No. 22A____

IN THE SUPREME COURT OF THE UNITED STATES

U.S. FOOD AND DRUG ADMINISTRATION, ET AL., APPLICANTS

v.

ALLIANCE FOR HIPPOCRATIC MEDICINE, ET AL.

APPLICATION TO STAY THE ORDER
ENTERED BY THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
AND FOR AN ADMINISTRATIVE STAY

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PARTIES TO THE PROCEEDING

Applicants were defendants-appellants below. They are the U.S. Food and Drug Administration (FDA); Robert M. Califf, M.D., in his official capacity as FDA's Commissioner of Food and Drugs; Janet Woodcock, M.D., in her official capacity as Principal Deputy Commissioner of FDA; Patrizia Cavazzoni, M.D., in her official capacity as Director of FDA's Center for Drug Evaluation and Research; the U.S. Department of Health and Human Services (HHS); and Xavier Becerra, in his official capacity as Secretary of HHS.

Respondents were plaintiffs-appellees below. They are Alliance for Hippocratic Medicine; American Association of Pro-Life Obstetricians & Gynecologists; American College of Pediatricians; Christian Medical & Dental Association; Shaun Jester, D.O.; Regina Frost-Clark, M.D.; Tyler Johnson, D.O.; and George Delgado, M.D.

Danco Laboratories, LLC was an intervenor-defendant below.

RELATED PROCEEDINGS

United States District Court (N.D. Tex.):

- Alliance for Hippocratic Medicine, et al. v. U.S. Food and Drug Administration et al., No. 22-cv-223 (April 7, 2023)

United States Court of Appeals (5th Cir.):

- Alliance for Hippocratic Medicine, et al. v. Food and Drug Administration et al., No. 23-10362 (April 12, 2023) (denying stay pending appeal)

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Pursuant to Rule 23 of the Rules of this Court and the All Writs Act, 28 U.S.C. 1651, the Solicitor General, on behalf of applicants the U.S. Food and Drug Administration (FDA), et al., respectfully applies to stay the order entered on April 7, 2023, by the United States District Court for the Northern District of Texas (App., infra, 43a-109a), which stayed FDA's approval of mifepristone and related agency actions. The government seeks a stay pending the consideration and disposition of its appeal to the United States Court of Appeals for the Fifth Circuit and, if the court of appeals affirms, pending the timely filing and disposition of a petition for a writ of certiorari and any further proceedings in this Court. The government also respectfully requests an im-

mediate administrative stay to preserve the status quo while the Court considers this application. Portions of the district court's order would otherwise take effect at 1:00 a.m. ET on Saturday, April 15.

This application concerns unprecedented lower court orders countermanding FDA's scientific judgment and unleashing regulatory chaos by suspending the existing FDA-approved conditions of use for mifepristone. In 2000, FDA approved mifepristone for termination of early pregnancy based on the agency's expert judgment that the drug is safe and effective. FDA has maintained that scientific judgment across five presidential administrations, and it has modified the original conditions of mifepristone's approval as decades of experience have conclusively demonstrated the drug's safety. Public health authorities around the world have likewise approved mifepristone, and the World Health Organization has included it on a list of "Essential Medicines." C.A. Add. 672. More than five million Americans have ended their pregnancies using the drug. Today, more than half of women in this country who choose to terminate their pregnancies rely on mifepristone to do so. And study after study has shown that when mifepristone is taken in accordance with its approved conditions of use, serious adverse events are "exceedingly rare." Id. at 707.

In a sweeping order, the district court invoked 5 U.S.C. 705 to suspend FDA's 2000 approval of mifepristone and a series of subsequent FDA actions modifying the drug's approved conditions of

use. Like all preliminary relief, a Section 705 order is supposed to "preserve status or rights" pending review. Ibid. But the district court's order would do exactly the opposite: By nullifying FDA's approval and effectively prohibiting mifepristone's sponsors from introducing the drug into interstate commerce, the order would upend the status quo based on the court's deeply misguided assessment of mifepristone's safety. And the court took that extraordinary step even though respondents' own conduct belies any need for extraordinary relief: They did not sue until more than two decades after mifepristone's approval, delayed three years before petitioning FDA to reconsider its modifications to the conditions on mifepristone's distribution, waited nearly a year to sue after FDA denied that petition, and then unsuccessfully urged the district court to defer consideration of preliminary relief until after a trial on the merits.

The Fifth Circuit stayed the district court's suspension of FDA's original approval of mifepristone. But it refused to stay the suspension of subsequent updates to the conditions on the drug's use, which have governed the drug's distribution for seven years and provided a safe and effective option for women who would otherwise have to undergo a surgical abortion. If allowed to take effect, the lower courts' orders would upend the regulatory regime for mifepristone, with sweeping consequences for the pharmaceutical industry, women who need access to the drug, and FDA's ability to implement its statutory authority.

As explained in the attached declaration of the Principal Deputy Director of FDA, the lower courts' orders would "create significant chaos for patients, prescribers, and the health care delivery system." App., infra, 116a. The orders would "immediately" render all extant doses of mifepristone misbranded because their labeling would be inconsistent with the operative conditions of approval. Id. at 115a. The generic version of the drug would cease to be approved altogether. Id. at 116a. FDA and mifepristone's sponsor would have to adjust the drug's labeling to account for the lower courts' actions -- a process that could take months. Id. at 115a-116a. The resulting disruption would deny women lawful access to a drug FDA deemed a safe and effective alternative to invasive surgical abortion. And even after FDA made the required changes, it appears that the lower courts' orders would obligate it to reinstate a now-obsolete and "unfamiliar" dosing regimen that includes "higher doses of mifepristone than what we now know are needed for the intended use." Id. at 114a; see id. at 115a.

The abrupt shift in the regulatory landscape that would be required by the lower courts' orders raises a host of unprecedented issues and has put FDA and regulated entities in an impossible position. Regulated entities are trying to discern their legal duties and urgently demanding guidance. FDA has spent the last week first grappling with the implications of the district court's order, then racing to untangle the different and enormously more complicated issues raised by the Fifth Circuit's decision. And in

the meantime, another district court has enjoined FDA from doing anything to change the conditions on the distribution of mifepristone in 17 States and the District of Columbia -- which means that FDA risks contempt if it takes action to permit the marketing of mifepristone in a manner consistent with the Fifth Circuit's order.

This Court should put a stop to that untenable situation by staying the district court's order in full. To the government's knowledge, this is the first time any court has abrogated FDA's conditions on a drug's approval based on a disagreement with the agency's judgment about safety -- much less done so after those conditions have been in effect for years. And the lower courts reached that unprecedented result only through a series of fundamental errors that violate black letter Article III and administrative law principles.

First, respondents lack Article III standing, and the Fifth Circuit could hold otherwise only by ignoring this Court's precedent. Respondents are doctors and associations of doctors who oppose abortion. They neither take nor prescribe mifepristone, and FDA's approval of the drug does not require them to do or refrain from doing anything. Yet the Fifth Circuit held that the associations have standing because some of their members might be asked to treat women who are prescribed mifepristone by <u>other</u> providers and who then suffer an exceedingly rare adverse event. This Court has squarely rejected that statistical approach to associational standing, explaining that it would "make a mockery" of

Article III. Summers v. Earth Island Inst., 555 U.S. 488, 498 (2009). But the Fifth Circuit did not even cite Summers.

Second, respondents' challenges to FDA's conditions of approval fail on the merits. FDA's actions were amply supported by an exhaustive review of a record developed over decades of safe use of mifepristone in the United States and around the world. While FDA justified its scientific conclusions in multiple detailed reviews, including a medical review spanning more than 100 pages and assessing dozens of studies and other scientific information, the Fifth Circuit swept the agency's judgments aside in three cursory paragraphs that constituted the sum total of its merits analysis. That brief discussion rested in critical respects on demonstrably erroneous characterizations of the record.

Finally, the overwhelmingly one-sided balance of the equities by itself should have precluded the abrupt and profoundly disruptive nationwide relief granted below. If allowed to take effect, the lower courts' orders would thwart FDA's scientific judgment and undermine widespread reliance in a healthcare system that assumes the availability of mifepristone as an alternative to more burdensome and invasive surgical abortions. Those harms would be felt throughout the Nation because mifepristone has lawful uses in every State -- even those with restrictive abortion laws. And the rushed and scattershot course of this litigation since the district court's order is profoundly unsettling to drug sponsors, healthcare providers, patients, and the public -- all of whom rely

on FDA's exercise of scientific judgment and orderly administration of the Nation's complex system of drug regulation. In contrast, respondents have not shown that they will be injured at all, much less irreparably harmed, by maintaining the status quo they left unchallenged for years.

STATEMENT

A. Statutory Background

Congress has entrusted FDA with the authority and responsibility to ensure that "new drug[s]" are safe and effective. 21 U.S.C. 321(p), 355; see 21 U.S.C. 393(b)(2)(B). The Federal Food, Drug, and Cosmetic Act (FDCA) directs FDA to approve a new drug if, among other things, the sponsor's application contains evidence demonstrating that the drug is safe and effective for its intended use. 21 U.S.C. 355(d); see 21 C.F.R. 314.50, 314.105(c).

In 2007, Congress codified and expanded on FDA's prior regulatory practice by authorizing the agency to require a "risk evaluation and mitigation strategy" (REMS) when it determines that such a strategy is necessary to ensure that the benefits of a drug outweigh the risks. 21 U.S.C. 355-1; see Food and Drug Administration Amendments Act of 2007 (FDAAA), Pub. L. No. 110-85, Tit. IX, § 901, 121 Stat. 823. Under the REMS framework, FDA's approval of a drug may include "elements to assure safe use," such as a requirement that a drug's prescribers have particular training or that a drug be dispensed only in certain settings. 21 U.S.C. 355-1(f)(3). FDA may modify an approved REMS if it determines that

new requirements are needed to assure safe use or that existing requirements are no longer necessary. 21 U.S.C. 355-1(g) and (h).

The FDCA generally prohibits the interstate distribution of new drugs that have not received FDA approval. 21 U.S.C. 331(d), 355(a). The FDCA also requires that drugs bear labeling containing adequate directions for use. 21 U.S.C. 352(f)(1). For prescription drugs like mifepristone, the drug must be accompanied by FDA-authorized labeling. 21 C.F.R. 201.100(c)(2). A drug that does not contain correct, FDA-approved labeling is considered "misbranded" and may not be distributed in interstate commerce. 21 U.S.C. 331(a).

B. FDA's Actions Addressing Mifepristone

1. In 2000, after a four-year review of the original sponsor's application, FDA approved mifepristone under the brand name Mifeprex. C.A. Add. 181-191. Mifepristone is approved for use with another drug, misoprostol, to end an early pregnancy. A patient who follows the two-drug regimen experiences cramping and bleeding similar to that associated with a miscarriage. Id. at 727-729. In approving mifepristone, FDA invoked then-applicable regulations known as "Subpart H" to impose requirements to assure the drug's safe use, including a requirement that mifepristone be dispensed in person by or under the supervision of a doctor with specified qualifications. Id. at 186. FDA concluded based on a review of clinical trials and other scientific evidence that, under

those conditions, mifepristone was safe and effective to terminate pregnancy through seven weeks of gestation. Id. at 181-188.[1]

2. In 2016, FDA approved a supplemental new drug application from mifepristone's sponsor, intervenor-applicant Danco Laboratories, that sought to alter the drug's conditions of use (including the REMS). C.A. Add. 768-775. FDA's approval followed a comprehensive review of the safety and efficacy of the proposed modifications that considered "20 years of experience with [mifepristone], guidelines from professional organizations here and abroad, and clinical trials that have been published in the peer-reviewed medical literature." Id. at 677; see id. at 661-760. Three aspects of FDA's 2016 action are relevant here.

First, FDA made changes to mifepristone's conditions of use. Relying on safety and efficacy data from nearly two dozen studies, FDA increased the gestational age limit from seven to ten weeks. Id. at 689-698, 790-791. In reliance on an additional dozen studies, FDA also reduced the number of required in-person clinical visits from three to one. Id. at 698-701, 791-792. And FDA modified the REMS to allow the sponsors to distribute the drug to a broader set of healthcare providers, rather than only physicians, to prescribe and dispense mifepristone -- just as they routinely

[1] When Congress adopted the REMS framework in 2007, it deemed drugs with existing Subpart H restrictions -- including mifepristone -- to have an approved REMS imposing the same restrictions. Pub. L. No. 110-85, Tit. IX, § 909(b) (21 U.S.C. 331 note). Since 2007, therefore, the conditions on mifepristone's use have been governed by the REMS framework.

prescribe and dispense other drugs. Id. at 703-704, 791-793. The agency concluded that the use of mifepristone under the revised conditions would be "safe," emphasizing that major adverse events "are exceedingly rare." Id. at 707.

Second, FDA also changed the approved dosing regimen. C.A. Add. 666. For example, FDA reduced the amount of mifepristone from 600 mg to 200 mg, increased the amount of misoprostol, and called for the misoprostol to be administered buccally (dissolved in the cheek pouch) rather than orally. Ibid. Respondents have not specifically challenged those changes in this litigation, and the lower courts did not suggest that they were unlawful.

Third, FDA modified a prior requirement that, in the Prescriber Agreement Form, prescribers of mifepristone agree to report certain adverse events such as hospitalizations and blood transfusions to the drug's sponsor. C.A. Add. 802. FDA concluded based on "15 years of reporting" that the requirement was no longer warranted and that, as with numerous other drugs, information on non-fatal adverse events could instead be "collected in the periodic safety update reports and annual reports" submitted by the drug's sponsor to FDA. Ibid.

3. In 2019, FDA approved an application of another sponsor, GenBioPro, to market a generic version of mifepristone based on FDA's determination that it was therapeutically equivalent to Mifeprex. D. Ct. Doc. 1-37; see 21 U.S.C. 355(j). The same REMS covers both versions of the drug. D. Ct. Doc. 1-37, at 1-2.

4. In April 2021, to avoid requiring women to make unnecessary clinical visits during the pandemic, FDA announced that it would exercise its discretion not to require the sponsors to enforce the REMS's in-person dispensing requirement. C.A. Add. 841. FDA explained that its decision "was the result of a thorough scientific review by experts" who evaluated evidence including "clinical outcomes data and adverse event reports." Ibid.

C. Respondents' Citizen Petitions

Before filing a suit challenging FDA's decision to take or refrain from taking action with respect to a drug, a party must file a citizen petition with FDA. 21 C.F.R. 10.45(b). Respondents filed two citizen petitions relevant here.

In 2002, two respondents filed a petition asking FDA to withdraw its 2000 approval of mifepristone. C.A. Add. 804. FDA denied the petition in March 2016, on the same day it approved modifications to mifepristone's indication, labeling, and REMS. C.A. Add. 804-836. FDA explained that "adequate and well-controlled clinical trials" had "supported the safety of Mifeprex" at the time of the 2000 approval, and that "over 15 years of postmarketing data and many comparative clinical trials in the United States and elsewhere continue to support [its] safety." Id. at 820.

In 2019, two respondents filed a petition challenging FDA's 2016 changes to mifepristone's indication, labeling, and REMS. C.A. Add. 192-217. In December 2021, FDA denied that petition in relevant part. Id. at 837-876. FDA determined that "the in-

person dispensing requirement" -- which was already subject to enforcement discretion -- "is no longer necessary to assure the safe use of mifepristone." Id. at 842. In addition to reviewing the available scientific literature, FDA relied on data showing that "mifepristone may be safely used without in-person dispensing" and that "there does not appear to be a difference in adverse events when in-person dispensing was and was not enforced." Id. at 863; see id. at 863-872. FDA thus directed Danco and GenBioPro to initiate the process of modifying the REMS. Id. at 842-843; see 21 U.S.C. 355-1(g)(4)(B). And in 2023, after this suit was filed, FDA approved the sponsors' applications to remove the in-person dispensing requirement from the REMS. FDA, Risk Evaluation & Mitigation Strategy (REMS) Single Shared System for Mifepristone 200 mg (Jan. 2023), https://perma.cc/MJT5-35LF.

D. Proceedings Below

1. In November 2022, respondents filed this suit in the U.S. District Court for the Northern District of Texas, challenging six FDA actions spanning more than twenty years: the 2000 approval of Mifeprex; the 2016 REMS changes; the 2019 approval of generic mifepristone; the 2021 exercise of enforcement discretion; and the 2016 and 2021 denials of respondents' citizen petitions. C.A. Add. 161-177. Respondents sought a preliminary injunction ordering FDA to suspend all of those actions. App., infra, 47a.

The district court directed the parties to submit briefs "on whether the court should consolidate the injunction hearing and

the trial on the merits." D. Ct. Doc. 32. Respondents urged the court to defer ruling on their motion for a preliminary injunction until after the production of the administrative record and a full trial on the merits, D. Ct. Doc. 68, at 4-9, but the court ultimately declined that request to delay consideration of whether to issue preliminary relief, D. Ct. Doc. 117.

2. On the evening of Friday, April 7, the district court granted respondents' motion for preliminary relief. App., infra, 43a-109a. The court rejected the government's arguments that respondents lack standing, id. at 48a-59a, and that some of their claims were untimely, id. at 60a-67a. On the merits, the court held that FDA's actions were arbitrary and capricious, largely based on the court's own interpretation of extra-record publications. Id. at 91a-102a. The court separately held that statutory provisions derived from the 1873 Comstock Act prohibited FDA from removing the in-person dispensing requirement. Id. at 74a-80a; see 18 U.S.C. 1461-1462. Although respondents styled their motion as seeking a preliminary injunction, the district court instead invoked 5 U.S.C. 705 to "stay" the effective date of "FDA's September 28, 2000 Approval of mifepristone and all subsequent challenged actions" -- even though those actions had already been in effect for many years. App., infra, 107a-109a. The court stayed its order for seven days to allow the government to seek emergency relief from the Fifth Circuit. Id. at 109a.

3. On Monday, April 10, the government and Danco sought stays pending appeal and administrative stays to allow the Fifth Circuit and this Court to consider their stay requests in an orderly fashion. At 11:55 p.m. ET on Wednesday, April 12, a divided panel issued a 42-page order granting a stay in part, denying it in part, and denying the requested administrative stay. App., infra, 1a-42a.[2]

The panel majority first held that respondents likely have Article III standing. App., infra, 10a-23a. It reasoned that some fraction of women who take mifepristone will experience adverse events or require surgical abortions, id. at 12a-13a; that some fraction of that fraction will seek emergency care, id. at 13a; that respondents have alleged that some of their members have been asked to provide such care in the past, id. at 12a-14a; that "it's inevitable that one of the thousands of doctors in [respondent] associations will" be asked to provide such care in the future, id. at 18a; and that this "statistical certainty" satisfies Article III, id. at 17a. The majority also held that respondents have standing to challenge FDA's 2016 changes to the adverse-event reporting requirements because they allege that they have spent

[2] Judge Haynes would have granted an administrative stay and deferred the stay motions to the merits panel. App., infra, 2a. The panel unanimously denied respondents' motion to dismiss the appeals, explaining that the district court's order was appealable under 28 U.S.C. 1292(a) because it had "the practical effect of an injunction." App., infra, 8a n.3 (citing Abbott v. Perez, 138 S. Ct. 2319-2320 (2018)).

"time, energy, and resources to compensate for this lack of information by conducting their own studies." Id. at 22a.

The panel majority next held that respondents' challenge to FDA's 2000 approval of mifepristone was likely time-barred, App., infra, 23a-30a, although the court considered that a "close call" and resolved the issue based only on being "unsure" about it "at this preliminary juncture and after truncated review," id. at 25a. The court next held that respondents' challenge to the 2016 changes was timely because they sued within six years after FDA's 2021 decision denying their citizen petition seeking to reverse those changes. Id. at 23a; see 28 U.S.C. 2401(a). The panel also held that although respondents had not challenged the 2023 REMS changes, which occurred only after this suit was filed, those changes were also subject to review. App., infra, 6a n.2. And although the district court had not purported to grant relief as to the 2023 changes, the panel majority appeared to view its order as suspending them as well. Id. at 7a, 18a, 40a.

Turning to the merits, the panel majority held that respondents were likely to succeed on their claim that FDA's 2016 and 2021 actions were arbitrary and capricious. App., infra, 33a-35a. As to the 2016 changes to mifepristone's conditions of approval, the panel acknowledged that FDA had relied on studies showing that each change was safe. Id. at 35a. But it asserted that FDA acted arbitrarily because it had identified "zero studies that evaluated the safety-and-effectiveness consequences of the 2016 Major REMS

changes as a whole." Ibid. The court further held, without explanation, that FDA acted arbitrarily in changing the adverse-event reporting requirement in 2016. Ibid. And it concluded that FDA acted arbitrarily in deciding in 2021 that it could eliminate the in-person dispensing requirement because the agency relied in part on adverse-event data that was supposedly tainted by the changed reporting requirement. Ibid. The court's merits discussion did not mention FDA's 2019 approval of generic mifepristone. Id. at 33a-35a.

On the balance of the equities, the panel majority stated that FDA had not shown that the suspension of seven years' worth of its regulatory actions would impose any irreparable harm on the agency. App., infra, 36a. And the majority believed that the stay preserving the 2000 approval of mifepristone eliminated any irreparable harm to Danco. Id. at 37a. On the other side of the ledger, the majority relied on its conclusion that FDA's challenged actions impose "non-speculative" injuries on respondents. Id. at 38a. Finally, the majority stated that its analysis of the equities was informed by the Comstock Act. Id. at 40a-42a. The majority did not adopt the district court's reading of the Act and did not rely on it in holding that respondents were likely to succeed on the merits. But it stated that "[t]o the extent the Comstock Act introduces uncertainty into the ultimate merits of the case, that uncertainty favors the plaintiffs." Id. at 42a.

The panel majority directed that the case be expedited and assigned to the next available oral argument calendar. App., infra, 42a. The Fifth Circuit has scheduled argument for May 17.

E. The Washington Injunction

In the meantime, a few minutes after the district court issued its order, another district court enjoined FDA from "altering the status quo" with respect to mifepristone's availability in certain States. Washington v. FDA, No. 23-cv-3026, Doc. 80 at 30 (E.D. Wash. Apr. 7, 2023). The government moved for clarification, highlighting the apparent tension between that injunction and the district court's order here and seeking to understand FDA's obligations under the injunction if the order in this case takes effect. Yesterday, the Washington court responded by stating that its injunction "must be followed" "irrespective of the Northern District of Texas Court ruling or the Fifth Circuit's anticipated ruling." No. 23-cv-3026, Doc. 91 at 5-6 (E.D. Wash. Apr. 13, 2023).

ARGUMENT

An applicant for a stay pending appeal and certiorari must establish (1) "a reasonable probability that this Court would eventually grant review," (2) "a fair prospect that the Court would reverse," and (3) "that the applicant would likely suffer irreparable harm absent the stay" and "the equities" support relief. Merrill v. Milligan, 142 S. Ct. 879, 880 (2022) (Kavanaugh, J., concurring). Each of these considerations weighs decisively in

favor of staying the district court's destabilizing order in full and preserving a status quo that has been settled for years.

I. THIS COURT WOULD LIKELY GRANT REVIEW IF THE COURT OF APPEALS AFFIRMED THE DISTRICT COURT'S ORDER

This Court's review would plainly be warranted if the Fifth Circuit affirmed the district court's order -- whether as a whole or as limited to FDA's post-2015 actions.

If affirmed in full, the district court's order would impose an unprecedented and profoundly disruptive result: Neither respondents nor the courts below identified any prior decision abrogating FDA's approval of a drug based on a disagreement with the agency's judgment about safety or effectiveness. In taking that step here, the district court countermanded a scientific judgment FDA has maintained across five administrations; nullified the approval of a drug that has been safely used by millions of Americans over more than two decades; and upset reliance interests in a healthcare system that depends on the availability of mifepristone as an alternative to surgical abortion for women who choose to lawfully terminate their early pregnancies.

A decision upholding the district court's order as limited to the post-2015 changes would be similarly unprecedented and destabilizing. As FDA's Principal Deputy Director has explained, the immediate effect of that order is to effectively prevent the introduction of mifepristone into interstate commerce until FDA and the drug's sponsors can take the steps necessary to update the

drug's labeling to be consistent with the obsolete conditions of approval that the lower courts have abruptly mandated. App., infra, 115a-116a. And it is unclear how FDA could take those steps without risking contempt under the Washington injunction.

Quite apart from those destabilizing practical consequences, a decision affirming the district court's order in whole or in part would warrant this Court's review because of its profound legal errors. No prior decision has endorsed the lower courts' view that an organization can challenge agency action based on speculation that it will result in future injuries to third parties that some unknown physicians who are members of the organization might be asked to treat. And no prior decision has endorsed the lower courts' approach to reviewing FDA's decisions regarding drug approvals and REMS, which would deeply disrupt the pharmaceutical industry. Indeed, industry participants have already warned that, "[i]f allowed to take effect, the district court's decision will result in a seismic shift in the clinical development and drug approval processes, erecting unnecessary and unscientific barriers to the approval of lifesaving medicines, chilling drug development and investment, threatening patient access, and destabilizing the pharmaceutical industry." Pharmaceutical Companies C.A. Amicus Br. 24-25.

II. THE GOVERNMENT IS LIKELY TO SUCCEED ON THE MERITS

If the Court granted review, it would likely reverse the district court's order because respondents lack standing and their

claims fail on the merits. All of FDA's actions addressing mifepristone were amply supported by the record and entirely consistent with applicable law.

A. Respondents Lack Article III Standing

Under Article III, "a plaintiff must show (i) that he suffered an injury in fact that is concrete, particularized, and actual or imminent; (ii) that the injury was likely caused by the defendant; and (iii) that the injury would likely be redressed by judicial relief." TransUnion LLC v. Ramirez, 141 S. Ct. 2190, 2203 (2021). To establish injury in fact, respondents were required to show "an invasion of a legally protected interest" that is both "concrete and particularized" and "actual or imminent, not conjectural or hypothetical." Spokeo, Inc. v. Robins, 578 U.S. 330, 339 (2016) (citation omitted). Thus, "'allegations of possible future injury' are not sufficient." Clapper v. Amnesty Int'l USA, 568 U.S. 398, 409 (2013) (brackets and citation omitted). Respondents fall far short of making those showings.

Respondents oppose abortion and therefore oppose the use of mifepristone. But respondents "are not required to receive" or prescribe mifepristone, and "[t]hey do not have standing to challenge FDA's decision to allow other people to receive" or prescribe the drug because that decision does not impose any concrete, particularized, or imminent harm on respondents. Coalition for Mercury-Free Drugs v. Sebelius, 671 F.3d 1275, 1277 (D.C. Cir. 2012) (Kavanaugh, J.). "The Constitution therefore requires that [re-

spondents] direct their objections to the Executive and Legislative Branches, not to the Judiciary." Id. at 1283. The Fifth Circuit identified no sound basis for avoiding that straightforward conclusion.

1. Respondents and their members are not required to prescribe mifepristone to their patients and do not purport to do so. Instead, the Fifth Circuit held that respondents have Article III standing on the theory that other providers will prescribe mifepristone to patients; that some small fraction of those other providers' patients will experience (extremely rare) serious adverse events; that some subset of that small fraction of patients, who by definition chose to have an abortion, will then seek care from respondents or their members, doctors opposed to abortion with whom they lack any prior relationship; and that patients will do so in sufficient numbers to burden those physicians' medical practices or to require them to provide emergency medical treatment against their consciences. App., infra, 11a-18a.

To describe that theory is to refute it. This Court has repeatedly rejected theories of standing that rest on a "speculative chain of possibilities," Clapper, 568 U.S. at 414, especially where, as here, those possibilities depend on "unfettered choices made by independent actors," Lujan v. Defenders of Wildlife, 504 U.S. 555, 562 (1992) (citation omitted). In Clapper, for example, this Court reversed a decision finding standing based on "an objectively reasonable likelihood" that plaintiffs would suffer in-

jury from the challenged policy. 568 U.S. at 410. The Court emphatically rejected that probabilistic approach as "inconsistent with [the] requirement that 'threatened injury must be certainly impending.'" Ibid. (citation omitted). So too here.

The court of appeals relied on respondents' allegation that some of their members have treated complications from mifepristone in the past. App., infra, 13a-17a. But even though mifepristone has been taken by millions of women and respondents claim to have thousands of members practicing around the country, C.A. Add. 75-77, they allege only sporadic incidents. See D. Ct. Docs. 1-8 at 5–6, 1-9 at 4–9, 1-10 at 6–7, 1-11 at 5–6, 1-53 at 5. And in any event, even assuming that treating a patient qualifies as a legally cognizable Article III injury to a doctor, standing to seek prospective relief cannot be based on such "past injury"; instead, plaintiffs must show an "imminent future injury." Summers v. Earth Island Institute, 555 U.S. 488, 495 (2009).

Respondents have not done so. Instead, their theory mirrors the "hitherto unheard-of test for organizational standing" that this Court flatly rejected in Summers, 555 U.S. at 497 -- a decision neither court below even acknowledged. Summers explained that it "would make a mockery" of Article III to find associational standing whenever, based on an "organization's self-description of the activities of its members, there is a statistical probability that some of those members are threatened with concrete injury." Id. at 497-498. Yet that is precisely what the Fifth Circuit did

here: It held that "even if one of the named doctors never sees another patient, it's inevitable that one of the thousands of doctors in plaintiff associations will." App., infra, 18a.

Under the Fifth Circuit's "novel" standing analysis, Summers, 555 U.S. at 498, associations of doctors could sue to challenge any government action that might affect the practices of one or another of their associations' members. Pulmonologists could sue the Environmental Protection Agency to challenge regulations that increased (or reduced) air pollution; pediatricians could sue the Department of Agriculture to challenge standards that imperiled (or improved) student nutrition; and emergency room doctors could sue the government to challenge regulations that loosened (or restricted) access to firearms. That extravagant concept of standing is not the law.

2. The Fifth Circuit suggested that its decision is "narrow" because the "record" here supposedly demonstrates that "hundreds of thousands of women will * * * need emergency care" after using mifepristone, and "plaintiff doctors and their associations will necessarily be injured by the consequences." App., infra, 19a. Under Summers, those assertions would not establish Article III injury even if they were correct. But they are incorrect.

Indeed, the Fifth Circuit fundamentally misunderstood the record. The court relied on the statement in the Patient Agreement Form that "in about 2 to 7 out of 100 women who use [mifepristone and misoprostol]," "the treatment will not work." App., infra,

12a ¶ 6. In that event, the Form advises the patient to "talk with [her] provider" -- not one of respondents or their members, who do not prescribe mifepristone -- "about a surgical procedure to end [her] pregnancy." Ibid. The Fifth Circuit reasoned that because FDA's 2016 and 2023 decisions allow healthcare providers who are not physicians to prescribe mifepristone, women could not go to such a prescriber for a surgical abortion and must seek "emergency care" from a qualified physician. Id. at 13a. The court then calculated that FDA's own documents "prove that emergency room care is statistically certain in hundreds of thousands of cases" and that respondent doctors are "statistically certain" to provide emergency care in the future. Id. at 22a.

The court of appeals badly misread the document on which it purported to rely. The relevant paragraph of the Form states that for 2 to 7 percent of women, "the treatment will not work," App., infra, 12a -- i.e., that it will not be effective in completely terminating their pregnancies -- and that the patients will then talk with their providers about the alternative of a surgical procedure.[3] This paragraph does not address "emergency care" at all. The subject of "emergency care" is instead addressed in a different paragraph, which identifies certain indicia of condi-

[3] The court of appeals erred to the extent it suggested that an "unsuccessful" treatment will always require a surgical procedure in an operating room. App., infra, 13a. As FDA explained in evaluating the 2016 changes, "when a 'failure'" of mifepristone occurs, "options that are now commonly available include" "expectant management (wait and see)," and "additional doses of misoprostol." C.A. Add. 793.

tions that "could require emergency care," and states that the patient's provider has informed her to contact her provider or another person specified by her provider in that instance. Ibid.[4]

The actual incidence of serious adverse events that would require emergency care is extremely low. The mifepristone labeling indicates, for example, that sepsis and hemorrhage rates are each 0.2% or less and that rates of transfusion and hospitalization related to medical abortion are each 0.7% or less. See Mifepristone Labeling at 8, https://perma.cc/PU3Y-7TSK; see also C.A. Add. 786-787. And there is no reason to assume that any woman in need of emergency care would go to a hospital where one of respondents' members happened to be present, or that the member would be compelled to assist in a procedure that was contrary to his beliefs. See, e.g., 42 U.S.C. 238n, 300a-7(c) & (d) (federal conscience protections); Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, Div. H., Tit. V, §§ 506-507 (similar). Indeed, FDA requires all prescribers to either have the "[a]bility to provide surgical intervention" where necessary or to "ma[k]e plans to provide such care through others." Mifepristone Prescriber Agreement Form, https://perma.cc/MJT5-35LF. There is thus no basis to conclude patients will go to respondents' emergency rooms rather than

[4] The court of appeals also relied (App., infra, 20a-21a) on the "Black Box" warnings for mifepristone. But the 2016 warning states that "[s]erious and sometimes fatal infections and bleeding occur very rarely following" miscarriage, surgical abortion, and medical abortion -- and that "[n]o causal relationship between the use of [mifepristone] and misoprostol and these events has been established." Id. at 21a.

follow other plans put in place by their providers. See, e.g., C.A. Add. 848 (explanation from FDA about common referral practice).

3. The Fifth Circuit also committed another fatal error. It is axiomatic that "standing is not dispensed in gross; rather, plaintiffs must demonstrate standing for each claim that they press and for each form of relief that they seek." TransUnion, 141 S. Ct. at 2208. Here, the Fifth Circuit held that respondents' challenge to FDA's original 2000 approval of mifepristone is likely time barred, and that they can only challenge FDA's subsequent changes to the conditions of approval. The court thus should have asked whether respondents are injured by the incremental effects of those changes. But the court did not even purport to do that. Instead, it asked whether respondents are injured by the availability of mifepristone as a general matter. See, e.g., App., infra, 12a-13a (counting every adverse event in its statistical analysis). In other words, the Fifth Circuit did precisely what TransUnion forbids, dispensing standing to challenge all actions related to mifepristone "in gross" rather than asking whether respondents have standing "for each claim" and "form of relief." 141 S. Ct. at 2208.

Nor is that a mere technicality. Even accepting the Fifth Circuit's flawed mode of analysis and dubious statistics, it is exceedingly implausible that the incremental effects of the changes made in 2016, 2021, and 2023 contribute to a sufficient

number of adverse events to establish the "statistical certainty" that the Fifth Circuit purported to require. App., infra, 17a. The court certainly pointed to no studies or other reliable evidence suggesting that the changes in the conditions for use that it allowed to remain suspended have had a substantial effect on the likelihood of adverse events that would require women to seek emergency care from respondents or their members. In fact, the record demonstrates that adverse events remain extremely infrequent with the relevant changes in place. See, e.g., C.A. Add. 658-659 (reporting adverse events received by FDA through June 30, 2021); id. at 874 (study finding "no statistically significant difference between the overall complication rates between an 'at home' and 'at the hospital' abortion"); id. at 431 (showing lower rates of hospitalization for medication as compared to surgical abortion); see also Mifepristone U.S. Post-Marketing Adverse Events Summary through 06/30/2022, https://perma.cc/LAM4-KVDZ.

4. Finally, the Fifth Circuit briefly held that the respondent associations have standing based on allegations that, in light of FDA's changes to adverse event reporting requirements in the REMS governing prescribers, respondents have spent "time, energy, and resources" to "conduct[] their own studies and analyses of available data." App., infra, 22a. But the court of appeals cited no precedent suggesting that a plaintiff suffers Article III injury merely because the government changes reporting requirements applicable only to third parties. Here, any injury from

those changes is entirely "self-inflicted," Clapper, 568 U.S. at 418. And in any event, even if the court of appeals were correct to find standing based on respondents' alleged informational injury, that would support, at most, an order requiring greater reporting. It would not justify staying all of the agency's 2016 changes and the actions that followed.

B. FDA's Actions Were Lawful

Even if respondents could establish Article III standing, their claims fail on the merits. The Fifth Circuit's contrary conclusion -- which the court supported with a scant three paragraphs of analysis -- rests on a series of fundamental errors.

1. 2016 Changes to Conditions of Approval

a. In 2016, FDA approved an application to change mifepristone's conditions of approval by, as relevant here, (a) increasing the gestational age limit from seven to ten weeks; (b) reducing the number of required clinical visits from three to one; and (c) allowing non-physician health care providers to prescribe and dispense mifepristone. C.A. Add. 768-775. This Court has repeatedly admonished that, in reviewing such claims under the APA's deferential arbitrary-and-capricious standard, a court's role is to "simply ensur[e] that the agency has acted within a zone of reasonableness." FCC v. Prometheus Radio Project, 141 S. Ct. 1150, 1158 (2021). And where, as here, the parties disagree on matters relating to public health, "courts owe significant deference to the politically accountable entities with the 'background, compe-

tence, and expertise to assess public health.'" Food & Drug Admin. v. Am. Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578, 579 (2021) (Roberts, C.J., concurring in grant of application for stay) (citation omitted); id. at 584 (Sotomayor, J. dissenting) ("agree[ing] that deference is due" when FDA has documented its scientific judgment in a "reasoned decision").

FDA's approval of the 2016 changes was plainly "reasonable and reasonably explained." Dep't of Commerce v. New York, 139 S. Ct. 2551, 2571 (2019). FDA based its decision on an exhaustive review of "data gained in the last 20 years from millions of women in the US and abroad," among other information. C.A. Add. 693; see id. at 678-679 (listing 14 "major studies and review articles covering over 45,000 women"); id. at 751-758 (listing 79 total publications examining safety and efficacy). And FDA carefully explained how the available scientific evidence supported each change. Id. at 781-785. To take just a few examples:

- Increase in gestational age. FDA examined safety and efficacy data from nearly two dozen studies. C.A. Add. 689-698, 790-791. "[F]our studies" and a "systematic review" including "over 30,000" women had "evaluated the exact proposed dosing regimen through 70 days gestation." Id. at 782. These publications showed that mifepristone's success rate at later stages of pregnancy was "comparable to (and in several studies, greater than) the success rates for medical abortion in the initial 2000 decision for Mifeprex up to 49 days gestation." Id. at 698.

- Reduction in clinical visits. FDA relied on nearly a dozen studies involving "large numbers of women in the U.S." and other countries, all of which showed that permitting women to complete the two-drug protocol at home was "associated with exceedingly low rates of serious adverse events, and

with rates of common adverse events comparable to those in the studies of clinic administration of misoprostol that supported the initial approval in 2000." C.A. Add. 791; see also id. at 700 (citing studies); id. at 708 (discussing "studies including well over 30,000 patients" that "demonstrat[ed] an acceptable safety profile").

- Prescriptions by licensed non-physicians. FDA relied on "four studies with 3,200 women in randomized controlled clinical trials and 596 women in prospective cohorts." C.A. Add. 785. Those studies found "no differences in efficacy, serious adverse events, ongoing pregnancy or incomplete abortion" depending on whether a physician provided the drug. Id. at 739. In fact, one study found that mifepristone was more effective when provided by nurses instead of physicians. Id. at 785.

b. The Fifth Circuit was thus demonstrably wrong when it asserted that FDA "failed to 'examine the relevant data'" because it "eliminated REMS safeguards based on studies that included those very safeguards." App., infra, 34a (citation omitted). As just shown, each of the challenged changes was supported by studies showing that mifepristone is safe and effective when dispensed and used pursuant to the revised conditions. The court accordingly was forced to acknowledge that FDA did rely on studies that did not include the conditions it decided could be safely eliminated. Id. at 35a. The court's holding that the 2016 changes were arbitrary and capricious thus ultimately rests on its assertion that FDA failed to cite a study that evaluated the effects of those changes "as a whole." Ibid. In other words, the court appeared to hold that FDA cannot change a drug's conditions for approval unless it can cite a single study that combines all of the relevant changes. That holding contradicts settled principles of adminis-

trative law, the FDCA, and common sense. And it is factually incorrect in any event.

First, the APA requires an agency to review the record before it, "reasonably consider[] the relevant issues," and "reasonably explain[] [its] decision." Prometheus, 141 S. Ct. at 1158. Here, FDA grounded its judgment in a voluminous body of medical evidence on the widespread, worldwide use of mifepristone over decades. And the agency carefully explained why the available data supported its conclusion that the 2016 changes would allow the drug to continue to be used safely and effectively -- as in fact it has been. C.A. Add. 720-727, 790-793.

The Fifth Circuit did not claim that FDA ignored any study in the administrative record. Nor did it identify any evidence that combining the proposed changes would lead to unsafe outcomes. Indeed, the relevant paragraph of the court's order does not cite the record at all. App., infra, 35a. Instead, the court demanded that studies be conducted to produce evidence that would meet a legal requirement that does not exist. But as this Court explained in rejecting a similar argument, it was not arbitrary or capricious for FDA to "rel[y] on the data it had (and the absence of any countervailing evidence) to predict" that changes it had determined were safe individually would also be safe collectively. Prometheus, 141 S. Ct. at 1159.

Second, the Fifth Circuit's "study match" requirement finds no support in the FDCA. Congress directed FDA to evaluate drug

safety based on "the information submitted * * * as part of the application" and "any other information" before the agency. 21 U.S.C. 355(d)(4). No provision requires FDA to limit approval conditions to the precise protocols in clinical trials or existing studies. If Congress had intended such a requirement, it would have imposed one. Instead, Congress granted FDA broad authority to "exercise [its] discretion or subjective judgment in determining whether a study is adequate and well controlled." Weinberger v. Hynson, Westcott & Dunning, Inc., 412 U.S. 609, 621 n.17 (1973).

Nor is there any scientific basis for a "study match" requirement. As FDA explained, "[m]any clinical trial designs are more restrictive * * * than will be necessary or recommended in post-approval clinical use; this additional level of caution is exercised until the safety and efficacy of the product is demonstrated." C.A. Add. 831. FDA thus routinely approves drugs with conditions that differ from clinical trial protocols. For example, routine biopsies were performed in trials for menopause hormonal therapy drugs to establish their safety, but FDA did not require biopsies in those drugs' approved conditions of use. Id. at 831, 470-473, 517-518; see, e.g., id. at 530, 563 (for Aveed, liver function tests required in clinical trials but not approved conditions of use); id. at 599, 632 (for Cialis, same for electrocardiograms); id. at 634, 654 (for Lipitor, same for routine measurement of creatinine kinase levels).

Finally, the Fifth Circuit was wrong on the record. Numerous studies FDA examined combined aspects of the challenged modifications, such that FDA relied on data from those studies "to support multiple changes." C.A. Add. 781. And FDA considered at least two studies that closely mirrored all challenged aspects of the 2016 conditions. Sanhueza Smith et al. 2015 (cited at C.A. Add. 782 n.3) considered the relevant dosing regimen through 70 days' gestation, with the only difference from the 2016 changes being an in-person visit to the clinic seven days after taking mifepristone to assess abortion status. Similarly, Winikoff et al. 2012 (cited at C.A. Add. 782 n.1) was also consistent with the 2016 changes, except the authors required study participants to have a gestational age of 57 through 70 days confirmed using ultrasound. The studies FDA reviewed thus strongly supported the agency's conclusion that the combined modifications would not change the well-established effectiveness or safety profile of mifepristone.

c. The district court -- but not the Fifth Circuit -- also questioned the substance of FDA's assessment of the data before the agency, highlighting some reports of particularly serious events, including deaths. E.g., App., infra, 96a. But the fact that a drug is associated with an adverse event for reporting purposes does not mean that it actually caused that event. As of June 2022, only 28 deaths had been reported among the more than 5 million women who have taken mifepristone, and some of them had obvious alternative causes -- including homicide, drug overdose,

and other factors entirely unrelated to mifepristone. See Mifepristone U.S. Post-Marketing Adverse Events Summary through 06/30/2022, https://perma.cc/LAM4-KVDZ. In addition, pregnancy itself entails a significantly higher risk of serious adverse events, including a death rate 14 times higher than that associated with legal abortion. C.A. Add. 807.[5]

Regardless, the FDCA does not require FDA to approve drugs only when they are without risk -- no drug is -- but instead to consider whether "the expected therapeutic gain justifies the risk entailed by its use." United States v. Rutherford, 442 U.S. 544, 555 (1979); see 21 U.S.C. 355(d) (FDA must make a "risk-benefit assessment" that "balance[s] consideration of benefits and risks"). That is what FDA did here. Although FDA has acknowledged that serious adverse events can occur with mifepristone use, it found that they are "exceedingly rare." C.A. Add. 707. And it concluded that the evidence relating to the proposed changes "d[id] not suggest a safety profile different from the original approved Mifeprex dosing regimen." Id. at 787.

[5] The district court premised many of its conclusions about mifepristone's safety on its own lay interpretation of articles, studies, and websites identified by respondents, their amici, or the court itself. Some of those publications were never submitted to FDA, and others post-date the challenged FDA actions. For example, in concluding that no women should have access to mifepristone on the theory that it is harmful to their mental health, the court relied on a 2021 article based on fewer than 100 anonymous blog posts submitted to a website entitled Abortion Changes You, App., infra, 88a; see Katherine A. Rafferty & Tessa Longbons, #AbortionChangesYou: A Case Study to Understand the Communicative Tensions in Women's Medication Abortion Narratives, 36 Health Comm. 1485, 1492 (2021) https://perma.cc/K69Y-FJXQ.

2. 2016 Change To Adverse Event Reporting Requirements

FDA's 2016 action also changed the requirement that prescribers of mifepristone agree to report certain adverse events such as hospitalizations and blood transfusions to the drug's sponsor -- a requirement that applied above and beyond FDA's standard reporting requirements for drug sponsors, which are applicable to all drugs. C.A. Add. 802, 856. FDA determined that "after 15 years of reporting serious adverse events, the safety profile for Mifeprex is essentially unchanged," id. at 802, and that the continued reporting of non-fatal adverse events by prescribers under the REMS was "not warranted" because mifepristone's "known risks occur[] rarely," id. at 856. While FDA changed the requirement for certified prescribers to report certain adverse events to the sponsor, FDA did not alter the detailed adverse event reporting requirements applicable to mifepristone's sponsors (Danco and, today, GenBioPro). As FDA explained (id. at 856), those companies remained (and still remain) under an obligation to report all "serious and unexpected" adverse events to FDA within 15 days, and to report all other adverse events annually. See 21 C.F.R. 314.80, 314.98.

The Fifth Circuit appeared to hold that FDA's change to the reporting requirement was arbitrary and capricious (and it must have done so, because it left intact the portion of the district court's order suspending it). App., infra, 35a. But the Fifth

Circuit did not even acknowledge -- much less find any fault with -- FDA's explanation for the change.

3. Removal Of In-Person Dispensing Requirement

The lower courts likewise erred in concluding that FDA acted arbitrarily and capriciously by eliminating the in-person dispensing requirement for mifepristone. The agency originally relied on its FDCA authority to require in-person dispensing, but it decided to lift that requirement in 2021 because the evidence showed that such a requirement was no longer needed to assure mifepristone's safe use -- and thus that the FDCA no longer justified a prohibition on filling a prescription for mifepristone at a retail pharmacy or by mail. C.A. Add. 863-872. FDA's decision "was the result of a thorough scientific review by experts within FDA's Center for Drug Evaluation and Research (CDER), who evaluated relevant information, including available clinical outcomes data and adverse event reports." Id. at 841.[6]

The Fifth Circuit suggested that because FDA had, as part of the 2016 changes, eliminated a requirement for prescribers to report non-fatal adverse events to the sponsor, it was "unreasonable" for FDA to "use the resulting absence of data to support its decision." App., infra, 35a. This assertion misunderstands the

[6] FDA formalized the removal of the in-person dispensing requirement in 2023, after respondents filed suit. Respondents did not challenge that decision in their complaint, and the district court did not purport to invalidate it. But the Fifth Circuit nonetheless concluded that it could review -- and, apparently, suspend -- FDA's 2023 decision anyway. App., infra, 6a n.2; see id. at 7a, 40a.

record. As explained above, when FDA changed the reporting requirements under the REMS for certified prescribers to report certain adverse events to the sponsor, it left undisturbed the detailed reporting requirements governing mifepristone's sponsors. See p. 35, supra. And as FDA explained, adverse event reports are contained in the FDA Adverse Reporting System (FAERS) database, which FDA "routinely monitors." C.A. Add. 862. FDA's decision to remove the in-person dispensing requirement thus incorporated information about all adverse event reports it had received, including non-fatal adverse events. See ibid. The court of appeals was thus badly mistaken in asserting that FDA took an "ostrich-head-in-the-sand" approach. App., infra, 35a.

Moreover, adverse event reports were not the only evidence FDA considered in 2021. FDA also specifically sought out data from the drug's sponsors and from other sources and concluded that the nonenforcement of the in-person dispensing requirement during periods in 2020 and 2021 did not appear to affect adverse event rates. C.A. Add. 861-862. FDA also relied on "an extensive review of the published literature," including studies that "examined replacing in-person dispensing in certain healthcare settings" with "dispensing at retail pharmacies" and "dispensing mifepristone from pharmacies by mail." Id. at 864. FDA's analysis of those studies spans nearly ten full pages in the record. Id. at 863-872. But the Fifth Circuit did not even acknowledge it or explain why it was insufficient.

III. THE REMAINING FACTORS OVERWHELMINGLY FAVOR A STAY

Absent a stay from this Court, the lower courts' orders will upend the status quo and scramble the complex regulatory regime governing mifepristone. That disruptive result would profoundly harm women, the Nation's healthcare system, FDA, and the public interest. By contrast, respondents' alleged harms are attenuated, speculative, and do not remotely justify upending the status quo.

1. The Fifth Circuit appeared to believe that it was averting the most disruptive consequences of the district court's order because it stayed the suspension of the original approval of the drug. But the immediate effect of the Fifth Circuit's own order would be almost equally disruptive: All extant doses of mifepristone would immediately become misbranded, the generic version of the drug would cease to be approved, and the branded version could not be marketed until FDA and the sponsor sort through the current uncertainty and take steps to bring the drug's labeling and other conditions into compliance with the new legal regime the lower court has abruptly imposed -- a process that FDA currently estimates could take "months." App., infra, 115a-116a; see id. at 113a-114a (describing necessary changes to labeling, prescriber agreements, patient agreements, and provider certifications, among other steps).

The resulting loss of access to mifepristone would be profoundly damaging. For many patients, mifepristone is the best method to lawfully terminate their pregnancies. They may choose

mifepristone over surgical abortion because of medical necessity, a desire for privacy, or past trauma. C.A. Add. 321-323, 330-337, 350-351. Surgical abortion can be an invasive medical procedure with greater health risks for some patients, such as those who are allergic to anesthesia. Id. at 184-186, 319-320, 330, 333, 342, 349-350, 808.

Those harms will be felt in every State. Many States broadly permit first-trimester abortions. Even in States with more restrictive laws, abortion is lawful under circumstances where mifepristone may be the best treatment option. See, e.g., Tex. Health & Safety Code § 170A.002(b) (certain health risks); Miss. Code Ann. §§ 41-41-34.1, 41-41-45(2) (rape). Thus, notwithstanding the court of appeals' partial stay, the district court's order will foreclose or make it more difficult for residents in all States to access a treatment option that may best serve their needs.

Limiting access to mifepristone further harms patients by unnecessarily burdening the healthcare system. Patients who must seek surgical abortions will face long waits for care from a limited number of providers capable of providing them, generating harms to them, their families, and providers. C.A. Add. 294-303. Other patients will experience related harms, as they too wait for healthcare in a system with limited providers and resources being unnecessarily diverted to surgical abortions. Ibid.

2. The Fifth Circuit suggested that FDA itself would not suffer "any irreparable harm" absent a stay. App., infra, 36a.

But the interests of the government and the public "merge" in this context. Nken v. Holder, 556 U.S. 418, 435 (2009). And "[a]ny time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury." Maryland v. King, 567 U.S. 1301, 1303 (2012) (Roberts, C.J., in chambers) (brackets and citation omitted). A fortiori that must be true for the federal government, which is responsible for implementing Acts of Congress that serve and protect the people of all the States. This Court thus has not hesitated to grant stays where nationwide lower court orders have frustrated significant government policies or programs -- including, as particularly relevant here, FDA's judgments about the appropriate conditions on mifepristone's approval. FDA v. Am. Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578 (2021); see, e.g., DHS v. New York, 140 S. Ct. 599 (2020). FDA is irreparably harmed when it is blocked from fulfilling its statutory responsibilities in accordance with its scientific judgment.

FDA is also irreparably harmed by the disruptive practical effects of the district court's order. As the foregoing discussion makes clear, the Fifth Circuit's order has already required, and would continue to require, an enormous expenditure of resources to sort through the "difficult and novel questions" it creates and to make the necessary adjustments to the regulatory scheme. App., infra, 115a. And that harm has been greatly exacerbated by the lower courts' arbitrarily compressed timelines.

Finally, FDA faces an obvious threat of irreparable harm from conflicting court orders. For FDA to authorize continued distribution of mifepristone consistent with the lower courts' orders in this case, the sponsor would have to submit a supplemental NDA, which FDA in turn would have to review and approve, with prescribing information and REMS materials that conform to the pre-2016 conditions of use. App., infra, 113a-115a. But it is far from clear how FDA could take those actions without contravening the preliminary injunction issued by the district court in the Washington litigation: Any action FDA takes to adjust mifepristone's labeling or other conditions of approval to account for the changes wrought by the lower courts' orders in this case risks being challenged as an action that "alter[s] the status quo" with respect to mifepristone's availability. Washington v. FDA, No. 23-cv-3026 (E.D. Wash. Apr. 7, 2023).

3. The Fifth Circuit sought to buttress its equities analysis with a tentative invocation of statutory provisions derived from the 1873 Comstock Act. In their current form, those provisions restrict the importation, mailing, or interstate distribution by common carrier of drugs "intended for producing abortion," among other items. 18 U.S.C. 1461-1462. The Fifth Circuit neither endorsed the district court's view that those provisions categorically prohibit the mailing of mifepristone nor relied on the Act in holding that respondents were likely to succeed on the merits. Instead, the Fifth Circuit concluded that "[t]o the extent the

Comstock Act introduces uncertainty into the ultimate merits of the case, that uncertainty favors plaintiffs." App., infra, 42a. But no such uncertainty exists because the Comstock Act does not prohibit the mailing of mifepristone for lawful abortions.

As originally enacted, the Comstock Act prohibited selling drugs for "causing unlawful abortion" (among other items) in federal territories, Act of Mar. 3, 1873, § 1, 17 Stat. 598, 598-599; mailing drugs for "procuring of abortion," id. § 2; and importing the "hereinbefore-mentioned articles," id. § 3. The next year, Congress clarified that the importation restriction, like the federal territory restriction, was limited to drugs for "causing unlawful abortion." Rev. Stat. § 2491 (1st ed. 1875), 18 Stat. pt. 1, at 460 (emphasis added). Despite "slight distinctions in expression," the Act's restrictions were part of a unified scheme, and courts and the Postal Service consistently interpreted all of the restrictions relating to contraceptives and abortions as limited to articles to be used unlawfully. United States v. One Package, 86 F.2d 737, 739 (2d Cir. 1936); see id. at 740 (Learned Hand, J., concurring); see also Application of the Comstock Act to the Mailing of Prescription Drugs That Can Be Used for Abortions, 46 Op. O.L.C. ___, at 5-11 (Dec. 23, 2022) (reprinted at C.A. Add. 258-278) (collecting cases). And Congress ratified that established judicial and administrative construction by repeatedly amending the Comstock Act without material change after that construction had been specifically called to the "attention of Con-

gress" in a Historical and Revision Note set out in the United States Code itself in 1948. Id. at 12-15 (C.A. Add. 269-272); see 18 U.S.C. 1461 note.

The court of appeals ignored that history, emphasizing what it regarded as the Act's "plain text." App., infra, 40a. But reading the words in their context and with a view to their place in the overall statutory scheme, the Act never prohibited the distribution of abortion drugs for lawful uses. See FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 133 (2000). At most the texts of the various provisions are internally inconsistent: The statute does not uniformly specify whether it applies to drugs for "any" or only "unlawful" abortion. 18 U.S.C. 1461-1462. Various versions of the statute used "abortion" and "unlawful abortion" interchangeably (and one, 19 U.S.C. 1305(a), still includes the adjective). And neither of the lower courts cited even a single prior decision holding that the Comstock Act prohibits the mailing of drugs for otherwise-lawful purposes. There was accordingly no basis to conclude that the Comstock Act somehow impairs FDA's showing on the balance of the equities.

4. On the other side of the ledger, respondents have failed to establish any non-speculative injury, much less the type of irreparable harm that might justify upending the status quo for FDA, providers, mifepristone's sponsors, and the public. See pp. 20-28, supra. Respondents waited more than three years before filing their citizen petition challenging the 2016 changes and did

not file this suit until nearly a year after that petition was denied. Respondents also encouraged the district court to consolidate their preliminary injunction motion with a bench trial, demonstrating that their interests would not be prejudiced by forgoing preliminary relief and waiting months for trial. See C.A. Add. 362. Respondents' own conduct thus confirms that there is no basis -- in either irreparable harm or the broader equities -- for extraordinary nationwide relief that would inflict grave harm on women, the medical system, the agency, and the public.

* * *

The course of this litigation has been troubling at every level. The district court granted sweeping nationwide relief to respondents with only the most threadbare claim of injury. It did so based on a series of novel and unsupportable rulings. And even though the court's order upset a longstanding status quo and neither respondents nor the court itself had been moving with any particular urgency, the court imposed a seven-day clock on its administrative stay, forcing the parties to brief complex and important questions in a matter of days.

Rather than extending the district court's arbitrary deadline with an administrative stay, the court of appeals issued a 42-page order only hours after the briefing on the motion concluded. That order completely transformed the case: The Fifth Circuit declined to adopt much of the district court's reasoning, injected new legal issues, expanded the agency actions under review, and granted a

partial stay without apparent appreciation for its disruptive practical consequences. The court of appeals did all that just 48 hours before the district court's order is set to take effect -- yet it refused to grant even a modest reprieve to allow this Court to consider the government's stay request in an orderly fashion.

Issues of such imperative public importance should not be litigated in this manner. This Court should stay the district court's opinion in full and maintain the long-settled status quo pending the completion of orderly appellate review. But given the profound disruption and grave harm the lower courts' orders would produce, in no event should they take effect without further merits review. If this Court declines to stay the orders, it may wish to grant an administrative stay, construe this application as a petition for a writ of certiorari before judgment, grant the petition, and set this case for expedited briefing and argument on a schedule that would allow it to be argued and decided before the Court's summer recess.

CONCLUSION

The application to stay the district court's order should be granted. The Court should also grant an immediate administrative stay while it considers this application.

Respectfully submitted.

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