**No. 26-30203**

# In the United States Court of Appeals for the Fifth Circuit

STATE OF LOUISIANA, ET AL.,
*Plaintiffs-Appellants/Cross-Appellees,*

v.

FOOD & DRUG ADMINISTRATION, ET AL.,
*Defendants-Appellees,*

v.

GENBIOPRO, INC.,
*Intervenor-Appellee/Cross-Appellant,*

v.

DANCO LABORATORIES, L.L.C.,
*Intervenor-Appellee/Cross-Appellant.*

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF LOUISIANA, LAFAYETTE DIVISION
NO. 6:25-CV-1491

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**BRIEF OF 168 REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE ORGANIZATIONS AS AMICI CURIAE IN SUPPORT OF INTERVENORS-APPELLEES**

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Emily Merrifield
Sara Stappert
JENNER & BLOCK LLP
353 N. Clark Street
Chicago, IL 60654
(312) 222-9350

Jessica Ring Amunson
*Counsel of Record*
Varsha Midha
JENNER & BLOCK LLP
1099 New York Ave NW,
Suite 900
Washington, DC 20001
(202) 639-6048
jamunson@jenner.com

## CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that *amici curiae* are unaware of any persons with any interest in the outcome of this litigation other than the signatories to this brief and their counsel, and those identified in the party and *amicus* briefs filed in this case. A full list of signatories to this brief can be found in the Appendix. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Except as stated below, *amici curiae* certify that they have no outstanding shares or debt securities in the hands of the public, and they have no parent companies. Except as stated below, no publicly held company has a 10% or greater ownership interest in any of the *amici curiae*.

- Endora is fiscally sponsored by Aspiration Tech. No publicly traded corporation owns 10% or more of its stock.
- Abortion Access Front is fiscally sponsored by NEO Philanthropy.
- The Protect Our Care Education Fund is fiscally sponsored by the New Venture Fund (NVF).
- Reproductive Futures and the Reproductive Futures Action Fund (C4) are fiscally sponsored by Global Impact.
- Defend Public Health is fiscally sponsored by Peace Development Fund.

*s/Jessica Ring Amunson*
Jessica Ring Amunson
*Counsel for* Amici Curiae

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## INTEREST OF *AMICI CURIAE*[1]

*Amici* are 168 reproductive health, rights, and justice organizations, as well as other organizations with a strong interest in access to reproductive care. *Amici* include, *inter alia*, healthcare organizations that prescribe mifepristone and are directly impacted by an order requiring mifepristone to be picked up in person at a health center; research organizations with specialized expertise in the safety of mifepristone and the harms caused by abortion restrictions; organizations that work directly with people seeking abortion care and witness firsthand the enormous challenges they face when forced to travel for care; and organizations that advocate on behalf of people who need abortions and the clinicians who care for them. A complete list of *amici* is in the Appendix.

*Amici* have seen the importance of medication abortion to individuals' health and bodily autonomy, as well as mifepristone's efficacy and safety as a tool for achieving those goals. *Amici* also have a unique window into the benefits that mifepristone provides, including when prescribed via telehealth[2] and dispensed by

[1] Pursuant to Federal Rule of Appellate Procedure 29, *amici curiae* certify that this brief was not authored in whole or in part by counsel for any party and that no person or entity other than *amici*, their members, or their counsel has made a monetary contribution intended to fund the preparation or submission of this brief. This brief is filed with the consent of all parties.

[2] In using the term "prescribed via telehealth" in this brief, *amici* refer to patients who are prescribed mifepristone by a licensed healthcare provider using telehealth and then receive their prescription either by mail or at a pharmacy.

mail or pharmacies, and the immense harms of restricting such access. *Amici* urge this Court to affirm the district court's denial of Plaintiffs-Appellants' motion for preliminary injunctive relief.

## SUMMARY OF ARGUMENT

*Amici* write to emphasize the overwhelming consensus of the scientific and medical community that medication abortion using mifepristone—including when prescribed via telehealth—is safe, effective, and medically necessary. The evidence confirming mifepristone's safety and efficacy has only grown more compelling since the Food and Drug Administration ("FDA") first approved it in 2000. Since then, more than 7.5 million people have safely used the medication, and hundreds of high-quality studies and the experience of millions of patients have confirmed mifepristone's exceptional safety record, whether dispensed in person or through telehealth. There is no medical justification for a nationwide requirement that patients across the country travel to a healthcare provider for the sole purpose of picking up medication that they can later take at home.

*Amici* also write to explain what is at stake. Barring patients from obtaining mifepristone by mail and at pharmacies imposes devastating and medically unjustified burdens on patients' access to mifepristone. Preserving patients' ability to obtain care through telehealth is critically important, particularly for people in

rural areas, low-income communities, communities of color, and survivors of intimate partner violence, who already face the steepest barriers to in-person care. Reinstating the in-person dispensing requirement undermines access to abortion and miscarriage care—and thereby worsens patients' health and autonomy—nationwide. If this Court does not step in to block this request by a single state, it will impact people across the country. Indeed, if forced to travel to a healthcare provider to pick up mifepristone, many people in states where abortion remains legally protected will be unable to obtain mifepristone in a timely fashion, and others will be unable to access this essential medication at all. Neither science nor law supports upending the safe and effective ways this medication has been delivered for the past five years—therefore, this Court should affirm the denial of Plaintiffs-Appellants' motion.

## ARGUMENT

### I. Mifepristone Dispensed Via Telehealth is Safe, Effective, and Widely Used.

Mifepristone is one of two medications (along with misoprostol) in the FDA-approved regimen for medication abortion.[3] Decades of scientific evidence and real-

[3] While there are alternative regimens used for medication abortion, existing research suggests that they may be less effective and lead to more side effects than the combined mifepristone-misoprostol regimen. *See* Elizabeth Raymond et al., *Effectiveness and Safety of Misoprostol-Only for First Trimester Medication Abortion: An Updated Systematic Review and Meta-Analysis*, 127 Contraception 110 (2023); Soc'y of Family Planning, *Science Says: Misoprostol Only is Safe and Effective* 1 (updated Aug. 21, 2023), https://societyfp.org/wp-content/uploads/2023/02/SFP_ScienceSays_misoprostol.pdf.

world use by millions demonstrate that using mifepristone for medication abortion is exceptionally safe and effective, including when the medication is dispensed by mail and at pharmacies after patients receive care through telehealth. Mifepristone's safety is endorsed by—and restrictions on telehealth access to mifepristone are overwhelmingly opposed by—major medical associations such as the American Medical Association, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Society for Academic Specialists in General Obstetrics and Gynecology, Society of Family Planning, Society for Maternal-Fetal Medicine, and Society of General Internal Medicine.[4] Consistent with this scientific consensus, between 2011 and 2023, the FDA repeatedly affirmed mifepristone's exceptional safety and efficacy record.[5]

Mifepristone is central to reproductive healthcare today. Medication abortion using mifepristone is the most common method of abortion in the United States, both

[4] *See* Am. Coll. of Obstetricians & Gynecologists et al., *Leading Medical Organizations Call for the FDA to Permanently Remove Restrictions on Mifepristone* (June 18, 2024), https://www.acog.org/news/news-releases/2024/06/leading-medical-organizations-call-for-fda-to-permanently-remove-restrictions-on-mifepristone.

[5] *See Study: FDA Regulation of Abortion Drug Mifepristone from 2011 to 2023 Shaped by Evidence and Caution*, Johns Hopkins Bloomberg Sch. Pub. Health (Jan. 12, 2026), https://publichealth.jhu.edu/2026/study-fda-regulation-of-abortion-drug-mifepristone-from-2011-to-2023-shaped-by-evidence-and-caution; FDA Ctr. for Drug Eval. & Research, *Medical Review, Application No. 020687Orig1s020* at 5, 14–17 (Mar. 29, 2016) [hereinafter "2016 FDA Approval"], https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf.

because of its safety and efficacy and because many patients prefer it.[6] Medication abortion is approved in more than 100 countries and accounts for half of all abortions in most high-income nations.[7] In 2023, mifepristone was used in 63% of all abortions in the United States.[8]

The FDA approved mifepristone in 2000 after a thorough, nearly five-year scientific review determined mifepristone was safe for widespread use. *Hundreds* of high-quality studies conducted since that initial approval confirm mifepristone's safety. Indeed, mifepristone has been part of over 600 published clinical trials and discussed in over 900 medical reviews.[9] Mifepristone has an exceedingly low rate of serious adverse events.[10] The National Academies of Sciences, Engineering, and Medicine ("National Academies"), a highly respected nonpartisan advisory

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[6] *See generally, e.g.*, M. Antonia Biggs et al., *A Cross-Sectional Survey of U.S. Abortion Patients' Interest in Obtaining Medication Abortion Over the Counter*, 109 Contraception 25 (2022); Leah R. Koenig et al., *Patient Acceptability of Telehealth Medication Abortion Care in the United States, 2021–2022: A Cohort Study*, 114 Am. J. Pub. Health 241 (2024).

[7] *Mifepristone Approved List*, Gynuity Health Projects (updated May 2024), https://gynuity.org/assets/resources/mife_by_country_and_year_en.pdf.

[8] *See* Rachel K. Jones & Amy Friedrich-Karnik, *Medication Abortion Accounted for 63% of All US Abortions in 2023—An Increase from 53% in 2020*, Guttmacher Inst. (Mar. 2024), https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020.

[9] Based on a review of publications on PubMed.

[10] 2016 FDA Approval, *supra* note 5, at 14-17; Ushma Upadhyay et al., *Effectiveness and safety of telehealth medication abortion in the USA*, 30 Nature Med. 1191, 1197 (2024) [hereinafter *Effectiveness and Safety of TMAB*]; Ushma Upadhyay et al., *Abortion-Related Emergency Department Visits in the United States: An Analysis of a National Emergency Department Sample*, 16 BMC Med. 1, 7-10 (2018).

institution, concluded that the risks of medication abortion involving mifepristone are "similar in magnitude to the reported risks of serious adverse effects of commonly used prescription and over-the-counter medications."[11] Beyond abortion, mifepristone is regularly prescribed for the management and treatment of miscarriages, which can be life-threatening without adequate treatment.[12]

In 2016, the FDA modified mifepristone's Risk Evaluation and Mitigation Strategies ("REMS") and labeling based on evolutions in evidence-based practice. These changes included allowing prescription by a broader set of qualified healthcare providers and updating the labeling to reflect use at a wider range of gestational durations and to remove references to multiple in-person clinic visits, consistent with the evidence-based standard of care. In support of its decision, the FDA relied on a wealth of updated data, including more than eighty high-quality studies analyzing outcomes for hundreds of thousands of patients, as well as years of real-world evidence underscoring mifepristone's safety without these

[11] Nat'l Acads. of Sci., Eng'g. & Med., *The Safety and Quality of Abortion Care in the United States* 45, 56-68, 79 (2018).

[12] *See, e.g.*, Elise W. Boos et al., *Trends in the Use of Mifepristone for Medical Management of Early Pregnancy Loss From 2016 to 2020*, 330 JAMA 766 (2023), https://jamanetwork.com/journals/jama/fullarticle/2807775Courtney A. Schreiber et al., *Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss*, 378 New Eng. J. Med. 2161 (2018); Justin J. Chu, et al., *Mifepristone and Misoprostol Versus Misoprostol Alone for the Management of Missed Miscarriage (MifeMiso): A Randomised, Double-Blind, Placebo-Controlled Trial*, 396 Lancet 770 (2020).

impediments.[13] The FDA's 2016 decision cited a host of studies showing that the rate of major adverse events was roughly 0.3%.[14] Recent peer-reviewed research confirms that serious complications among mifepristone users remain extremely rare, and FDA data from more than two decades of mandatory reporting of any potentially associated fatalities show that the number of deaths associated with mifepristone use remains infinitesimally low (fewer than forty recorded deaths out of more than 7.5 million uses since mifepristone's approval, or 0.00048%—and none of those deaths can be causally attributed to mifepristone).[15]

Given its exceptional safety record, leading medical associations have long called on the FDA to lift all of its medically unnecessary restrictions on mifepristone, including its in-person dispensing requirement, and instead regulate mifepristone like other prescription drugs.[16] After extensive review of real-world data and peer-reviewed studies, the FDA found in 2021 that mifepristone would "remain safe and effective for medication abortion if the in-person dispensing requirement is

[13] *See generally* 2016 FDA Approval, *supra* note 5.

[14] *Id.* at 56.

[15] U.S. Food & Drug Admin., NDA 020687 & ANDA 091178, *Mifepristone U.S. Post-Marketing Adverse Events Study through 12/31/2024* (2025), https://www.fda.gov/media/185245/download; Am. Coll. of Obstetricians & Gynecologists, *Citizen Petition* (Feb. 4, 2025), https://www.regulations.gov/document/FDA-2025-P-0377-0001.

[16] Am. Coll. of Obstetricians & Gynecologists et al., *supra* note 4; Am. Coll. of Obstetricians & Gynecologists, *supra* note 15.

removed."[17] In 2023, the FDA formalized its 2021 conclusion, permanently eliminating this requirement. Removal of the in-person dispensing requirement meaningfully increased access to mifepristone without compromising the safety or efficacy of this important medication. However, despite this change, the FDA continues to unnecessarily restrict mifepristone more stringently than other drugs with similarly low risks; in 2023, the agency maintained all of its restrictions on mifepristone other than the in-person dispensing requirement.[18]

Telehealth, an increasingly common method of healthcare delivery across all areas of medicine, is now a standard method of care for medication abortion in the United States and around the world.[19] Unlike the in-person dispensing requirement, which forced every patient to travel to a health center just to pick up their

[17] U.S. Food & Drug Admin., REMS Modification Rationale Review, NDA 020687 & 91178, at 39 (Dec. 16, 2021).

[18] In October 2025, a federal court found that the FDA has failed to justify its *current* overly restrictive regulation of mifepristone compared to other prescription drugs under the governing statute. *See Purcell v. Kennedy*, No. CV 17-00493 JAO-RT, 2025 WL 3101785, at *2, *18 (D. Haw. Oct. 30, 2025). *See also* Am. Coll. of Obstetricians & Gynecologists et al., *supra* note 4 (preeminent medical associations calling on the FDA to lift its special restrictions on mifepristone altogether given mifepristone's strong safety profile); Daniel Grossman & Erica Chung, *Evidence Supports Removing Restrictions on Mifepristone*, JAMA (June 12, 2025), https://jamanetwork.com/journals/jama/article-abstract/2835287 (discussing the REMS modifications for flibanserin and PrEP regimens, sexual and reproductive health medications with similar or higher risks and incidence of adverse events).

[19] Am. Coll. of Obstetricians & Gynecologists, *Medication Abortion Up to 70 Days of Gestation*, Practice Bulletin No. 225, at 35 (Oct. 2020, reaff'd 2023), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation; World Health Organization, *Abortion Care Guideline*, at 95 (Mar. 8, 2022), https://www.who.int/publications/i/item/9789240039483.

mifepristone prescription, even when there was no clinical need for any in-person care, telehealth care is individually tailored to each patient's circumstances, with in-person testing or examination ordered when appropriate based on individualized patient screening. Rigorous studies from the past several years resoundingly reinforce that patients can be screened and counseled for medication abortion via telehealth as safely and effectively as in-person screening and dispensing.[20] For instance, a study of over 6,000 telehealth patients demonstrated that telehealth-prescribed medication abortion provides statistically equivalent safe and effective results as in-person care.[21] Numerous other studies and systematic reviews reached the same conclusion, further supporting that access to mifepristone via telehealth provides necessary care with the same safety levels and effective outcomes.[22]

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[20] *See, e.g.*, Daniel Grossman et al., *Medication Abortion With Pharmacist Dispensing of Mifepristone* 137 Obstetrics & Gynecology 613 (2021); Ushma Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 JAMA Internal Med. 482 (2022); Leah R. Koenig et al., *Effectiveness and Safety of Medication Abortion With vs Without Screening Ultrasonography or Pelvic Examination*, 233 Am. J. Obstetrics & Gynecology 453e1 (2025); Silpa Srinivasulu et al., *Telehealth Medication Abortion in Primary Care: A Comparison to Usual in-Clinic Care*, 37 J. Am. Bd. Fam. Med. 295 (2024); Ushma Upadhyay et al., *Effectiveness and Safety of TMAB*, *supra* note 10.

[21] Ushma Upadhyay et al., *Effectiveness and Safety of TMAB*, *supra* note 10.

[22] *See, e.g.*, Lauren J. Ralph et al., *Comparison of No-Test Telehealth and In-Person Medication Abortion*, 332 JAMA 898, 903 (2024); Holly A. Anger & Elizabeth G. Raymond, *Clinical and Service Delivery Outcomes Following Medication Abortion Provided With or Without Pretreatment Ultrasound or Pelvic Examination: An Updated Comparative Analysis*, 140 Contraception 1 (2024); *see also* Amanda Cleeve et al., *The Use of Telemedicine Services for Medical Abortion*, 6 Cochrane Database Syst. Rev. CD013764 (2025) (finding that "the use of telemedicine for medical abortion in early pregnancy is generally safe, effective, and acceptable;"

Plaintiffs-Appellants and their *amici*'s reliance on emergency room visits following mifepristone use is misplaced. Indeed, the FDA itself recognizes that an emergency room visit alone is not an adverse outcome.[23] As the FDA acknowledged in its 2021 REMS review,[24] many emergency room visits after a medication abortion involve no treatment at all; patients may seek care in the emergency room after a medication abortion to ask questions, to ensure their symptoms are normal, or to confirm that they are no longer pregnant, especially because an emergency department may be the closest or most convenient option.[25]

Plaintiffs-Appellants' unfounded assertions are contradicted by ample evidence of mifepristone's safety, including: the millions of safe outcomes for people across the country who have used mifepristone since its approval in 2000; the FDA's conclusion, after thorough review of the scientific evidence, that medication abortion with mifepristone remains safe and effective whether dispensed by mail, at pharmacies, or at health centers; and the decades of reputable scientific

noting that the review's findings were "consistent with the conclusions of previous work on the topic"; and reaffirming that "serious adverse events are rare").

[23] U.S. Food and Drug Admin., *What is a Serious Adverse Event?*, https://www.fda.gov/safety/reporting-serious-problems-fda/what-serious-adverse-event.

[24] *See* ECF No. 1-51 at 29 (FDA 2021 REMS Modification Review).

[25] UCLA Center of Reproductive Health, Law, and Policy, *Comment on Citizen Petition* (Aug. 27, 2025); Brief of FemInEM Foundation and American Academy of Emergency Medicine as *Amici Curiae* in Support of Applications by Danco Laboratories, L.L.C., and GenBioPro, Inc., *Danco Laboratories, LLC v. Louisiana*, Nos. 25A1207, 25A1208 (U.S. May 6, 2026).

evidence and analysis that reaffirm the FDA's findings.[26] The FDA's decision to lift the in-person dispensing requirement was a reasoned decision in light of the extensive safety data and the millions of safe outcomes for people across the country.

## II. Removing Telehealth Access to Mifepristone Will Endanger Many Communities' Health and Autonomy.

Requiring that mifepristone be dispensed in person at a health center will gravely harm patients across the country. The ability to fill a prescription for mifepristone through the mail or at a local pharmacy after consultation with a healthcare provider is critical for patients needing abortion and miscarriage care, particularly for populations most in need of access to medication abortion for their health and autonomy. Shuttering this essential avenue of healthcare puts people's health at risk nationwide. In the face of such unprecedented disruption and irreparable harm to critical care, this Court should affirm the denial of Plaintiffs-Appellants' request for a stay of the 2023 REMS.

### A. Telehealth Provides Essential Access to Abortion Care.

Telehealth is indispensable to legal abortion care. Medication abortion now accounts for 63% of all abortions in the United States, and more than one in four abortions is obtained via telehealth services.[27] In certain states, the reliance on

[26] *Id.*

[27] Jones & Friedrich-Karnik, *supra* note 8; Soc'y of Family Planning, *#WeCount Report, April*

telehealth is even more pronounced. For example, in 2024, 40% of abortions in Delaware and 34% of abortions in Nevada were obtained through telehealth.[28] Telehealth is not a peripheral convenience; it is essential for many patients to access the care they need. Disrupting this key component of the nation's healthcare infrastructure reduces access to necessary healthcare, particularly for populations who have difficulty traveling to an abortion provider.

Telehealth has also been essential for meeting dramatically increased demand in states where abortion is legally protected.[29] Abortion bans have placed extraordinary strain on the remaining brick-and-mortar providers in states that support abortion access, who face an influx of appointments from patients who must travel across state lines for care. Telehealth enables providers in states where abortion is legal to absorb this surge in patients and helps mitigate long appointment wait times that would otherwise delay care.[30]

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*2022 to December 2024* (June 23, 2025), https://societyfp.org/research/wecount/wecount-december-2024-data/.

[28] Soc'y of Family Planning, *supra* note 27.

[29] Leah R. Koenig et al., *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, 9 JMIR Pub. Health & Surveillance e45671 (2023).

[30] Rachel K. Jones et al., *The Number of Brick-and-Mortar Abortion Clinics Drops, as US Abortion Rate Rises: New Data Underscore the Need for Policies that Support Providers*, Guttmacher Inst. (June 2024), https://www.guttmacher.org/report/abortion-clinics-united-states-2020-2024.

Even setting aside the increased demand from out-of-state patients traveling for care, telehealth is crucial in states that protect abortion access to overcome the significant geographic barriers that can make it difficult to serve residents in need of medical care. The average American now lives 86 or more miles from an abortion provider, making in-person access to time-sensitive care logistically difficult or impossible for many patients.[31] Telehealth plays a key role in promoting equitable access by reaching patients who might otherwise be unable to travel to a clinic in time to access care.[32] Mounting concerns around a national shortage of obstetrician-gynecologists and rising rates of maternal healthcare deserts further emphasize the importance of telehealth in ensuring that patients can access reproductive healthcare when and where they need it.[33]

### B. Forcing Patients to Travel to a Health Center for Mifepristone Will Impact Already Vulnerable Communities the Most.

Telehealth is especially crucial for protecting abortion access for vulnerable communities, including people living in poverty, people living in rural areas, people

[31] Selena Simmons-Duffin & Shelly Cheng, *How Many Miles Do You Have to Travel to Get Abortion Care? One Professor Maps It*, NPR (June 21, 2023), https://www.npr.org/sections/health-shots/2023/06/21/1183248911/abortion-access-distance-to-care-travel-miles#:~:text=Just%20a%20year%20ago%2C%20%22less,large%20cities%20in%20the%20South.

[32] Leah R. Koenig et al., *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, 9 JMIR Pub. Health & Surveillance e45671 (2023).

[33] Katherine J. Kramer et al., *Trends and Evolution in Women's Health Workforce in the First Quarter of the 21st Century*, 5 World J. Gynecology & Women's Health 622 (2022), https://pubmed.ncbi.nlm.nih.gov/35601601/.

subject to intimate partner violence, people who cannot get time off from work or find childcare, and people of color. When patients can no longer access mifepristone via telehealth, people in these already marginalized groups are the most likely to suffer.

Congress expressly limited the FDA's authority to ensure it does not impose REMS restrictions that result in these kinds of harms. The REMS statute requires that FDA-imposed restrictions on approved drugs shall "not be unduly burdensome on patient access to the drug, considering in particular . . . patients who have difficulty accessing healthcare (such as patients in rural or medically underserved areas)."[34] Requiring every mifepristone patient in the country to travel in person to a hospital, clinic, or medical office just to pick up their prescription imposes exactly this kind of unlawful burden.

Abortion patients are disproportionately poor: nearly half of all abortion patients live below the federal poverty line.[35] When abortion restrictions prevent patients from being able to access the care they seek, a variety of harms ensue. For patients living in or near poverty, being denied an abortion deepens the very economic hardship that already constrains their access to care. Women denied

[34] 21 U.S.C. § 355-1(f)(2)(C).

[35] Liza Fuentes, *Inequity in US Abortion Rights and Access: The End of Roe Is Deepening Existing Divides*, Guttmacher Inst. (Jan. 2023).

abortions are nearly four times more likely to be living in poverty six months after being denied care than women who were able to access abortions.[36] They also have more than three times greater odds of being unemployed and are more likely to be enrolled in public safety net programs than women who were able to access abortion care.[37] Being denied an abortion also increases women's debt and negative public financial records, including bankruptcies and evictions.[38]

Telehealth is uniquely positioned to prevent these outcomes because it directly addresses many of the barriers to healthcare that poverty creates. Nearly 20% of abortion patients report postponing purchasing food to cover costs associated with their abortion—costs that include not only the cost of the abortion itself but also transportation, missed wages, and childcare.[39] Households below 200% of the federal poverty line are far more likely to lack vehicle access, making travel to a clinic logistically impossible for many.[40] Telehealth eliminates or reduces these

[36] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 112 Am. J. Pub. Health 1290 (2022).

[37] *Id.*

[38] Sarah Miller, Laura R. Wherry & Diana Greene Foster, *The Economic Consequences of Being Denied an Abortion*, 15 Am. Econ. J.: Econ. Pol'y 394 (2023).

[39] Samuel Dickman et al., *Financial Hardships Caused by Out-of-Pocket Abortion Costs in Texas, 2018*, 112 Am. J. Pub. Health 758, 759 (2022).

[40] *See* Comment of The Boston University School of Law's Program on Reproductive Justice (BUPRJ), Immigrants' Rights and Human Trafficking Program (IRHTP), and the Racial Justice and Movement Lawyering Clinic (RJMLC) on FDA-2025-P-3287-0001, at 9 (Oct. 11, 2025), https://www.regulations.gov/comment/FDA-2025-P-3287-0060.

secondary costs by allowing patients to seek care without traveling, missing work, or securing childcare.[41] Research confirms that telehealth reduces missed appointments and improves continuity of care—outcomes that are particularly vital for working-class and low-income patients whose access to paid leave, reliable transportation, and flexible schedules is limited.[42]

Restricting telehealth also disproportionately harms rural and geographically isolated communities. More than one-third of women of reproductive age live more than an hour away from their nearest abortion facility.[43] Research confirms the concrete consequences of these distance barriers: an increase in travel distance from 0–50 miles to 50–100 miles has been found to reduce abortion rates by 16%.[44] And telehealth is particularly vital for Indigenous communities, who face severe barriers due to federal law restrictions on Indian Health Service facilities and geographic isolation on Tribal lands.[45]

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[41] *See id.* at 8.

[42] *Id.*

[43] Benjamin Rader et al., *Estimated Travel Time and Spatial Access to Abortion Facilities in the US Before and After the* Dobbs v. Jackson Women's Health *Decision*, 328 JAMA 2041 (Nov. 1, 2022), https://jamanetwork.com/journals/jama/fullarticle/2798215?guestAccessKey=70c1bc40-5cc0-4bcf-a73d-a5b9b26ccf01&utm_source=For_The_Media&utm_medium=referral&utm._campaign=ftm_links&utm_content=tfl&utm_term=110122.

[44] Jason M. Lindo et al., *How Far Is Too Far?: New Evidence on Abortion Clinic Closures, Access, and Abortions*, 55 J. Hum. Res. 1137 (2020).

[45] Lauren Van Schilfgaarde et al., *Tribal Nations and Abortion Access: A Path Forward*, 46 Harv. J.L. & Gender 1 (2023).

While Plaintiffs-Appellants and their *amici* claim that restricting access to mifepristone helps survivors of intimate partner violence,[46] the evidence overwhelmingly demonstrates the opposite: cutting off telehealth access to mifepristone places survivors of intimate partner violence at much higher risk.[47] Nearly half of women in the United States have been affected by intimate partner violence, and women of color, women living in rural areas, women in poverty, and noncitizens are disproportionately impacted.[48] Survivors of intimate partner violence are nearly three times more likely to conceal an abortion from their partners due to safety concerns.[49] Abusers often exert coercive control over survivors' reproductive choices, including through birth control sabotage and forced pregnancies. In one survey of patients seeking contraceptive care, 19% reported experiencing coercion to become pregnant.[50]

[46] *See* Pls.-Appellants' Opening Br. at 29, *Louisiana v. FDA*, No. 26-30203 (5th Cir. June 15, 2026), ECF No. 147 [hereinafter Opening Br.].

[47] *See, e.g.*, Dhaval Dave et al., *Abortion Restrictions and Intimate Partner Violence in the* Dobbs *Era*, 104 J. Health Econ. 103074 (2025).

[48] M.C. Black et al., *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report*, Ctr. for Disease Control & Prevention 48 (2011).

[49] Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and At-Home Reproductive Care*, 32 Const. Comment. 341, 373 (2017).

[50] Elizabeth Miller, et al., *Pregnancy Coercion, Intimate Partner Violence and Unintended Pregnancy*, 81 Contraception 316 (2010).

Plaintiffs-Appellants and their *amici* wrongly suggest that coercion to terminate a pregnancy is widespread, but that claim is not backed up by evidence.[51] The few studies that have addressed partner coercion or pressure to terminate a pregnancy have found a low prevalence.[52] Consistent with that fact, reputable research supports that virtually all abortion patients in the United States consider that "abortion was the right decision for them at all times."[53]

More importantly, cutting off access to abortion care is not an effective way of addressing reproductive coercion; it will only compound harm to survivors of intimate partner violence.[54] For people in a coercive relationship, the ability to access abortion care discreetly, without an abuser's knowledge, is a lifeline. Telehealth serves that function precisely because it offers survivors privacy,

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[51] *See* Brief of *Amicus* Center for Law and Justice at 15. Among other flaws, Plaintiffs-Appellants' *amicus* relies on self-selected surveys of clients of anti-abortion crisis pregnancy centers that "*cannot be generalized* to the average woman seeking abortion in the US," Priscilla Coleman, et al., *Women Who Suffered Emotionally from Abortion: A Qualitative Synthesis of Their Experiences*, 22 J. Am. Physicians and Surgeons 115, 117 (2017) (emphasis added), and articles that conflate any feelings of outside "pressure" related to an abortion decision with "coercion," without any attempt to define "pressure" or its role in the woman's decision to have an abortion, Vincent Rue, et al., *Induced Abortion and Traumatic Stress: A Preliminary Comparison of American and Russian Women*, 10 Med. Sci. Monitor 9, SR9 (2004).

[52] Karen Trister Grace & Jocelyn C. Anderson, *Reproductive Coercion: A Systematic Review*, 19 Trauma Violence Abuse 371 (2018).

[53] Corinne Rocca et al., *Emotions and Decision Rightness over Five Years Following an Abortion: An Examination of Decision Difficulty and Abortion Stigma*, 248 Social Science & Medicine 112704 (2020).

[54] Brief of Legal Voice, National Domestic Violence Hotline, et al. as Amicus Curiae in Support of Applicants at 16–23, *Danco Labs., L.L.C. v. Louisiana*, Nos. 25A1207, 25A1208 (U.S. filed May 7, 2026).

autonomy, and a means of safely accessing care outside the surveillance or control of an abuser. Restricting telehealth access to mifepristone forces survivors to navigate the very barriers that abusers exploit: the need to travel to an in-person appointment, arrange childcare, take time off work, and explain absences to a controlling partner. Abusers commonly restrict their partners' ability to access transportation, making an in-person dispensing requirement an insurmountable barrier for many of those facing intimate partner violence to seek care.[55] Research has found that the privacy afforded by telehealth may better facilitate patients' disclosure of coercion, enabling survivors to speak more openly with providers about their experiences in settings where an abusive partner is less likely to monitor or control the interaction.[56] As advocates have warned, restricting access to mifepristone limits survivors' ability to access abortion care, thus gravely increasing their risk of health complications, violence, and homicide.[57] When pregnant women are killed, it is most often by an abusive partner.[58] These serious harms and

[55] Kristen E. Ravi et al., *"He Was Afraid I Wouldn't Come Back": Experiences of Transportation Coercion Among Survivors of Intimate Partner Violence in the United States*, J. Fam. Violence (Nov. 2024).

[56] Elizabeth C. Romanis et al., *Safeguarding and Teleconsultation for Abortion*, 398 Lancet 555, 556 (2021).

[57] *See* Comment of Legal Voice et al. on FDA-2025-P-3287 (Nov. 27, 2025), https://www.regulations.gov/comment/FDA-2025-P-3287-0068.

[58] Maeve E. Wallace, *Trends in Pregnancy-Associated Homicide, United States, 2020*, 112 Am. J. Pub. Health 1333, 1333 (2022) ("[M]ost cases of pregnancy-associated homicide involve domestic violence[.]").

potentially fatal risks fall hardest on survivors in marginalized communities who already face the steepest barriers to in-person care.

Along with the myriad harms discussed above, restricting telehealth access to mifepristone will disproportionately harm people of color and immigrant communities who already face greater barriers to accessing healthcare, including abortion. Women of color account for a majority of those seeking abortion care.[59] Factors such as time, travel, and the general costs associated with accessing abortion care already prohibit many women of color from accessing mifepristone in a timely manner.[60] Telehealth addresses many of these barriers by eliminating the need for long-distance travel and reducing the secondary costs—missed wages, childcare, transportation—that fall most heavily on communities of color.

The same is true for immigrant communities. Immigrants are generally less likely to drive than their native-born counterparts, making travel to in-person appointments particularly difficult.[61] And telehealth addresses not only logistical barriers but also linguistic ones: approximately 20% of patients who are asylum

[59] Jillian McKoy, *Travel Times to Abortion Facilities Have Increased Drastically in Post*-Roe *Era*, Bos. Univ. Sch. of Pub. Health (Nov. 23, 2022).

[60] Ushma D. Upadhyay et al., *Sociodemographic Characteristics of Women Able to Obtain Medication Abortion Before and After Ohio's Law Requiring Use of the Food and Drug Administration Protocol*, 2 Health Equity 122 (2018).

[61] Alexa Delbosc & Rahman Shafi, *What Do We Know About Immigrants' Travel Behaviour? A Systematic Literature Review and Proposed Conceptual Framework*, 43 Transport Revs. 914 (2023).

applicants do not pursue medical care due to fear of miscommunication or not understanding their provider.[62] Telehealth can help bridge this gap by connecting patients with language-concordant providers who may not be available in their immediate geographic area. For communities already navigating the intersection of immigration status, poverty, and limited English proficiency, telehealth is often the only realistic path to timely reproductive care. Eliminating it risks leaving these patients with nowhere to turn.

### C. Restricting Abortion Access Worsens Public Health Outcomes.

Telehealth for abortion, like abortion more generally, is essential to public health. Contrary to Plaintiffs-Appellants' repeated claims that restricting mifepristone access would save women from harm,[63] it is the restriction of abortion access—not its availability—that endangers patients' health and lives. Access to safe abortion is a critical component of the broader healthcare system; curtailing it through telehealth restrictions produces the very harms Plaintiffs-Appellants claim to oppose.

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[62] *See* Comment of The Boston University School of Law's Program on Reproductive Justice (BUPRJ), *supra* note 40.

[63] *See* Compl. ¶¶ 120–131, *Louisiana v. FDA*, No. 6:25-cv-01491 (W.D. La. Oct. 6, 2025), ECF No. 1 (asserting quasi-sovereign harms to Louisiana women from mifepristone); Opening Br. at 43 (asserting harm to Louisiana residents from mifepristone).

The historical record is unambiguous on this point. The gradual legalization of abortion in the years leading up to *Roe v. Wade* reduced maternal mortality among people of color by 30–40%.[64] Research since *Dobbs* confirms that this pattern is now reversing. The racial dimensions of these harms are particularly stark. Black women are already two to four times more likely than white women to experience maternal mortality or morbidity.[65] Abortion bans in thirteen states have also increased infant mortality, with an estimated 478 additional infant deaths above what would have been expected.[66] Research following Texas's 2021 abortion ban estimated a 6–13% increase in infant mortality.[67] Black infants have been hit hardest, dying at a rate 11% higher than expected following abortion bans.[68] These are not abstract projections. They are documented consequences of restricting access to care.

Abortion restrictions have also been shown to increase disparities in premature birth and low birthweight between Black and white infants by 3–6%.[69]

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[64] Sherajum Monira Farin et al., *The Impact of Legal Abortion on Maternal Mortality*, 16 Am. Econ. J.: Econ. Pol'y 174 (2022), https://www.aeaweb.org/articles?id=10.1257/pol.20220208.

[65] Alexis A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008–2010*, 210 Am. J. Obstetrics & Gynecology 435.e1 (2014).

[66] Alison Gemmill et al., *US Abortion Bans and Infant Mortality*, 333 JAMA 1315 (2025).

[67] Alison Gemmill et al., *Infant Deaths After Texas' 2021 Ban on Abortion in Early Pregnancy*, 331 JAMA 1609 (2024).

[68] *Id.*

[69] Graham Gardner, *The Maternal and Infant Health Consequences of Restricted Access to Abortion in the United States*, 98 J. Health Econ. 102938 (2024).

And state-level abortion restrictions enacted prior to 2022 were associated with increases in intimate partner violence–related homicides of women and girls.[70] Restricting telehealth access to mifepristone compounds each of these outcomes by erecting additional barriers to reproductive healthcare for communities that already bear the greatest burdens.

Restricting mifepristone access will cause profound harm. Abortion access saves lives, reduces maternal and infant mortality, narrows racial health disparities, and protects survivors of violence. Telehealth is the mechanism through which hundreds of thousands of patients access that care. Reinstating the in-person dispensing requirement will cause the gravest harm to those who can least afford it.

[70] Maeve E. Wallace et al., *States' Abortion Laws Associated with Intimate Partner Violence–Related Homicide of Women and Girls in the US, 2014–20*, 43 Health Aff. 682 (2024).

## CONCLUSION

For the foregoing reasons, *amici* respectfully urge this Court to affirm the denial of Plaintiffs-Appellants' motion.

Dated: July 22, 2026.

Respectfully submitted,

*s/Jessica Ring Amunson*

Jessica Ring Amunson
*Counsel of Record*
Varsha Midha
JENNER & BLOCK LLP
1099 New York Ave NW, Suite 900
Washington, DC 20001
(202) 639-6048
jamunson@jenner.com

Emily Merrifield
Sara Stappert
JENNER & BLOCK LLP
353 N. Clark Street
Chicago, IL 60654
(312) 222-9350

## CERTIFICATE OF COMPLIANCE

Pursuant to Fifth Circuit Rule 32.2, the undersigned certified that this brief complies with:

(1) the type-volume limitation of Fed R. App. P. 32(a)(7)(B) because it contains 5,687 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f); and

(2) the typeface requirements of Fed. R. App. P. 32(a)(5)(A) and the type style requirements of Fed. R. App. P 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Times New Roman) using Microsoft Word.

Dated: July 22, 2026

*s/Jessica Ring Amunson*
Jessica Ring Amunson
*Counsel for* Amici Curiae

## CERTIFICATE OF SERVICE

I hereby certify that on July 22, 2026, an electronic copy of the foregoing brief was filed with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system. I further certify that all parties or their counsel of record are registered CM/ECF users and will be served by the appellate CM/ECF system.

*s/Jessica Ring Amunson*
Jessica Ring Amunson
*Counsel for* Amici Curiae

# APPENDIX

## List of *Amici Curiae*

10,000 Women Louisiana

2+ Abortions Worldwide

A Woman's Choice Clinics: Jacksonville, FL; Charlotte, NC; Raleigh, NC; Danville, VA

Abortion Access Front

Abortion Action Missouri

Abortion Care Network

Abortion Coalition for Telemedicine

Abortion Forward (f/k/a Pro-Choice Ohio)

Abortion Freedom Fund

Access Health Center Ltd

ACCESS REPRODUCTIVE JUSTICE

Advocates for Youth

Alamo Women's Clinic of Albuquerque

Alamo Women's Clinic of Illinois

All Families Healthcare

Alyssa Rodriguez Center for Gender Justice

American Civil Liberties Union Foundation

American College of Nurse-Midwives, Oregon Affiliate

American Society for Emergency Contraception

Americans United for Separation of Church and State

Ancient Song, Inc.

Avow Texas

AWAKE Tennessee

Blue Mountain Clinic

Bread and Roses/Gainesville Woman Care

Brevard NOW

Bristol Women's Health Clinic

California Women Lawyers

Cambridge Reproductive Health Consultants

CARE Colorado

Carolina Abortion Fund

CE Repro Fund

Cedar River Clinics

Center for Reproductive Rights

Center for Women's Health

Chicago Abortion Fund

CHOICES Center for Reproductive Health

Choices Women's Center

Coalition of Labor Union Women, AFL-CIO

Cobalt Advocates

Collective Power for Reproductive Justice

Colorado Organization for Latina Opportunity & Reproductive Rights (COLOR)

Columbia NOW (Columbia, SC)

Defend Public Health

Desert Star Institute for Family Planning

Desiree Alliance

El Pueblo

Emergent Transformative Justice

Endora

Equal Rights Advocates

Essential Access Health

Every Mother Counts

Faith Choice Ohio

Faith Roots Reproductive Action

Family Planning Associates Medical Group

FemHealth USA d/b/a carafem

Feminist Center for Reproductive Liberation

FL National Organization for Women

Forward Midwifery

Frontera Fund

Full Circle Health Center

Fund Texas Choice

Gender Justice

Gender Justice League

Greater Orlando National Organization for Women

Greenville Women's Clinic PA

GSBA, Washington's LGBTQ+ Chamber of Commerce

Guttmacher Institute

Health Imperatives Inc.

Hydra Fund

Ibis Reproductive Health

Idaho Abortion Rights

If/When/How: Lawyering for Reproductive Justice

Indigenous Women Rising

International Action Network for Gender Equality & Law (IANGEL)

International Medical Consulting

Ipas US

Jane's Due Process

Juniper Midwifery

Just The Pill

JustChoice

Justice and Joy National Collaborative

Lambda Legal Defense and Education Fund, Inc.

Lawyering Project

Legal Momentum, The Women's Legal Defense and Education Fund

Lift Louisiana

Louisiana Abortion Fund

Luna Flow Health

Mabel Wadsworth Center

Maine Family Planning

Metro Area Advanced Practice Healthcare

Michigan Chamber for Reproductive Justice

Michigan Voices

Middle Georgia 4 Choice

Midwest Access Coalition

Miscarriage and Abortion Hotline

My Sunny Health

National Abortion Federation

National Asian Pacific American Women's Forum

National Family Planning & Reproductive Health Association

National Health Law Program

National Network of Abortion Funds

National Organization for Women Foundation

National Organization for Women, Jacksonville Chapter

National Perinatal Association

National Women's Law Center

National Women's Liberation

National Women's Political Caucus

New York Abortion Access Fund (NYAAF)

New York Midwives

NOISE FOR NOW

North Seattle Progressives (NSP)

Northland Family Planning Centers

Northwest Health Law Advocates

National Association of Nurse Practitioners in Women's Health (NPWH)

Nurses for Sexual Reproductive Health

Oklahoma Call for Reproductive Justice

Partners in Abortion Care

People For the American Way

People Power United

Physicians for Human Rights

Pinellas County National Organization for Women

Planned Parenthood Federation of America

Power to Decide

Pregnancy Justice

Pro-Choice North Carolina

Protect Our Care, a fiscally sponsored project of New Venture Fund

PUSH for Empowered Pregnancy

Reclaim, Inc.

Red River Women's Clinic

REPRO Rising Virginia

Reproaction

Reproductive Equity Now Foundation

Reproductive Freedom for All

Reproductive Freedom Fund of New Hampshire

Reproductive Futures

Reproductive Health Access Project

Rhia Ventures

Robbinsdale Clinic, PA

Rocky Mountain Equality

Roxy Clinic

Save Secular Healthcare Washington

Service Employees International Union

SHERo Mississippi

SisterLove, Inc.

SisterSong National Women of Color Reproductive Justice Collective

Southwestern Women's Options

State Innovation Exchange

Stigma Relief Fund

Tennessee Freedom Circle

Texas Equal Access Fund

The Brigid Alliance

The Jane Network

The National Partnership for Women & Families

Truth Pregnancy Resource Center

Ubuntu Black Family Wellness Collective

UCSF Bixby Center for Global Reproductive Health

URGE: Unite for Reproductive & Gender Equality

Virginia Affiliate of the American College of Nurse-Midwives

Wavelength Psychological Services

Whole Woman's Health

Whole Woman's Health Alliance

Wild West Access Fund of Nevada

Women Lawyers On Guard Inc.

Women Lawyers of Ventura County

Women's Bar Association of the District of Columbia

Women's Health Specialists

Women's Law Project