (see *additional site locations box above*) before the distributor can ship the product to the facility.

By signing below, you agree that you meet the qualifications and that you will follow the guidelines for use on page 1 of the Prescriber Agreement.

Print Name _____ Signature _____

Medical License # _____ Date _____

FAX THIS COMPLETED FORM TO THE AUTHORIZED DISTRIBUTOR. FAX: 1-877-239-8036

Please fax any questions to the above number or call 1-877-239-8036

PATIENT AGREEMENT FORM — Mifepristone Tablets, 200mg

Healthcare Providers: *Counsel the patient on the risks of mifepristone. Both you and the patient must sign this form.*

Patient Agreement:

1. I have decided to take mifepristone and misoprostol to end my pregnancy and will follow my provider's advice about when to take each drug and what to do in an emergency.
2. I understand:
   a. I will take mifepristone on Day 1.
   b. My provider will either give me or prescribe for me the misoprostol tablets which I will take 24 to 48 hours after I take mifepristone.
3. My healthcare provider has talked with me about the risks including:
   - heavy bleeding
   - infection
   - ectopic pregnancy (a pregnancy outside the womb)
4. I will contact the clinic/office right away if in the days after treatment I have:
   - a fever of 100.4°F or higher that lasts for more than four hours
   - severe stomach area (abdominal) pain
   - heavy bleeding (soaking through two thick full-size sanitary pads per hour for two hours in a row)
   - stomach pain or discomfort, or I am "feeling sick", including weakness, nausea, vomiting, or diarrhea, more than 24 hours after taking misoprostol
5. My healthcare provider has told me that these symptoms could require emergency care. If I cannot reach the clinic or office right away my healthcare provider has told me who to call and what to do.
6. I should follow up with my healthcare provider about 7 to 14 days after I take mifepristone to be sure that my pregnancy has ended and that I am well.
7. I know that, in some cases, the treatment will not work. This happens in about 2 to 7 out of 100 women who use this treatment. If my pregnancy continues after treatment with mifepristone and misoprostol, I will talk with my provider about a surgical procedure to end my pregnancy.
8. If I need a surgical procedure because the medicines did not end my pregnancy or to stop heavy bleeding, my healthcare provider has told me whether they will do the procedure or refer me to another healthcare provider who will.
9. I have the MEDICATION GUIDE for mifepristone. I will take it with me if I visit an emergency room or a healthcare provider who did not give me mifepristone so that they will understand that I am having a medical abortion with mifepristone.
10. My healthcare provider has answered all my questions.

Patient Signature: _____ **Patient Name** (print): _____ **Date**: _____

The patient signed the PATIENT AGREEMENT in my presence after I counseled her and answered all her questions. I have given her the MEDICATION GUIDE for mifepristone.

Provider's Signature: _____ **Name of Provider** (print): _____ **Date**: _____

After the patient and the provider sign this PATIENT AGREEMENT, give 1 copy to the patient before she leaves the office and put 1 copy in her medical record.

05/2016

EXHIBIT 58

HHS, Marking the 50th Anniversary of Roe: Biden-Harris Administration Efforts to Protect Reproductive Health Care (Jan. 19, 2023)

Marking the 50th Anniversary of Roe:
Biden-Harris Administration Efforts to Protect

Reproductive Health Care

A REPORT BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Marking the 50th Anniversary of *Roe*:

Biden-Harris Administration Efforts to Protect Reproductive Health Care

A Report by the U.S. Department of Health and Human Services

On June 24, 2022, the Supreme Court of the United States overturned *Roe v. Wade* and eliminated a woman's right to make decisions about her own health care. As of today, more than a dozen states have abortion bans in place. These restrictions have impacted the health and wellbeing of millions of women and allowed for government interference in deeply personal medical decisions.

HHS Actions Since *Dobbs*

In the face of this health crisis, the Department of Health and Human Services (HHS) continues to take the actions possible to defend reproductive rights and support access to the full spectrum of reproductive care, including abortion and contraception. In response to President Biden's Executive Order 14076, HHS issued an Action Plan to Protect and Strengthen Reproductive Care that outlined the Department's approach. HHS Secretary Becerra co-chairs the White House Interagency Task Force on Reproductive Healthcare Access, which was established by President Biden in Executive Order 14076 and coordinates efforts across the Federal government to protect access to reproductive healthcare services. Separately, Secretary Becerra established and leads HHS's Task Force on Reproductive Healthcare Access, which is composed of senior-level HHS officials and regularly meets to coordinate policymaking, program development, and outreach efforts across the Department.

Our strategy has focused on:

1. **Protecting Access to Abortion Services**
2. **Safeguarding Access to Birth Control**
3. **Protecting Patient Privacy**
4. **Promoting Access to Accurate Information**
5. **Ensuring Non-discrimination in Healthcare Delivery**
6. **Evidence-Based Decision Making at FDA**

We continue to activate all divisions of the Department in service to our commitment to ensuring women across the country are able to access the care they need. Secretary Becerra and senior officials at HHS continue to travel the country, meeting with Americans in their communities, listening to their stories, and making sure they know their rights.

Below is a summary of actions HHS has taken since the *Dobbs* decision, using the authorities available to the Department, to protect access to reproductive rights, including abortion and contraception.

1. Protecting Access to Abortion Services

- **Protecting Emergency Medical Care:** HHS issued guidance and a letter from Secretary Becerra to reaffirm that the Emergency Medical Treatment and Labor Act (EMTALA) protects providers in Medicare-participating emergency departments when offering legally mandated, life- or health-saving abortion services as stabilizing care for emergency medical conditions.[1]
- **Encouraging States to Pursue Medicaid Waivers:** Secretary Becerra and CMS Administrator Chiquita Brooks-LaSure issued a letter to U.S. governors inviting them to apply for Medicaid section 1115 demonstration projects to provide increased access to reproductive health care for women.

2. Protecting Access to Birth Control

- **Clarifying Protections for Women with Private Health Insurance.** Under the Affordable Care Act (ACA), most private health plans are required to provide birth control and family planning counseling with no out-of-pocket costs. With the Departments of the Treasury and Labor, HHS convened a meeting with health insurers and employee benefit plans and sent them a letter, calling on the industry to commit to meeting their obligations to cover contraceptive coverage as required under the ACA. Later, in response to this conversation, HHS issued guidance to clarify protections for birth control coverage under the ACA.
- **Ensuring Access to Family Planning Services at Health Centers:** In December 2022, the Health Resources and Services Administration (HRSA) provided updated technical assistance to HRSA-funded community health centers to reiterate the statutory and regulatory requirements for these providers to provide family planning services to their patients. The technical assistance included evidence-based recommendations and resources to support health centers in providing these services.
- **Supporting Quality Family Planning Services:** HHS awarded more than $106 million to support reproductive health services and adolescent health that includes:
    - $7.75 million, with nearly $3 million in new funding, to provide training and technical assistance for staff working in the nationwide network of Title X family planning services projects and Teen Pregnancy Prevention grantees through the

[1] In Texas v. Becerra, the court ordered the following preliminary relief with regards to the Centers for Medicare & Medicaid Services's July 11, 2022 Guidance, entitled "Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals-UPDATED JULY 2022)," and Secretary Becerra's accompanying July 11, 2022, Letter: (1) The defendants may not enforce the Guidance and Letter's interpretation that Texas abortion laws are preempted by EMTALA; and (2) The defendants may not enforce the Guidance and Letter's interpretation of EMTALA—both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against AAPLOG's members and CMDA's members.

Reproductive Health National Training Center and the National Clinical Training Center for Family Planning; and

- $6.2 million in Title X Family Planning Research grants, Research to Practice Center grants, and Teenage Pregnancy Prevention Evaluation and Research grants as part of HHS' work to protect and expand access to reproductive healthcare.

3. Protecting Medical Privacy

- **Protecting Medical Privacy:** HHS issued guidance that addresses how federal law and regulations protect individuals' private medical information (known as protected health information or PHI) relating to abortion and other sexual and reproductive health care – making it clear that providers are not required to disclose private medical information to third parties.
- **Empowering Patients to Protect Their Medical Information on Smart Phones and Apps:** HHS issued guidance that addresses the extent to which private medical information is protected on personal smart phones and tablets, and provides tips for protecting individuals' privacy when using period trackers and other health information apps.
- **Clarifying the Use of Online Tracking Technologies:** HHS issued guidance on how federal law and regulations apply to online tracking technologies that are used to collect and analyze user information on various websites and smartphone apps. Some regulated entities regularly share electronic protected health information (ePHI) with online tracking technology vendors and some may be doing so in a manner that violates the HIPAA Rules. The Bulletin explains what tracking technologies are, how they are used, and what steps regulated entities must take to protect ePHI when using tracking technologies.

4. Ensuring Access to Accurate Information

- **Providing Accurate Information on Health and Rights for Patients and Providers:** HHS launched the ReproductiveRights.gov public awareness website, which includes accurate information about reproductive health, including a Know-Your-Rights patient factsheet to help patients and providers.
- **Hearing Directly from Communities Across the Country:**
  - In response to Executive Order 14079 HHS has held national convenings in-person and remotely with providers, patient advocates, provider associations and other stakeholders to inform patients of their rights and providers of their obligations under Federal non-discrimination laws and potential consequences of non-compliance as well as listening sessions with patients, providers, and others regarding reproductive health. Discussions have centered around concerns regarding information providers can and cannot share with their

patients; to what extent federally funded sites can provide reproductive health care; and general concerns about inaccurate information.

- Secretary Becerra and other senior leaders have continuously engaged local and state officials on the frontlines of these efforts, regularly communicating with governors, state Attorneys General, and state Medicaid directors on what they're seeing in their states and how HHS can support them and their residents in protecting and expanding access to reproductive health care.

5. Ensuring Nondiscrimination in Healthcare Delivery

- **Protecting Patients and Providers from Discrimination**
  - HHS issued a proposed rule that would strengthen the regulations interpreting the nondiscrimination provision of the ACA and would reinforce that discrimination on the basis of sex includes discrimination on the basis of pregnancy or related conditions.
  - After hearing concerns that individuals were experiencing delays and denials of lawfully prescribed medications, HHS issued guidance to roughly 60,000 U.S. retail pharmacies, clarifying their obligations under federal civil rights laws to not discriminate on the basis of sex or disability. These civil rights requirements prohibit discrimination in supplying medications; making determinations regarding the suitability of a prescribed medication for a patient; and advising patients about medications to ensure these actions are done in manner that does not discriminate against patients.

6. Evidence-Based Decision Making at FDA

- **Emergency Contraceptive Labeling**: In December 2022, the FDA approved changes to the labeling for Plan B One Step, a type of emergency contraception, after FDA scientists carefully reviewed the available data and evidence. FDA determined the current science supports a conclusion that Plan B One-Step works by inhibiting or delaying ovulation and the midcycle hormonal changes. The evidence also supports the conclusion that there is no direct effect on fertilization or implantation. Accordingly, FDA approved labeling changes that remove descriptions of fertilization and implantation from the discussion of Plan B One Step's mechanism of action. These updates were made in response to the drug manufacturer's request for updates to the labeling to make it more accurate and to reduce consumer confusion. These labeling changes help ensure that providers, pharmacists, and consumers understand how Plan B One Step works and enables women to make the decision that's right for them.
- **Mifepristone for Medical Termination of Early Pregnancy:** Mifepristone has been approved by the FDA as safe and effective for over 20 years for medical termination of early pregnancy. Medication abortion accounts for the majority of early abortions in the United States. Based on a comprehensive review of the

Mifepristone Risk Evaluation and Mitigation Strategy (REMS) Program, in January 2023 the FDA approved modifications to the REMS so that Mifepristone is no longer required to be dispensed in-person. In addition, the FDA eliminated the previous REMS requirement that did not allow the drug to be dispensed by retail pharmacies; under the REMS, any pharmacy that meets the requirements, and is certified, may dispense mifepristone based on a prescription from a certified prescriber.

EXHIBIT 59

Press Release, HHS,
HHS Releases Report Detailing Biden-Harris Administration Efforts to Protect Reproductive Health Care Since Dobbs
(Jan. 19, 2023)

U.S. Department of Health and Human Services
Enhancing the health and well-being of all Americans

FOR IMMEDIATE RELEASE
January 19, 2023

Contact: HHS Press Office
202-690-6343
media@hhs.gov

HHS Releases Report Detailing Biden-Harris Administration Efforts to Protect Reproductive Health Care Since Dobbs

Sunday Marks 50th Anniversary of Supreme Court's Roe v. Wade Decision

Today, the U.S. Department of Health and Human Services (HHS) released a report entitled: "Marking the 50th Anniversary of Roe: Biden-Harris Administration Efforts to Protect Reproductive Health Care," which outlines the actions HHS has taken in the face of the health crisis precipitated by the *Dobbs* decision, which overturned *Roe v. Wade*.

"On the 50th anniversary of the *Roe v. Wade* decision, abortion, contraception, and other forms of reproductive health care are under attack in our nation like never before because the Supreme Court undermined nearly half a century of precedent protecting women's access to this critical care," said HHS Secretary Xavier Becerra. "As a result, our daughters have fewer rights than their mothers and grandmothers, and women seeking care are being put in dangerous situations with heartbreaking results."

"The Biden-Harris Administration continues to fight shoulder-to-shoulder with women and families who face this frightening new reality in states across the nation. This anniversary reminds us of what America's women lost as a result of the *Dobbs* decision, and of the importance of HHS's work to protect and expand women's access to reproductive health care. Our work won't stop until all women have access to this critical care."

Since *Dobbs,* HHS has worked to protect and expand access to reproductive care amidst unprecedented efforts by Republican officials at the national and state level to restrict access to abortion and contraception. They have taken action using the tools available to them under the Department's jurisdiction in light of the *Dobbs* decision. HHS actions have been centered on six core priorities:

1. **Protecting Access to Abortion Services**

2. **Safeguarding Access to Birth Control**
3. **Protecting Patient Privacy**
4. **Promoting Access to Accurate Information**
5. **Ensuring Non-discrimination in Healthcare Delivery**
6. **Evidence-Based Decision Making at FDA**

A few key actions HHS has taken include:

- Reaffirming the Department's commitment to protecting the right to abortion care in emergency settings under EMTALA.
- Issuing guidance <https://rejouer.perma.cc/replay web page/w/id 55f3852527e2/mp_/https://www.hhs.gov/about/news/2022/07/28/hhs-dol-treasury-issue-guidance-regarding-birth-control-coverage.html> to clarify protections for birth control coverage under the Affordable Care Act.
- Protecting medical privacy by empowering patients to protect their medical information on smart phones and Apps.

The full report can be read at https://www.hhs.gov/sites/default/files/roe-report.pdf - PDF <https://rejouer.perma.cc/replay-web-page/w/id-55f3852527e2/mp_/https://www.hhs.gov/sites/default/files/roe-report.pdf>.

This week, Secretary Becerra will meet with advocates and providers in Wisconsin, a state where abortion care is no longer being provided, and Minnesota, a state where abortion remains legal and legislators recently introduced a bill to codify the right to abortion into state law. During these visits, he will reiterate the Biden-Harris Administration's steadfast commitment to protecting access to reproductive health care, including abortion and contraception.

###

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Last revised: January 19, 2023

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For general media inquiries, please contact media@hhs.gov.

Content created by Assistant Secretary for Public Affairs (ASPA)
Content last reviewed January 19, 2023

EXHIBIT 60

White House,
FACT SHEET: The Biden-Harris Administration's
Record on Protecting Access to Medication Abortion
(Apr. 12, 2023)

APRIL 12, 2023

FACTSHEET: The Biden-Harris Administration's Record on Protecting Access to Medication Abortion

Protecting access to reproductive health care has been a priority since the beginning of the Biden-Harris Administration, made even more urgent by the Supreme Court's decision to overturn Roe v. Wade. The President and Vice President are focused on ensuring access to mifepristone, which the FDA first approved as safe and effective to end early pregnancy more than twenty years ago and which accounts for more than half of abortions in the United States.

Despite this decades-long safety record, a single court in Texas has taken the dangerous step of attempting to override FDA's approval of medication abortion—which is used not only for abortion but also for helping women manage miscarriages. If this decision stands, it will put women's health at risk and undermine FDA's ability to ensure patients have access to safe and effective medications when they need them.

This lawsuit is part of broader efforts to ban abortion nationwide and to prevent women from making their own decisions about their own bodies without government interference.

The Administration is fighting this ruling in the courts, and stands by FDA's scientific and evidence-based judgment that mifepristone is safe and effective. Shortly after the ruling last Friday, the Justice Department filed a notice of appeal to the Fifth Circuit and sought a stay of the injunction pending appeal. A wide range of stakeholders, including FDA scholars, leading medical organizations, and pharmaceutical companies, have expressed their support for maintaining access to this FDA-approved medication.

In addition to defending in court FDA's ability to approve safe and effective medications, the Biden-Harris Administration has taken the following steps to protect access to medication abortion:

- Elevating Medication Abortion in the Administration's Response to the Dobbs Decision. On the day of the Supreme Court's decision to overturn *Roe v. Wade* in June 2022, the President identified preserving access to medication abortion as one of two key priorities to guide the Administration's immediate response to the ruling. President Biden directed the Secretary of the Department of Health and Human Services (HHS) to ensure that mifepristone is as widely accessible as possible in light of the FDA's determination that the drug is safe and effective. He also emphasized the need to protect access to medication abortion in the face of attacks and to stand with medical experts who have stressed that restrictions on medication abortion are not based in science. On the same day, the Attorney General made clear that states may not ban mifepristone, a drug used in medication abortion, based on disagreement with the FDA's expert judgment about its safety and efficacy.

- Issuing an Executive Order to Protect Access to Abortion, including Medication Abortion. In an Executive Order on Protecting Access to Reproductive Healthcare Services issued in July 2022, President Biden reiterated the importance of medication abortion and directed the Secretary of HHS to identify potential actions to protect and expand access to abortion care, including medication abortion. In response, HHS developed an action plan to protect and strengthen access to reproductive care and has made significant progress in executing this plan and protecting access to care nationwide.

- Addressing Barriers to Accessing Care. In his second Executive Order on Securing Access to Reproductive and Other Healthcare Services issued in August 2022, President Biden addressed the challenges that women have faced in accessing prescription medication at pharmacies in the wake of *Dobbs*, including medication abortion, which is also used to manage miscarriages. These included reports of women of reproductive age being denied prescription medication at pharmacies—including medication that is used to treat stomach ulcers, lupus, arthritis, and cancer—due to concerns that these medications, some of which can be used in medication abortion, could be used to terminate a pregnancy. To help ensure access to medication, HHS issued guidance to roughly 60,000 U.S. retail pharmacies to emphasize their obligations under federal civil rights laws to ensure access to comprehensive reproductive health care services.

- Directing Further Efforts to Ensure Safe Access to Medication Abortion. On what would have been the 50th anniversary of *Roe v. Wade* in January 2023, President Biden issued a Presidential Memorandum on Further Efforts to Protect Access to Reproductive Healthcare Services to further protect access to medication abortion. The Presidential Memorandum directed the Attorney General, the Secretary of the Department of Homeland Security, and the Secretary of HHS to consider new actions to protect the safety and security of patients, providers, and pharmacies who wish to legally access or provide mifepristone.

This Presidential Memorandum was issued in the face of attacks by state officials to prevent women from accessing mifepristone and discourage pharmacies from becoming certified to dispense the medication. These attacks, and the Presidential Memorandum, followed independent, evidence-based action taken by FDA to allow mifepristone to continue to be prescribed by telehealth and sent by mail as well as to enable interested pharmacies to become certified.

- Engaging Medical Experts and Reproductive Rights Leaders to Underscore the Need for Medication Abortion. In February 2023, Vice President Harris convened a roundtable of leading medical experts and reproductive rights advocates to discuss how a court decision to invalidate the approval of mifepristone would affect patients and providers. Participants represented Physicians for Reproductive Health, American Medical Women's Association, the Society of Family Planning, the American Academy of Family Physicians, Planned Parenthood of Metropolitan DC, the National Women's Law Center, NARAL Pro-Choice America, the Center for Reproductive Rights, the American College of Obstetricians and Gynecologists, the ACLU, and Sister Song.

###

EXHIBIT 61

HHS, Secretary's Report,
Health Care Under Attack: An Action Plan to Protect and Strengthen Reproductive Care
(Aug. 2022)

Secretary's Report

HEALTH CARE UNDER ATTACK

An Action Plan to Protect and Strengthen Reproductive Care

A Report Required by Executive Order 14076

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Version date: August 2022*

* The posted version of the report includes a minor correction, made in November 2022, to avoid confusion.

MESSAGE FROM SECRETARY

For nearly 50 years, women in America lived in a country that guaranteed them the freedom, privacy, and autonomy to control their own bodies. Women could make decisions on their health care in consultation with their physicians, faith leaders, partners, families or whoever they trusted, without interference from a politician or the government.

On June 24, 2022, the Supreme Court of the United States overturned *Roe v. Wade*, a longstanding precedent, undermining women's privacy, autonomy, health and rights. At the Department of Health and Human Services (HHS), we have been preparing for such a decision for some time.

Earlier this year, on the 49th anniversary of *Roe v. Wade*, we launched a Reproductive Healthcare Access Task Force at HHS to plan for every action necessary to protect women's access to reproductive health care in case the unimaginable became a reality. In the time since the Supreme Court ruled in *Dobbs v. Jackson Women's Health,* we have taken several actions to protect Americans' reproductive rights and care:

Protecting Emergency Medical Care: HHS issued guidance[1] and a letter from Secretary Becerra[2] to reaffirm that the Emergency Medical Treatment and Active Labor Act (EMTALA, also known as the Emergency Medical Treatment and Labor Act) protects providers when offering legally-mandated, life- or health-saving abortion services as stabilizing care for emergency medical conditions.[3]

Safeguarding Information on Health and Rights for Patients and Providers: HHS launched the ReproductiveRights.gov public awareness website, [4] which includes accurate information about reproductive health, including a Know-Your-Rights patient fact sheet to help patients and providers.

Protecting Patients and Providers from Discrimination:

- HHS issued a proposed rule that would strengthen the regulations interpreting the nondiscrimination provision of the Affordable Care Act (ACA) and would reinforce that discrimination on the basis of sex includes discrimination on the basis of pregnancy or related conditions.[5]

- HHS issued guidance to roughly 60,000 U.S. retail pharmacies, clarifying their obligations under federal civil rights laws.[6]

Protecting Patient Privacy: HHS issued guidance that clarifies to patients and providers the extent to which federal law and regulations protect individuals' private medical information when seeking abortion and other forms of reproductive health care, as well as when using apps on smartphones.[7]

Supporting Quality Reproductive Health Care: HHS announced nearly $3 million in new funding to bolster training and technical assistance for the nationwide network of Title X family planning providers.[8]

Protecting Access to Birth Control:

- With the Departments of the Treasury and Labor, we convened a meeting with health insurers and sent them a letter, calling on the industry to commit to meeting their obligations to provide contraceptives as required by the ACA.[9]

- Later, in response to this conversation, we issued guidance to clarify protections for birth control coverage under the ACA.[10] Under the ACA, most private health plans are required to provide birth control and family planning counseling at no additional cost.

This report builds on these efforts and initiatives and outlines an action plan in response to the President's call for us to act. Further, it demonstrates the importance and continued commitment of the Administration in responding to this national crisis.

This is a critical moment in history and how we respond will speak to how we view the rights, dignity, and well-being of women everywhere. Therefore, until the day that the freedom and the autonomy to control their own bodies is afforded to all women in this country once again, we will use every tool at our disposal to protect the reproductive health of women in this country.

Xavier Becerra

Executive Summary

On June 24, 2022, the Supreme Court of the United States upended decades of precedent and well-established reproductive and privacy rights when it overturned the constitutional right to safe and legal abortion care recognized by *Roe v. Wade* and *Planned Parenthood v. Casey*.

On July 8, 2022, President Biden issued Executive Order 14076, "Executive Order on Protecting Access to Reproductive Healthcare Services," which among other things, requires the Secretary of Health and Human Services (HHS) to submit a report to the President identifying a plan and supporting actions to:

- Protect and expand access to the full range of reproductive health care, including abortion care;
- Increase outreach and education about access to reproductive health care services, including by launching a public awareness initiative; and
- Ensure all patients receive the full protections for emergency medical care afforded under the law.[11]

On August 3, 2022, President Biden issued Executive Order 14079, "Securing Access to Reproductive and Other Healthcare Services," which applauded the work already in progress by HHS and directed it to:

- Consider additional actions to advance access to reproductive health care services, including through Medicaid for patients traveling out of state for medical care;
- Consider all appropriate actions to ensure health care providers that receive federal financial assistance comply with federal non-discrimination law; and
- Evaluate the adequacy of current interagency data collection and analysis on the effect of access to reproductive healthcare on maternal health outcomes and take actions to improve these efforts.[12]

This report responds to these Executive Orders and outlines actions to protect and expand access to abortion care and other reproductive health care nationwide. It also includes an overview of the historical and legal context relevant to the Executive Orders and current and potential HHS actions to: (a) protect and expand access to abortion care and the full range of reproductive health care services; (b) bolster outreach and education about access to reproductive health care, including medication abortion and contraception; and (c) ensure women, pregnant individuals, and those experiencing pregnancy loss receive the full protections available under federal law with regards to emergency medical care.

In response to the Supreme Court's *Dobbs v. Jackson Women's Health* decision, Secretary Becerra directed HHS to take immediate action to help people across the country as they face this harsh new reality of restricted health care and rights.[13] As a result, HHS took swift, concrete actions to protect access to reproductive health care, consistent with the Administration's priorities.

In the weeks and months to come, access to reproductive health care will continue to face new attacks, in addition to ongoing challenges. Because of the *Dobbs* decision, access to reproductive health care services now depends on where an individual lives to an even greater extent than it did before. The United

States of America has an expanding patchwork of laws, wherein some states criminalize health care providers and others for providing or facilitating medical care—sometimes without meaningful exceptions for the life or health of the woman, or when the pregnancy is a result of rape or incest. Some states and localities have expressed their intention to have prosecutors enforce restrictions against women, health care providers, and others. Further, health care providers in many jurisdictions are facing potential criminal and civil liability as well as loss of licensure for providing necessary abortion related services.

Additional efforts are underway that imperil other basic health care and rights. There have been numerous reports of women denied health- and life-saving emergency care, as providers fearful of legal reprisal delay necessary treatment for patients until their conditions worsen to dangerous levels. There are also reports of women of reproductive age being denied prescription medication at pharmacies—including medication that is used to treat stomach ulcers, lupus, arthritis, and cancer—due to concerns that these medications, some of which can be used in medication abortions, could be used to terminate a pregnancy. Bans and limits are being considered on access to birth control care, including emergency contraception.

This new reality will only worsen health outcomes for women and families, especially individuals who are already underserved in our health care system, including women of color, working families, people with disabilities, and LGBTQI+ patients. The Supreme Court's *Dobbs* decision also renders the United States an outlier globally, putting our nation on a short list of countries seeking to restrict, rather than expand, access to sexual and reproductive health care.[14]

Now, more than ever, the federal government needs to play a critical role helping to ensure access to reproductive health care, including by creating safeguards for providers and patients. HHS will continue to use its authority to protect access to care, including abortion care, and enforce federal law when women's rights to care are violated.

Introduction

On June 24, 2022, the Supreme Court of the United States eliminated the constitutional right to an abortion in its ruling on *Dobbs v. Jackson Women's Health*, reversing a nearly 50-year precedent established by *Roe v. Wade* and subsequently reaffirmed in *Planned Parenthood v. Casey*—and with it, decades of accepted law. At the time of the *Dobbs* ruling, thirteen states had laws in place to ban abortion under varying circumstances in the event that *Roe v. Wade* and *Planned Parenthood v. Casey* were overturned. Several other states are considering laws to ban or further restrict abortion access in the near future.

The Supreme Court's *Dobbs* ruling and state actions to ban health care have already had dire consequences for women across the country. These restrictions will exacerbate preexisting inequities and worsen maternal health outcomes and fuel a national public health crisis with negative effects on how women access and receive care. These impacts will be felt most acutely by underserved communities, including those with low incomes and people of color. The decision is also an assault on patient privacy and bodily autonomy, with broader implications for the freedoms millions of Americans hold dear. Further, for those states and localities that intend to have prosecutors enforce restrictions against women and others who facilitate their access to health care, this may exacerbate existing disparities in the criminal justice system broadly.

It is well established that both medication and surgical abortions are safe and effective.

There have been several studies examining the impact of abortion on the health and well-being of women. For instance, the National Academies of Science, Engineering, and Medicine (NASEM) conducted a comprehensive review of the literature on the physical and mental health implications of abortion and found consistent, high-quality evidence that, contrary to certain misconceptions, abortion does not increase the risk of breast cancer, secondary infertility, pregnancy-related hypertensive disorders, preterm birth, depression, anxiety, posttraumatic stress disorder, or other mental health harms. Given strong evidence from numerous studies showing that lower socioeconomic status is associated with shorter life expectancy and various forms of morbidity including worse mental health,[15,16,17,18,19] lack of access to abortion may lead to compounding adverse health effects in the future.

This report makes recommendations on actions to help protect access to abortion care, as well as broader reproductive health care services, in the wake of the *Dobbs* decision.

SECTION 1. Access to Medication Abortion and Contraception

Abortion Care

Medication Abortion Background:

The use of medication abortion is becoming increasingly common and may help preserve access for women seeking abortions in certain circumstances who may otherwise not have access. The regulatory history of mifepristone, the FDA-approved product for medication abortion, spans more than two decades. On September 28, 2000, FDA approved Mifeprex (mifepristone, 200 mg), in a regimen with another drug (misoprostol), as safe and effective for the medical termination of early pregnancy through seven weeks gestation; and that approval was extended through ten weeks gestation in 2016.[20] Misoprostol is also sometimes prescribed by providers to help women experiencing miscarriages.

Enforcement Discretion on the REMS—COVID-19

The Mifepristone Risk Evaluation and Mitigation Strategy (REMS) Program currently requires, among other things, that the product be dispensed in-person by a certified prescriber in certain types of health care settings, as well as the use of a Patient Agreement Form.[21]

In April 2021, FDA communicated that, provided all other requirements of the Mifepristone REMS Program are met, the Agency was exercising its enforcement discretion to not pursue violations of the in-person dispensing requirement of the Mifepristone REMS Program during the COVID-19 public health emergency (PHE), including any in-person requirements that may be related to the Patient Agreement Form. The COVID-19 PHE is ongoing, and thus FDA intends to continue to exercise its enforcement discretion in this manner. As a result, pharmacies are dispensing mifepristone to patients by mail on behalf of certified health care prescribers who have purchased the product.

FDA has also undertaken a full review of the Mifepristone REMS Program and has determined that the in-person dispensing requirement is no longer necessary to assure the safe use of mifepristone for medical termination of early pregnancy, provided all the other requirements of the REMS continue to be met and that dispensing pharmacies are certified. **HHS will continue its work to protect access to FDA-regulated products for abortion that have been found to be safe and effective.**

Initiation of the REMS Modification Process

On December 16, 2021, FDA sent REMS modification notification letters to the applicants for Mifeprex and the approved generic version of Mifeprex, Mifepristone Tablets 200 mg, subject to the standard process for this type of REMS modification.[22] In response to these letters, the applicants prepared proposals to modify the REMS and submitted them to FDA. FDA is currently reviewing these REMS modifications. If the REMS modification submissions are approved, the REMS modifications will become effective. Should the submissions be approved consistent with the December 2021 letters to the applicants, people seeking medication abortion will continue to have access to Mifeprex and the approved generic version without in-person dispensing via mail-order pharmacy once the COVID-19 PHE is over.

FDA will continue the REMS modification process and review the applicants' proposed changes to the REMS related to removing the in-person dispensing requirement.

Federal Preemption—Protecting Access to Medication Abortion

The Attorney General of the United States made clear that states may not ban mifepristone based on disagreement with FDA's expert judgment about its safety and efficacy.[23] **HHS is working with the U.S. Department of Justice (DOJ) to help ensure access to care and preserve FDA's role in determining what is safe and effective for patients.**

Coverage of Abortion Services

The Hyde Amendment

The Hyde Amendment permits use of federal funds for abortions only in limited circumstances: when the pregnancy is the result of rape or incest, or when the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed. The Hyde Amendment applies to federal funds in programs and activities across HHS, including Medicaid, Medicare, the Children's Health Insurance Program, and others.[24,25]

In the wake of the *Dobbs* decision, the Centers for Medicare and Medicaid Services (CMS) continues to evaluate the impact of Hyde restrictions on coverage and further steps to expand care. **To that end, the Centers for Medicare & Medicaid Services (CMS) continues to evaluate the effect of *Dobbs* and will work to ensure states provide reproductive health care in federally funded programs, consistent with applicable Hyde Amendment restrictions.**

The Hyde Amendment disproportionately impacts access to abortion for low-income communities, people of color, and people with disabilities nationwide for whom Medicaid is the primary source of coverage for health care.[26, 27]

CMS will work with states to advance access to reproductive health care, including to the extent permitted by federal law, through Medicaid for patients traveling across state lines for medical care consistent with President Biden's Executive Order 14079. It took a first step on this action in releasing a letter to states, inviting them to work with HHS on Medicaid waivers to increase access to reproductive health care within the legal limits of the Medicaid Act.

Federal Protections for Family Planning and Birth Control Care

Reproductive Health Care Coverage—Private Market and Medicaid

Private Market

The Affordable Care Act (ACA) helps make prevention services affordable and accessible for all Americans by requiring most employer health plans and other health insurance plans to provide coverage to their enrollees for certain recommended preventive services at no additional cost. A recent HHS report

estimated that more than 58 million women were benefiting from these provisions.[28] The recommended preventive services include preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). The Women's Preventive Services Initiative reviews and recommends updates to the guidelines, including contraception and contraceptive counseling. The guidelines were last updated in December of 2021, effective for plan years starting on or after December 30, 2022, and are reviewed on an annual basis.[29]

Following President Biden's July 2022 Executive Order on ensuring access to reproductive health care, HHS, alongside the Departments of Labor and of the Treasury (the Departments), released guidance to clarify protections for birth control coverage under the ACA.[30] Under the ACA, most private health plans are required to provide coverage of birth control and family planning counseling at no additional cost. This guidance followed action in June, when the three Departments sent a letter to health insurers and employer health plan organizations,[31] and the Departments convened a meeting with them, calling on the industry to commit to meeting their obligations to provide coverage for contraceptive services at no additional cost as required by the ACA. **HHS will enforce the law to ensure access to birth control coverage under the ACA and continue to work to ensure that patients understand their coverage rights.**

Medicaid

Medicaid plays a critical role in helping to ensure access to reproductive health care for the populations it serves, including women's preventive care, family planning, and pregnancy-related care such as prenatal care, childbirth, and postpartum care. Nearly all women use some form of family planning during their reproductive years, and Medicaid is the largest source of public funding for family planning services nationally.[32] The mandatory Medicaid family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include education and counseling in the method of contraception desired or currently in use by the individual, a medical visit to change the method of contraception, and infertility treatment. States receive an enhanced federal matching rate of 90 percent for expenditures for family planning services and supplies. **CMS will continue to work with states to expand access to reproductive health care.**

Federal Family Planning Programs – Title X, Community Health Centers and More

The Office of the Assistant Secretary for Health runs the Title X program, which supports high-quality, family planning services, and preventive care including breast and cervical cancer screening, contraceptive counseling and care, sexually transmitted infection testing and treatment, and HIV screening. In October 2021, HHS issued a final rule to strengthen the nation's family planning program with nationally recognized standards of care. Subsequently, HHS awarded more than $270 million to support family planning service delivery, and more than $16 million to support telehealth enhancement and expansion. A critical part of this was funding released in Fall 2021 to help clinics in dire need as a result of the Texas abortion ban, SB 8. This funding went to support clinics in eight states. **HHS is considering other grants to help with training and capacity for clinics on sexual and reproductive health and will make family planning care a priority in its programs and services, as well as considering options to make family planning a specific condition for certain grants.**

As a result of state abortion bans, abortion providers are closing their doors and patients are at risk of losing access to providers they trust and the care they need. On June 29, 2022, HHS further issued guidance to clinics, providers, others on how Title X projects can support pregnant clients and use funds to respond to changing reproductive health care needs. **HHS is evaluating the opportunity to provide**

grants to clinics to support patient navigation and ongoing clinic stability in underserved areas that may face closure from revenue losses and state bans. Further, HHS will continue to work to make more funding available under the Title X program to help clinics with capacity limitations and support increased needs in providing Title X services to patients who travel from states where clinics have closed due to bans on abortion. HHS has also made clear to Congress that more funding is needed for the Title X program given the capacity issues in both states with bans and those without restrictions on reproductive health care.

In addition to helping clinics navigate the post-*Dobbs* reality, **HHS is also working to support more training and resources to help providers build capacity and expertise as the need for family planning care and patient information continues to grow. HRSA plans an initiative for the fall of 2022 to increase capacity for recipients of the Ryan White HIV/AIDS Program** to implement evidence-informed interventions and promising strategies around reproductive health care needs for people with HIV. This will include preventive screenings, education (including pre-conception counseling), family planning, and other reproductive health care needs for people with HIV, as well as post-natal care. CDC serves as a source of clinical guidance for health care providers and provides evidence-based guidance to reduce medical barriers to contraception access and use.[33] **CDC anticipates issuing an updated Contraceptive Guidance for Health Care Providers and has conducted the initial steps for this update**—including soliciting public comments and conducting systematic reviews.

HRSA runs our nation's health centers program. These centers provide primary and preventive health services to underserved communities, including family planning services. Services include patient-centered counseling, contraceptive services (including the full range of FDA-approved methods), pregnancy testing and counseling, assistance for patients who want to conceive, basic infertility services and screening for sexually transmitted infections. It is critical that these providers stay up to date on reproductive health care and are able to continue providing services that meet the necessary standard of care. **HRSA is in the process of updating its technical assistance guide and HHS will update and expand technical assistance guidance for Title X and community health center providers.**

Section 2: Access to Care Under the Law

Nondiscriminatory Access to Healthcare

Since the *Dobbs* decision, there have been an uptick in cases around the country where people—especially women of reproductive age—have been denied care, including medical care that is not directly related to reproductive health. Such incidents have happened in pharmacies when persons with disabilities seek their prescribed medications, some have impacted women experiencing miscarriages, and others have been the product of confusion from the decision and resulting denials of care.

The Office for Civil Rights (OCR) enforces a range of federal civil rights laws, including Section 1557 of the ACA (Section 1557),[34] which prohibits discrimination based on sex in health programs and activities. Sex discrimination includes discrimination based on current pregnancy, past pregnancy, and related medical conditions.

Section 1557 and Section 504 of the Rehabilitation Act of 1973 (Section 504) prohibits discrimination on the basis of disability by recipients of federal funding, and Title II of the Americans with Disabilities Act prohibits disability discrimination by state and local government entities. Under these laws, a covered entity cannot deny, exclude, or fail to provide an equal opportunity to benefit from a program, service, or activity, including reproductive health care services to people with disabilities. These laws prohibit discrimination in a covered entity's provision of reproductive health care services, and individuals experiencing discrimination in the provision of such care can file complaints with HHS OCR.[35] OCR is actively monitoring cases around the country and will act against entities not following their obligations under federal law. To that end, the Administration for Community Living (ACL) funds Protection and Advocacy Systems in each state that also can provide legal assistance to individuals with disabilities who face barriers in accessing reproductive health care services.[36]

Pharmacies that receive federal financial assistance are covered entities under Section 1557 and other federal civil rights laws, including Section 504. On July 13, 2022, OCR released guidance to pharmacies on their obligations under federal civil rights laws to ensure nondiscriminatory access to pharmacy services.[37] The guidance reminds covered pharmacies that they may not discriminate on the grounds prohibited by Section 1557 and Section 504, including with regard to supplying medications; making determinations regarding the suitability of a prescribed medication for a patient; or advising patients about medications and how to take them.

On August 3, 2022, President Biden signed Executive Order 14079 on "Securing Access to Reproductive and Other Healthcare Services," which directed OCR to consider all appropriate actions to advance the prompt understanding of and compliance with nondiscrimination law in obtaining medical care. This includes providing technical assistance to providers, convening providers to increase awareness of the law, and working to promote compliance. **OCR will take further action in response to this Executive Order to promote compliance, including vigorous enforcement of federal civil rights laws. As part of this important work, OCR will continue to provide technical assistance to providers on their obligations under federal civil rights law and will convene providers to help ensure providers understand their obligations under federal civil rights laws.**

On August 4, 2022, OCR published a notice of proposed rulemaking (NPRM) on Section 1557 of the Affordable Care Act.[38] The proposed rule, among other things, implements the statutory prohibition on

discrimination on the basis of sex in federal health programs and activities. The NPRM recognizes discrimination on the basis of pregnancy or related conditions as a form of prohibited sex discrimination and seeks comment on whether the Final Rule should include a stand-alone provision to this effect and what impact, if any, the *Dobbs* decision has on the implementation of Section 1557 and the implementing regulations.

Access to Emergency Medical Care

The Emergency Medical Treatment and Labor Act (EMTALA) requires that all patients who present at an emergency department of a hospital that receives Medicare funds and who request examination or treatment shall receive an appropriate medical screening examination, stabilizing treatment, and transfer if necessary, irrespective of any directly conflicting state laws or mandates. CMS released guidance on September 17, 2021, and again on July 11, 2022, emphasizing that under EMTALA, a health care provider has a legal duty to provide stabilizing medical treatment to a patient who presents to the emergency department and is found to have an emergency medical condition, and that requirement preempts any directly conflicting state law or mandate that might otherwise prohibit such treatment. [39] **HHS will continue to make information available to help patients and providers understand this important right and provide technical assistance and information to providers on their obligations under EMTALA.**[40]

As indicated in CMS guidance, the determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. Emergency medical conditions involving pregnant patients may include but are not limited to ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as severe preeclampsia. Any state laws or mandates that employ a more restrictive definition of an emergency medical condition that directly conflicts with the EMTALA definition are preempted by the EMTALA statute to the extent of this conflict.

The course of treatment necessary to stabilize such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., abortion, removal of one or both fallopian tubes, anti-hypertensive therapy, methotrexate therapy, etc.), irrespective of any directly conflicting state laws or mandates.

Thus, if a physician believes that a pregnant patient presenting at an emergency department, including certain labor and delivery departments, is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve the emergency medical condition, the physician must ensure that the patient receives that treatment. And when a state law directly conflicts with EMTALA because it prohibits abortion and does not include an exception for the life and health of the pregnant woman—or draws the exception more narrowly than EMTALA's emergency medical condition definition—that state law is preempted in the area of this direct conflict.

The enforcement of EMTALA is generally a complaint-driven process. **HHS will continue to enforce EMTALA and investigate complaints where consistent with law.**

Investigating

CMS investigations of a hospital's policies, procedures and processes, or the actions of medical personnel, are initiated by a complaint. Complaints can be filed in each state. CMS may also open an investigation based on public reports.

Enforcement

If the results of a complaint investigation indicate that a hospital violated one or more of the provisions of EMTALA, a hospital may be subject to termination of its Medicare provider agreement and/or the imposition of civil monetary penalties. Civil monetary penalties and exclusion from Medicare and Medicaid participation may be imposed against individual physicians for EMTALA violations. Furthermore, where a state purports to prohibit providers from offering the emergency care that EMTALA requires, HHS will not hesitate to refer the matter to the DOJ to take appropriate legal action. On August 2, 2022, the United States sued the State of Idaho over a law that imposes a ban on abortion.[41] Under the Idaho law, a prosecutor can indict, arrest and prosecute a physician merely by showing that an abortion has been performed, without regard to the circumstances. A physician who provides an abortion in Idaho can ultimately avoid criminal liability only by establishing as an affirmative defense that "the abortion was necessary to prevent the death of the pregnant woman" or that, before performing the abortion, the pregnant patient (or, in some circumstances, their parent or guardian) reported an "act of rape or incest" against the patient to a specified agency and provided a copy of the report to the physician. The Idaho law provides no defense for an abortion necessary to protect the health of the pregnant patient.

Idaho's criminal prohibition of all abortions, subject only to the statute's two limited affirmative defenses, directly conflicts with EMTALA and stands as an obstacle to the accomplishment of EMTALA's federal objectives of providing stabilizing care and treatment to anyone who needs it. On August 24, 2022, the United States, represented in this matter by HHS alongside DOJ, was awarded a preliminary injunction prohibiting enforcement of the Idaho law to the extent of its conflict with EMTALA. **HHS will continue to enforce the law as appropriate.**

Section 3: Protecting Patient Privacy

Recent reports indicate that state Attorneys General and other state actors may seek to use patient data to track women seeking reproductive health care, violating patient trust and privacy and creating dangerous and untenable situations for patients who are already facing limited options. Further, there have been reports about the risks posed by smart phones and mobile applications that allow patient data related to reproductive health to be shared, such as period trackers and geolocation data. These data may be used against patients and may also lead patients to feel stigma when accessing care or to not seek care at all.

The complexity of protecting the privacy of patients' reproductive health data is compounded by the dynamic nature of electronic health information and the ways it is encoded within health information technology systems. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) plays an important role in patient privacy. Information relating to a patient's sexual and reproductive health can be directly accessed or indirectly inferred based on a wide range of data points that can be included within a patient's longitudinal care record. For example, a medication list could be used to infer medical or surgical abortion care. It is essential to protect the entirety of a patient's health information.

HIPAA Compliance

OCR issued guidance on June 29, 2022, to help protect patients seeking reproductive health care, as well as their health care providers.[42] The guidance addresses how the HIPAA Privacy Rule protects individuals' private medical information ("protected health information," or PHI) relating to abortion and other sexual and reproductive health care—making it clear that HIPAA does not require providers to disclose private medical information to third parties. **HHS will continue to rigorously enforce the HIPAA Privacy, Security, and Breach Notification Rules to help protect patients seeking reproductive health care.**

OCR also issued guidance outlining best practices for consumers that addresses the extent to which private medical information is protected on personal cell phones and tablets.[43] This guidance explains that, in most cases, the HIPAA Privacy, Security, and Breach Notification Rules do not protect the privacy or security of individuals' health information when they access or store the information on personal cell phones or tablets. This guidance provides tips about steps an individual can take to decrease how their cell phone or tablet collects and shares their health and other personal information without the individual's knowledge. **HHS will continue to issue guidance, technical assistance, and support to help protect the privacy of individuals' PHI related to abortion and other sexual and reproductive health care and will provide further guidance and policies to safeguard patient privacy.**

The Office of the National Coordinator for Health IT (ONC) certification and information blocking regulations already provide for protection of patient privacy and choice when it comes to sharing electronic health information. **HHS will continue to publish guidance reinforcing health care providers' awareness of the ways in which information blocking regulations support their ability to provide care while protecting patient privacy.**

Protecting patient privacy is a critical priority for HHS, which has already begun this important work. **HHS will also host public meetings with providers and others in the health care system, including health**

information technology developers and other stakeholders, to encourage awareness of how patients can obtain their electronic health information and make informed choices about whether to share it with others (including the use of mobile health applications).

Section 4: Improving Awareness, Education and Access to Accurate Information

This section describes actions HHS has taken or will take to provide education and outreach to individuals on how to access reproductive health care services and about their rights relating to privacy, as well as outreach to key partners on the Administration's actions in response to the *Dobbs* decision.

Federal Resources and Information—ReproductiveRights.gov

HHS has launched ReproductiveRights.gov, a website that serves as a central location for information on federal reproductive rights, including rights associated with accessing abortion, birth control, and other preventive services. This site provides accurate information in an accessible format to consumers to help them understand their rights to emergency care, birth control, medication, abortion services, and other preventive health services in one location. It also provides information for individuals who do not have health insurance, including information on how to locate Title X Family Planning Clinics, health centers, and Ryan White HIV/AIDS Programs. Additionally, the public can find information regarding filing a complaint with HHS OCR if a person's civil rights or health information privacy rights are violated. This website will continue to add timely, relevant information on a range of reproductive health issues to reflect the shifting environment, and efforts are underway to ensure that materials are accessible to individuals with limited English proficiency.

Reproductiverights.gov is also cross-linked with the DOJ's Reproductive Rights website, which provides information about federal legal protections for accessing reproductive health services.[44] DOJ's website provides helpful information for clinics and individuals seeking access to reproductive health services, such as the Freedom to Access Clinic Entrances (FACE) and how to report property damage, violence or threats of violence directed at providers.[45]

HHS will continue to add timely, relevant information on a range of reproductive health issues to the website.

Outreach Efforts

HHS launched a campaign to ensure the public has information on how to access birth control. Specifically, this campaign aims to provide patients and consumers with information regarding the requirement for most health insurance plans to cover the full range of FDA-approved contraceptives including emergency contraceptives and intrauterine devices with no cost to the consumer. Additionally, information will be provided to notify the public of the ability to access, depending on income, no-cost or low-cost contraceptive services, as well as cervical cancer screenings, sexually transmitted infection (including HIV) testing, and referrals for abortion and other patient care.

OCR plans to convene with health care providers to discuss federal civil rights and health privacy obligations. This will facilitate OCR's efforts to provide informative and timely guidance to covered entities and is in furtherance of President Biden's Executive Order 14079. Through these convenings OCR will provide support in complying with the law and also help inform areas where additional policy changes or technical assistance may be helpful to advance reproductive health care.

The HHS Reproductive Access Task Force also met with advocacy organizations, providers, civil rights groups, medical experts, and faith-based partners to better understand and respond to needs following *Dobbs*. These efforts helped inform HHS's early action in response to the *Dobbs* decision. **Further, HHS will leverage external relationships in communities across the country to improve education and understanding about women's preventive health services, including birth control coverage and family planning care, at Title X clinics, community health centers, and other HHS programs and services nationwide using its existing network of providers to expand information and access to coverage for patients.**

Countering Inaccurate Information

The Office of the Surgeon General has addressed the challenges of inaccurate health information with the release of the Surgeon General's Advisory on Health Misinformation in July of 2021.[46] This advisory outlined the harms of inaccurate health information and the ways individuals, health professionals, technology platforms, and many others can combat it. In November of 2021, the Office of the Surgeon General released a Community Toolkit for Addressing Health Misinformation to help educate the public on ways to identify and appropriately engage with others about inaccurate health information.[47] Thousands of individuals, community leaders, educators, and health workers have used the toolkit for teaching and training. These efforts will continue to create a safer information environment to inform health decisions, including those on reproductive health. **HHS will work with providers and patients nationwide to counter inaccurate information.**

Section 5: Improving Data and Research

Restrictions on abortions will likely have significant impacts on maternal health outcomes. This section briefly reviews data sources that are available to monitor maternal health outcomes and track access to reproductive health services. The Department is making a number of investments to improve maternal health data infrastructure. Some of this work is improving electronic health records data and linking mothers with their children to support longitudinal studies on maternal health.[48,49] On August 3, 2022, as part of Executive Order 14079 on Securing Access to Reproductive and Other Healthcare Services, HHS was directed to evaluate the adequacy of research, data collection, and data analysis and interpretation efforts at the National Institutes of Health (NIH), the CDC, and other relevant HHS components in accurately measuring the effect of access to reproductive health care on maternal health outcomes and other health outcomes.

The Department is taking additional steps to increase its monitoring and data collection to better understand the impact on health disparities and equity as well as determine areas with needs for increased federal resources and support to protect access to health care and patient privacy. **HHS is actively exploring approaches to improve its ability to track and understand the implications of lack of access to abortion through improved comprehensive and timely data.**

Tracking Maternal Mortality and Morbidity Data

Measures of maternal mortality and severe maternal morbidity are reported on an annual basis including the CDC's maternal mortality rate and pregnancy-related mortality ratio, and severe maternal morbidity rates measured by the Agency for Healthcare Research and Quality (AHRQ). **HHS will continue these reporting systems to better understand the impact of abortion bans on maternal mortality and morbidity.**

Tracking Abortion Data

The CDC collects data that states may voluntarily report on legal abortions, which includes information on the number and type of abortions and on basic characteristics of the women who receive them.[50] Given the voluntary nature of this data collection, these data are not complete. The CDC also runs the Pregnancy Mortality Surveillance System.[51] This system monitors the impact of abortion deaths from legal abortions, illegal abortions, or abortion arising from miscarriages or pregnancy related complications. These data are also available in the Abortion Surveillance Report.[52]

Family Planning Data

Self-reported information directly from women about access to and use of services such as family planning and contraception is another relevant data resource. **Early reporting suggests that there have been changes in the types of contraceptive methods some women are seeking since the *Dobbs* decision was announced with as much as 21 percent of women reporting that they changed their contraception method in the preceding month.**[53] The CDC's Pregnancy Risk Assessment Monitoring System collects state-level population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy, as well as pregnancy intention and contraceptive use.[54] The CDC also conducts the National Survey of Family Growth, which collects information about fertility, contraceptive-use, pregnancy-

intention, adoption-intention, and pregnancy, among other related topics which will help measure the impact of the *Dobbs* decision on health care decisions in family planning care.

CDC's Behavioral Risk Factor Surveillance System includes questions in the Family Planning Module to understand contraceptive use. Data collected in 2017 and 2019 from 45 jurisdictions were used to estimate the proportion of women aged 18 to 49 years who were at risk for unintended pregnancy and had ongoing or potential need for contraceptive services.[55] The CDC's Youth Risk Behavioral Surveillance System has also monitored health-related behaviors and experiences among high school students, including sexual health behaviors, unintended pregnancy, and sexually transmitted diseases.[56] These data become imperative as we examine national impacts.

Conclusion

HHS will continue to work to strengthen and expand access to reproductive health care services. As part of this work, the Secretary has directed every part of HHS to evaluate its work and act accordingly. Specifically, the Department is taking all possible steps to increase access to medication abortion and contraception; ensure access to health care under the law; protect patient privacy related to reproductive health; increase awareness, education, and access to accurate information; and expand the collection of accurate data and research in this sphere. HHS will also continue to work across the federal government to provide its expertise and partner with federal partners on its work.

Abortion is health care, and access to it and comprehensive reproductive health services can make a huge difference in a person's life—from the autonomy to make decisions about one's own body to improved health outcomes. This report lays out our current work and actions to address the proliferation of bans and restrictions on reproductive health care nationwide. We will continue this important work until every woman has equal, access to health care, privacy, and reproductive rights.

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[21] A REMS is a drug safety program the FDA can require for particular medications with safety concerns to ensure that the benefits outweigh the risks. REMS are designed, for instance, to reinforce safe medication use by preventing, monitoring, or managing a specific risk for a particular drug. For more information, *see* Food & Drug Admin., Risk Evaluation and Mitigation Strategies | REMS (last updated Dec. 17, 2021).
[22] When FDA determines that a REMS must be modified, FDA will notify the applicant of the determination and describe the required change and the type of submission that is needed. For the REMS modifications here, the applicants were required to submit supplemental applications proposing revisions consistent with the FDA

determination. The applications must be reviewed and approved by FDA prior to implementing any changes proposed in the applications.

[23] Press Release, U.S. Dep't of Just., Attorney General Merrick B. Garland Statement on Supreme Court Ruling in *Dobbs v. Jackson Women's Health Organization* (June 24, 2022).

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[25] *Id.* ("Because Congress reauthorizes the Hyde Amendment annually as an attachment to the appropriations bill for HHS, it also restricts abortion funding under the Indian Health Service, Medicare, and the Children's Health Insurance Program.").

[26] Ctr. on Budget & Pol'y Priorities, Medicaid Works for People with Disabilities (Aug. 29, 2017).

[27] U.S. Gov't Accountability Off., GAO-19-159, Medicaid: CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements (2019).

[28] Off. of Health Pol'y, Assistant Sec'y for Plan. & Evaluation, U.S. Dep't of Health & Human Servs., Access to Preventive Services Without Cost-Sharing: Evidence from the Affordable Care Act (Jan. 11, 2022).

[29] Women's Preventive Services Guidelines, Health Res. & Servs. Admin (last updated Aug. 2022).

[30] Dep't of Labor et al., FAQs About Affordable Care Act Implementation Part 54 (July 28, 2022).

[31] Press Release, U.S. Dep't of Health & Human Servs., Secretaries Becerra, Walsh and Yellen Underscore Contraceptive Coverage Requirements for Private Insurance (June 27, 2022).

[32] Ivette Gomez et al., Medicaid Coverage for Women, Kaiser Fam. Found. (Feb. 17, 2022).

[33] CDC Contraceptive Guidance for Health Care Providers, Ctrs. for Disease Control & Prevention (last updated May 20, 2021).

[34] 42 U.S.C. § 18116.

[35] Complaint Portal Assistant, U.S. Dep't of Health & Human Servs. (last visited Aug. 25, 2022).

[36] Protecting Rights and Preventing Abuse of People with Disabilities, Admin. for Cmty. Living (last updated July 27, 2022).

[37] Off. for C.R., U.S. Dep't of Health & Human Servs., Guidance to Nation's Retail Pharmacies: Obligations Under Federal Civil Rights Laws to Ensure Access to Comprehensive Reproductive Health Care Services (last visited Aug. 25, 2022).

[38] Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824 (proposed Aug. 4, 2022) (to be codified at 42 C.F.R. 438 *et seq.*).

[39] Memorandum from Ctrs. for Medicare & Medicaid Servs., *supra* note 1.

[40] On August 24, 2022, the Northern District of Texas issued a preliminary injunction prohibiting certain applications of this guidance. *Texas v. Becerra*, No. 5:22-CV-185-H (N.D. Tex.). HHS will comply with the court's injunction.

[41] Press Release, U.S. Dep't of Just., Justice Department Sues Idaho to Protect Reproductive Rights (Aug. 2, 2022).

[42] HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care, U.S. Dep't of Health & Human Servs. (June 29, 2022).

[43] Protecting the Privacy and Security of Your Health Information When Using Your Personal Cell Phone or Tablet, U.S. Dep't of Health & Human Servs. (June 29, 2022) ("The HIPAA Rules generally *do not* protect the privacy or security of your health information when it is accessed through or stored on *your* personal cell phones or tablets. The HIPAA Rules apply only when PHI is created, received, maintained, or transmitted by covered entities and business associates.").

[44] Reproductive Rights, U.S. Dep't of Just. (last updated Aug. 2, 2022).

[45] National Task Force on Violence Against Reproductive Health Care Providers, U.S. Dep't of Just. (last updated Sept. 17, 2021).

[46] To view this advisory, *see* Surgeon Gen. of the U.S., Confronting Health Misinformation: The U.S. Surgeon General's Advisory on Building a Health Information Environment (2021).

[47] To view this toolkit, *see* Off. of U.S. Surgeon Gen., A Community Toolkit for Addressing Health Misinformation (2021).

[48] Andre Chappel et al., Addressing the Maternal Health Crisis Through Improved Data Infrastructure: Guiding Principles for Progress, Health Affs. Blog (Aug. 11, 2021).

[49] Violanda Grigorescu, Improving Data Capacity for Maternal Health Research Through EHR Data Standards, Healthcare IT News (May 31, 2022).
[50] For more information about these data, *see* CDCs Abortion Surveillance System FAQs, Ctrs. for Disease Control & Prevention (Nov. 22, 2021).
[51] Pregnancy Mortality Surveillance System, Ctrs. for Disease Control & Prevention (June 22, 2022).
[52] Katherine Kortsmit et al., Abortion Surveillance – United States, 2019, 70 Morbidity & Mortality Wkly. Rpt., Nov. 26, 2021.
[53] Harris Poll, A Notable Sum of Women are Considering Permanent Contraception (July 26, 2022).
[54] Pregnancy Risk Assessment Monitoring System, Ctrs. for Disease Control & Prevention (May 23, 2022).
[55] For the underlying data and the report produced from it estimating the need for contraceptives, *see* Lauren B. Zapata et al., Need for Contraceptive Services Among Women of Reproductive Age – 45 Jurisdictions, United States, 2017–2019, 70 Morbidity & Mortality Wkly. Rpt., June 25, 2021; Data and Statistics: Need for Contraceptive Services Among Women of Reproductive Age, Ctrs. for Disease Control & Prevention (June 24, 2021).
[56] Youth Risk Behavioral Surveillance System, Ctrs. for Disease Control & Prevention (Oct. 27, 2020).

EXHIBIT 62

Abuzz,

Abortion Pill Access in Louisiana

abuzz

X Quick Exit

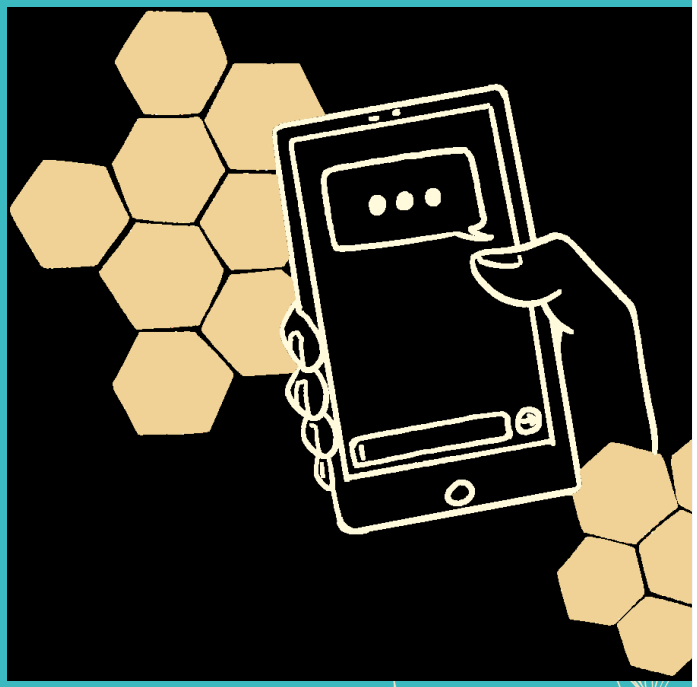
Abortion Pill Access in Louisiana

Abuzz helps people in Louisiana access abortion pills and virtual support.

People in this state may face legal risks when accessing abortion pills by mail. You can learn more about these risks here.

To get care through Abuzz, complete the short form below. You'll be referred to a licensed clinician who will review your eligibility for safe abortion care at home. If you are approved, you'll receive your FDA approved medication discreetly packaged and delivered by mail.

Fill Out The Form ›



You can find other abortion care options at INeedAnA

For help paying for a procedure and travel, call the clinic to ask about sources of financial assistance when you book your appointment.

ineedana.com

Find a clinic

Abuzz: Abortion Pill Access At Home

About Us
How it Works
FAQ
Terms of Use
Privacy Policy
Provider Payments

Donations allow us to help all pregnant people, regardless of their ability to pay. Please consider supporting our work.

DONATE

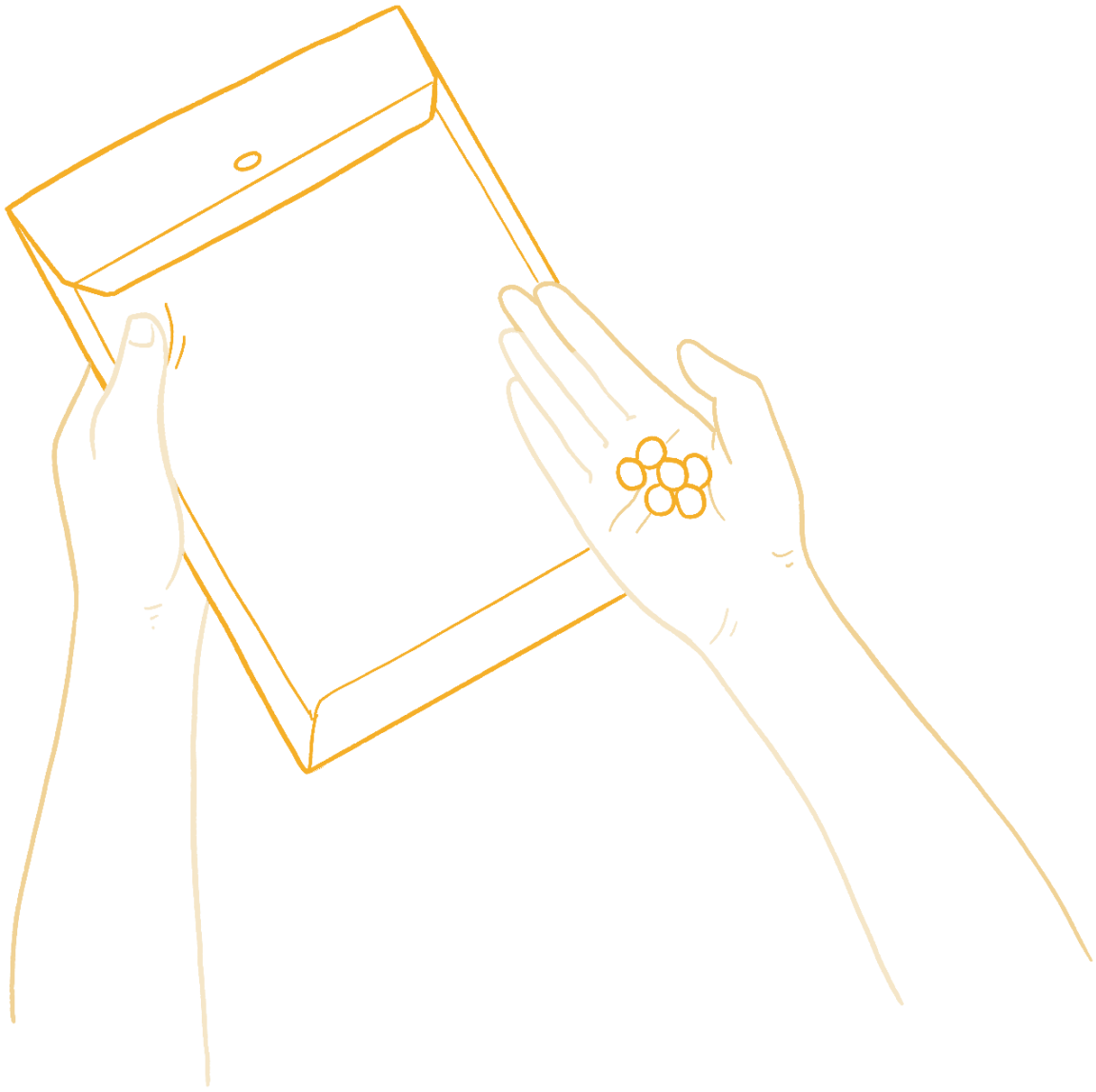
EXHIBIT 63

Abuzz,

Need abortion care at home?

Need abortion care at home?

Get access today

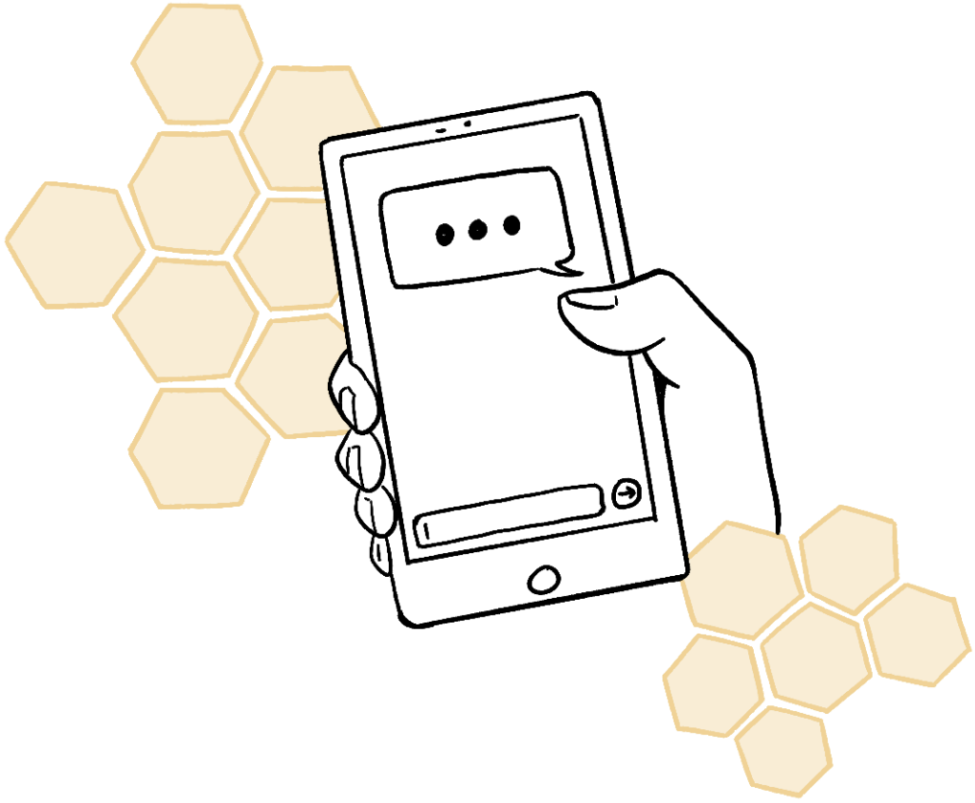


Fast, discreet shipping.

Packages arrive in 2-5 days. Medications are shipped in a plain mailing envelope.

Affordable care for everyone.

Accessing safe and affordable healthcare is a fundamental right. Services are available for $0-150 sliding scale.



The support you need, when you need it.

An experienced medical team is here to answer your questions, provide support, and guide you through the process.

Abuzz may be able to help you if...

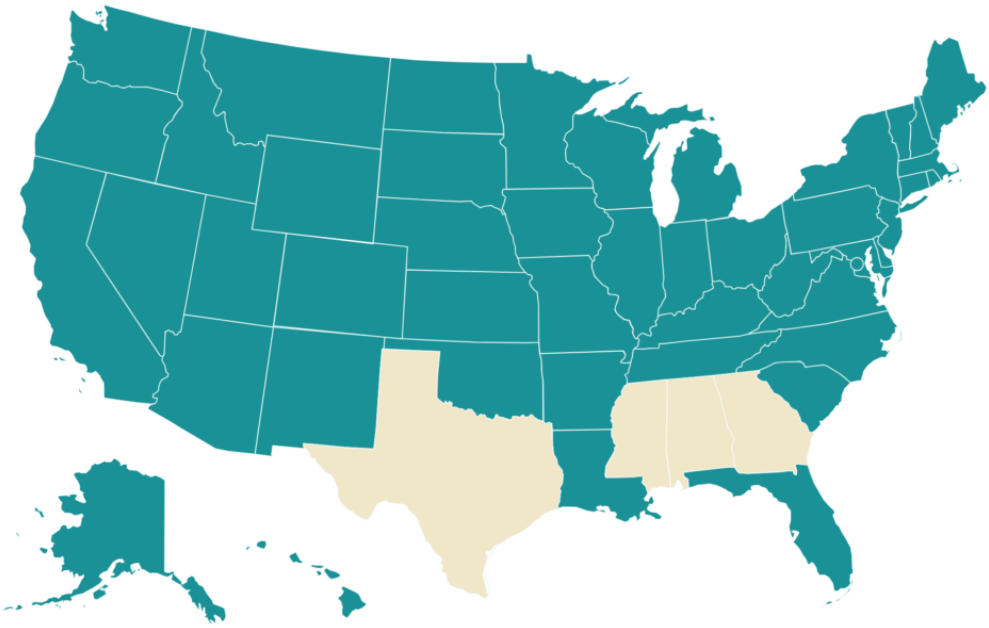
You're less than 13 weeks pregnant.

You must be less than 13 weeks pregnant to access abortion through Abuzz. Remember that pregnancy is measured from the first day of your last menstrual period, which is around two weeks before conception.

How do I estimate the length of my pregnancy? →

You're comfortable with virtual abortion care.

In most cases, providers do not require a phone call or video visit. After you fill in the form, a clinician will arrange payment with you and review your information. If you're approved to receive abortion pills by mail, your pills will be shipped out in 1-2 business days.



You have a mailing address in one of our states.

Options for at-home abortion pill access will vary based on your location. Click below to find options in your state or territory.

Select Your State ▾

Still have questions? Check out our FAQ

Go to the FAQ →

Abuzz: Abortion Pill Access At Home

About Us

How it Works

FAQ

Terms of Use

Privacy Policy

Provider Payments

Donations allow us to help all pregnant people, regardless of their ability to pay. Please consider supporting our work.

DONATE

EXHIBIT 64

A Safe Choice,
Home

A Safe Choice.
The decision is yours.

A Safe Choice is **a referral network of caring and experienced medical doctors** who provide safe, private, and effective medication abortions to women nationwide.

Call Today: **(707) 710-8866**

Trusted By:

AbortionFinder

How our service works: If you'd like to speak by phone with a doctor in the A Safe Choice network, click the link below. The initial consultation is free and confidential.

Visit Doctor's Website

Or, if you're ready to order, simply complete our quick, confidential, secure, HIPPA compliant online consultation form (no phone call required).

Go to Consultation Form

After reviewing your information, a doctor in A Safe Choice network will send abortion pills (mifepristone and misoprostol) to you discreetly via Priority Mail. The package will not identify the contents.

Price: $150. This includes a mifepristone pill, 12 misoprostol pills, shipment via US Postal Service Priority Mail, as well as medical advice and support via phone.

Click on the following links for more information

Medication Abortion

A medication abortion, also known as a medical abortion, refers to an abortion that results from taking a combination of two FDA-approved medications, **mifepristone** and **misoprostol**. Many clinical trials of medication abortion have demonstrated to be exceptionally effective and safe. Click on our Support & Resources tab to see summaries of published clinical research studies.

Telehealth medication abortion

Abortion Shield Law

All of the doctors in our network are certified mifepristone prescribers in the Food and Drug Agency's (FDA's) Mifepristone REMS Program who are licensed to practice medicine in the state of California. For more information, you can click here to learn about California's Abortion Shield Law.

Possible legal risks to you

A Safe Choice and the doctors in our network will never give or sell any of your information. We use the best and latest data security technology to ensure that whatever information you share with us stays with us.

Click on the following links for more information

Medication Abortion

Telehealth medication abortion

Mifepristone

Misoprostol

Advance provision

You can order and keep on hand abortion pills (mifepristone and misoprostol) for future use if you

want. You can keep the mifepristone and misoprostol in a cool, dark place for at least 2 years.

Privacy, confidentiality, and data security

Abortion Shield Law

Possible legal risks to you

A Safe Choice and the doctors in our network will never give or sell any of your information. We use the best and latest data security technology to ensure that whatever information you share with us stays with us.

EXHIBIT 65

A Safe Choice,

Online Consultation Form

Online Consultation Form

Your First and Last Name *

First Name

Last Name

Date of Birth *

Month Day Year

Email Address *

Email Address

Phone Number *

(000) 000-0000

Do you consent to email communication?

Yes No

Shipping Address *

Address

City *

City

State *

State

Zip Code *

Zip Code

Name of Person Receiving Package (if different than your name) (optional)

Name

Are you pregnant now? *

Yes No

List your health or medical conditions. Let us know you if you have had an allergic reaction to the medication Mifepristone or Misoprostol.

Do you have any questions for our doctors?

Services List

☐ Healthcare Services $ 150

Total: $ 0

Credit Card *

Cardholder First Name | Cardholder Last Name | Email

1234 1234 1234 1234 Autofill link | MM / YY | CVC

By completing and submitting this form, you consent to this online telehealth consultation that will be reviewed by a physician.

Within 24 hours of submitting your payment you will receive 3 emails:

1. Receipt of payment;

2. Your USPS Priority Mail tracking number; and

3. Physician instructions regarding the use of the medications.

EXHIBIT 66

Choices Rising,
Abortion Pill

CHOICES RISING

Abortion
PILL

EASY STEPS TO GET YOUR ABORTION PILL

Have photo ID and debit/credit card handy.
There is no need to have a telehealth consultation. Communication can happen via text message, email or phone call, whichever method you prefer.

STEP 1

Complete a 5 – 7 Minute Online Questionnaire

Share details about your pregnancy and medical history.

Upload a picture of your ID card.

Make a payment of $150.

Verify your phone number

Submit the intake form

Within 12-24 business hours, a Choices Rising Health Care provider will review your request.

START HERE | EMPEZAR (Español)

STEP 2

Complete the Registration Process

You will receive a link with to create a secure patient portal account.

CHOICES RISING

All forms are to be completed and submitted prior to receiving care.

STEP 3

You have been approved to receive care!

If no additional steps are required, our healthcare provider will prescribe medications. Package tracking information will be shared with you.

STEP 3

Get your medication delivered

Your package should be delivered in 3-5 days business days.

You will receive an unmarked package to protect your privacy.

ABORTION PILL (MEDICATION ABORTION)

Get the FDA-approved abortion pill prescribed by licensed abortion providers and delivered discreetly to your door a few days after your initial request.

How does the abortion pill work?

1. The first medicine you take is mifepristone, which blocks the pregnancy hormone (progesterone) and stops the pregnancy from growing.

3. You can expect bleeding like a heavy period.
4. Taken together, these two pills work up to 98 out of 100 times to end an early pregnancy.
5. After you take mifepristone (the first medication), you must complete the abortion. If treatment with medication does not work the first time, you may have the option to repeat the medicines or you will need an in-clinic procedural abortion.

Are medication abortions safe?

1. Medication abortion ("abortion pill") is one of the SAFEST medical procedures.
2. Complications occur in less than 0.4% of patients.
3. Side effects such as fever, chills, nausea, vomiting, or diarrhea are common for up to 24 hours after taking the second medication (misoprostol).

What are the risks?

1. Complications are rare and most are not serious.
2. The most common complication is a continued pregnancy. If the pregnancy continues after taking the abortion pill, you may be able to take more medicine or you will need to have an abortion procedure.
3. Serious risks, such as heavy bleeding and infection, are very rare.

What is included with the cost?

- Initial evaluation
- Abortion medications (misoprostol and mifepristone)
- Free shipping
- Aftercare instructions and care package
- Follow up email after 1 week

There is no need to have a Telehealth consultation. Communication can happen via text message, email or phone call, whichever method the patient prefers.

or more.

Who is not eligible for abortion pill

Not eligible if one of the following applies:

- Have a pregnancy that is more than 11 weeks (measured from the first day of your period)
- Are using an IUD (intrauterine device)
- Have been told by your healthcare provider that you have a pregnancy outside the uterus (ectopic pregnancy)
- Have problems with your adrenal glands (chronic adrenal failure)
- Take blood thinners
- Have a bleeding disorder
- Have porphyria (a rare disorder that affects the skin and internal organs)
- Take certain steroid medications
- Are allergic to mifepristone or misoprostol or medicines that contain misoprostol such as Cytotec or Arthrotec.

EXHIBIT 67

MAP,

Frequently asked questions

EN ES

The Massachusetts Medication Abortion Access Project (The MAP) uses an asynchronous telemedicine platform to provide medication abortion care to abortion seekers throughout the United States.

If you live in the US and your last menstrual period began less than 11 weeks ago, you may be eligible for our service. We offer medication abortion pills for immediate use, for future use, for miscarriage management, and for use as period pills.

We believe abortion care should be available and accessible to everyone. For patients who need abortion pills now, we use a pay-as-much-as-you-can-afford-to-pay model and ask for a minimum payment of $5. If you are able to pay more, please do! It helps us provide care to more patients in need.

How does The MAP work? How much does it cost? How do abortion pills work?
Other frequently asked questions

I want pills

CRHC HIPAA Privacy Policy

How does The MAP work?

If you need an abortion now…

- Step 1: Complete the initial intake form to request pills. The information you share is confidential and will allow us to contact you. The form will take less than 5 minutes to complete.
- Step 2: Once the initial intake is reviewed, we will email you a link to a medical history form and consents to sign related to obtaining abortion pills through the mail. This process will take about 15 minutes.
- Step 3: Within 24 hours a licensed clinician will review your medical history and consent forms.
- Step 4: If you are eligible for the abortion pills and nothing else is required, we will send an email with instructions for payment. Sometimes we will ask for more information or request that you have an ultrasound before mailing pills.
- Step 5: Once we receive your payment, we will ship the medications and instructions to you. We will email you the tracking information so you can keep track of your package.
- Step 6: The pills arrive in the mail and you take them at home or wherever is comfortable for you!

We will also follow-up with you after you receive the pills in the mail

- One to two weeks after you take your medications, we will email you a link with an online questionnaire to see how you are doing. The questionnaire takes less than 5 minutes to complete. A clinician will review the information and will email you if you need anything.
- Five to six weeks after you receive the medications in the mail, we will email you a link with an online questionnaire that takes less than 5 minutes to complete. We will also ask you to take a pregnancy test at that time. A clinician will review the information and will email you if anything else is required.

We can send packages to any address in the US.

If you have any technical issues, feel free to reach out: admin@crhcmap.org

How much does it cost?

For those who want pills for immediate use, we require a minimum payment of $5. If you can afford to pay more, we ask that you pay more so that we can help as many patients in need as possible.

If you are seeking pills for use in the future – you are not pregnant now but want them on hand – our service costs $150. If you are seeking period pills – you have missed a period but have not taken a pregnancy test – our service costs $75. If you are seeking pills for miscarriage management we offer care on a sliding fee scale.

We accept payments via Cash App, Zelle and Stripe (which accepts Credit cards, Apple Pay, and Google Pay). We will not charge you unless you are eligible to receive medication abortion pills from our service. Your payment covers everything, including the medications, the clinician review, and shipping. And although we ask for a minimum payment of $5 you can reach out to us if that poses a hardship.

We cannot provide subsidized care to those seeking pills for future use or those who want period pills.

Refund policy: CRHC cannot offer refunds after the pills have shipped, unless the package does not arrive (as verified by tracking).

How do abortion pills work?

Medication abortion is a safe and effective way to end a pregnancy. The medication abortion process causes cramping and bleeding that can last several hours or more. You can be at home, or wherever is comfortable for you, during the abortion process.

The medication abortion care we provide involves two types of pills: mifepristone and misoprostol.

- First, you will take 1 mifepristone pill. This pill stops the pregnancy from growing and starts the abortion process.
- Next, you will take 4 misoprostol pills. You will take these pills 24-48 hours after you take the first pill. This medicine causes cramping and bleeding that empties your uterus. The pregnancy tissue will come out through your vagina. The process is very similar to an early miscarriage or a very heavy and crampy period.
- Finally, you will take 4 more misoprostol pills. You will take these pills 4 hours after you take the first set of misoprostol pills. This helps ensure that the abortion is complete. If you are over 9 weeks gestation, we will send a third set of misoprostol pills.

Frequently asked questions

About our service | Taking the first pill (mifepristone) | Taking the second pills (misoprostol) | Side effects | What to expect after the abortion | If you need care

Is this a legitimate service?

We have been sending medication to patients all over the United States since September 28, 2023. We have been featured in The New York Times, The Boston Globe, NPR, and The Wall Street Journal. In 2024 we provided care to more than 10,000 patients.

How does your service work?

We use doctors in Massachusetts to prescribe FDA-approved abortion medication to patients who apply through our website.

How long will it take for me to get medications?

Most patients have medication in their hands less than a week after initially contacting us.

Once the forms are fully filled out, it takes 12-24 hours for one of our doctors to review and prescribe.
Once approved, we will send you information including payment information.
Once you have paid, we ship in 1-2 business days and shipping usually takes 2-5 days.

How can you provide these medications so cheaply?

We have received generous support from donors to help us provide care to as many people as possible. Our donors are as committed to abortion rights and access as we are.

How do I get in touch with you if I have questions?

Once you have completed our intake and the doctor has approved your forms, you will receive contact information. Many common questions are on our website - please look it over! We have an interactive chatbot (in the corner of each page). However, our doctors can talk to you if you have specific concerns or needs.

Cambridge Reproductive Health Consultants is a member of the National Abortion Federation, the professional society of abortion providers and clinics. We follow the National Abortion Federation's Clinical Policy Guidelines in caring for our patients. For more information about the National Abortion Federation please see their website at prochoice.org.

Cambridge Reproductive Health Consultants

1770 Massachusetts Avenue,
Suite 181
Cambridge, MA 02140

admin@crhcmap.org

Stay updated on our work

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EXHIBIT 68

Scott Calvert,
The Parties Where Volunteers Pack Abortion Pills for Red-State Women,
Wall St. J. (Aug. 12, 2024)

https://www.wsj.com/us-news/abortion-pill-parties-shipping-148e3c15

The Parties Where Volunteers Pack Abortion Pills for Red-State Women

Amid risks, volunteers are mobilizing to assist networks that mail abortion medication to women in states with strict limits

By Scott Calvert Follow | *Photographs by Kayana Szymczak for WSJ*

Aug. 12, 2024 9:00 pm ET

SOMERVILLE, Mass.—The women huddling around the conference table shuttled the small cardboard boxes along, assembly-line style. Into each went medical-information paperwork and a handwritten note proclaiming, "We wish you the best!" Then came the critical addition, a two-drug regimen that ends a pregnancy.

This tiny Boston-area office represents a new bulwark in America's abortion battle. Volunteers are mobilizing with growing frequency for pill-packing parties to help strangers in faraway states circumvent strict laws. On a recent Monday evening, the group filled 350 boxes—in-home abortion kits ready for mailing to women in states such as Texas and Florida with near-total or six-week abortion bans.

Melissa Fischer, a 57-year-old internist, sees these efforts as a way to assist people tripped up by geography. "I strongly believe where somebody lives shouldn't dictate their access to critical healthcare," she said.

Retirees and professionals ate pizza, sipped Chardonnay in red plastic cups and chatted while working purposefully. Many portray the sessions as a tangible way to push back against the 2022 Supreme Court ruling that eliminated a constitutional right to abortion.

"It's a little bit of an antidote to hopelessness," said Judy Fleishman, 70, a medical educator. "There's something you can do."

Women prepare in-home abortion kits at a 'pill-packing party' at the MAP's offices.

Growing urgency

The parties support the Massachusetts Medication Abortion Access Project, also known as the MAP, part of a growing movement to send abortion pills into ban states, often for just a few dollars. The nearly year-old MAP, like similar programs, leverages a state shield law meant to protect clinicians from legal jeopardy, including extradition. Massachusetts is among eight states with such laws.

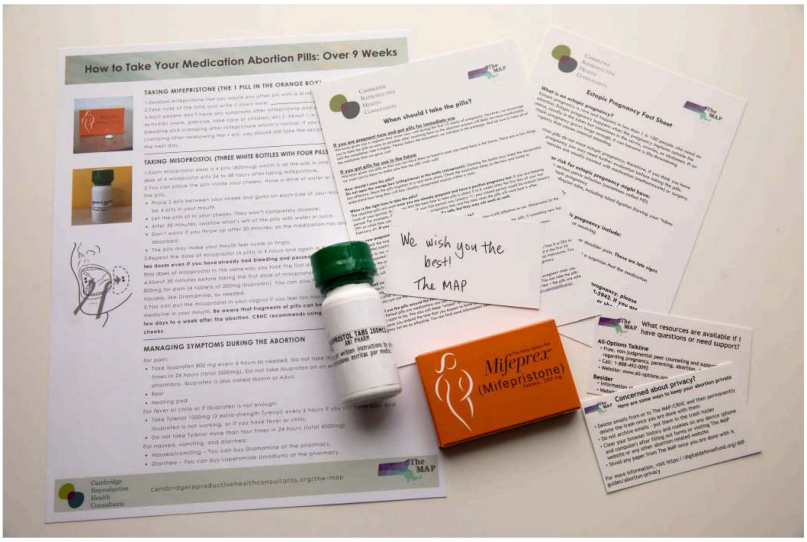
These operations are intensifying amid more heated political debates. Vice President Kamala Harris is spotlighting abortion rights in her presidential bid, while Republicans struggle to articulate a winning message.

From July 2023 to March, shield-law groups provided more than 68,000 abortion kits by mail to residents in states with tight limits on the procedure or telemedicine, according to WeCount, an abortion-data project sponsored by the Society of Family Planning, which backs abortion rights.

Shield-law providers accounted for about 9,500 medication abortions in March, up from 5,620 in July 2023, WeCount says.

"I think as long as we see states that are passing more and more restrictions, we're going to see these numbers

continue to grow," said WeCount co-chair Ushma Upadhyay, a professor at the University of California at San Francisco.



Patient packages include two abortion medications, instructions and additional information.

Abortions reached nearly 100,000 nationwide in March, up from 84,000 in May 2022, according to WeCount, despite 18 states imposing near-total or six-week bans. Medication abortions now outnumber surgical procedures. Nearly 20% of all abortions are via drugs sent by mail, including from bricks-and-mortar clinics.

So far, efforts targeting telemedicine abortions have failed. The Supreme Court in June rejected a bid to restrict access to mifepristone, one of the two abortion drugs. Some Republicans in Congress, including vice presidential nominee JD Vance, have called for enforcing the 1873 Comstock Act, a federal law barring the shipping of abortion drugs. More recently Vance has said the issue should be left to states.

Risk and pushback

MAP co-founder Angel Foster said the pill-packing parties are essential to its operations.

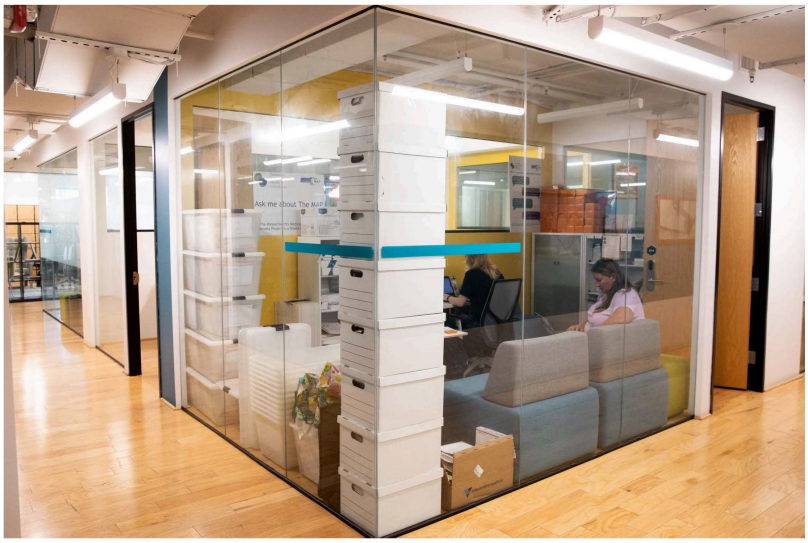
Still, legal experts say there are risks for those involved in mailing pills to states with bans.

Angel Foster, 50, a doctor who helped launch the MAP last fall, trusts the Massachusetts shield law. But because it doesn't apply in other states, she won't visit her mother and stepfather in South Carolina and avoids flights that require stopovers in Texas.

Maureen Paul, the MAP's medical director, doesn't feel safe visiting her brother in Florida, where a six-week ban took effect in May. "We are no strangers to risk. I've had my home picketed, I've had death threats," she said. "But we're not fearful, we're not paralyzed. We're determined to act."

Frustrated officials in states with stringent laws can't disrupt the mail, but some are warning providers. Arkansas Attorney General Tim Griffin, a Republican, demanded two entities in May stop helping state residents get the pills, asserting such actions violate Arkansas law.

One warning went to Choices Women's Medical Center in New York, which doesn't mail pills but removed from its website wording about Arkansans taking clinic-provided pills at home. Founder Merle Hoffman said she thinks Griffin misunderstood how her clinic operates. A cease-and-desist letter also went to Aid Access, the largest shield-law provider, which disputes the allegations.



The Massachusetts Medication Abortion Access Project's office in Somerville, Mass.

Antiabortion groups say it is dangerous for women to take these pills without medical supervision. Providers say it's safe and that they screen for potential problems.

Pill-mailers are in new legal terrain. "No one has challenged any of these laws yet," said Rachel Rebouché, dean of the Temple University Beasley School of Law. "Texas has not tried to prosecute [clinicians], they haven't been sued, a medical board hasn't tried to discipline them. That's not to say those things aren't possible."

In Massachusetts, Paul, a 74-year-old doctor, is one of four prescribers at the MAP. In 1968, pregnant at age 18, she couldn't get a hospital abortion and feared seeking an illegal one. She carried to term and gave up her child for adoption, an experience she calls "deeply traumatic and defining."

Launched last fall, the MAP is a project of Cambridge Reproductive Health Consultants, a nonprofit co-founded by Foster that has worked to boost medication abortion access in countries including Thailand, Pakistan and Uganda—and saw a need for similar work in the U.S. MAP harnesses websites like plancpills.org to get the word out to women nationwide. Prospective patients fill out intake forms online and mainly correspond by email, although some talk by phone with Foster or a prescriber.

The program accepts patients up to the 11th week of pregnancy, aiming to get pills to them by 12 weeks. Most are earlier than nine weeks, Foster said. Despite a $250 list price, patients pay about $130 on average; a third pay $25 or less.

The 6 p.m. party

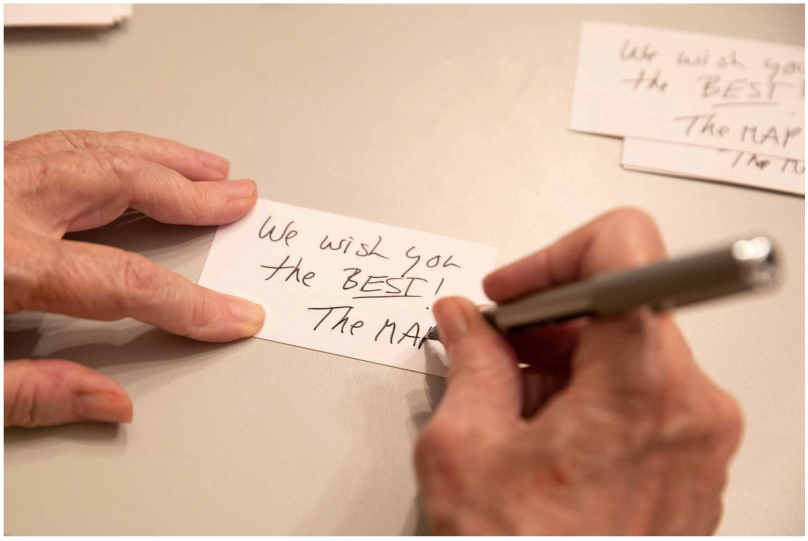
Tote bags containing the MAP's patient packages are carried to a post office for mailing.

At the MAP's office, before the recent pill-packing party, Foster read aloud comments women shared on intake forms. A Nebraska mother wrote: "I was using protection, but it failed, and I cannot afford to have another child right now." A Florida woman with a diabetic 5-year-old said: "I am struggling to pay my bills, and I'm not mentally ready to bring another child into my life yet."

Nearby, a MAP staffer printed address labels for 45 boxes of pills before packing them into tote bags for the trip to the post office. They were bound for 19 states, including Texas, Georgia and Florida.

Around 6 p.m., the volunteers filed in from work or home to replenish the supply of preloaded boxes. The gatherings jumped from monthly to twice-monthly in July, the MAP's busiest month with 560 boxes shipped, and are set to go weekly this fall.

Sonia Dettmann, 81, a retired clinical social worker, hasn't missed any. "I feel that abortion care is healthcare, and this is one way of supporting healthcare for folks from states where abortion is banned. It's that simple," she said as she dropped mifepristone cartons into each box.



A handwritten card is included with each MAP package.

Another regular, Erin Gately, 47, likes to write notes in gold ink for "a little extra touch." An OB-GYN nurse practitioner, she sees "the challenges that come with an unplanned pregnancy and, whether somebody decides to continue with that unplanned pregnancy or not, it's their choice."

As boxes circulated around the table, conversation pinged from the Paris Olympics to a promising birth-control gel for men. Amid upbeat banter, the crew kept their production line humming. Though they fell short of Foster's goal of packing 475 boxes, she assured them 350 was more than fine.

"I am very impressed with us," she said.

Write to Scott Calvert at scott.calvert@wsj.com

Appeared in the August 13, 2024, print edition as 'Abortion Fight Has New Front: Pill Parties'.

EXHIBIT 69

Rachel Roubein,
'Shield' Laws Make it Easier to Send Abortion Pills to Banned States,
Wash. Post. (July 20, 2023)

Health Brief

e Washington Post's essential guide to health policy news

'Shield' laws make it easier to send abortion pills to banned states

July 20, 2023

Analysis by Rachel Roubein
with research by McKenzie Beard

Happy Thursday! A big shout out to **Caroline Kitchener** for her excellent reporting in the top of today's newsletter.

And one note: I'll be heading out on summer vacay for a few days, and you'll have a great rotating cast of Post reporters bringing you this newsletter. See you next week! In the meantime, send all your news and tips to mckenzie.beard@washpost.com.

Today's edition: A hearing continues today on a lawsuit seeking clarity over exceptions to Texas's strict abortion ban. Sen. **Bernie Sanders** (I-Vt.) introduces a competing bill to fund community health centers as a critical

deadline nears. **But first …**

Aid Access launches new way to send abortion pills into states with bans

Packets of mifepristone, a commonly used abortion pill. (Paul Ratje/The Washington Post)

There's a new, more efficient pipeline sending abortion pills into states with bans.

Europe-based **Aid Access,** one of the largest abortion pill suppliers, revamped its protocols in mid-June. **The result?** Doctors in certain Democratic-led states with "shield" laws can now mail and prescribe pills directly to patients in antiabortion states.

The new process could ignite a complex interstate battle over abortion, where U.S. doctors in blue states are empowered to legally circumvent abortion laws in red states. The move could also undermine abortion bans at a time when antiabortion groups and doctors are seeking to revoke the approval of key medication used in over half of all abortions in the country.

Our colleague **Caroline Kitchener** dove deep into the new effort — and here's what she found.

e details

Previously, Aid Access only allowed Europe-based doctors to prescribe abortion pills to women in states where abortion is restricted. Those pills were shipped from India, and often took weeks to get to patients, which could push abortions well into the second trimester. (The **Food and Drug Administration** has approved mifepristone through 10 weeks gestation, though some studies have shown it can be used safely and effectively later in pregnancy.)

But new laws enacted over the past year are helping to streamline the process. Democratic-led states have moved to protect medical professionals and others who practice in states where abortion is legal from potential punishment in states with bans. **New York, Massachusetts, Washington, Vermont** and **Colorado** explicitly protect abortion providers who mail pills to restricted states from inside their borders, Caroline writes.

The new landscape: In less than a month, seven U.S.-based providers affiliated with Aid Access have mailed **3,500 doses** of abortion pills to people residing in states with bans. All together, the small group could help facilitate at least **42,000 abortions** in antiabortion states in a year. (Those numbers could grow, of course, if more providers join in.)

- As one expert told Caroline, the shield laws are "a huge breakthrough for people who need abortions in banned states," said **David Cohen,** a **Drexel University** law professor who focuses on abortion legislation. "Providers are protected in many ways as long as they remain in the state with the shield law."

Could doctors face legal risks?

That's a key question. And it could ultimately be resolved by the courts.

Some lawyers say the doctors — who are preparing and packaging the pills sent to restricted states themselves — could face repercussions, even if they don't travel to states that prosecute abortion providers. Some wonder whether states with abortion bans would try to extradite medical providers from states with shield laws, though that could prove difficult.

Jonathan Mitchell, the former solicitor general of Texas and architect of the state's roughly six-week ban, said it seems too early to predict what will happen, but that "there absolutely is a world in which they could get in trouble for it." (In many states with bans, those found guilty of distributing abortion pills could be sentenced up to at least several years in prison.)

But some involved in the effort say they're not worried.

"Everything I'm doing is completely legal," a doctor in New York's Hudson Valley, who spoke on the condition of anonymity to protect her safety, told Caroline. "Texas might say I'm breaking their laws, but I don't live in Texas."

Read the full story here.

EXHIBIT 70

Rebecca Grant,
Group Using 'Shield Laws' to Provide Abortion Care in States That Ban It,
The Guardian (July 23, 2023)

Abortion

This article is more than **1 year old**

Group using 'shield laws' to provide abortion care in states that ban it

Aid Access ships medication abortion to all 50 states under the protection provided to clinicians serving patients in banned states

Boxes of mifepristone. Each of the Aid Access providers is sending approximately 50 packages a day. Photograph: Evelyn Hockstein/Reuters

Rebecca Grant

Sun 23 Jul 2023 07.00 EDT

Dr Linda Prine is providing abortion access to people in all 50 states, even those that have banned it. That might seem like an admission to be discreet about in post-Roe America, but Prine and her colleagues at Aid Access, a telemedicine abortion service, are doing it openly and in a way they believe is on firm legal ground.

On 14 July, Aid Access announced that over the past month, a team of seven doctors, midwives and nurse practitioners have mailed medication abortion to 3,500 people under the protection of "shield laws", which protect clinicians who serve patients in states where providing abortion is illegal. As soon as she learned about shield laws, Prine knew it represented an opportunity to go on the offensive, for those bold enough to try it.

"It made me think, OK, we need to fight back," Prine said. "We can't just take this lying down. We've got to do something. And this was what we can do."

From its origins, Aid Access has always been willing to test legal boundaries. It was started in 2018 by the Dutch physician Dr Rebecca Gomperts. At the time, FDA regulations prevented licensed US providers from mailing mifepristone, one of the two drugs in the medication abortion regimen, so Aid Access was structured like Gomperts' other telemedicine service, Women on Web. That process involved abortion seekers filling out an online consultation, and if eligible, Gomperts wrote a prescription from Europe and the pills were dispatched by a pharmaceutical partner in India.

Then, in 2020, Covid hit. And a federal judge suspended the FDA's in-person dispensing requirement for mifepristone. For the first time, legally prescribed medication abortion could be put in the mail. Aid Access used this opportunity to implement a hybrid model: in states where telemedicine abortion was legal, US clinicians handled the prescriptions, while in states where it wasn't, the pills continued to be mailed from India.

One drawback of shipping from India was the packages could take weeks to arrive. In addition to the stress and uncertainty involved in waiting, the time

lag could push people past the 12-week limit recommended by the World Health Organization (although there is some emerging research that abortion pills can safely be taken later.) Covid also created concerns about shipping delays, and there was always the chance that customs could seize the packages.

> *The experience of wanting an abortion and then needing to wait three or four weeks to get it to happen ... that's just so hard*
> Dr Linda Prine

"The whole experience of wanting an abortion and then needing to wait three or four weeks to get it to happen, and not even be sure if those pills are ever going to come, that's just so hard," said Prine, who started working with Aid Access in 2021. "Who wants to do that? Nobody."

In March 2022, Prine read an op-ed by three legal scholars - David S Cohen of Drexel University, Rachel Rebouché of Temple University, and Greer Donley of the University of Pittsburgh - that introduced her to the idea of shield laws. The trio had published a paper titled The New Abortion Battleground in the Columbia Law Review, which outlined the ways that shield laws could protect abortion providers who treated patients in banned states if Roe fell.

"Certainly, it's not a surprise that post-Dobbs, there are going to be medical care providers who want to push the limits and care for as many people as they can, including people in other states," Cohen said in an interview. "People are going to do this, so we were thinking about what can the states where they live do to help them the most?"

Inspired by their work, a wave of states started passing shield laws. The first, in Connecticut, passed in May 2022. Massachusetts, the fifth state to pass a shield law in July 2022, was the first to include a telemedicine provision, meaning the state pledged to protect a provider licensed there who prescribed and mailed medication abortion pills, via telemedicine, to a patient in a state where abortion was banned - like Texas or Alabama. Currently, 15 states have shield laws in place, and five - Massachusetts, Washington, Vermont, Colorado and New York - have specific telemedicine protections.

> *Post-Dobbs, there are going to be medical providers who want to push the limits and care for as many people as they can*
> David S Cohen

Before Aid Access, no US providers had publicly tested them. Then, on 18 June, the organization started serving patients nationwide with providers licensed in those five states. Up to 13 weeks, they offer prescriptions for $150 with a sliding scale that asks people to pay whatever they can afford, with a shipping time of two-five days. (In a physical clinic, the median cost of medication abortion is over $500.)

"Now Aid Access is completely US provider-led," Lauren Jacobson, a nurse practitioner licensed in Massachusetts who joined Aid Access in February 2023, told the Guardian this month. "I think this is important because it sends the broader message that this is an American issue, a US problem, and taking advantage of the shield laws means we are returning this to an at-home solution."

In addition to enabling faster shipping times, Jacobson said some people also feel more secure knowing that the pills are coming from licensed clinicians through an FDA-approved pipeline. This is part of what distinguishes Aid Access from abortion pill suppliers that operate through unofficial channels, such as unregulated online pharmacies and clandestine community networks. While the non-profit Plan C has found those medications to be as advertised, and reliably safe and effective (and also, in the case of community networks, free), they don't offer interaction with a licensed clinician, and some people want that support as part of the process.

Right now, each of the Aid Access providers is sending approximately 50 packages a day. Prine said all the packing and postage and shipping tasks are a "big pain in the rear", but it's manageable. They are prepared to scale, both in terms of infrastructure and in terms of the legal challenges their actions could invite.

Cohen suggests there will be a "coming battle" as shield laws get tested, and emphasized that providers have the greatest amount of protection while they are in shield law states. Jacobson and Prine are not overly concerned about legal repercussions, but that doesn't mean they're not taking precautions.

"If it happens, it happens, and we are prepared," Prine said. "But I'm definitely not taking any vacations in Texas."

Because shield laws are designed to protect providers, patient risk is a separate factor - one that's particularly acute for people from communities that face heightened surveillance from law enforcement. A state doesn't need to have an explicit law criminalizing people who have abortions to prosecute them, often under unrelated statutes, like the illegal concealment of human remains. Even before Dobbs, people were arrested for self-managing abortions. The risk is real, but in a moment where people have too few options and time is of the essence, Prine said, every option counts.

"I do consults all the time, and people are not saying, 'What about the legality of this?'" Prine said. "That is not their concern. Their question is, 'How soon will the pills arrive?' That is the number one question."

Betsy Reed
Editor, Guardian US

EXHIBIT 71

Aid Access,

Get Abortion Pill Online in Louisiana

Get Abortion Pill Online in Louisiana · Order Here

You can buy an abortion pill online and get it by mail in Louisiana. The FDA has approved abortion pills by mail. Aid Acces works with U.S. based abortion providers in so called shield law states (this means that the states will protect the providers against legal action). Therefor Aid Access can provide abortion services to all 50 U.S. states including Louisiana.

Aid Access will help you order abortion pills and have them delivered to your home in New Orleans, Baton Rouge, Shreveport, Metairie, Lafayette, or anywhere else in Louisiana.

Louisiana abortion pill online orders:

- Louisiana abortion pill online orders costs $150 USD
- Reliable abortion pill shipping to Louisiana in 1-5 days
- Tracking numbers provided when the pills are mailed
- Help desk support available in 16 languages

An infographic explaining how to get an abortion pill in Louisiana from Aid Access.

How to order abortion pills in Louisiana

You can get a prescription from Aid Access and have abortion pills delivered to your home in Louisiana. **Order abortion pills by mail here.** These are the steps to get abortion pills delivered to your home by mail:

1 Start your online consultation for abortion pills in Louisiana

Once you begin your online consultation for abortion pills in Louisiana, you will be asked some questions about your health and pregnancy to ensure you are eligible. All information you share with us is private and protected.

2 Our U.S. based doctors approve your online abortion pill order

Your consultation will immediately be reviewed by our medical team. Our help desk will email you the next steps, ask you to send a donation of $150 USD, and then approve your online abortion pill order within 24 hours.

3 Receive abortion pills by mail in LA in 1-5 days

The abortion pills will be shipped by mail to your home in LA within 24 hours of your your order being approved. You will receive a tracking number so you can follow your package as it moves through the mail.

Start now: Get the abortion pill online here

More ways to get Louisiana abortion pill access

If Aid Access is not able to meet your reproductive health needs, there are multiple ways people get Louisiana abortion pill access. To learn about other online telehealth services that are available to you, visit the Plan C Guide to Abortion Pills: **How to Order an Abortion Pill Online in Louisiana**

Louisiana abortion clinic guides from Plan C Pills

If you determine that abortion pills will not meet your reproductive health needs, you can find information about local abortion support resources near you in the **Louisiana Abortion Clinic Guide** from Plan C Pills.

Additional guides to abortion clinics near Louisiana from Plan C Pills:

- **Abortion clinics near Baton Rouge, LA**
- **Abortion clinics near New Orleans, LA**
- **Abortion clinics near Shreveport, LA**
- **Abortion clinics near Metairie, LA**
- **Abortion clinics near Lafayette, LA**

[Abortion clinics near Lake Charles, LA]

Abortion laws in the State of Louisiana

For the most up to date information about abortion laws in Louisiana, visit Guttmacher Institute, Center for Reproductive Rights, or AbortionFinder.org.

How much does the abortion pill cost in Louisiana?

The abortion pill service costs $150 USD when shipping the pills to Louisiana. If you cannot afford this, please tell us you need help after you fill in the form.

Begin here: Order abortion pills online from Aid Access

Which Louisiana cities does Aid Access provide online abortion pill service?

Aid access provides online abortion pill order access throughout Louisiana including these cities and everywhere in-between:

Order the abortion pill in Kenner, Louisiana

Get abortion pills in Bossier City, Louisiana

Buy an abortion pill in Monroe, Louisiana

Buy abortion pills in Alexandria, Louisiana

Start your consultation now: Order abortion pills online

EXHIBIT 72

Elissa Nadworny,
Inside a medical practice sending abortion pills to states where they're banned,
NPR (Aug. 7, 2024)

NATIONAL

Inside a medical practice sending abortion pills to states where they're banned

AUGUST 7, 2024 · 9:00 AM ET

Elissa Nadworny

“Welcome to modern abortion care,” says Angel Foster, who leads operations at what’s known as the MAP, a Massachusetts telehealth provider sending pills to people who live in states that ban or restrict abortion.

Elissa Nadworny/NPR

The packages, no bigger than a hardcover book, line the walls of the nondescript office near Boston. It's not an Etsy retailer or a Poshmark seller or, as the nearby post office workers believe, a thriving jewelry business.

These boxes contain abortion pills.

"Welcome to modern abortion care," says Angel Foster, as she holds up a box for mailing. Foster, who has an M.D. degree, leads operations at what's known as the MAP, a Massachusetts telehealth provider sending pills to people who live in states that ban or restrict abortion.

The MAP is one of just four organizations in the U.S. operating under recently enacted state shield laws, which circumvent traditional telemedicine laws requiring out-of-state health providers to be licensed in the states where patients are located. Eight states have enacted these shield laws.

Pregnant patients can fill out an online form, connect with a doctor via email or text and, if approved, receive the pills within a week, no matter which state they live in.

POLICY-ISH

Abortion is becoming more common in primary care clinics as doctors challenge stigma

Shield law practices account for about 10% of abortions nationwide. There were 9,200 abortions a month provided under shield laws from January to March of this year, according to fresh data from the Society of Family Planning's WeCount project. And some researchers estimate that this number has risen since then and could be as high as 12,000 per month.

The rise of telehealth is part of why the number of abortions in the U.S. has continued to go up since the Supreme Court overturned *Roe v. Wade* in 2022 — even though 14 states have near-total abortion bans. In those states, shield law providers represent the only legal way people can access abortions within the established health care system.

"If you want to have your abortion care in your state and you live in Texas or Mississippi or Missouri, right now shield law provision is by far the most dominant way that you'd be able to get that care," says Foster.

Elissa Nadworny/NPR

Back in Massachusetts, Foster glances down at the list of today's patients. The practice's four OB-GYNs have signed off on prescriptions for nearly two dozen women — in Texas, Florida, Tennessee, Georgia, Alabama, Oklahoma and South Carolina. Most of today's patients are around six weeks along in their pregnancy. Many already have children.

"I really need an abortion pill. My state has banned it. My funds are really low," one patient wrote on the online form she filled out for the doctor.

"I'm a single mom with a kid under two," another wrote. "I can't afford a baby. I can't even afford this abortion."

Foster and her team serve patients who are up to 10 weeks pregnant and who are 16 or older. It costs $250 to get the two-drug regimen — mifepristone and misoprostol — in the mail, but there's a sliding scale and patients can pay as little as $5. The MAP is funded through abortion funds, individual donations and philanthropic gifts, and Foster has plans to apply for grants and state funding to help make the organization more sustainable. The MAP currently sends out about 500 prescriptions a month.

Yet to be tested in court, shield laws have some legal vulnerability

In the eight states with shield laws, abortion providers can treat out-of-state patients just as if they were in-state patients. The laws give abortion providers some protection from criminal prosecution, civil claims and extradition, among other threats. The laws have yet to be tested in court, but they certainly haven't gone unnoticed by lawmakers and groups looking to limit abortion.

"These websites are breaking the law … aiding and abetting crimes in Texas," says John Seago, the president of Texas Right to Life. "We want to use all the instruments that we have, all the tools available, to really fight against this new trend of abortion pills by mail."

Seago says providers should still be held responsible for committing a crime that is executed across state lines. "Mailing the abortion pill is a state jail felony according to our pro-life laws," he says, "but enforcement of those policies has been a real, real challenge."

Mifepristone, a drug used in abortion care, at the MAP's office in Massachusetts.
Elissa Nadworny/NPR

His organization has been looking for the right individual or circumstance to challenge shield laws directly in court. Three Republican-led states recently tried to sue the Food and Drug Administration over regulations allowing doctors to send pills through the mail, but the Supreme Court threw out the case in June over issues of standing. Those plaintiffs say they'll fight on. And a Republican attorney general in

Arkansas sent a cease-and-desist letter to a shield law provider.

PUBLIC HEALTH

Abortion providers back to 'business as usual' after high court's mifepristone ruling

Seago thinks many conservative prosecutors have been hesitant to take legal action, especially in an election year. But he says it's important to act quickly, before abortion by mail becomes pervasive.

The people who are sending these pills know that there's risk in what they're doing. Some providers say they won't travel to or through states with bans so that they can't be subpoenaed, be served legal papers or even be arrested if there's a warrant. That may mean avoiding layovers at Dallas Love Field airport or a detour around those places on a cross-country road trip. For Foster, it means she can't visit her mom and stepdad, who retired to South Carolina.

"The thing about shield laws is that they're new, so we don't have a precedent to go off of," says Lauren Jacobson, a nurse practitioner who prescribes abortion medication through Aid Access, the largest of the four shield law providers. She says she avoids large swaths of the United States. "We don't really know what will or won't happen. But I'm not going to Texas. I've been before though, so that's OK for me."

SHOTS - HEALTH NEWS

Abortion bans still leave a 'gray area' for doctors after Idaho Supreme Court case

Shield laws don't offer blanket protection. The doctors and nurse practitioners who prescribe the pills have malpractice insurance in their states, but it's unclear whether those policies would cover suits from states with abortion restrictions. Patients use third-party payment services like Cash App or PayPal, which are also untested in how they would work under a shield law. Would they give up information on a provider or patient if requested to do so by law enforcement?

How the experience looks

Lauren, who is 33 and lives in Utah, got pregnant while on birth control and decided that she couldn't afford another child. (NPR is not using her last name because she's worried about professional repercussions.)

Abortion is legal in Utah until 18 weeks, but there are only a handful of clinics in the state. The closest one to Lauren was several hours away by car. Several years prior, she had an abortion at a clinic in Salt Lake City, and it hadn't been a pleasant experience — she had to walk through protesters. The guilt from her conservative Christian upbringing was overwhelming.

Shield law practices account for about 10% of abortions nationwide. There were 9,200 abortions a month provided under shield laws from January to March of this year, according to fresh data from the Society of Family Planning's WeCount project. Some researchers estimate that this number has risen since then and could be as high as 12,000 per month.

Elissa Nadworny/NPR

"I got in my car and I cried," she recalls. "I just never wanted to go through it again."

This time, Lauren got pills from Aid Access, a shield law provider similar to the MAP. "I was a little bit sketched out, I won't lie," she says. "Because like, well, where is this coming from? Who is this under? How are they prescribing this?"

She and her partner did research to try to figure out whether what they were doing was legal. She says ultimately she couldn't find anything that clearly stated that what she wanted to do — have pills sent from an out-of-state doctor — was illegal.

She filled out a form online with questions about how far along she was and her medical history and then connected with a doctor via email and text messages. She googled the doctor, who she found was legit and practicing out of New York.

A few days later, she received abortion medication in the mail and had her abortion at home.

"To do it in the privacy of your own home, where I felt more support as opposed to going through protesters," Lauren says. "Especially with a provider within the state of Utah. I feel like there's always a judgmental indication or undertone."

The online doctor also followed up to make sure everything had gone OK, which Lauren appreciated. "I felt it was a little bit more thorough," she says. "They're checking in on you, like, 'How did you respond? What symptoms? What's going on?'"

A staff member of the MAP brings the boxes containing abortion medication to the local post office.
Elissa Nadworny/NPR

In Massachusetts, the folks who run the MAP hear much the same from their patients. Many emails and messages are logistical, like this email: "I took the first pill on Friday and all the other pills on Saturday. For how long should I be bleeding as I'm still bleeding this morning?"

Many others offer disbelief, relief and gratitude. "I just wanted to say thank you so much," wrote one woman. "I was terrified of this process. It goes against everything I believe in. I'm just not in a place where I can have a child. Thank you for making the pills easily accessible to me."

When Foster, who runs operations for the MAP, does a final tally of the patients who are ready to have their pills sent out, she notices a new note from a woman who just paid, bringing the day's total number of patients from 20 to 21.

"I am a single mother on a fixed income, and I can not afford a kid right now."

It's from a woman in Alabama who is six weeks pregnant and filled out her form around lunchtime. Within an hour, a MAP doctor had reviewed her case and prescribed her the medication. She paid the fee as soon as she was approved. All in all, the whole process took about three hours. Foster is able to pack up those pills and add them to the batch headed to the post office.

By 3 p.m., the Alabama woman's package is scanned by the Postal Service worker.

It's expected to arrive by the week's end.

abortion drugs mifepristone abortion provider misoprostol dobbs v jackson women's health organization roe v. wade

EXHIBIT 73

Abigail Brooks & Dasha Burns,
How a network of abortion pill providers works together in the wake of new threats,
NBC News (April 7, 2024)

ABORTION RIGHTS

How a network of abortion pill providers works together in the wake of new threats

Groups such as Aid Access, Hey Jane and Just the Pill stay in close contact to help women seeking abortions in states with bans.

A shield law provider packs abortion pills into envelopes to be sent from New York to states with bans. Callan Griffiths / NBC News

April 7, 2024, 7:00 AM EDT

By Abigail Brooks and Dasha Burns

When the U.S. Supreme Court heard oral arguments in March about restricting access to the abortion drug mifepristone, Elisa Wells, co-founder and co-director of Plan C, was ready.

Plan C, an information resource that connects women to abortion pill providers, almost immediately saw a spike in searches for the medication.

With Florida's Supreme Court paving the way for the state's six-week abortion ban, Wells says she's expecting even more search activity and more creative thinking from providers.

"When these egregious decisions happen, first, they cause harm," she says. "And the second thing that happens is people get organized and mad and take action."

Since the Supreme Court overturned Roe v. Wade in its 2022 Dobbs decision, upending abortion access in the U.S., a network of abortion providers has sprung into action, weaving an abortion safety net across the country even as the procedure has been effectively banned in 15 states.

Providers such as Aid Access, Hey Jane and Just the Pill operate both within and outside the established health care system – including mailing abortion medications to women in states with bans, setting up mobile clinics and offering financial assistance – often staying in close contact with one another.

— Bottles of Misoprostol Tablets. NBC News

Many of those efforts center on access to abortion medication by mail, which the Food and Drug Administration made fully legal in 2021, creating a sort of "sisterhood of the traveling pill" that keeps groups connected as new restrictions on abortion arise.

Wells says Plan C called different providers for a meeting on how best to pivot in the changing abortion landscape.

“We had meetings where we introduced the providers to one another,” she said. “All of these groups that normally would be competing with one another to come together and discuss, you know, how can we make a difference? How can we collectively address this issue?”

One such group is Aid Access, an online-only service based in the Netherlands. Originally a resource for women in the U.S. to get abortion pills from overseas, providers for the organization now ship pills from within the U.S. under telemedicine shield laws. The shield laws have been enacted in six states: California, Colorado, Massachusetts, New York, Vermont and Washington. The laws protect providers who prescribe and ship abortion pills to patients who live in states where abortion is banned or severely restricted.

“Before we had the shield law, we were mailing pills to the blue states, and only [pills from] overseas could be sent to the restricted states,” said Dr. Linda Prine, a New York City-based shield law provider.

After New York’s shield law passed, Prine said, “the first month we sent about 4,000 pills into restricted states, and now we’re up to around 10,000 pills a month.”

In a basement in upstate New York, another Aid Access provider who asked to not be identified for safety reasons underscored the importance of sending these pills from the U.S., rather than overseas.

“Sometimes they got stuck in customs,” the provider explained as more than 100 prescriptions were being packaged around them, preparing to be shipped into states with bans.

“When you’re doing a medication abortion, the faster you can get these medications, the better,” the provider said in an interview. “It’s easier, there’s less bleeding, there’s less cramping, and not to mention the anxiety that these women go through when they’re waiting for those medications to get to them in the mail.”

— Boxes of pills will be packed into envelopes to ship around the country. Callan Griffiths / NBC News

Aid Access providers say they're sending pills to some who are in the most desperate situations – people who are willing to risk going outside the established health care system to access abortion services. The organization is exploring contingency plans in the event that access to the abortion pill through the mail is disrupted.

"We have so many patients who write to us who've been raped, who can't travel," the provider explained. "So we have to come up with other ways. I would say the last resort would be that these medications come again from overseas."

And while shield laws have yet to be challenged in courts, anti-abortion groups have taken notice.

"The fact remains that just because you are sitting in California does not mean that you are not violating the laws of Florida, Texas and 30 other states," Katie Daniel, state policy director for the anti-abortion group Susan B. Anthony Pro-Life America, told NBC News. "So I think they have a false sense of security about this."

In the six months after Dobbs, researchers saw an increase in women getting abortion medication outside the traditional health care system, with more than 27,000 additional instances, according to a recent study in the journal JAMA.

"These are groups like Las Libres, WeSaveUs, Arkansas Together," said Wells, who was a co-author of the study. "They're serving a significant number of people for an all volunteer-led effort."

Even within the traditional health care system, abortions via medication are increasing, too. Medication abortions accounted for 63% of all abortions in 2023, up 10% from the year before, according to research from reproductive rights

think tank the Guttmacher Institute, making it the most common method for terminating a pregnancy.

— Envelopes filled with abortion pills. Callan Griffiths / NBC News

New York-based Hey Jane has seen that demand firsthand. Founder Kiki Freedman, an early Uber employee, launched the telemedicine-only abortion provider in 2018 after seeing other startups deliver medications and savings to customers via online-only prescription services. After the FDA eased restrictions on mifepristone prescriptions during pandemic, allowing women to get the abortion pill through the mail, Hey Jane took off. The company has shipped abortion pills to at least 50,000 patients, according to a statement.

“We have the added benefit of this sort of geographic fluidity where a doctor in New York can serve a patient in Illinois, or New Mexico if the doctor in New Mexico or the provider in New Mexico is busy,” said Freedman. “The other piece is financial accessibility and being able to access scalable ways of doing that, so via insurance, in particular.”

Hey Jane only prescribes and ships abortion medication to states where it’s legal, marking a difference from shield law providers and organizations like Aid Access.

Access to medication abortion helps patients avoid traveling and wait times at in-person clinics, and allows them to take the pills in private at home. While providers who ship to states with bans have struggled with traditional payment platforms, Hey Jane’s focus is on keeping access covered by insurance.

“Still, 75% of abortions are taking place in these 20 states we’re in. It’s still where the vast majority of care occurs,” said Freedman. “It’s not like access in those states has been seamless to date, right? It’s always been difficult even there, and particularly post-Dobbs, wait times and things like that have really surged within those states.”

— Empty pill bottles in the basement of a shield law provider in New York will be filled with abortion medication.
Abigail Brooks / NBC News

Just the Pill provides abortion access to women in states with bans using discreet mobile clinics set up just across state lines.

The group has bulletproof vans in Colorado, Minnesota and Montana, and a brick-and-mortar location in Wyoming. Appointments are conducted via telemedicine, always within a state where abortion is legal, making shield laws unnecessary, a backstop a Just the Pill provider said is intentional, so care won't be interrupted if the shield laws are challenged.

"I totally support what these other organizations are doing," she said in an interview, asking not to be identified for safety reasons. "I'm cheering them on from afar, but want to make sure our service isn't challenged."

Just the Pill works with abortion funds, which provide financial assistance to patients who are seeking the procedure, to help patients travel across state lines for their appointments. After a telemedicine visit, pills are then prescribed and patients can pick them up and take them, all within the borders of a state where the procedure is legal. Because Just the Pill's clinics are mobile, they can travel along the borders of banned states and ensure they get as close as possible to women traveling from rural areas or long distances for care.

Meanwhile, Plan C is already working with more international pill providers to help with telehealth prescription access in the U.S. if telehealth visits for mifepristone are affected here, Wells said.

“We know we live in a time when anything can happen,” Wells said. “We want to have as many alternate routes and access as possible. Many eggs and many baskets.”

Abigail Brooks
Abigail Brooks is a producer for NBC News.

Dasha Burns
Dasha Burns is a correspondent for NBC News.

EXHIBIT 74

Pam Belluck,
Abortion Shield Laws: A New War Between the States,
N.Y. Times (Feb. 22, 2024)

The New York Times https://www.nytimes.com/2024/02/22/health/abortion-shield-laws-telemedicine.html

Abortion Shield Laws: A New War Between the States

Doctors in six states where abortion is legal are using new laws to send abortion pills to tens of thousands of women in states where it is illegal.

By Pam Belluck
Pam Belluck spent time with abortion providers sending pills to states that outlaw abortion and talked with patients receiving those pills.

Published Feb. 22, 2024 Updated Feb. 23, 2024

Behind an unmarked door in a boxy brick building outside Boston, a quiet rebellion is taking place. Here, in a 7-by-12-foot room, abortion is being made available to thousands of women in states where it is illegal.

The patients do not have to travel here to terminate their pregnancies, and they do not have to wait weeks to receive abortion medication from overseas.

Instead, they are obtaining abortion pills prescribed by licensed Massachusetts providers, packaged in the little room and mailed from a nearby post office, arriving days later in Texas, Missouri and other states where abortion is largely outlawed.

This service and others like it are operating under novel laws enacted in a half-dozen states — Massachusetts, Washington, Colorado, Vermont, New York and California — that have sought to preserve abortion access since the Supreme Court overturned the nationwide right to abortion in June 2022. The laws have been in use only since the summer and have not been tested in the courts, but they are already providing abortion access to tens of thousands of women in states with bans, especially low-income patients and others who cannot travel.

Called telemedicine abortion shield laws, they promise to protect doctors, nurse practitioners and midwives licensed in those six states who prescribe and send abortion pills to patients in the nearly two dozen states that ban or sharply restrict abortion.

The laws stipulate that officials and agencies of their states will not cooperate with another state's efforts to investigate or penalize such providers — a stark departure from typical interstate practices of extraditing, honoring subpoenas and sharing information, legal experts on both sides of the abortion issue say. Many expect them to ultimately be challenged in federal court.

Abortion opponents see the laws as brazen infringement on state sovereignty.

"You have states not just picking their own strategy but really trying to completely sabotage the governing efforts of their neighboring states," John Seago, the president of Texas Right to Life, said.

"It can't stand, and we can't be content with this new development," he added.

"Some people who might not have gotten an abortion if they had to take off work and go to a clinic, or wait three weeks and all of that, are doing it now," said Dr. Linda Prine, a New York shield-law provider. Ilvy Njiokiktjien for The New York Times

The threat of shield laws is one reason that three states — Idaho, Kansas and Missouri — petitioned to join a case the Supreme Court will hear next month that seeks to bar the mailing of abortion pills and to require in-person doctor visits

instead of telemedicine. The petition was denied.

“When you have states actively seeking to circumvent each other’s laws, that raises a very real legal problem that will stretch far beyond just the abortion sphere,” said Will Scharf, a Republican candidate for attorney general in Missouri, who helped draft anti-abortion legislation when serving as policy director for the state’s governor six years ago.

Pills have become the most common abortion method nationally, and abortion rights advocates consider shield laws a crucial way to counter the wave of bans enacted since the Supreme Court’s decision in Dobbs v. Jackson Women’s Health Organization.

“This might be the most important event since Dobbs on so many levels,” said Rachel Rebouché, the dean of Temple University Law School, who has worked with shield law advocates and legislators. “Thousands and thousands of pills are being shipped everywhere across the United States from a handful of providers. That alone speaks to the nature of what mailed medication abortion can do.”

Before shield laws were enacted, Aid Access, one of the organizations in the forefront of telemedicine abortion, served patients in states with bans by issuing prescriptions from Europe and shipping pills from a pharmacy in India. Pills could take weeks to arrive, potentially putting patients beyond 12 weeks’ gestation, the recommended threshold for taking the medication.

With shield laws, “some people who might not have gotten an abortion if they had to take off work and go to a clinic, or wait three weeks and all of that, are doing it now,” said Dr. Linda Prine, a New York shield law provider.

Aid Access providers are now using shield laws to serve about 7,000 patients a month, nearly 90 percent of them in states with bans or severe restrictions, according to Dr. Abigail Aiken, an associate professor at the University of Texas at Austin, who studies Aid Access data.

The shield laws upend the usual telemedicine model, under which out-of-state health providers must be licensed in the states where patients are located.

Beyond providing abortion access to individual patients, the shield-law movement carries broader implications for abortion politics, and supporters are working to enact similar laws in as many states as possible so the approach becomes commonplace, according to Francine Coeytaux, a co-founder of Plan C, a clearinghouse for medication abortion information.

“The shield laws are about a state’s legislative and justice system having skin in the game,” she said.

Inside the room

Telemedicine abortion shield laws are intended to protect doctors, nurse practitioners and midwives who prescribe and send abortion pills to patients in the nearly two dozen states that ban or sharply restrict abortion. Sophie Park for The New York Times

Carol, who asked to be identified by her middle name to help keep her role private, met me behind the brick building outside Boston and escorted me through a back door, down a warren of hallways. Others who rent offices in the building haven't asked what she does there, she said, adding: "I'm kind of hoping that most people aren't really that curious about what's going on."

At a plain white table, Carol, who has a master's degree in public health, began her routine: checking a spreadsheet of prescriptions; printing out labels with medication information and patients' names; printing address labels with tracking numbers and adding them to the spreadsheet.

Patients contact this service and others online and fill out forms providing information about their pregnancy and medical history. Carol's colleague, Lauren Jacobson, a nurse practitioner, writes prescriptions, evaluating whether patients are medically eligible. They can be up to 12 weeks pregnant and must have no disqualifying medical issues like an ectopic pregnancy or a blood-clotting disorder. Patients and providers can communicate by email or phone if needed.

"We're a free country," said Ms. Jacobson, who sometimes writes 50 prescriptions a day. "So let's put that to the test. Here we are and we're not going to be intimidated, and we have our states backing us."

Carol pulled the two abortion medications from storage boxes: mifepristone, which stops a pregnancy from developing, and misoprostol, taken 24 to 48 hours later to spur contractions to expel pregnancy tissue.

"I don't really consider myself a rule breaker," she said. "So it's funny that here I am sitting in this tiny little closet surrounded by pill bottles."

Carol and others who use shield laws to send abortion pills to patients are taking precautions to protect themselves, including not traveling to states with abortion bans, where they could be more vulnerable to arrest. Sophie Park for The New York Times

The operation resembles a small-scale assembly line, preparing medication for six packages at a time: one mifepristone pill in a manufacturer's prepackaged box and 12 misoprostol tablets counted out by hand from bottles of 100 supplied by a wholesaler. Carol slid the medications into plain envelopes lined with bubble

wrapping, along with a 10-page pamphlet from the mifepristone manufacturer and illustrated instructions from Aid Access about taking the medication and expected side effects, like cramping and bleeding.

She drove several miles to a post office to mail the envelopes.

“Getting ready for Christmas?” another customer in the post office asked one day, she recalled.

“Surprise, I’m actually Santa Claus,” she replied cheerfully.

One of Carol’s envelopes arrived at the home of Ashley Dickey in Texas.

Ms. Dickey has two young children and said she had experienced serious postpartum depression after those pregnancies. She said she dissolved in tears when she became pregnant again and concluded that she could not manage another pregnancy and raise another child. “It’s just not good for anybody,” she said.

When she learned she could receive pills by mail, “I was so grateful,” she said, adding, “If I would have had to travel somewhere, it would have been catastrophic, financially and then just emotionally.”

"If I would have had to travel somewhere, it would have been catastrophic, financially and then just emotionally," said Ashley Dickey, a Texas patient who received abortion pills from Massachusetts shield law providers. Montinique Monroe for The New York Times

Reaching low-income patients

Supporters say shield laws are already making substantial progress toward an important goal: helping patients who cannot afford — financially or logistically — to travel to another state for an abortion.

“It’s reaching the ones that were impacted the most: low-income, poor people, communities of color, Indigenous,” said Michelle Colón, the executive director of SHERo Mississippi, an organization supporting reproductive rights for people of color.

Nationally, there are three main providers: Aid Access; the Massachusetts Medication Abortion Access Project (called The MAP); and a service called Abuzz, which does not yet serve all states with abortion bans. They charge $150 or $250, though all three services provide pills for reduced prices or even at no cost, based solely on what patients say they can pay.

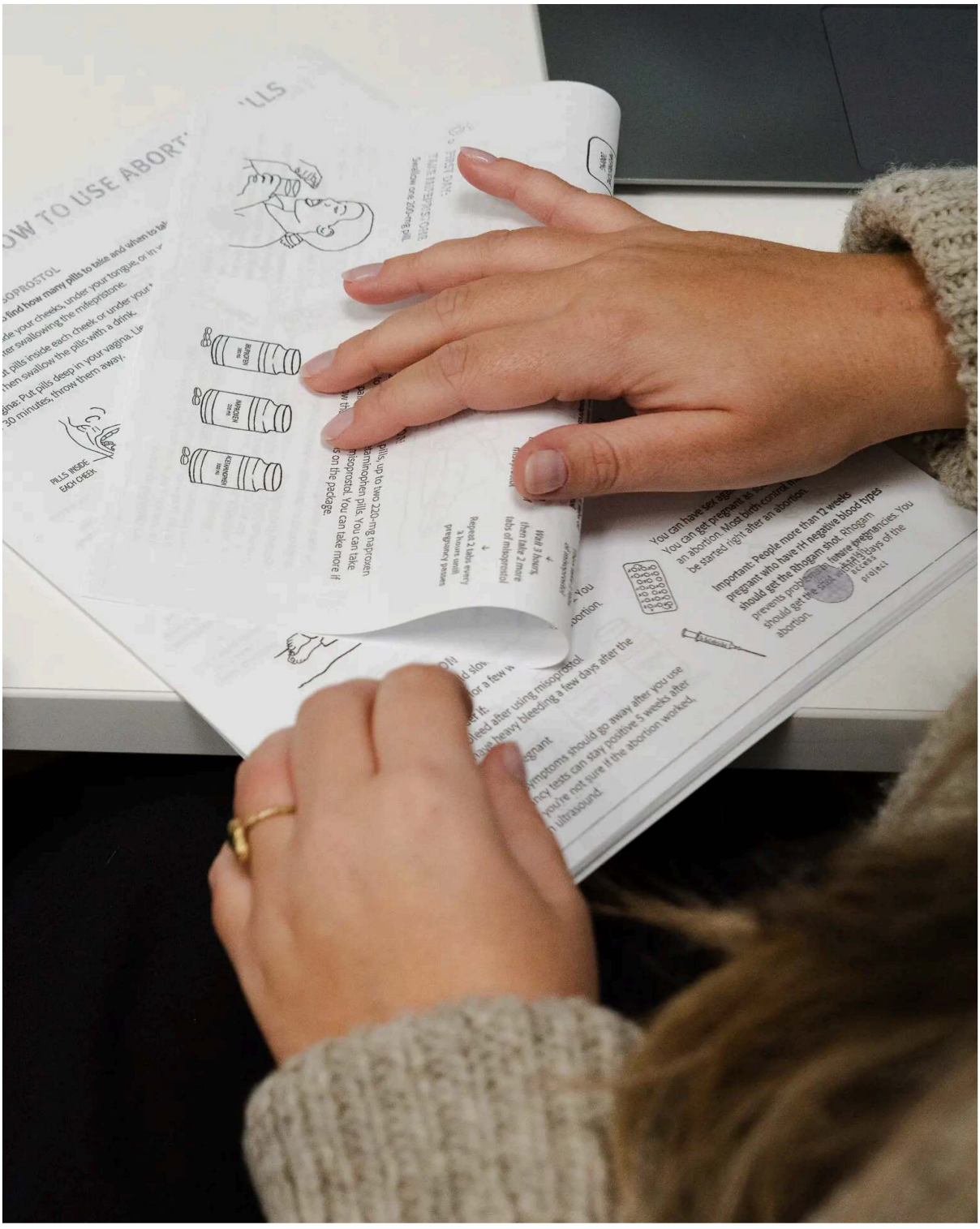
Dr. Rebecca Gomperts, a Dutch physician who founded Aid Access, said over half of its shield-law patients cannot pay full price. About a third of The MAP’s patients can afford only the service’s $5 minimum, said Dr. Angel M. Foster, director of The MAP.

But shield-law providers say it is uncertain whether they can sustain their pay-what-you-can approach. Most providers are absorbing the cost for thousands of patients who can’t pay full price. So far, most abortion funds — organizations that provide financing to help patients obtain abortions — have not given money for sending pills to anti-abortion states, partly because they do not know if shield laws would protect the funds.

“I’ve had several funds say, ‘Our lawyers say we cannot do this,’” said Susan Yanow, a longtime reproductive health activist working with The MAP, who has nonetheless gotten some funds to contribute.

A few funds openly support shield-law activity. “We are here to boldly make a statement,” said Karen Middleton, president of Cobalt Abortion Fund in Colorado, which gives $2,500 a month to that state’s provider. And some advocates are starting funds, including Jodi Jacobson, an activist based in California, who said she wanted to support “providers who are losing money” performing what she called “medical civil disobedience.”

Legal strategizing



Authorities in states with abortion bans have not yet tried to prosecute, sue or otherwise target shield law providers, but some advocates on both sides say it is only a matter of time before that happens. Sophie Park for The New York Times

Several Republican attorneys general from states with strict abortion prohibitions declined requests to discuss shield laws. But Mr. Scharf, who is challenging Missouri's incumbent attorney general in the Republican primary, predicted that the shield laws would almost certainly be challenged in court.

"Constitutional litigation is obviously an option here," he said. "Ultimately, whenever you get attempts like this to circumvent our constitutional system of federalism, that's going to be something that's litigated."

Dr. Seago of Texas Right to Life said taking action against shield-law providers would be "a difficult challenge" that would require "the right case," including a patient "on the receiving side of those illegal activities" who would cooperate with a civil suit or prosecution.

"We can definitely promise that in a pro-life state like Texas with committed elected officials and an attorney general and district attorneys who want to uphold our prolife laws, this is not something that's going to be ignored for long," he said.

Many shield-law providers are taking precautions, including not traveling to states with abortion bans, where they could be more vulnerable to arrest. Some are not sending pills to states where they have family. Some are creating trusts to protect their assets from civil suits.

"At any moment, I might get a cease-and-desist order, or I might get a lawsuit, or I might get some district attorney coming after me, I have no idea," said Dr. David Wiebe, who operates under Colorado's shield law. "I'm absolutely flying out at full risk here."

The MAP has taken several protective steps. All of its prescribers are within Massachusetts. Pills are stocked and packaged at a separate location by workers hired by Cambridge Reproductive Health Consultants, a nonprofit Dr. Foster leads. "Our model is about distributing risk," she said.

One national mail-order pharmacy, Honeybee Health, based in California, is evaluating whether it can send pills to states with abortion bans under California's shield law, a step that would allow providers in any shield-law state to send their

prescriptions to Honeybee and avoid stocking and shipping pills themselves.

Honeybee's co-founder and president, Jessica Nouhavandi, said she hoped to do so, but worried about jeopardizing her business, which dispenses other medications too. If an anti-abortion state like South Carolina pulled her license, "what happens to my thousands of South Carolina patients who get their blood thinners from me?" she said.

"We're a free country," said Lauren Jacobson, a nurse practitioner who sometimes writes 50 prescriptions a day. "So let's put that to test. Here we are and we're not going to be intimidated, and we have our states backing us." Ilvy Njiokiktjien for The New York Times

Another unknown is the outcome of the lawsuit by abortion opponents seeking to curtail mifepristone. An appeals court ruling effectively barred the mailing of mifepristone and required in-person doctor visits. The case is now before the

Supreme Court.

“If we prevail on that, all these shield laws will be rendered moot at that point because then there’ll be a federal policy prohibiting such a transaction,” said Erik Baptist, senior counsel for the Alliance Defending Freedom, which represents abortion opponents in that case. Some shield law providers say they will look for legal ways to continue.

Texas, which has strict bans, is home to about a third of shield-law patients, including Elizabet, who asked to be identified by her middle name to protect her privacy. She considered traveling to California, where a friend lives, but medication abortion at a clinic there would cost $750, plus transportation expenses.

She was relieved to find Aid Access and to receive pills mailed from Massachusetts. Although abortion bans target providers and not patients, she said she was still nervous about people in Texas finding out.

“That’s been very scary,” she said, “but I was like, you know what, I have to trust it.”

Weeks later, Elizabet said she planned to visit a doctor for birth control, but worried about being asked if she’d taken abortion pills.

Ms. Jacobson, who prescribed her the medication under Massachusetts’ shield law, reassured her, noting that there was no medical reason to disclose having taken abortion pills.

“The symptoms that the abortion pills cause are exactly the same as those that a miscarriage causes, so there is no possible way for a provider, a doctor, to look at you, do any test and know that you took the pills,” she said, adding, “We’ve helped a lot of people navigate situations in places like Texas.”

Pam Belluck is a health and science reporter, covering a range of subjects, including reproductive health, long Covid, brain science, neurological disorders, mental health and genetics.

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: New Shield Laws Allowing Women Abortion Access

EXHIBIT 75

Caroline Kitchener,

Alone in a bathroom: The fear and uncertainty of a post-Roe medication abortion,

Wash. Post (April 11, 2024)

Alone in a bathroom:

The fear and uncertainty of a post-Roe medication abortion

By Caroline Kitchener

April 11, 2024 at 6:00 a.m.

Angel tucked two white pills into each side of her mouth, bracing herself as they began to dissolve.

Angel at her home in Oklahoma. (Desiree Rios for The Washington Post)

Angel had wanted to talk to a doctor before she took the pills to end her pregnancy, worried about how they might interact with medication she took for her heart condition.

But in her home state of Oklahoma, where almost all abortions are banned, that wasn't an option.

The pain kicked in after about an hour, around midnight on a Sunday in January, eventually becoming sharp enough that the 23-year-old said she struggled to stand. While Angel would be fine by the next morning, she worried that something might be very wrong as she lay on the cold bathroom tile, her body racked by some of the worst pain she could remember.

When Angel's fiancé came in to check on her, she was having diarrhea while vomiting into their popcorn bowl.

"F---," she remembered yelling, over and over. "I feel like I need to push."

Overwhelming evidence shows that abortion pills are safe and effective, and that many patients who take them go through the process without much difficulty, experiencing little more than the sharp cramping and bleeding of an unusually heavy period. That is true even when the pills, approved by the U.S. Food and Drug Administration with a prescription for use through 10 weeks of pregnancy, are taken somewhat independently — administered by a doctor over text, email, or a call and mailed to the patient at home.

But the experience can feel very different in states where abortion is illegal. As more women in states with abortion bans choose to end their pregnancies on their own, without directly interacting with a medical professional, they are thrust into a largely ad hoc, unregulated system of online and grass-roots abortion pill distributors — an experience that, while deemed generally safe by medical experts, can be confusing, scary and, at times, deeply traumatic.

"I feel like I need to push."

"Self-managed" abortions increased dramatically after *Roe v. Wade* was overturned — with women in antiabortion states obtaining pills through several distinct channels. At least 6,000 women every month in states with bans are now receiving pills from Aid Access, a Europe-based online clinic that prescribes the medication without requiring a patient to interact with a doctor in real time,

according to founder Rebecca Gomperts. Thousands of others are turning to at least 25 nonmedical websites that sell the pills, or one of several volunteer-led networks that distribute them for free.

With abortion clinics shuttered across the South and Midwest, many women said they have nowhere to go to confirm that their abortion pill supplier is "legit" or that their symptoms after taking the medication are normal. They worry that a call to a doctor or a trip to the emergency room could land them in jail. And while abortion rights advocates have tried to build new infrastructure to support women in these situations — with volunteer doctors answering phone calls or former abortion providers staffing the occasional bricks-and-mortar office in an antiabortion state — organizers say that such resources are no replacement for the array of choices women had before *Roe* fell.

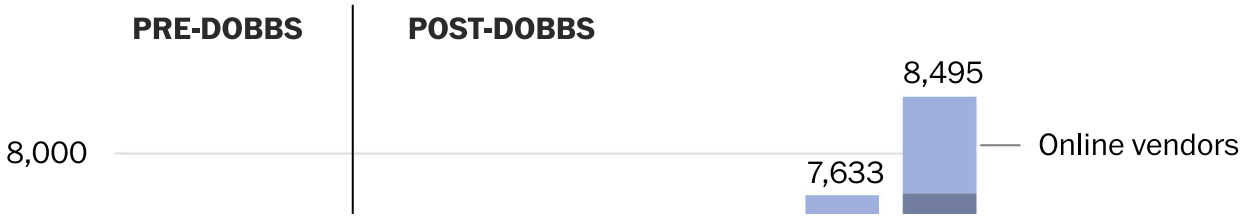
The demand for self-managed abortions in states with bans, already enormous, is sure to increase dramatically in the coming weeks, as strict new abortion laws take effect in Florida and Arizona — the result of two recent court rulings.

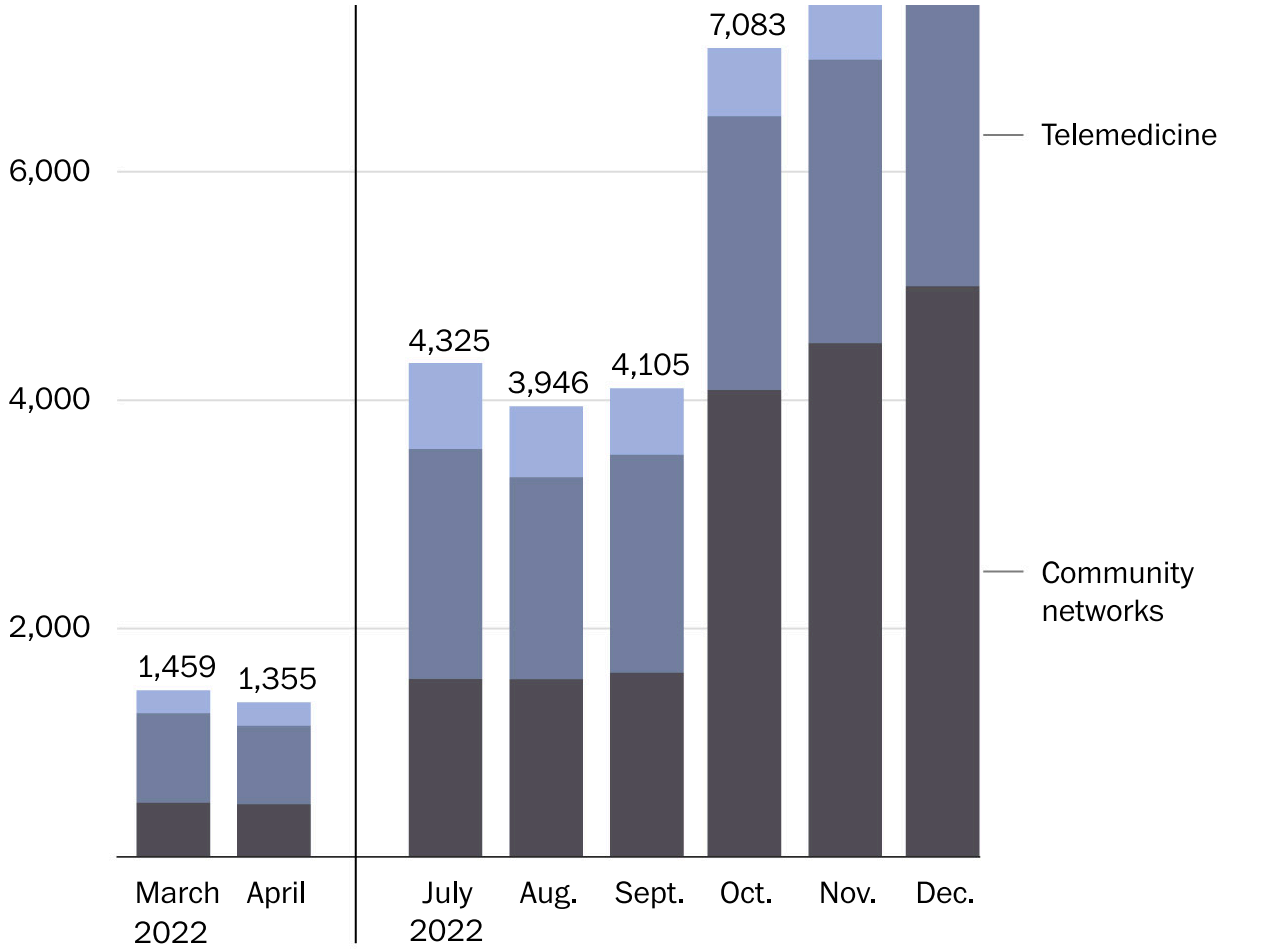
"This is not the way health care should be," said Linda Prine, a New York-based doctor who prescribes pills through Aid Access and co-founded a hotline for people taking them. "All the options have been taken away from people by these bans and this is all that's left," she added, referring to the networks providing pills for women self-managing their abortions.

"It really is all we can do."

Supply of abortion pills for self-managed abortions

The supply of abortion pills outside of the formal health-care setting increased sharply in the six months after *Dobbs v. Jackson Women's Health Organization*, a landmark ruling that eliminated the constitutional right to abortion. A major factor in the increase was the rise of community-based, volunteer-led networks that organized to help women in states with abortion bans.





Source: JAMA (2024)

Adding to the difficulty is a polarized political debate with dueling narratives about what it's actually like to take abortion pills. Antiabortion activists say the pills are highly dangerous, or even deadly, for pregnant women — false assertions based largely on studies that have now been retracted by the journal that published them. Meanwhile, many abortion rights advocates describe the experience as straightforward and easy to handle on your own, a characterization that some women say glosses over what can be a more complicated reality of ending a pregnancy alone in your bathroom.

The Washington Post spoke with more than three dozen doctors, advocates, leading researchers, and women who took the pills in states where abortion has been banned since *Dobbs v. Jackson Women's Health Organization,* the Supreme Court case that overturned *Roe* in June 2022. Over the phone and in person, many women described experiencing deep anxiety and uncertainty about doing something they assumed was illegal. These feelings often intensified

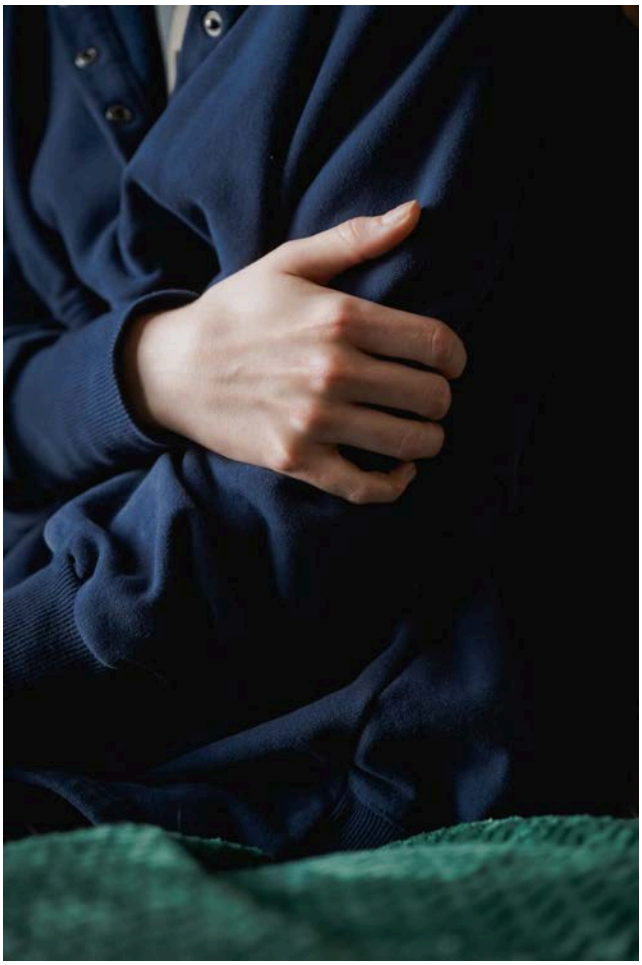
after they took the medication, with some not expecting the level of pain or amount of bleeding they would experience, or how much of the fetus they would see. A few used the pills later in pregnancy than the FDA recommends.

“I wish I would have known that it wasn’t just blood clots. … I was really confused and shocked,” said Briana, a 34-year-old in Alabama who took pills she ordered online when she was at least five weeks beyond the FDA’s 10-week limit. Like other women interviewed for this article, Briana spoke on the condition that her last name not be used so she could discuss sensitive medical information in a state that outlaws abortion — describing her experience in graphic detail because she said she wanted other women to know what to expect.

The complex legal landscape can be hard to understand. Abortion bans do not allow people seeking abortions to be prosecuted, targeting only doctors and others involved in facilitating the abortion. But people have been charged under other laws for self-managing their abortions, especially later in pregnancy.

A legal challenge to the abortion drug mifepristone brought by conservative advocates — which drew skeptical questions from the Supreme Court during oral arguments last month — seeks to further restrict the post-*Roe* landscape by requiring in-person medical visits for all legally administered medication abortions. Such a change could prevent U.S.-based medical providers from mailing pills into antiabortion states under “shield laws,” recently enacted in a handful of blue states, that protect doctors from prosecution under red state bans.

Angel pours out her heart medication at her home. (Desiree Rios for The Washington Post)



Angel was worried about how abortion pills might interact with medication she takes for her heart condition.

In Oklahoma, Angel ordered her pills from Aid Access, according to emails reviewed by The Post, and took them five to six weeks into her pregnancy. She'd told doctors at the online clinic about her heart medication when she filled out its online form, she said, but no one ever reached out about it — a silence easily explained, Prine said, because Angel's medication is not one that would raise concerns.

Angel had no way of knowing that.

Sitting on the toilet, she could hear her heart pounding in her ears. She placed two fingers on the side of her neck to take her pulse and started a timer, she

recalled — counting about 190 beats per minute.

With her heart condition, she said, she was supposed to seek medical attention if her heart rate got that high.

Angel had no idea who to call. She vaguely remembered a hotline number in the Aid Access instructions, but figured the line would be closed that time of night. The hospital didn't feel like an option, either: She worried about the questions she might get from suspicious doctors if she showed up at the emergency room.

She closed her eyes and tried to steady her breath, determined to keep her heart rate down. Then she spoke to herself as she imagined a doctor might.

"You will be okay," said Angel, who would wake up the next morning no longer pregnant, the worst moments of her abortion behind her.

"This pain can't last forever."

A doctor answers panicked calls

Linda Prine was answering a few emails, coffee mug in hand, when her cellphone rang.

“Hi, this is the hotline doctor,” the 72-year-old said from her New York City home one Sunday morning in January. “Can I help you?”

The voice Prine heard was quiet and scared — belonging to a 15-year-old with an area code in a state with an abortion ban who had taken pills and passed a fetus larger than she’d expected.

Unable to flush the fetus down the toilet, the girl asked about throwing it away.

She was young enough to be Prine’s granddaughter.

Prine cradled the phone in both hands and leaned in, trying to channel every ounce of reassurance and understanding she could muster through the phone line.

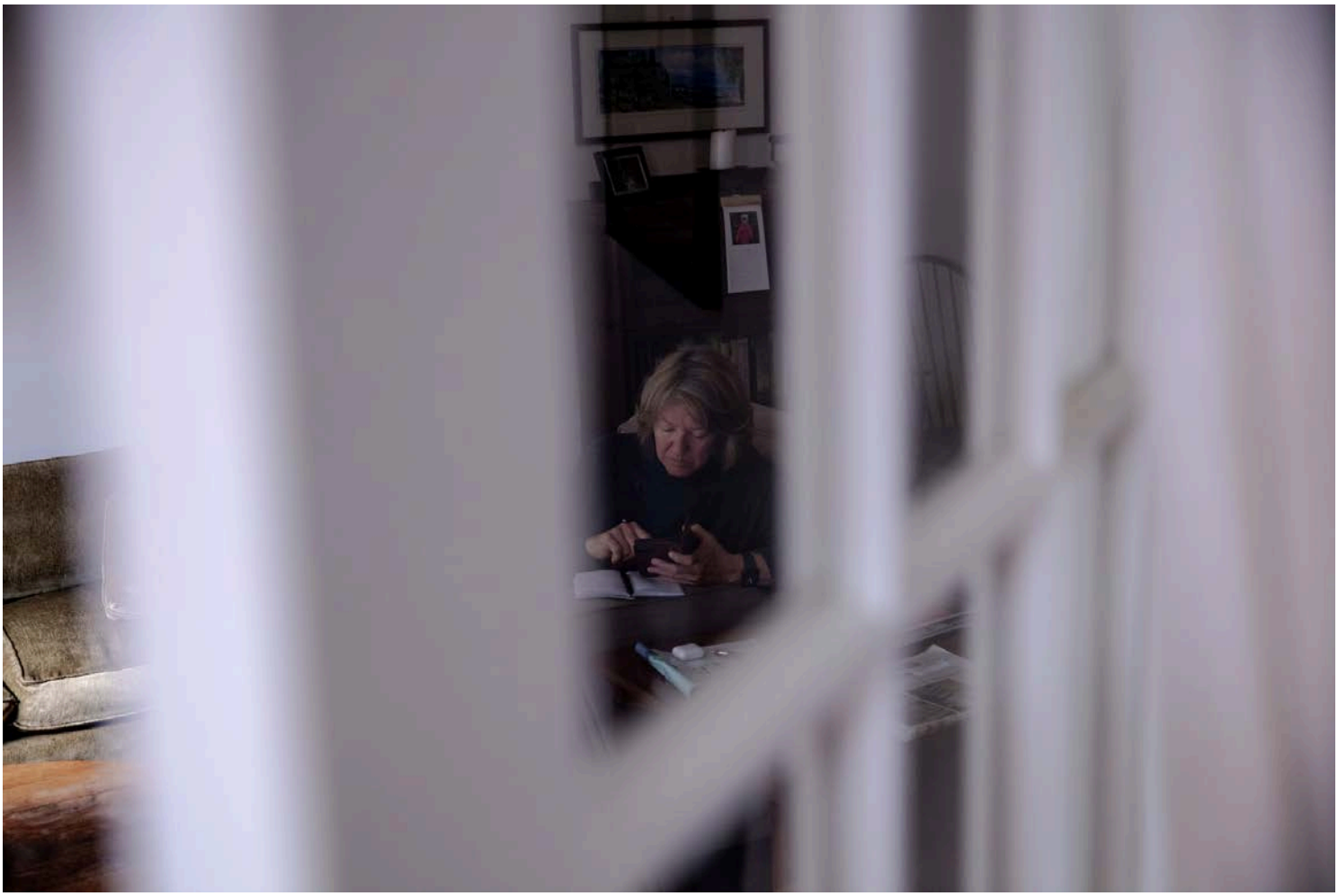
“There’s nothing in there that’s traceable back to you,” she said. “As long as you don’t tell anybody.”

The girl asked if the abortion made her a bad person.

“No it doesn’t,” Prine said. “Not a bit.”

“You are doing what’s right for you and your future family,” she added, her voice firm.

“This way you can be a good mom when you’re ready to be a good mom.”



Linda Prine answers calls and texts for the Miscarriage and Abortion Hotline. (Natalie Keyssar for The Washington Post)

A semiretired family medicine physician, Prine co-founded the Miscarriage and Abortion Hotline in 2019 as a resource for people self-managing miscarriages or abortions at home. She got the idea from Gomperts, of Aid Access, who had already been mailing pills to Americans who struggled to access abortion. The American patients had a lot of questions and concerns about ordering pills outside a formal health-care setting, Gomperts told Prine — and her inbox was constantly flooded with emails.

They needed a U.S.-based doctor to call.

> “You are doing what’s right for you and your future family.”

Calls to the hotline surged after Texas enacted an early law banning most abortions in the fall of 2021, Prine said, and again after new abortion bans took effect across the South and Midwest when *Roe* fell. Now the line is staffed by over 50 U.S.-based medical providers who volunteer their time, a mix of doctors, midwives, nurse practitioners and physician assistants with experience in abortion care. The doctors who run the hotline recruit volunteers through word-of-mouth recommendations, then administer a few hours of virtual training before they start.

In interviews, Prine stressed that hotline doctors are not practicing medicine under their licenses or establishing a doctor-patient relationship — a posture Prine said legally protects the physicians. By design, the hotline volunteers don't ask for the names, locations or full medical histories of the people who call. On the hotline's website, a disclaimer notes that they are not offering "legal or medical advice," and that the information they provide "does not substitute for the … advice of a doctor."

The hotline typically receives roughly 30 calls and 50 texts from people every day. Many say they are in states that ban abortion.

"They'll say, 'I'm in a state where this is illegal, so I can't go get medical care. I want to check in and make sure everything is going okay,'" Prine said.

She and her colleagues hear the same questions again and again: Am I bleeding too much? Am I not bleeding enough? Is it normal to have this much pain? People call to see if they can drink alcohol or smoke marijuana after taking the pills. One woman asked whether it was safe to walk up the stairs.

[What to know after taking abortion pills]

Anxiety and uncertainty are common even among patients who receive the medication at an abortion clinic in a state where abortion is legal, said Prine — because they're at home by the time they start feeling the full effects.

"People from anywhere can be freaking out because everyone is taking these pills at home alone," Prine said.

Still, some feel better taking the pills after having a direct conversation with a medical professional. Since *Dobbs*, many women in antiabortion states who have the resources to travel have continued to leave the state to obtain pills at a clinic instead of ordering online, preferring the experience of being face to face with a doctor, even if it means a long drive or a flight.

The Miscarriage and Abortion Hotline is staffed by over 50 U.S.-based medical providers, a mix of doctors, midwives, nurse practitioners and physician assistants with experience in abortion care. (Natalie Keyssar for The Washington Post)

A cross stitch at the home of Linda Prine.

For those who choose to self-manage their abortions, Prine said, she is there to offer reassurance that their experiences are nothing out of the ordinary, and that they almost certainly don't need to go to the emergency room. A medication abortion is just like a miscarriage, she'll tell them, with hundreds of women going through the same process every day.

Of the approximately 5.9 million patients in the United States who took mifepristone — the first drug in a two-step medication abortion regimen — between its 2000 approval and December 2022, just 32 died, according to the FDA. Those cases, the agency says, "cannot with certainty be causally attributed

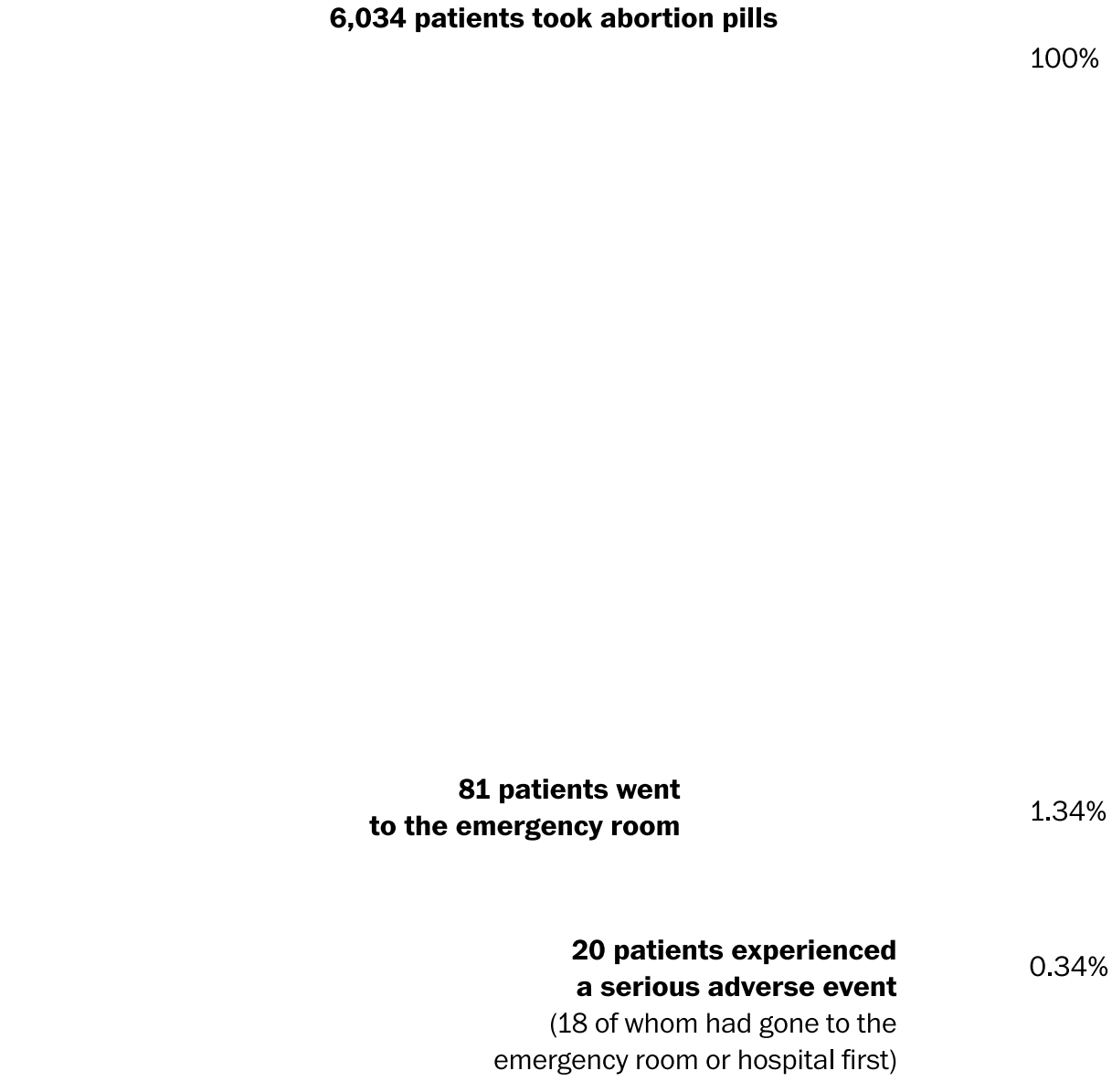
to mifepristone." Major adverse events — in which a blood transfusion, major surgery or overnight hospital stay is required — occur in fewer than 0.5 percent of cases, a figure that remains the same whether a patient has met with a doctor in person.

A significantly larger share of patients who take abortion pills seek emergency care, ranging from 1.3 to 8 percent in leading studies.

Adverse effects are extremely rare among those who take abortion pills

A tiny fraction of patients who take abortion pills have a serious adverse event such as a blood transfusion, major surgery or overnight hospital stay.

= 10 estimated patients who took abortion pills



Note: Estimated patient numbers are based on percentages included in a 2024 study and are rounded to whole people.

Source: Ushma Upadhyay/Nature Medicine

Antiabortion activists portray those emergency room visits as an indication of a safety issue, but leading medical experts say they instead highlight the confusion and fear that many women experience after taking the pills. Patients often go for a gut check, doctors and medical researchers said, wanting to confirm that they're not bleeding too much, or that the pills worked and they are no longer pregnant. Studies show that 35 to 50 percent of people who go to an ER after taking abortion pills receive no treatment.

"With medication abortion, there's no one saying, 'You're doing great. This is normal,'" said Ushma Upadhyay, a professor at the University of California at San Francisco and a leading researcher on the safety of abortion pills, drawing a distinction between the pill and a surgical procedure. "Often people are going through it alone, so they want to know everything is okay."

On the hotline, Prine said she's felt the need to send someone to the emergency room only once in nearly five years.

"Your uterus knows what to do," Prine told a woman who called that January morning with reports of unexpectedly heavy bleeding. "It's going to take care of itself."

Others in the medical community are quicker to suggest that someone be seen in person.

On the infrequent occasions when a patient calls with concerns about their medication abortion, Clayton Alfonso, an OB/GYN at Duke University, said he'll try to evaluate how much she is bleeding and how her body is tolerating the blood loss. But he said it can sometimes be difficult to make those assessments over the phone.

"When you take a patient call, it's always hard because their definition of heavy bleeding could be different from my definition of heavy bleeding," said Alfonso, adding that he usually tries to bring patients into his clinic if he has space on the schedule. "I would much rather see someone than leave someone in limbo at home not knowing what to do."

In states with abortion bans, the emergency room is often the only option for women who want in-person care during their medication abortions. Even if they say they had a miscarriage — a condition that presents with symptoms indistinguishable from a medication abortion — many women in these situations have bad experiences at the hospital, Prine said, encountering physicians who provide inaccurate information or ask suspicious questions about why they're bleeding.

"Your uterus knows what to do."

Prine said she recognizes that the landscape for self-managed abortions is tenuous. The antiabortion movement is ready to seize on any experience with pills that is difficult or complicated, she said, especially the relatively rare cases in which women take pills later in pregnancy.

At the Conservative Political Action Conference last year, prominent antiabortion activist Abby Johnson said women are delivering "fully formed babies" in their bathrooms — a false description of what women see during a medication abortion, even in the second trimester.

"They're passing these babies into the toilet," said Johnson, founder of the antiabortion group And Then There Were None. "Then these women have to make a decision: What do I do with this fully formed baby?... Do I flush my child down the toilet?"

These kinds of incendiary attacks make it hard for abortion rights advocates to discuss the details of a medication abortion later in pregnancy, said Prine and

Gomperts — because the specifics could be weaponized by the antiabortion movement.

As a result, Prine said, women who take pills later in pregnancy are sometimes surprised by what they see.

A woman struggles to pass her pregnancy

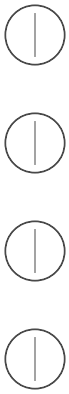
At her home in Alabama, Briana waited to take the pills until she'd put all of her children to sleep.

The cramps in her lower back came first, followed by full-body chills and, eventually, contractions more painful than those she remembered from childbirth.

After lying in bed for two hours, Briana felt something "pop" under the comforter, followed by a gush of warm liquid seeping down her legs. She ran to the bathroom, she recalled in interviews and a journal entry, where she felt a mass larger than her palm drop into the toilet.

"This can't be happening," she thought to herself.

Then she looked down to see a bloody umbilical cord dangling between her legs.



When the pills first arrived in the mail a few days earlier, in April 2023, Briana had expected her experience would be more difficult than most. The doctors who administered the medication through Aid Access cautioned Briana that they "do not like to recommend medical abortions" as far into pregnancy as she would be when the pills reached her, according to emails reviewed by The Post.

Briana felt she had no choice. By the time she found out she was pregnant, she was already 11 or 12 weeks along. The abortion clinic she'd called in a different state, more than a six-hour drive from her home in Alabama, where abortion is banned, was booked for surgical procedures for over a month, busy treating patients from other antiabortion states across the South. She spent nearly two weeks researching her other options, then the pills she ordered took two weeks to arrive.

The 34-year-old was struggling to support the kids she already had.

"I didn't want to take any more away from them … time, attention, money," said Briana, who estimates that she was 15 or 16 weeks along when she took the pills.

"This can't be happening."

Experts and advocates say it is relatively rare for women to self-manage their abortions well beyond the FDA's 10-week limit, particularly since passage of the shield laws, allowing U.S.-based doctors to mail pills directly into antiabortion states instead of relying on international pharmacies. That change has reduced the shipment time from several weeks to between three and five days.

At the time Briana ordered her medication, over a year ago, Aid Access generally did not send pills to anyone who said they were further than 11 weeks into their pregnancy, Gomperts said. It now allows people to place orders through 12 weeks of pregnancy, because pills reach patients more quickly.

"If we think people might be longer than that, they get an email to make sure they can navigate the situation," said Gomperts, who personally prescribed Briana's medication, according to documentation reviewed by The Post. "Women have agency. They are perfectly capable of making these choices about their own health, and we are there to support them the best we can."

According to data compiled by Aid Access, and shared with The Post, 1 in 20 patients who responded to the organization's survey in January took the pills beyond 11 weeks of pregnancy. One in 100 took the pills beyond 13 weeks. (About 20 percent of people who took the pills responded to the survey.)

Still, Prine said, she has fielded far more of these calls from women later in pregnancy than she would like — averaging one a day on the hotline in the months after the Supreme Court decision. Some of the callers had no idea how far along they were until they passed the pregnancy, she said. Others knew, but chose to go ahead anyway.

Beyond 12 or 13 weeks, women will see a much more developed fetus, with identifiable features.

"We hear the trauma when we talk to people," Prine said. "It's an image you can't get out of your head."

How we reported this story

Caroline Kitchener reported this story from four states. She witnessed Ashley's ultrasound in Texas, watched Linda Prine answer hotline calls in New York, and interviewed Angel and Briana in Oklahoma and Alabama. She also spoke on the phone to women who self-managed their abortions at home.

Alone in her bathroom, Briana had no idea what to do. The Aid Access doctors had told her to expect nausea, vomiting, chills, blood clots and a fetus at least the size of an orange, emails show.

They said nothing about an umbilical cord.

"Do I pull the cord out?" Briana wondered, frantically trying to remember what the doctors had done when she gave birth. "Do I just wait to try to push it out?"

Her boyfriend was sleeping in the next room. Even if she woke him up, she wondered, what could he do? If she went to the emergency room, she said, she felt sure she'd be prosecuted.

Finally, Briana decided to call the number for the Miscarriage and Abortion Hotline she'd seen in an email from Aid Access.

"That's the placenta you need to push out," Briana recalled the woman on the hotline saying. "When you feel the next contraction, I want you to push like you're giving birth."

Briana said she sat there with her umbilical cord hanging loose for at least 15 minutes before the placenta finally dropped into the toilet.

While there are no major U.S.-based studies on the experience of self-managing an abortion with pills later in pregnancy, international research suggests that women in these situations more frequently seek in-person care. One study conducted with patients in Argentina, Nigeria and Southeast Asia between nine and 16 weeks of pregnancy found that about 24 percent went to a medical facility during or after the experience of taking the pills on their own. Approximately 10 percent required medical intervention to complete the abortion or treat a complication.

One major concern later in pregnancy is that the body won't be able to expel all of the pregnancy tissue, several doctors said.

When the Miscarriage and Abortion Hotline received its first call from a woman who was unable to pass her placenta — at least five weeks further into her pregnancy than the FDA's 10-week limit — a group of hotline doctors started messaging one another, trying to decide what to say to her, Prine said.

One doctor in the group insisted that the woman had to go straight to the ER, but Prine and others disagreed. Worried the woman could face prosecution or mistreatment if she went to the hospital, Prine said, they walked her through her abortion at home, instructing her to take more abortion pills and gently massage her stomach until the placenta came free — the same advice Briana said she received.

"We didn't feel like it was a medical emergency. She wasn't bleeding heavily and she wasn't lightheaded," said Prine, adding that they would have recommended the woman go the ER if a hospital visit was medically necessary.

A woman in that situation could have hemorrhaged or become septic, according to five OB/GYNs interviewed for this article.

"Whenever there is something inside the uterus that is trying to come out and won't come out, the risk of bleeding and infection gets higher with every passing moment," said Keri Garel, an OB/GYN at Boston Medical Center, adding that she would advise someone in Briana's situation to go to the hospital immediately. "At that point, your life is the most important thing."

"Do I pull the cord out?"

As difficult as the situation was, Briana says she is extremely grateful that Aid Access was willing to send her the pills — and that someone on the hotline was available to talk her through taking them.

"Without the hotline I would have been completely lost and literally completely alone," she said.

"The lady … stayed talking to me for hours," Briana added. "I wish I knew her name."

Briana stayed in the bathroom that night for more than an hour. She knew she shouldn't look at the fetus, she said, but she couldn't help it. In the toilet bowl, she could make out a head. She remembered thinking that the legs looked long.

"I felt like a monster," she said, reflecting back on that moment.

A year later, Briana said, she is certain she made the right decision for herself and her family. But she wishes someone had told her more about what to expect. If she had known the full extent of what could happen during a medication abortion at 15 or 16 weeks, she said, she probably would have searched harder for an out-of-state clinic with available appointments — and figured out a way to drive six hours or more to Florida, Illinois or North Carolina.

Before *Roe v. Wade* was overturned, Briana could have gone to a clinic less than

30 minutes from her house.

A former abortion provider offers some relief

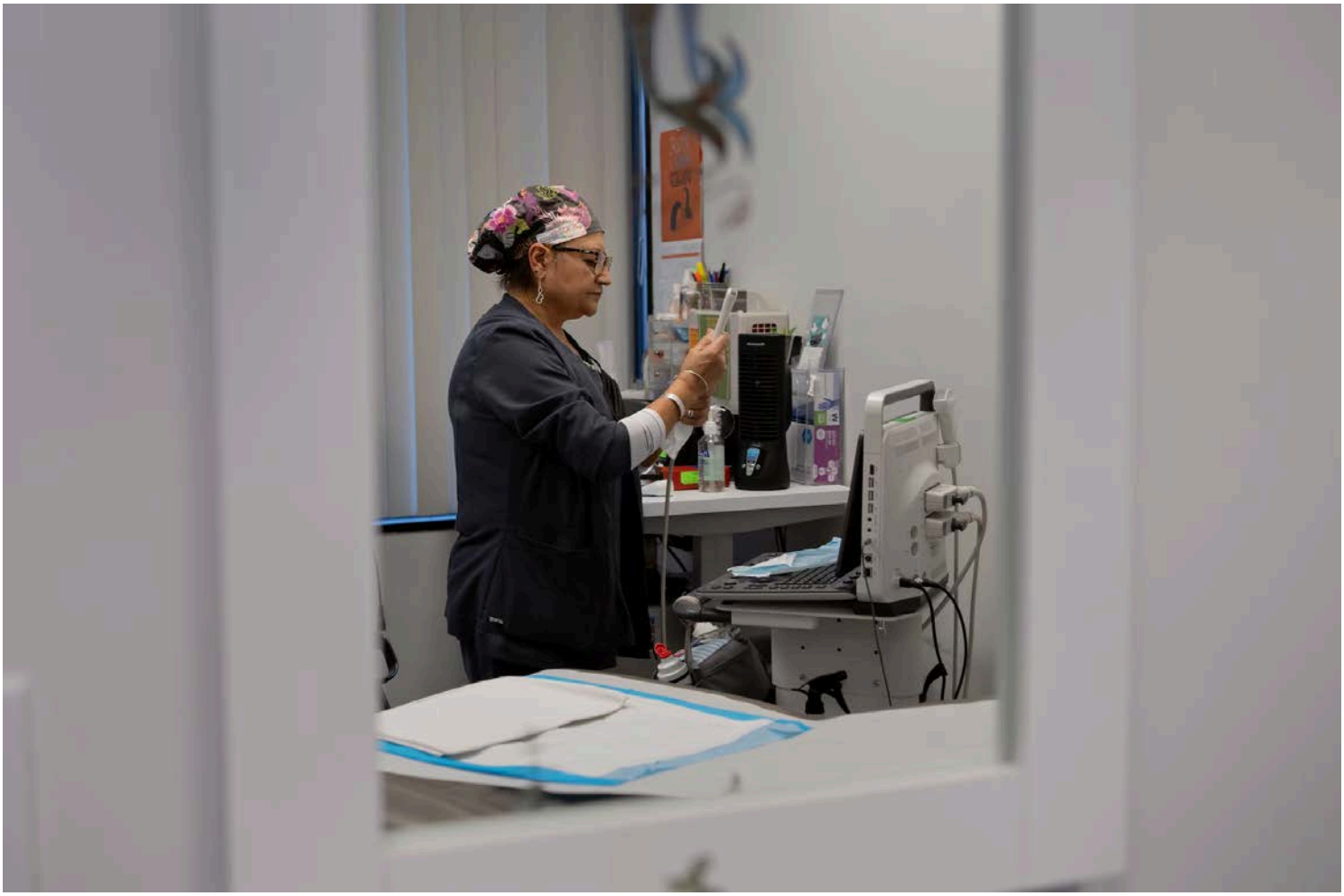
In Houston, a woman lay back on an exam table in a clinic that once offered abortions, hoping to hear that her medication abortion was finally complete.

Ashley, a 25-year-old mother with a baby, opened her legs and stared up at a mermaid mobile hanging from the ceiling, her sweatpants and Converse sneakers in a heap on the floor.

“Are you ready?” Glenda Lima, the sonographer, asked on a Tuesday morning in mid-February. “There will be a little cold and just a little pressure, okay?”

It was Ashley’s fourth visit in two months to Houston Women’s Reproductive Services, one of a handful of former abortion clinics that have remained open in states with near-total abortion bans. While the staff originally imagined a new version of the clinic that offered ultrasounds and referrals to patients planning

to travel out of state for medication and procedures, a large share of the women they serve are now self-managing their abortions with pills they got online.



Glenda Lima cleans ultrasound equipment at Houston Women's Reproductive Services in Texas. (Danielle Villasana for The Washington Post)

As soon as she found out she was pregnant in mid-December, Ashley had ordered pills from Aid Access, which she'd heard about on TikTok. But the whole process seemed a little sketchy, she said. What kind of medical organization collected money through Venmo, she wondered? They were asking for a picture of her driver's license. What if it was all a scam?

She decided that she needed to talk to someone. Not a disembodied voice on the phone or an anonymous commenter in an online forum — but a real, live person she could actually meet.

"If I'm putting this in my body," Ashley recalled thinking to herself, "I need to

know I'm going to be okay."

Ashley struggled to come up with the right terms to Google, she said, wondering if it was even possible to get advice on abortions in a state where abortion is banned. She came across contact information for Houston Women's Reproductive Services only after first messaging a crisis pregnancy center — an email thread she abandoned when she realized it was actually an antiabortion organization designed to dissuade women from ending their pregnancies.

Kathy Kleinfeld, the administrator of Houston Women's, responded to Ashley's panicked message on a Sunday, offering her an appointment for a pre-abortion ultrasound and consultation the next day the clinic was open.

"I was like, 'Oh my God, I feel like I have been searching for this,'" Ashley said. For the first time since finding out she was pregnant, she said, "I just felt safe."

Glenda Lima performs an ultrasound for a patient at Houston Women's Reproductive Services. (Danielle Villasana for The Washington Post)

A patient holds her hands while getting an ultrasound at Houston Women's Reproductive Services.

As other Texas clinics moved to New Mexico and Illinois after *Roe* was overturned, Kleinfeld and Lima decided to downsize and stay put, anticipating that some women would continue to seek out ultrasounds, emotional support

and general guidance in their home state, services that remain legal under Texas law. If all the abortion clinics shuttered, they said, they knew crisis pregnancy centers would be the only places left to go.

Now, the women see their clinic as a helpful counterpart to the online pill networks: a soothing space with a "relaxation" scented diffuser and three portraits of the late Supreme Court justice Ruth Bader Ginsburg, where Texans can get the help they need to feel comfortable self-managing their abortions at home.

There are major challenges to providing this kind of care in a state where abortion is illegal. Perhaps the biggest, Lima said, is that women assume there are no abortion resources left in Texas. Those that find them often do so by chance.

Lima said she regularly gets frantic calls and texts from Spanish-speaking patients she's never met before on her cellphone, a number she gives out only to patients she sees in the clinic.

"I ask them, 'How did you get my number?'" she said. "They say, 'A friend of a friend of a friend.'"

"I need to know I'm going to be okay."

Kleinfeld acknowledges that the very existence of a clinic like theirs — which, unlike some other former abortion clinics that have remained open in states with bans, has no doctors on site and offers no health services other than ultrasounds — is somewhat controversial in the abortion rights community. With abortion rights advocates arguing vehemently that in-person consultations and ultrasounds are entirely unnecessary for a medication abortion, Kleinfeld said, some likely see her clinic as an impediment to women accessing the care they need.

Kleinfeld would never want to see an in-person visit mandated for all patients — most women have no problem handling everything at home, she said. But she has learned that some need the additional hand-holding, especially when they are obtaining pills from unfamiliar sources.

“Not everybody needs an ultrasound, not everyone needs a phone number to call,” Kleinfeld said. “But some really do.”

Blair Cushing, a family medicine doctor who provided abortions in McAllen, Tex., before the clinic there was forced to close, recently opened a small medical practice near the Mexico border to offer ultrasounds and other support to women who self-manage their abortions. When she meets with patients, she said, they’ll often stay to talk for an hour or more — experiencing “information overwhelm” from everything they’ve read online and desperate for reassurance.

“They’re worried because something didn’t go the way they were expecting,” Cushing said. “They need to decompress about this experience they had and make sure they’re okay.”

Ashley holds her baby at her home. (Danielle Villasana for The Washington Post)

As soon as she found out she was pregnant in mid-December, Ashley ordered pills from Aid Access.

Ashley first went to Houston Women's Reproductive Services for an ultrasound before she took the pills on Dec. 19 — then returned a week later, wondering why she was still bleeding and experiencing a dull pain in her lower back.

Lima, the sonographer, told Ashley that she still had some blood clots left in her uterus. And while Lima assured her that this was nothing to worry about — the body can typically expel remaining clots without any medical intervention — Ashley wanted to be sure.

She returned to Houston Women's for three more appointments, until Lima was able to confirm that all the clots were gone.

"Your uterus looks beautiful … nice and clean," Lima said at Ashley's final appointment in mid-February. "You're good to go, okay?"

Ashley smiled, closing her eyes as she felt all the muscles in her shoulders finally relax.

"Thank you," she said. "That's all I needed to hear."

Ashley carries her baby outside her home. (Danielle Villasana for The Washington Post)

About this story

Editing by Peter Wallsten. Photo editing by Natalia Jimenez. Copy editing by Thomas Heleba and Martha Murdock. Design editing by Madison Walls. Graphics editing by Emily M. Eng. Graphics reporting by N. Kirkpatrick. Design and development by Agnes Lee. Andrew Tran contributed to this report.

EXHIBIT 76

Her Safe Harbor,
Abortion Pills Online

Skip The Clinic, Get FDA Approved

Abortion Pills Prescribed By Licensed Healthcare Providers With Free On-Demand Medical Support.

We Help Women in all 50 States!

Begin Consultation

Abortion With Medicines Until 10 Weeks After Your Last Period.

- Click **Begin Consultation** to answer questions about your situation and medical health.
- The person requesting the consultation must answer the questions truthfully. We do not share any information about you with others!
- You need to upload an ID.
- A healthcare provider reviews your information to ensure you can safely use the medication. If the provider needs more information, we will contact you.
- **You will receive an email for your making your payment.**

- Your assigned healthcare provider writes your prescription after we receive your payment.
- Your order is processed and shipped with **1 mifepristone tablet and 2 doses of 4 misoprostol tablets** (FDA approved) and **2 Zofran (Anti Nausea), 4 Ibuprofen**. (You won't find anyone else who provides nausea and pain medication).

Shipping takes 4-6 days.

The help desk and providers are there to support you through email: **contact@hersafeharbor.com** or phone: **302-660-1273**

Begin Consultation | Donate

TeleMedicine Treatment For:

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- Yeast Infection
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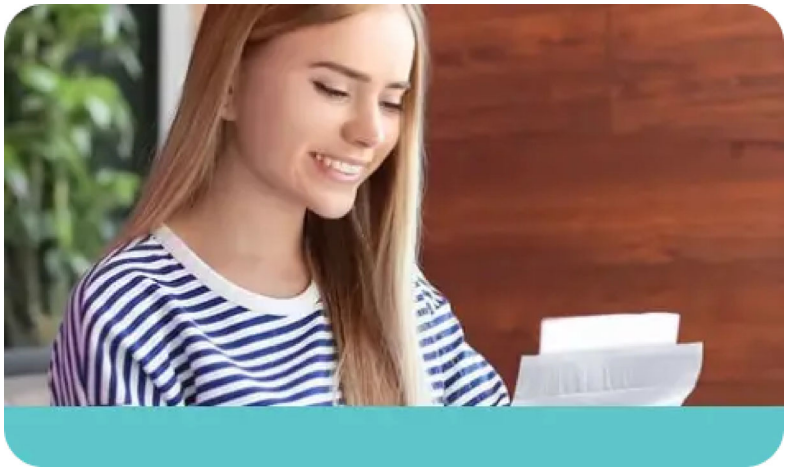

What's Included

Mifepristone (1)

Misoprostol 2 doses (8 tabs)

Zofran (Anti Nausea) 2 tabs

Ibuprofen 2 tabs

Begin Consultation

What People Are Saying

Jessica A.

“Thank you for being there. You saved my life.”

“You were there for

To reduce your digital footprint, the Digital Defense Fund recommends using privacy-forward search engines like DuckDuckGo, creating temporary email accounts for abortion care, and turning off location tracking on all of your devices.

Her Safe Harbor has never and will never disclose any private health data to any authority. We will not comply if we are ever subpoenaed.

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‘An extremely personal choice’: How two women reached their abortion decisions | Opinion

Janie anxiously searched online — Google, Planned Parenthood, Reddit, TikTok — trying to figure out how to end the pregnancy she had concluded she couldn’t keep…

Abortion pills by mail surge despite Texas’ bans. How long can it last? | Opinion

The large cardboard box in Debra Lynch’s living room contained enough pills for 162 medication abortions. Last summer, such a shipment would last a month…

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EXHIBIT 77

Pam Belluck,
A day with one abortion pill prescriber,
N.Y. Times (Jun. 9, 2025)

The New York Times https://www.nytimes.com/2025/06/09/health/a-day-with-one-abortion-pill-prescriber.html

A nurse practitioner spoke on the phone with patients in states with abortion bans, assessed their medical eligibility and sent pills. She took some unconventional steps to protect their privacy.

By Pam Belluck Photographs by Hannah Yoon

June 9, 2025

The young woman's voice trembled over the phone. Sitting in her car in Alabama, where abortion is almost totally banned, the 26-year-old mother of two was grappling with an unintended pregnancy.

"I'm like 'How in the world?'" she said, stifling a sob. "I already have two children, and I cannot. I can't. I just can't go through with it."

She wanted an abortion, she said, but was afraid of getting caught and didn't know what to expect from the process. "Growing up, I never really thought about actually doing something like this," she said.

On the other end of the line, at home on a quiet residential street in Delaware, Debra Lynch, a nurse practitioner who runs a service prescribing abortion pills, spoke calmly.

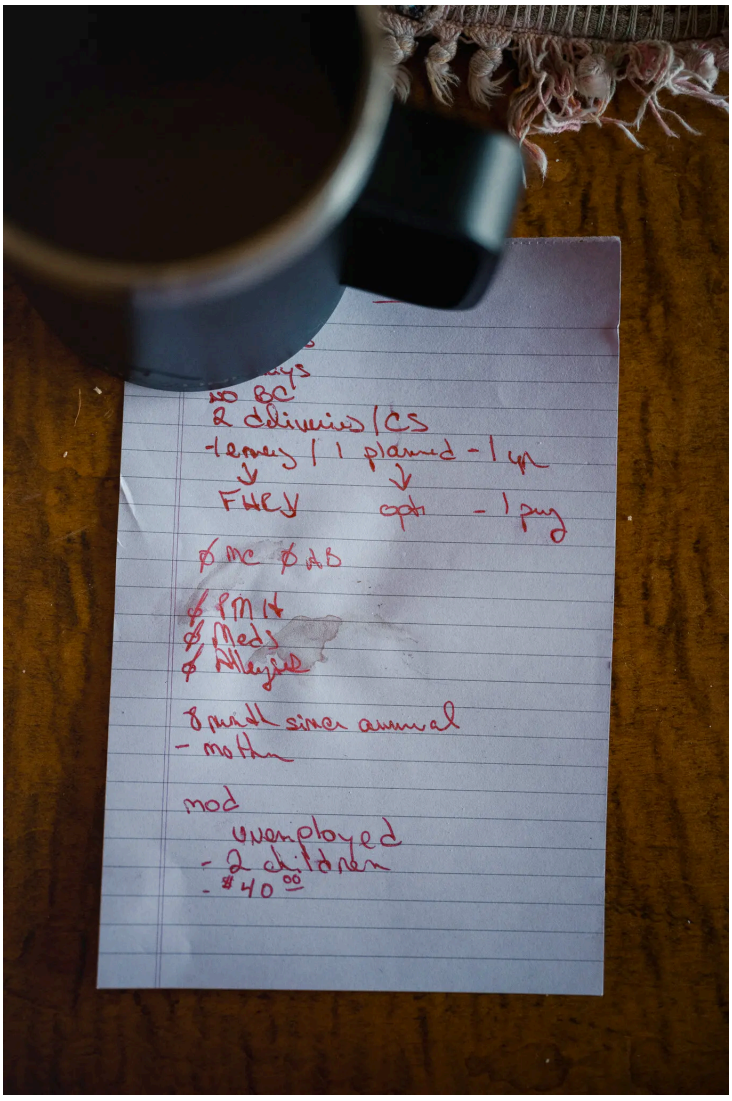
"It's completely valid to be scared," she said from her desk in a home office filled with plants and shelves of medication. "And that's why we want you to call us, even if you're calling just to say: 'I'm scared. I need to hear somebody tell me that what's going on right now is normal, and it's OK.'"

During the 25-minute conversation, Ms. Lynch asked the woman about her health history and pregnancy and assessed that she was medically eligible for abortion medications that can be taken in the first 12 weeks of pregnancy: mifepristone, which blocks a hormone necessary for pregnancy development, and misoprostol, taken 24 to 48 hours later, which causes contractions so pregnancy tissue can be expelled.

She carefully explained how to take them and mentioned that after the second medication, there would be cramping and bleeding that could continue for days.

Ms. Lynch's husband, Jay, packaged the pills into a plain white envelope and labeled it with the Alabama address, as well as their service's name and return address. A mail carrier picked it up from their mailbox. Included was a handwritten note on paper decorated with flowers: "We are here for you if you need us. You are not alone. Feel free to reach out anytime, no matter what you need."

Ms. Lynch is one of about several dozen providers in the country taking legal risks by prescribing and sending pills to patients in states with abortion bans. Many providers are based in states with shield laws, intended to offer them protection by preventing authorities there from cooperating with out-of-state officials who try to prosecute or sue them for serving people in their states.



Misoprostol and mifepristone awaiting packing and mailing.

Notes from a call.

About 20 states have adopted some type of abortion shield law since the Supreme Court overturned the national right to abortion in 2022. Eight explicitly protect telemedicine abortion prescribers who send medication to patients in any state. Delaware's shield law isn't as explicit, and there are different views on the scope of its protection, some legal experts said. Ms. Lynch said lawyers advised her that Delaware's laws appear to protect prescribers who mail pills to any state, but she recently decided to move to one of the eight states with the clearest protections.

The mailing of abortion pills has become a major issue for anti-abortion activists. In a lawsuit against the Food and Drug Administration, three Republican state attorneys general are seeking to reinstate rules requiring patients to obtain pills from providers in person. And abortion opponents are pressing for other state and federal actions to curtail the sending of abortion medication into states with bans.

"It is violating not only our pro-life laws but our homicide laws," said John Seago, president of Texas Right to Life.

He added: "We're really shocked that there's been a widespread embrace of this. And so for Texas, we've established it's immoral, it's unethical. We want to stop it."

Shield laws have become a key abortion-rights strategy, and each month, prescribers are sending medication to about 10,000 patients in states with bans. But the laws are beginning to be tested as authorities in states that outlaw abortion bring legal action against such prescribers, a confrontation many expect to reach the Supreme Court.

The first cases — a criminal indictment in Louisiana and a civil suit by the Texas attorney general — involve a New York doctor accused of sending abortion pills to those states. New York officials have refused to cooperate, invoking that state's shield law. But the cases have transformed the risk for abortion providers from theoretical to real.

Given the stakes, most prescribers sending pills to states with bans keep their names and other identifying information out of public view. Ms. Lynch was willing to be named, saying that to "step forward and identify who you are as an actual real live human" might help some women needing abortions feel less fearful.

She allowed The New York Times to spend a day with her as she had phone consultations with patients. (The Alabama woman and others allowed The Times to listen; to protect their identity, The Times agreed not to name the patients.)

Ms. Lynch with Jay, her husband, who handles logistics like answering the phone for the service.

The visit offered a rare look at the work of one unconventional prescriber and the delicate and complex circumstances women seeking abortions may experience.

Ms. Lynch operates the service, called Her Safe Harbor, with three other volunteer licensed prescribers and Mr. Lynch, who handles various operational responsibilities and formerly worked for Delaware's health and social services department. The service, which started last June, also provides contraceptive pills and treatment for gynecological infections. The Lynches said the service ships several hundred packages a month, mailing to any address patients request, including a general store in a Midwestern town.

Ms. Lynch's medical guidance follows what most medication abortion providers recommend. But some other steps she takes push the envelope in ways other prescribers do not. Those steps, she said, are intended to reach patients who are especially concerned about privacy or nervous about the abortion process.

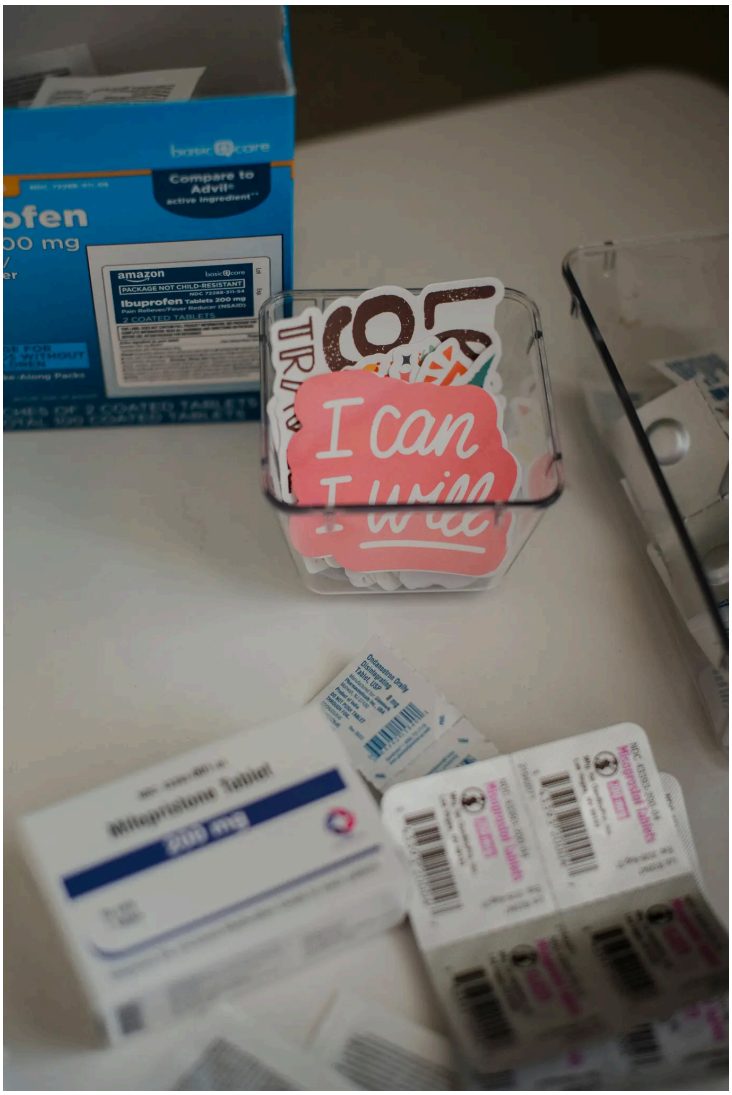
She says she believes the risks she is taking pale in comparison to the risks patients take in seeking abortions. "They are the ones who are really being brave, you know?" she said.

A Call From Texas

There were cries of young children in the background as a mother of two in Texas described over the phone how she learned during a routine gynecologist appointment that she was pregnant again. She told Ms. Lynch that she didn't want her husband to know because he had sometimes been abusive. She asked that the pills be mailed to a friend's house, where she planned to take them while her husband was at work.

There was another issue though: How would the woman explain to her doctor why she was no longer pregnant? She told Ms. Lynch that she thought that she should visit an emergency room after taking the pills, so a hospital could document that she had a miscarriage. But she was terrified about whether abortion pills or even the nausea medicine that the service sends in the package could be detected with blood tests. She asked if she could tell the hospital not to take blood.

Ms. Lynch told her that standard blood and urine tests don't detect those medications and advised that saying she was having a miscarriage but didn't want lab tests could raise suspicion and impede the hospital's ability to provide the miscarriage documentation she wanted. After the call, she said the woman seemed reassured about what to do.



Included in the packages are medical instructions and stickers with supportive phrases.

Mr. Lynch put two packages in the mailbox to be picked up by a mail carrier.

Many callers are in sensitive circumstances, Ms. Lynch said, including women who have been victims of date rape. She said concern for their safety and privacy was one reason she had adopted some practices that differ from other services.

“It’s not just obfuscation for the sake of obfuscation from law enforcement,” she said. “A lot of times, it’s because it’s a domestic violence situation or a high-risk-for-violence-in-the-home situation, or they live with other people who might out them.”

Women in states with bans have limited options for abortion. They can travel to states with legal abortion, but that can be costly and involve time away from jobs and children. Some obtain pills from informal community networks that don’t have medical professionals or prescription medication.

Many women choose another option: telemedicine abortion services that mail prescribed pills. Such prescribers often assess medical eligibility by reviewing forms that patients complete online, a system many patients consider convenient and efficient.

Ms. Lynch says her service works differently. It is designed for patients in states with abortion bans and restrictions who want to talk with a provider on the phone or who worry that online forms might leave an electronic footprint, she said.

Typically, abortion pill prescribers strictly comply with the laws of the state they’re licensed in, which helps ensure that their state’s shield law will protect them. For example, they carefully obey their state’s requirements about sending the prescriptions with the medication. Ms. Lynch, however, said that to better serve patients who are afraid to receive such documentation, she decided not to put copies of the prescriptions in the packages, although such a practice would trouble the providers who follow the rules.

“One of the main points that we heard from people was that they don’t want a prescription with their name on it,” she said. “So, we had to make a decision: Are we willing to potentially violate a Delaware law with the labeling of the prescriptions in order to remove this barrier that’s a very real barrier for a lot of people?”

Her service keeps prescriptions and other records for patients in paper files offsite, she said. To give patients additional “plausible deniability,” she said, she sends receipts with a medical code for a urinary tract infection consultation, one of the

conditions the service treats, along with written information about U.T.I.s. She doesn't ask patients in states with abortion bans or restrictions to provide identification like a driver's license.

Ms. Lynch, a Queens native, and Mr. Lynch, a Brooklyn native, have been married for over 30 years and have worked together before, including once running a children's theater.

Ms. Lynch, 56, has had an eclectic career and said she previously worked in geriatrics, chronic disease and other fields. Assisting a community Covid response team in Philadelphia "kind of redirected my career focus on being more social-needs-oriented," she said. After Roe v. Wade was overturned, she wanted to offer support to women seeking abortions and admired the shield-law providers' work, she said.

A Queens native, she is voluble and expressive. During the recent visit, she was wearing a long blue floral dress and pink head scarf and was barefoot with a flowery vine tattoo spiraling down one leg. She and Mr. Lynch, a 61-year-old Brooklyn native, have been married for over 30 years and have worked together before, including once running a children's theater.

During phone consultations, Ms. Lynch's questions mirror the online forms other services use and her responses generally echo those of other providers. For example, she won't prescribe abortion pills to women with bleeding disorders or ectopic pregnancies, in which the fertilized egg is outside the uterus and never produces a baby.

Some patients ask what they should do if they want or need to visit an emergency room. Serious complications from medication abortion are rare, and numerous studies have found it to be safe, including when pills are prescribed by telemedicine and mailed. Long before the F.D.A.'s 2021 decision permitting telemedicine abortion, the agency considered the medication safe enough to allow patients to take it at home and not in the presence of a doctor. But some women want a hospital to assess whether their bleeding level is normal or whether all the pregnancy tissue has been passed.

Ms. Lynch, like other abortion providers, counsels that there is no medical reason for women to tell hospitals they have taken abortion pills, and that they can allow hospitals to assume they are miscarrying, which involves the same symptoms and is often treated with the same medications.

Her service often conducts follow-up calls, checking on patients after they take the medication and sometimes for days afterward. On four occasions, she has suggested that a patient visit an emergency room, she said. One woman was dehydrated, and two wondered if they were bleeding excessively. She wanted the fourth to be evaluated because of heavy bleeding. All turned out to be fine and needed no treatment at the hospital, she said.

During phone consultations, patients often ask detailed questions.

A window charm and plants in Ms. Lynch's home office.

A 'Pro-Life' Caller

After another woman in Texas had a consultation with Ms. Lynch and took the medication, the woman and her husband wanted to check that the process was progressing normally. The patient's husband called and texted several times a day, sometimes late at night.

The man said they were devout Christians who considered themselves "pro-life" but found themselves in circumstances where abortion was right for them. "It's not very common that some grew-up-in-the-country Republican from Texas who loves guns changes his mind on things," he said on one call. "But here we are."

His wife has endometriosis and had been advised that pregnancy could be dangerous for her, he said. They worried that Texas' abortion ban made hospitals so afraid that if she miscarried or had pregnancy complications, doctors would have to wait to intervene until her condition became life-threatening.

"If you're a woman in Texas, and you're going through complications and a miscarriage," he said, "it's going to be difficult for you to find treatment, and that's not OK. And as a Christian, I understand that these laws stem from Christian values. But the one thing that we never really discuss is a woman's health."

Six days after his wife began the medication regimen, he called again, asking if they should be concerned that some bleeding was still occurring.

"No fevers, right?" Ms. Lynch asked.

"No nausea, no fevers," he said, adding that his wife "keeps bleeding and cramping, but it's not crazy excessive."

Ms. Lynch suggested the woman take an additional two misoprostol tablets, noting that some women need more than the initial four tablets to fully expel pregnancy tissue. If bleeding didn't lessen by the next day, she said, "then I probably would want to get her an ultrasound."

She quickly explained: "Now, she wouldn't have to go to the emergency room or anything, because as long as she doesn't have a fever or any signs of infection or continuous bleeding, it wouldn't be an emergency. So we could arrange for her to have an ultrasound there, locally, done without it going in her chart, or actually without the provider even having her name or any information."

Ms. Lynch sends each patient a handwritten note encouraging them to call with any questions.

Ms. Lynch's service has contacts for medical practitioners in many states who will provide ultrasounds and other care, she said, absorbing the cost themselves, as long as they aren't violating that state's abortion laws.

After the additional misoprostol, the bleeding eased, making an ultrasound unnecessary.

Like several other telemedicine abortion services, Her Safe Harbor typically charges $150 per order but also accepts whatever patients can afford. "Right now, I have like $40 on me, and I realize that's probably not enough for anything," the Alabama woman said.

Mr. Lynch, who handles logistics like billing and answering the phone, sent her the medications for free.

The Lynches recently decided to move to New York, which has one of the strongest shield laws. They've chosen a rural upstate community, where they can afford property large enough for a small clinic adjacent to their home. Ms. Lynch plans to apply for the necessary state nursing licenses.

To comply with New York's law, some of her practices would most likely need to change. But she said she appreciated that New York recently added another layer of protection by allowing providers to send patients prescriptions with the medical practice's name instead of the provider's name.

She applauded the state's forceful response to the Texas and Louisiana cases. Gov. Kathy Hochul of New York has refused to extradite the abortion provider, Dr. Margaret Carpenter, to Louisiana, and a county clerk blocked an attempt by Texas to enforce a $113,000 penalty against Dr. Carpenter.

Ms. Lynch said those actions sent a signal that "no matter what, we are going to protect the patients and we are going to protect the provider."

Susan C. Beachy contributed research.

Read by Pam Belluck

Audio produced by Sarah Diamond.

Pam Belluck is a health and science reporter, covering a range of subjects, including reproductive health, long Covid, brain science, neurological disorders, mental health and genetics.

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: Calm Voice on Phone, and Abortion Pills by Mail

EXHIBIT 78

Abuzz,
FAQs

abuzz

X Quick Exit

Frequently Asked Questions*

Services | *About Abortion Pills* | *Before Taking Abortion Pills* | *How to Use Abortion Pills* | *During An Abortion With Pills* | *After An Abortion With Pills*

Services

I can't afford $150. Can I still get help? −

Yes, you can still get help! Just let your provider know what you can afford when you fill out the form.

Can I get abortion pills even if I'm not pregnant? −

Yes, clinicians offer abortion pills "just in case" you do get pregnant. These are sometimes called "advance provision" or "pills for future use." Financial assistance is limited for this service, so there is a minimum fee of $90.

Do I have to have a video visit or phone call? −

In most cases, a phone or video call is not required. Everything is done through the intake form. You will receive a phone number so that you can contact the medical team for any follow up questions.

We are here to support you if you choose.

What happens after I fill out the form? −

We will connect you with a provider that is best suited to support your care. The provider will arrange payment with you and review your file. They might ask you some follow up questions. If you are eligible to receive services, they will mail you abortion pills.

How do I get started? −

Fill in the form here.

About abortion with pills

What comes in the abortion pill kit? −

The abortion pill kit has two medicines: mifepristone and misoprostol. The combination of mifepristone and misoprostol is very effective and has the fewest side effects.

How do the abortion pills work? −

Mifepristone stops the pregnancy from growing. Misoprostol makes the uterus contract and push out the pregnancy just like a natural miscarriage.

How effective are abortion pills? −

The combination of mifepristone and misoprostol has been shown to be 98% effective at ending a pregnancy.

Is there a difference between the generic (mifepristone) and brand (Mifeprex) versions of mifepristone? −

There is no difference between them.

Are abortion pills safe? −

They are very safe – safer than Tylenol and safer than driving in a car! The risk of severe, life-threatening complications requiring hospitalization is less than 1%.

If abortion pills are so safe, why are they so restricted? −

Restrictions on abortion pills have nothing to do with medical safety or effectiveness. The restrictions are made by politicians who are against abortion.

Will the abortion pills affect my ability to get pregnant in the future? −

No, abortion pills do not affect your future fertility. You can still get pregnant again.

I have an Rh negative blood type. Will I need Rhogam if I am less than 12 weeks when I take the abortion pills? −

No, Rhogam is only needed for people with Rh negative blood *after* 12 weeks.

Do abortion pills increase the risk of infection? −

Infections from abortions are very rare. They occur in less than 2% of all abortions and usually are easily treated with antibiotics when they do occur.

How far in pregnancy can I use abortion pills? −

The clinicians we refer to will send the pills to people up to 12 weeks and 6 days pregnant. If you are 13 weeks pregnant or more, you can find services here.

What is an ectopic pregnancy and how would I know if I had one? −

Ectopic (tubal) pregnancies are located outside of the uterus. The risk of having an ectopic pregnancy is very low (less than 2%), but if it bursts it is a medical emergency. The only way to know for sure if you have an ectopic pregnancy is by ultrasound. If you are pregnant and have any of the following signs of a ruptured ectopic pregnancy, you should go to the hospital right away: severe abdominal pain on one side, dizziness, lightheadedness, feeling very weak. There is a higher risk of ectopic pregnancy if you have an IUD or history of ectopic pregnancies.

Will the pills work if I have an ectopic pregnancy? −

The abortion pills will NOT work for an ectopic pregnancy. If you take abortion pills and do not have any bleeding within 24 hours after taking misoprostol, you should speak to your abortion pill provider right away. They may recommend an ultrasound to check the location of the pregnancy.

Can I use abortion pills if I have an IUD in place? −

It is very rare to become pregnant with an IUD in place. If you are pregnant with an IUD, there is a higher risk of it being an ectopic pregnancy. Ectopic pregnancies are dangerous because they can burst suddenly and cause severe internal bleeding. While an ultrasound is not required, it would show the location of the pregnancy and the IUD. You don't need to have the IUD taken out before taking abortion pills. They will still work (unless it is an ectopic pregnancy) and a risk is that the IUD may come out with the pregnancy. Since you have become pregnant, it also means you will need to have the IUD replaced after the abortion since it is no longer working correctly.

I got an abortion pill kit for future use. How long is it good for? −

You can store the pills for at least two years (and probably longer) in a cool, dry, dark place. It's not recommended to store them in the bathroom because the heat and humidity can make the pills less effective.

Can I receive just misoprostol? −

Using mifepristone and misoprostol together is considered the “gold standard” protocol for abortion with pills. Typically, clinicians prefer to prescribe the two medications together as they have fewer side effects and the process is easier. If you cannot take or do not want to take mifepristone, you can fill in the online form and ask your clinician about a misoprostol-only abortion.

Can I fill an abortion pill prescription at my local pharmacy? −

Local pharmacies in the U.S. are allowed to dispense mifepristone after getting certified. You can locate a pharmacy here. Some clinicians may be able to send a prescription for you to fill at a local pharmacy. At this time, Abuzz does not offer this service.

Before taking abortion pills

What should I do before taking abortion pills? −

Before taking pills, it is helpful to do a pregnancy test to confirm you’re pregnant. This avoids taking pills unnecessarily and prevents confusion. If you don’t want to take a pregnancy test, you don’t have to. You should also estimate how far along the pregnancy is. Pregnancies are measured starting from the first day of your last period (and not from conception or when you had sex). You can figure out how far along the pregnancy is using your last period in a **pregnancy calculator like this one** or by getting an ultrasound.

What kind of pregnancy test should I use before taking the pills? −

Almost any pregnancy test will work. Dollar store tests work great. We do not recommend using any digital (positive/negative or +/-) pregnancy tests because we have noticed many people having false positives (a positive test result when they are not actually pregnant).

Do I need to get an ultrasound before taking abortion pills? −

No, getting an ultrasound is not required for most people. You do not need to get an ultrasound as long as your provider can figure out how far along your pregnancy is and you do not have signs of an ectopic pregnancy.

How should I get ready to take my abortion pills? −

1. Read our information on how to take the pills, what you might see and feel, and how to identify signs of complications.
2. Have a plan for where and when you will take the pills. You will want to be in a comfortable place and have access to a bathroom for up to 12 hours after taking misoprostol (the second medicine).
3. Have a plan for how to get emergency medical care in the unlikely event that you need it. It can be good to have a support person (in-person or virtually) in case you need help – especially the day you take misoprostol because this is when you'll have the most cramping/pain and bleeding.
4. Have on hand whatever you usually use to help with your periods (ex: large overnight pads, painkillers, anti-nausea medicine, heating pads, comfortable clothes, snacks, netflix/movies, etc).

How to use abortion pills

How should I take the abortion pills? −

Check out the instructions. How you take the abortion pills depends on how far along the pregnancy is. You can figure out how far along the pregnancy is based on your last period or by getting an ultrasound. There are many different ways to take the pills and most work well. The World Health Organization recommends:

Less than 9 weeks	• Swallow 1 mifepristone 200mg pill orally • Wait 1-2 days • Take 4 misoprostol 200mcg pills under the tongue, in the cheek, or in the vagina. If you don't start bleeding after 24 hours, take another 4 pills.
9-11 weeks	• Swallow 1 mifepristone 200mg pill orally • Wait 1-2 days • Take 4 misoprostol 200mcg pills under the tongue, in the cheek, or in the vagina. 4 hours later, take another 4 misoprostol 200mcg pills.
12+ weeks	• Swallow 1 mifepristone 200mg pill orally • Wait 1-2 days • Take 2 misoprostol 200mcg pills under the tongue, in the cheek, or in the vagina every 3 hours until the pregnancy tissue is out.

How long do I have to wait to take misoprostol (the second medicine)? −

We recommend taking misoprostol 1-2 days (24-48 hours) after mifepristone because this will be the most effective.

How do I take misoprostol (the second medicine)? −

Misoprostol can be taken in 3 different ways – vaginally, buccally, or sublingually. Vaginally means inserting the medicine with your fingers into the vagina. Buccally means holding the medicine in your cheeks like how a chipmunk holds food. Sublingually means holding the medicine under your tongue. If you take the misoprostol sublingually or buccally, after 30 minutes you can swallow whatever remains of the pills.

What is the difference between putting the misoprostol (the second medicine) under your tongue, in your cheek, or in the vagina? −

In areas where abortion is restricted, it can be safer to put the misoprostol in your cheek or under your tongue. After 30 minutes you can swallow or spit out anything that is left. Using the medicines in your cheeks or under your tongue can give you more side effects (nausea, vomiting, diarrhea).

Using the medicines in the vagina gives you less side effects, but the pills could be seen during a vaginal exam. If this is a concern for you, we recommend that you use the pills in your cheek or under your tongue.

What can I take for nausea?

You can take over the counter anti-nausea medicine like Unisom or Dramamine. Other things that can help with nausea include ginger tea, chewing gum, and sucking on hard candies. A prescription for anti-nausea medication can be sent if needed.

What can I take for pain?

1. It's most effective to wait until you feel some pain before taking painkillers (but do not wait until the pain is unbearable). You can take over-the-counter painkillers like ibuprofen (Motrin/Advil) and acetaminophen (Tylenol). You can take 600-800mg ibuprofen every 6-8 hours with food. You can take 1000mg of acetaminophen every 6 hours. You can also take ibuprofen and acetaminophen together. If you do not want to use ibuprofen, you can try taking naproxen (Aleve) 550mg every 12 hours. To be more comfortable during the process, you can also try using a hot water bottle or heating pad on the belly, listening to music, having a support person, being someplace private, etc.

Why do I start with fewer misoprostol pills when I'm 12+ weeks pregnant?

The farther along you are, the fewer misoprostol pills you need for each dose. After 12 weeks, people should take 1 mifepristone followed by 2 misoprostol pills repeated every 3 hours until the pregnancy passes.

Why do I have extra pills and what should I do with them?

Extra misoprostol pills are sent in case:

1. You vomit after taking the pills
2. You don't bleed enough after taking the pills
3. You have too much bleeding after taking the pills

Please keep any extra misoprostol for at least 2 months. This way you will have it on hand in case you experience a complication and are advised to take it.

What do I do with my extra pills? −

Please keep any extra misoprostol for at least 2 months. This way you will have it on hand in case you experience a complication and are advised to take it.

What if I throw up after taking the abortion pills? −

As long as you can keep the mifepristone (first medicine) down for at least 30 minutes, it will most likely be effective. If you vomit less than 30 minutes after taking mifepristone, it might not be as effective, so contact us for further information.

As long as you keep the misoprostol (second medicine) in your mouth for at least 20 minutes, that should be enough time for the medication to absorb and be effective. If you vomit less than 20 minutes after taking the misoprostol by mouth, it's recommended to take anti-nausea medication, wait a few hours, and try again.

During an abortion with pills

What happens after taking the abortion pills? −

Most people don't have any symptoms after taking mifepristone (the first medicine). Some people might have light bleeding or nausea. The main symptoms of bleeding and cramping usually begin after taking the misoprostol (the second medicine).

How much bleeding and cramping will I have? −

Every person is different, and there is a range of normal bleeding and cramping. . Most people have bleeding and cramping that is heavier than a period and can include blood clots the size of lemons. Some people only have light bleeding. It usually starts 4-6 hours after taking the misoprostol (the second medicine) and starts to slow down within 1 day. Some people have mild pain, and other people have very intense cramps.

What if I start bleeding/having a miscarriage before I use the abortion pills? −

Signs of a miscarriage don't always mean you had a complete miscarriage so it is recommended that you still use the abortion pills to make sure the pregnancy passes fully.

What are the side effects of misoprostol (the second medicine)? −

The side effects of misoprostol include nausea, vomiting, headache, diarrhea, fever, and chills. These are usually temporary and go away on their own. If the fever (more than 101 degrees) continues for more than 24 hours after taking misoprostol, please contact your abortion pill provider because this can be a sign of infection.

How much bleeding is too much? −

It is normal to have heavy bleeding and blood clots. If you are soaking 2 large overnight pads per hour for 2 hours in a row (4 pads in 2 hours) that is too much bleeding. You should seek medical attention right away if this happens. Sometimes providers recommend taking 2 more misoprostol pills to slow the bleeding down while waiting for medical attention.

What are signs of a complication? −

If you have very heavy bleeding (soaking 2 large overnight pads per hour for 2 hours in a row), fever for over 24 hours since taking misoprostol, or severe pain that is not relieved by painkillers, these are signs of severe medical complications, and you should seek medical attention right away.

Will anyone be able to tell that I took abortion pills? −

No, there are no tests to detect that you took abortion pills by mouth. The only way for the providers to know is if you tell them or if you took the pills vaginally and they see them on an internal exam. You do not need to say that you took abortion pills.

If I have to go to the hospital, what should I say? −

The treatment for a miscarriage and abortion are the same, so you can just say something like "I'm bleeding but it doesn't feel like my usual period. I'm afraid something is wrong" or "I'm pregnant and bleeding. I'm scared there's something wrong" and you should get the care you need.

After an abortion with pills

How do I know if the abortion pills worked? −

Most people can tell if the pills worked by what they experience and how they feel. Some signs that the abortion pills worked can include: bleeding (light or heavy), cramping after taking the pills, passing clots and/or tissue, and no longer feeling pregnant. Pregnancy tests can stay positive for up to 5 weeks after a successful abortion, so they are not reliable before that time. If you still feel pregnant, you should contact your abortion pill provider.

What if I have little or no bleeding after taking the abortion pills? −

This could be a sign that the pills didn't work, so you need to talk to your abortion pill provider for further guidance.

How long will I bleed after taking abortion pills? −

Bleeding should start to slow down after the pregnancy passes. However, light bleeding and/or spotting can continue off and on for up to 6 weeks. If you have been bleeding more than 6 weeks, contact your abortion pill provider.

What if I have vaginal odor after using the pills? −

Your vagina needs time to adjust to the changing hormones after ending the pregnancy, so any odor changes can be normal. Burning or pain from the discharge are reasons to seek medical attention.

When can I get pregnant again after an abortion? −

You can get pregnant as soon as 1 week after your abortion. If you want to prevent pregnancy, it is important to start birth control soon after your abortion.

When can I start birth control after my abortion? −

You can start most methods right away. If you start within 1 week, you are protected from pregnancy right away. Here is a guide to starting birth control after an abortion.

When can I start exercising or return to work/school after an abortion with pills? −

Everybody is different. Most people are able to return to normal activities the day after you finish taking misoprostol (the second medicine).

When can I have sex again after an abortion? −

This is up to you and what feels right for your body. You can have sex again whenever you feel ready.

abuzz

Abuzz: Abortion Pill Access At Home

About Us

How it Works

FAQ

Terms of Use

Privacy Policy

Provider Payments

Donations allow us to help all pregnant people, regardless of their ability to pay. Please consider supporting our work.

DONATE

EXHIBIT 79

ACT,

Who We Are

OUR MISSION

The Abortion Coalition for Telemedicine (ACT) directly supports clinicians who make safe, timely, and affordable telemedicine abortion care available to patients in all 50 states. Medication abortion accounts for more than half of abortions performed in the U.S., making telemedicine care vital to closing the accessibility gap and empowering women and pregnant people to exercise their reproductive freedom.

OUR STORY

ACT was founded in 2022 after the Supreme Court overturned Roe v. Wade, resulting in 20 states severely limiting access to abortion and miscarriage-care. Our co-founders Dr. Linda Prine, Dr. Maggie Carpenter, and Julie F. Kay, JD, are leaders in the reproductive freedom movement who have harnessed their collective medical and legal expertise to meet this moment with comprehensive support for the clinicians stepping up to provide telemedicine care for patients in abortion-hostile states.

OUR IMPACT

ACT is the only nationwide advocacy organization proactively working to advance telemedicine abortion. We provide clinicians who are licensed in states where telemedicine abortion practitioners are shielded under the law with the technical assistance and consulting services needed to operate an interstate practice that serves patients who would otherwise be denied access to quality care because of where they live or their circumstances.

OUR VALUES

We are guided by the belief that reproductive freedom is a fundamental human right. It's no secret that abortion deserts disproportionately harm patients from marginalized and vulnerable communities, placing ACT's mission at the intersection of racial justice, gender equity, LGBTQ+ rights, economic inequality, rural health care disparities, and accessibility for disabled individuals. That's why it's now more important than ever to support the clinicians treating these populations with medication abortion via telemedicine.

Abortion Coalition For Telemedicine

Reproductive freedom is a human right. Join us on our mission to support the clinicians who serve patients across the U.S. with safe, timely & affordable telemedicine abortion care.

DONATE

SITEMAP

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- Our Mission
- ACT in the news
- Privacy & Security

GET INVOVLED

- Want to be a Shield Provider?
- Looking for an Abortion?
- FAQs
- Donate

DISCLAIMER

ACT is not a reproductive care or abortion provider, nor do we provide legal representation. If you're a patient interested in learning about telemedicine abortion and your legal rights, visit our **Resources** page for more information.

EXHIBIT 80

ACT,

What We Do

OUR WORK

ACT is solution-minded and result-driven.
After the Supreme Court overturned Roe v. Wade in 2022, we got to work advocating for and passing state-level legislation that shields clinicians licensed in states where abortion remains legal from criminal or civil liability. With laws on the books in states like NY, WA, CO, VT, MA, and CA, we established a playbook for shielded clinicians to provide safe, timely, and affordable medication abortion via telemedicine to patients in under resourced areas.
We're now focused on working directly with clinicians to launch shielded practices so more patients can legally receive interstate telemedicine abortion care.

WHY TELEMEDICINE ABORTION?

For more than two decades, since it was approved by the U.S. Food and Drug Administration (FDA), medication abortion has been a safe, timely, and evidence-based treatment for patients across the globe. Telemedicine abortion offers greater freedom for everyone to make their own reproductive health decisions and is now the most common form of abortion in the U.S. The two-step process of mifepristone and misoprostol is an FDA-approved method for terminating early pregnancies up to 12 weeks and can be done in the comfort of a patient's home with the support of a telemedicine provider. Access to medication abortion via telehealth is also critical for treating the communities most impacted by the overturning of Roe v Wade, particularly BIPOC, LGBTQ+, low-income, disabled, and rural patients – many of whom experience higher maternal mortality rates and significant barriers to care.

ACT's EXPERTISE

We understand that starting a shielded practice may seem complex and overwhelming, especially in such an uncertain political climate. That's why ACT is committed to providing clinicians with the medical, legal, and technical resources and assistance they need to begin treating patients across state lines, including:

- Licensure

- o Malpractice insurance
- o pLLC or PC business registration
- o Data security
- o Dispensing software
- o Pharmaceutical distributor contracts
- o Mifepristone and misoprostol distributor contracts
- o Mail-order pharmacy agreements

If you're a clinician licensed in a shielded state and interested in practicing telemedicine abortion care, read ACT's "Steps to Becoming a Shield Provider."

Steps to Becoming a Shield Provider

ACT
Abortion Coalition for Telemedicine

Reproductive freedom is a human right. Join us on our mission to support the clinicians who serve patients across the U.S. with safe, timely & affordable telemedicine abortion care.

SITEMAP

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- Our Mission
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ACT is not a reproductive care or abortion provider, nor do we provide legal representation. If you're a patient interested in learning about telemedicine abortion and your legal rights, visit our **Resources** page for more information.

EXHIBIT 81

ACT,

FAQs

FAQs

The following research is in response to frequently asked questions that have been asked regarding the telemedicine shield bills.
For more information, please contact ACT at info@theactgroup.org

1 Here are the most common questions ACT receives:

a. What are shield laws?

Access to abortion in many states is dire, with patients getting medication abortion pills from overseas or through underground networks. This access is often later in pregnancy than is ideal, resulting in a difficult or even traumatizing experience and sometimes medical complications, as well as an increased risk of legal liability as well. Telemedicine abortion access by licensed medical providers serving those in under resourced areas is urgently needed.

Telemedicine shield laws are an effective way for legislatures to provide some legal protection from criminal and civil liability for medical providers who seek to provide the full range of reproductive health care services to women and pregnant people nationwide. These providers are acting in response to the dramatic decrease in services for the most marginalized communities as a result of the Supreme Court decision to overturn Roe v. Wade. Providers practicing in states where abortion remains legally available are seeking to serve those denied abortion access elsewhere because they view access to abortion as a human right.

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b. What does ACT do?

ACT advocates for and passes state-level legislation to shield clinicians, licensed in states where abortion is legal, from liability. With laws in states like NY, WA, CO, VT, MA, and CA, we enable clinicians to provide safe, timely, and affordable medication abortion via telemedicine to patients in abortion deserts. We work directly with clinicians to launch shielded practices, expanding legal access to interstate telemedicine abortion care. Emphasizing telemedicine abortion's safety and evidence-based nature, we focus on supporting marginalized communities in under resourced areas. ACT provides expertise in licensure, malpractice insurance, business registration, data security, dispensing software, pharmaceutical distributor contracts, and mail-order pharmacy agreements to facilitate clinicians in starting shielded practices.

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c. What is medication abortion?

For more than two decades, since it was approved by the U.S. Food and Drug Administration (FDA), medication abortion has been a safe, timely, and evidence-based treatment for patients across the globe. Telemedicine abortion offers greater freedom for everyone to make their own reproductive health decisions and is now the most common form of abortion in the U.S. The two-step process of mifepristone and misoprostol is an FDA-approved method for terminating early pregnancies up to 12 weeks and can be done in the comfort of a patient's home with the support of a telemedicine provider. Access to medication abortion via telehealth is also critical for treating the communities most impacted by the overturning of Roe v Wade, particularly BIPOC, LGBTQ+, low-income, dis/abled, and rural patients – many of whom experience higher maternal mortality rates and significant barriers to care.

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d. Which states currently have telemedicine abortion shield laws?

Six states specifically protect providers and prevent abortion-hostile states from interfering with care for patients traveling for abortion services: California, Colorado, Massachusetts, New York, Vermont and Washington. Post-Dobbs v. Jackson Women's Health Organization (June 2022), abortion-friendly states enacted laws safeguarding providers and easing patient access for patients who are traveling. Notably, without a shield law for telemedicine, protection applies only when both the patient and provider are in the friendly state.

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2 Understanding Shield Laws

a. What are shield laws and why are they important?

Access to abortion in many states is dire, with patients getting medication abortion pills from overseas or through underground networks. This access is often later in pregnancy than is ideal, resulting in a difficult or even traumatizing experience and sometimes medical complications, as well as an increased risk of legal liability as well. Urgently needed is telemedicine abortion access provided by licensed medical providers to help close the gap in abortion accessibility.

Telemedicine shield laws are an effective way for legislatures to provide some legal protection from criminal and civil liability for medical providers who seek to provide the full range of reproductive health care services to women and pregnant people nationwide. These providers are acting in response to the dramatic decrease in services for the most marginalized communities as a result of the Supreme Court decision to overturn Roe v. Wade. Providers practicing in states where abortion remains legally available are seeking to serve those denied abortion access elsewhere because they view access to abortion as a human right.

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b. What are the basic protections shield laws provide?

Access to abortion in many states is dire, with patients getting medication abortion pills from overseas or through underground networks. This access is often later in pregnancy than is ideal, resulting in a difficult or even traumatizing experience and sometimes medical complications, as well as an increased risk of legal liability as well. Telemedicine abortion access by licensed medical providers serving those in under resourced areas is urgently needed.

Telemedicine shield laws are an effective way for legislatures to provide some legal protection from criminal and civil liability for medical providers who seek to provide the full range of reproductive health care services to women and pregnant people nationwide. These providers are acting in response to the dramatic decrease in services for the most marginalized communities as a result of the Supreme Court decision to overturn Roe v. Wade. Providers practicing in states where abortion remains legally available are seeking to serve those denied abortion access elsewhere because they view access to abortion as a human right.

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c. Why do specific states introduce shield laws? Will more states pass similar laws?

In the immediate aftermath of the Dobbs v. Jackson Women's Health Organization in June 2022, several abortion-friendly states passed a variety of laws to protect abortion providers and to facilitate access for patients within or traveling to their states. Seven states passed some type of law specifically to help protect providers and to prohibit an abortion-hostile states from taking action against the provision of care to a patient who had traveled to the abortion-supportive state for care. However, in the case of telemedicine, without a shield law, a provider is protected only when both the patient and provider are located in the friendly state.

Telemedicine shield laws are essential for those who cannot or do not want to travel to abortion-friendly states. Five states currently have telemedicine shield laws in place: New York, Massachusetts, Vermont, Washington and Colorado.

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3 Accessing Telemedicine Abortion Services

a. What happens if medication abortion (mifepristone) is taken off the market?

If FDA-approved mifepristone is removed from the market due to anti-abortion efforts, it would impact the widely used two-drug medication abortion protocol in the U.S., which is crucial for terminating pregnancies up to 11 weeks. Over half of U.S. abortions are medication abortions, offering a private and affordable option, especially post the 2022 Roe v. Wade overturn. Despite FDA approval, anti-abortion measures in states restrict mifepristone access, emphasizing the urgency of telemedicine prescriptions. Concerns about federal litigation in Texas potentially removing mifepristone highlight the importance of alternative options, such as misoprostol-only regimens, though less effective. The demand for telemedicine abortion providers is anticipated to surge if mifepristone becomes unavailable in the U.S. market.

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b. Does ACT provide telehealth abortion services?

No, ACT does not directly provide telehealth abortion services. Instead, the organization assists licensed clinicians who want to offer telemedicine abortion. After the 2022 overturn of Roe v. Wade, ACT focused on advocating for and passing state-level legislation to protect clinicians in states where abortion is legal. With established laws in states like NY, WA, CO, VT, MA, and CA, ACT created a playbook to guide shielded clinicians in providing safe and timely telemedicine abortion to patients in states with abortion deserts. The organization collaborates with clinicians to launch shielded practices, offering support in various areas such as licensure, malpractice insurance, business registration, data security, dispensing software, pharmaceutical distributor contracts, and mail-order pharmacy agreements.

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c. If I live in an abortion-hostile state, what should I do to connect with a shielded provider?

ACT is proud to work alongside an ever-growing coalition of medical experts, clinicians, policymakers, attorneys, community leaders, civil rights groups, activists, and grassroots supporters dedicated to preserving and expanding abortion access for all.
Check our Resources page for trusted organizations intended to educate and empower individuals to make informed decisions about their reproductive health. For example, if looking for an abortion in a hostile state - go to PlanCpills.org and Ineedana.org websites

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4 Providing Telemedicine Abortion Services

a. Where do providers need to be licensed, in order to provide telemedicine abortion services?

With telehealth shield laws, providers should hold valid licenses in the shield state and should be residing in the shield state.

b. How do shield laws impact current telemedicine laws in their states?

The proposed expansions of shield laws do not fundamentally redefine telemedicine in the shielded state. The shield laws simply define legally protected reproductive health care by telemedicine as having taken place where the licensed provider is located when they give care from their state. These shield laws do not define the scope of telemedicine across other fields of medicine.

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c. Do shield laws affect medical malpractice insurance?

Yes, shield laws protect medical malpractice insurance for providers who engage in lawfully protected reproductive healthcare. If expanded to include telemedicine across state lines, the shield laws would protect these providers as well.

These shield laws prohibit insurers from taking any adverse action against a health care provider solely on the basis that the health care provider provides lawfully protected reproductive healthcare. Adverse action might include refusing to renew or execute a contract, charging more in fees or copayments, or making other unfavorable changes in terms or amount of coverage, or reporting the provider to a government or private entity for potentially violating other state's laws.

Unfortunately, in all shielded states several barriers to accessing medical malpractice insurance coverage remain. This is due to factors such as the lack of clarity with insurers, continued bias against abortion providers generally and medication abortion specifically, and a lack of affordable insurance options for providers who work independently. In order for shield laws to be successfully implemented, particularly for those engaged in telemedicine across state lines, these concerns will have to be addressed by shield state officials and private insurers.

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d. How does ACT help providers launch shielded practices?

Once telemedicine abortion bills are enacted, several barriers to implementation still need to be overcome. Thus, our work includes support for solo practitioners or small group practices dedicated to providing telemedicine abortion. (Large abortion providing organizations are averse to interstate telemedicine abortion services in an uncertain political and legal climate.)

Dedicated clinicians need assistance with establishing a separate business or LLC, setting up electronic medical records systems, obtaining malpractice insurance, creating contracts with Mifepristone and misoprostol distributors as well as other nuts and bolts activities. Medical malpractice coverage for telemedicine-only abortion practices is either non-existent or prohibitively expensive because of the bias against abortion coverage. We have been working to identify investors interested in establishing a "risk management pool" to create independent coverage by working with non-biased insurance agents.

We discuss that civil and criminal law risks still remain for providers and their patients and discuss practices to minimize these risks. Our organization is working in several states to make connections, raise funds, and mentor clinicians so that these barriers can be overcome.

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5 Understanding the Legal Impact of Shield Laws

a. How do shield laws protect providers from various legal actions?

Telemedicine shield laws can provide protection by acting to:

- prohibit extradition (removal from an abortion-friendly state to a state where abortion is illegal) of a licensed healthcare provider who lawfully provides telemedicine care while they are physically located within the shield state to a person who is physically located in a state where medication abortion is unavailable. This protection is only available if the provider was located in the shielded state during the entirety of the time related to the care.

- prevent shield state law enforcement officials from cooperating with any investigation or inquiry from out-of-state officials

care was provided by telemedicine from the shielded state, and

- prohibit medical malpractice insurers from discriminating in coverage for state licensed health care professionals offering legally protected reproductive health care from shielded states to patients located outside of the state.

- prohibit state courts from cooperating with out-of-state subpoenas, deposition notices, summons, and other devices intended to force those in shield states to cooperate with out of state lawsuits and prosecutions.

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b. Do shield laws create conflicts with existing federal law or with other states & criminal laws, especially regarding extradition practices?

No, shield laws in this way do not create conflicts with federal or constitutional law. In general, states are able to define what does or does not violate their own state laws without implicating other states.

Interstate extradition is a legal proceeding based in constitutional law that allows one state (called the demanding state) to retrieve someone fleeing a crime committed in that state from another state (called the receiving state) to which they have fled. Extradition is for the purpose of standing trial in the demanding state. It requires a judge in the receiving state to authorize an arrest warrant.

However, the constitution only requires extradition (physical removal or arrest) from a state when the accused person has been physically present in the state where the alleged crime was committed. The case law around extradition is clear that it applies only if a person is alleged to have committed a crime while physically present in a state and then fled that state. This doctrine has existed for centuries. The Supreme Court in theory could overturn these precedents, but doing so would change the basics of long-existing extradition law.

Shield laws regarding telemedicine abortion do not raise any problems in this regard. In this scenario, the telemedicine abortion provider is not physically present in the state when providing care. Therefore, the extradition clause does not require extradition because the provider was never physically in the state and therefore never "fled." States can opt to extradite in a variety of situations, and most states have done so by statute. However, shield laws exempt lawful reproductive health care from this statutory obligation. Under the shield laws, shield state courts and law enforcement officials will not cooperate in physically turning over the charged person from the shielded state.

Some states have earlier versions of shield laws or executive orders that protect providers engaged in lawful reproductive health care from extradition but only when the patient is physically present in the shielded state or a state that permits abortion by telemedicine for telemedicine providers who are practicing across state lines. Telemedicine abortion shield laws (currently passed in NY, MA, VT, CO and WA) provide expanded protection to providers offering services by telemedicine across state lines.

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c. Do shield laws create conflicts with civil law at the federal or state level and the concept of giving full faith and credit?

No, shield laws do not create conflicts with the Constitution's full faith and credit doctrine. Shield laws also comply with existing civil law procedures between states.

The full faith and credit clause (Article IV, Sec I of the Constitution) requires state courts to respect a judgment by another state's court. Its purpose is to prevent conflict among the states and to create a level of dependability of legal rulings in civil cases from one state to another. It applies only to the final judgment by another state's court, not to subpoenas, depositions, summons, and other such intermediary orders.

It remains up to each individual state whether to recognize an intermediary or evidentiary ruling (subpoenas, discovery orders, and the like) by another state. Every state has procedures in place for doing so as a general matter. Shield laws exempt lawful reproductive health care from these provisions, meaning courts in the shielded state will not recognize or enforce out-of-state orders related to discovery, subpoenas, summons, or any other evidence-procuring procedures regarding lawful reproductive health care in the shield state. The shielded state also has no constitutional obligation to participate in out of state criminal or administrative investigations into legally protected reproductive health care. Shield laws that prohibit such cooperation stand on firm constitutional ground.

In contrast, all states, including shielded ones, are required to respect and enforce a final civil judgment. For example, let's say an abortion opponent files a civil lawsuit in an Alabama court claiming to be damaged by a New York based telemedicine provider who treated a patient in Alabama. The New York provider either loses or defaults, and the Alabama court issues a final judgment against the New York provider. As long as the Alabama court had proper jurisdiction over the provider and the lawsuit is about compensating the plaintiff rather than merely punishing the defendant, that judgment must be respected by the state of New York under the full faith and credit provision of the Constitution. The Alabama plaintiff may now move to collect damages through a

EXHIBIT 82

ACT,

Resources

RESOURCES

ACT is proud to work alongside an ever-growing coalition of medical experts, clinicians, policymakers, attorneys, community leaders, civil rights groups, activists, and grassroots supporters dedicated to preserving and expanding abortion access for all.

These resources come from trusted organizations and are intended to educate and empower individuals to make informed decisions about their reproductive health.

Telemedicine Abortion Care

- AbortionFinder
- Abortion on Demand
- AidAccess
- carafem
- Hey Jane
- ineedana
- Just the Pill
- Mayday Health
- Plan C
- Whole Women's Health

Support

Medical and Emotional

- Abortion on Our Own Terms
- All-Options
- Ally Chatbot
- Charley Chatbot
- Exhale Pro-Voice
- M+A (Miscarriage + Abortion) Hotline
- National Abortion Hotline
- National Domestic Violence Hotline
- National Sexual Assault Hotline
- Reprocare Healthline
- safe2choose
- SASS – Self-Managed Abortion; Safe & Supported

Legal

- Abortion Access Legal Defense Fund
- Jane's Due Process (TX only)
- Repro Legal Helpline
- Pregnancy Justice

Financial

- Abortion Freedom Fund
- National Network of Abortion Funds
- WRRAP (Women's Reproductive Rights Assistance Project)

Digital & Security

- Digital Defense Fund

Research & Policy

Nonprofits & Think Tanks

- ACOG (The American College of Obstetricians and Gynecologists)
- ACLU (American Civil Liberties Union)
- Center for American Progress
- Center for Reproductive Rights
- Guttmacher Institute
- Kaiser Family Foundation
- National Women's Law Center

Government

- Centers for Disease Control and Prevention
- ReproductiveRights.gov
- U.S. Food & Drug Administration

Academic Papers

- Columbia Law Review
- Stanford Law Review
- Patient Acceptability of Telehealth Medication Abortion Care in the United States, 2021–2022: A Cohort Study
- Evaluation of a "Smart" Screening Tool for Asynchronous Assessment of Medication Abortion Eligibility: A Pilot Study

Reproductive Justice & Advocacy

Academic Papers

- Advocates for Youth
- The Afiya Center
- Forward Together
- In Our Own Voice: National Black Women's Reproductive Justice Agenda
- Indigenous Women Rising
- Las Libres
- National Center for Lesbian Rights
- National Institute for Reproductive Health
- National Latina Institute for Reproductive Justice
- New Voices for Reproductive Justice
- Reproductive Health Access Project
- Shout Your Abortion
- Sister Song
- SPARK Reproductive Justice NOW
- Transgender Law Center
- We Testify
- WPATH (World Professional Association for Transgender Health)

DISCLAIMER

The contents of this webpage are for informational purposes only. This information is not, and is not intended to be a substitute for, medical or legal advice. Resources listed here do not imply endorsement of any content.

We value protecting the safety of your data and take steps to prevent it being used in retaliation for seeking abortion care."

Join us on our mission to support the clinicians who serve patients across the U.S. with safe, timely & affordable telemedicine abortion care.

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