Nos. 25A1207 & 25A1208

In The

Supreme Court of the United States

DANCO LABORATORIES, L.L.C.,
Applicant,

v.

THE STATE OF LOUISIANA, ET AL.,
Respondents

GENBIOPRO, INC.,
Applicant,

v.

STATE OF LOUISIANA, BY & THROUGH ITS ATTORNEY GENERAL, LIZ MURRILL, ET AL.,
Respondents

ON APPLICATIONS FOR STAY OF THE JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT
No. 26-30203

BRIEF OF AMICI CURIAE DISABILITY RIGHTS EDUCATION AND DEFENSE FUND ET AL. IN SUPPORT OF APPLICATIONS BY DANCO LABORATORIES, L.L.C. AND GENBIOPRO, INCORPORATED TO STAY OR VACATE THE FIFTH CIRCUIT'S STAY PENDING APPEAL

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INTERESTS OF THE AMICI[1]

Amici are disability organizations, scholars, and others[2] dedicated to advancing the civil and human rights of disabled people. Amici have a strong interest in ensuring that disabled people have equitable access to reproductive health care—including mifepristone delivered through mail or at pharmacies—so they can make autonomous decisions that protect their health and lives.

Amici submit this brief to provide the Court with a disability rights perspective absent from the parties' briefing. Reinstating the in-person dispensing requirement for mifepristone would violate the Food and Drug Administration Amendments Act of 2007 and Section 504 of the Rehabilitation Act, strip providers and pharmacies of their ability to meet independent obligations under the ADA, and compound the structural barriers disabled people already face in obtaining reproductive health care. For disabled people, those compounded harms are profound and irreparable.

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that they authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than amici or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

[2] Disability Rights Education and Defense Fund; American Association of People with Disabilities Autistic Self Advocacy Network; Autistic Women and Nonbinary Network; New Disabled South; Women Enabled International; Robyn Powell, PhD, JD, Assistant Professor, Stetson University College of Law (in an individual capacity and not representative of the institution); Ruth Colker, Distinguished University Professor and Heck Faust Memorial Chair in Constitutional Law at Moritz College of Law, Ohio State University (in an individual capacity and not representative of the institution); Tony Coelho, former U.S. Congressman, Founder of The Coelho Center for Disability Law, Policy, and Innovation; Katherine Pérez, Director of the Coelho Center for Disability Law, Policy, and Innovation, and Visiting Professor of Law at Loyola Law School (in an individual capacity and not representative of the institution).

The individual amici and their relevant background are listed below:

Disability Rights Education and Defense Fund ("DREDF") is a national nonprofit law and policy organization dedicated to protecting and advancing the civil rights of disabled people. Founded in 1979 and board- and staff-led by disabled people since its inception, DREDF pursues its mission through litigation, education, advocacy, and law reform. DREDF has a particular interest in ensuring that disabled people have full and meaningful access to mifepristone through modes of delivery—including mail and pharmacy dispensing—that address the well-documented barriers disabled people face to in-person care.

American Association of People with Disabilities ("AAPD") is a national cross-disability nonprofit dedicated to increasing the political and economic power of disabled people and advancing the rights of the more than 60 million Americans with disabilities. AAPD has a strong interest in ensuring that disabled people can access mifepristone on equal terms with others, including through mail and pharmacy dispensing—modalities that are, for many disabled people, the only practical means of overcoming the well-documented barriers to in-person care.

Autistic Self Advocacy Network ("ASAN") is a national nonprofit run by and for autistic people. ASAN advocates against stigmatization and discrimination, promotes access to health care in integrated community settings, and educates the public about the access needs of autistic people. Because autistic people often face significant sensory, logistical, and attitudinal barriers to in-person clinical settings,

ASAN has a particular interest in preserving accessible modes of reproductive health care delivery—including mail and pharmacy dispensing of mifepristone.

Autistic Women & Nonbinary Network ("AWN") provides community support, resources, and advocacy for Autistic women, girls, transfeminine and transmasculine nonbinary people, trans people of all genders, Two Spirit people, and all people of marginalized genders or of no gender. AWN is committed to reproductive justice and has a strong interest in preserving mail and pharmacy dispensing of medications like mifepristone for communities who face compounded barriers to in-person care.

New Disabled South is a regional nonprofit dedicated to improving the lives of disabled people and cultivating disability rights and disability justice frameworks across the South. Disabled people in the South face some of the most severe barriers to reproductive health care in the country—including provider shortages, limited transportation, and concentrated poverty—making mail and pharmacy dispensing of mifepristone an essential lifeline. Any restriction on those modalities will cause immediate, concrete harm to the communities New Disabled South serves.

Women Enabled International ("WEI") advances human rights and justice at the intersection of gender and disability, centering the voices of women, girls, and gender-diverse disabled people globally. WEI has documented how women and gender-diverse disabled people face compounded barriers to reproductive health care that make mail and pharmacy dispensing of mifepristone indispensable to their ability to exercise reproductive autonomy on equal terms with others.

Professors Robyn Powell, Ruth Colker, and Katherine Pérez, and former Congressman Tony Coelho participate as amici in their individual capacities, bringing decades of combined expertise in disability rights, health care law, and federal civil rights. Their scholarship and advocacy address disabled people's rights to access health care—including reproductive health care—on equal terms with others. They share a strong interest in ensuring that federal law is construed to account for the well-documented barriers disabled people face, and that mail and pharmacy dispensing of mifepristone, which for many disabled people is the only practical means of access, is preserved.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Amici support the applications to stay or vacate the Fifth Circuit's stay pending appeal. Leaving that order in place will strip disabled people of accessible options for obtaining mifepristone—a safe and essential reproductive health care medication—in direct conflict with federal law. The order contravenes the Food and Drug Administration Amendments Act of 2007 and Section 504 of the Rehabilitation Act of 1973, prevents providers and pharmacies from fulfilling their independent obligations under the ADA, and inflicts concrete and irreparable harm on disabled people by foreclosing access to care.

Maintaining the stay will exacerbate the substantial barriers disabled people already face—physical inaccessibility, transportation limitations, financial strain, and entrenched medical bias. For many, mail and pharmacy dispensing of mifepristone is not a convenience but a critical safeguard. That is especially true for disabled people who rely on others for daily assistance: that reliance can compromise

privacy and autonomy, and disabled people already experience heightened rates of reproductive coercion and intimate partner violence. Eliminating remote access removes a vital layer of safety and control.

The stakes are grave. Disabled people face elevated risks of severe pregnancy-related complications, worsening underlying conditions, and death. For some, being forced to continue a pregnancy is life-threatening. Remote access to mifepristone is not merely important—it is, for some, the difference between life and death.

Allowing the stay to stand will force patients into a demonstrably inaccessible system of care and cause profound, irreparable harm to pregnant people with disabilities. The Court should grant the applications**.**

ARGUMENT

I. THE FIFTH CIRCUIT'S REINSTATEMENT OF THE IN-PERSON DISPENSING REQUIREMENT VIOLATES FEDERAL LAW.

A. Congress Prohibited REMS Requirements That Unduly Burden Patient Access, Particularly For Patients With Functional Limitations.

Reinstatement of the in-person requirement in the Food and Drug Administration's 2023 Risk Evaluation and Mitigation Strategy ("REMS") contradicts congressional intent. By removing the in-person requirement in the 2023 REMS, the Food and Drug Administration ("FDA") eliminated a barrier to reproductive care that perpetuated access inequities and harmed disabled people, consistent with its mandate under the Food and Drug Administration Amendments Act of 2007 ("FDAAA"), Pub. L. No. 110-85, 121 Stat. 823 (2007), to strike the appropriate balance between patient safety and access to care.

Congress enacted the FDAAA to strengthen and expand the FDA's authority over prescription drug, vaccine, and medical device regulations to ensure their safety and effectiveness.[3] From the outset, Congress recognized that expanded regulatory authority carried the risk of restricting patient access. A central concern in the enactment of the FDAAA was therefore how to balance legitimate safety objectives against the equally vital need to ensure that patients can actually obtain medically appropriate care.[4]

The REMS framework was Congress's solution to this problem. The statute permits the FDA to impose additional conditions on prescribing or dispensing, but only to the extent necessary to ensure safe use. Critically, Congress made clear that REMS must not impede patient access. As then-Senator Tom Coburn emphasized before passage, restrictions on distribution "should not be imposed where less burdensome approaches are available" and must not impose "unduly restrictive actions" on patients.[5]

Consistent with these statutory constraints, Congress directed that REMS strike the appropriate balance: allowing the FDA to impose additional safety measures where necessary, while ensuring that patients retain access to medications

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[3] Susan Thaul, Cong. Rsch. Serv., RL34465, *FDA Amendments Act of 2007* 1 (2010).

[4] *Id.* at 2.

[5] 153 Cong. Rec. S11831, S11839–40 (daily ed. Sept. 20, 2007) (statement of Sen. Coburn).

that can be used safely.[6] To that end, the statute expressly prohibits REMS requirements that are "unduly burdensome on patient access to the drug," requiring the FDA to "consider[] in particular" the impact on: (i) patients with serious or life-threatening diseases or conditions; and (ii) patients who have difficulty accessing health care, (such as patients in rural or medically underserved areas).[7]

In 2018, Congress further strengthened these protections by amending the FDAAA to require explicit consideration of the burdens REMS impose on "patients with functional limitations."[8] This amendment reflects Congress's recognition that disabled people face distinct and compounding barriers to accessing health care, and that regulatory requirements can create significant obstacles.

In lifting the in-person requirement for mifepristone in 2023, the FDA acted squarely within this framework—concluding, based on evidence and in response to concerns raised by health care providers and advocacy organizations, that the restriction was no longer necessary and was actively harming patient access.[9] The Fifth Circuit's order overrides that determination. It reinstates a burden Congress

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[6] *See* 21 U.S.C. § 355-1(f).

[7] 21 U.S.C. § 355-1(f)(2)(C)(i)– (ii).

[8] 21 U.S.C. § 355-1(f)(2)(C)(iii), as amended by Pub. L. No. 115-271, tit. III, § 3032(b).

[9] Ctr. for Drug Evaluation & Research, Application Nos. 020687 & 91178 (Dec. 16, 2021) REMS Modification Rationale Review, No. 6:25-CV-01491 (W.D. La.), ECF No. 1-51, at 17–18 (discussing research indicating that, "if the in-person dispensing requirement for mifepristone were removed, . . . there may be a potential doubling" of obstetrician-gynecologists prescribing mifepristone to their patients).

specifically directed the FDA to avoid, on a population Congress specifically directed the FDA to protect.

B. Reinstatement of the In-Person Requirement Violates the Anti-Discrimination. Mandates of Section 504 And The ADA.

The Fifth Circuit's order contravenes two independent but convergent federal mandates. Section 504 of the Rehabilitation Act ("Section 504) applies directly to the FDA as a federal agency, prohibiting it from operating programs in ways that deny disabled people equal access to health care. 29 U.S.C. § 794. The Americans with Disabilities Act ("ADA") applies separately to the health care providers and pharmacies through which mifepristone reaches patients, requiring them to ensure that disabled individuals have equal opportunity to obtain the same benefit as nondisabled individuals. 42 U.S.C. §§ 12101(a)(3), 12132, 12182(a).

Both statutes require covered entities to ensure that disabled individuals have "equal opportunity to obtain the same result [or] to gain the same benefit" as nondisabled individuals. *Alexander v. Choate*, 469 U.S. 287, 301 (1985); 28 C.F.R. §§ 35.130(b)(1)(ii), 84.4(b)(1)(ii). To achieve that standard, covered entities bear an affirmative obligation to make reasonable modifications to their programs and services unless modification would fundamentally alter their nature. *Alexander*, 469 U.S. at 300–01; *Tennessee v. Lane*, 541 U.S. 509, 533 (2004); 28 C.F.R. §§ 35.130(b)(7)(i), 36.302(a). Courts of appeals have applied this obligation consistently

in health care settings, holding covered entities accountable for failures to modify absent a showing of undue burden or fundamental alteration.[10]

Reinstatement of the in-person requirement violates both statutes simultaneously. As to the FDA, it reimposed an access barrier on a population Congress specifically directed federal agencies to protect under Section 504. As to health care providers and pharmacies, it mandates elimination of the very modification through which those entities would otherwise meet their independent ADA obligations. Mail and pharmacy dispensing of mifepristone preserves meaningful access without fundamental alteration. Both statutes require that it remain available.

C. An In-Person Dispensing Mandate Is An Unlawful Structural Barrier Under Both The FDAAA And Federal Disability Nondiscrimination Law.

The Fifth Circuit's order operates as a structural barrier to care that violates both the FDAAA's prohibition on unduly burdensome REMS and federal disability nondiscrimination law. For the substantial number of disabled people who face documented, systemic disability-related barriers to in-person clinical access—including inaccessible facilities, lack of accessible transportation, provider bias, and financial hardship—the in-person mandate eliminates access to mifepristone and the reproductive health benefits it provides as part of a non-surgical, private option for

[10] *See Henrietta D. v. Bloomberg*, 331 F.3d 261, 273–76 (2d Cir. 2003) (analyzing ADA and Section 504 together and treating claims under both identically); *Liese v. Indian River Cnty. Hosp. Dist.*, 701 F.3d 334, 342–45 (11th Cir. 2012) (Section 504).

early abortion and miscarriage management. Both statutory frameworks prohibit precisely this type of barrier.

Under the FDAAA, the FDA may impose elements to assure safe use only to the extent necessary to mitigate identified safety risks, and it must ensure that such elements are not "unduly burdensome on patient access to the drug."[11] Congress specifically directed the Agency to consider the impact of REMS on patients with serious or life-threatening conditions, patients in medically underserved areas, and—following the 2018 amendment—patients with functional limitations. An in-person dispensing requirement that forecloses access to mifepristone by mail and at pharmacies, despite substantial evidence that the medication can be used safely without such a restriction, will impose exactly the kind of unnecessary access barrier Congress sought to prevent. Where a less burdensome alternative exists that achieves the Agency's safety objectives—as mail and pharmacy dispensing does here—reinstating an in-person mandate contravenes the statute's express command.

Federal disability law prohibits unnecessary barriers that deny disabled people equal access to health care. Congress recognized this denial often results from indifference to predictable burdens,[12] and that architectural, transportation, communication, and policy-based barriers function as mechanisms of discrimination.

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[11] 21 U.S.C. § 355-1(f)(2)(C).

[12] *See, e.g., Alexander*, 469 U.S. at 295 (recognizing that, in passing Section 504, "[d]iscrimination against the handicapped was perceived by Congress to be most often the product, not of invidious animus, but rather of thoughtlessness and indifference—of benign neglect").

An in-person dispensing mandate imposed without medical necessity will re-entrench those very barriers by conditioning access to a safe and essential medication on physical presence in clinical settings that many disabled people cannot safely, affordably, or privately navigate. When a regulation foreseeably deprives disabled people of timely access to medically necessary care—despite the availability of a safe and less burdensome alternative—it violates this statutory balance.

The Fifth Circuit's order will therefore not merely alter the method by which mifepristone is obtained. It will reimpose a structural barrier that Congress has expressly instructed federal agencies and regulated entities to avoid: a medically unnecessary condition that impedes access for patients with functional limitations and denies disabled people equal access to care. Under both the FDAAA and federal disability nondiscrimination law, such a barrier is unlawful.

II. THE FIFTH CIRCUIT'S ORDER REINSTATING THE IN-PERSON DISPENSING REQUIREMENT FOR MIFEPRISTONE WILL IMMEDIATELY AND IRREPARABLY HARM DISABLED PEOPLE.

Telemedicine has fundamentally expanded access to health care for people with disabilities, who face significant barriers to reproductive health care.[13] A 2025

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[13] *See* M. Antonia Biggs et al., *Access to Reproductive Health Services Among People with Disabilities*, 6 JAMA Network Open e2344877 (2023) (reporting that 69% of respondents with disabilities experienced barriers to accessing reproductive health care) [*hereinafter* Biggs, *Access to Reproductive Health*], https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812360; *see also* Tara Lagu et al., *Access to Subspecialty Care for Patients with Mobility Impairment*, 158 Annals Internal Med. 441 (2013) (finding that 44% of gynecology practices that were surveyed could not accommodate a patient with a mobility disability)

study found that 44.5% of people with disabilities used telemedicine in the prior year, most often for accessibility.[14] That reliance reflects necessity, not preference: disabled people routinely confront inaccessible health care facilities and equipment, inaccessible transportation, logistical hurdles such as arranging personal assistance, financial constraints, and persistent provider bias. These barriers collectively result in delayed, foregone, or wholly denied care.

Against this backdrop, telemedicine-based prescribing of mifepristone—dispensed by mail or pharmacy—is not simply a convenient alternative; it is a critical means of ensuring timely, accessible, and medically necessary reproductive health care for people with disabilities.[15] The current dispensing framework, which permits certified prescribers to evaluate patients via telemedicine and authorize mail or pharmacy dispensing, directly reduces or eliminates the access barriers that routinely prevent disabled people from obtaining in-person care. Eliminating mail and pharmacy dispensing of mifepristone would dismantle these gains. Disabled people who cannot navigate inaccessible clinics, secure accessible transportation, arrange personal care support, or take leave from caregiving responsibilities would be functionally excluded from this medication altogether—not because it is

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[*hereinafter* Lagu, *Access to Subspecialty Care*], https://pubmed.ncbi.nlm.nih.gov/23552258/.

[14] Nayoung Kim et al., *Understanding Telehealth Among U.S. Adults with Disabilities: Utilization Patterns, Associated Factors, and Motivations for Utilization*, 57 Am. J. Health Educ. 56 (2025).

[15] *See* Biggs, *Access to Reproductive Health*, *supra* note 13, at 10.

unavailable in the abstract, but because the only means of access that accounts for their disability-related needs will have been stripped away. Such a restriction would not merely inconvenience disabled people; it would deny them equal access to a time-sensitive medical intervention, with profound consequences for their health, autonomy, and reproductive lives.

A. Mail And Pharmacy Dispensing Of Mifepristone Protects The Privacy, Safety, And Medical Independence Of Disabled People By Reducing Exposure To Third-Party Coercion And Abuse.

Mail and pharmacy dispensing of mifepristone safeguards the health care privacy and reproductive autonomy of pregnant people with disabilities. Because many disabled people face significant transportation and logistical barriers, they often must rely on others to attend in-person medical appointments.[16] In the context of reproductive care, this reliance can force the disclosure of deeply private medical decisions and expose disabled patients to interference, pressure, or retaliation—turning in-person requirements from logistical hurdles into threats to autonomy.[17]

Mail and pharmacy dispensing of mifepristone allows disabled people to obtain care privately, without having to disclose their medical decisions to and risk coercion by third parties. The Fifth Circuit's reinstatement of the in-person dispensing requirement strips away this critical layer of protection.

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[16] Stephen Brumbaugh, *Travel Patterns of American Adults with Disabilities* (U.S. Dep't of Transp., Sept. 2018), https://www.bts.gov/sites/bts.dot.gov/files/2022-01/travel-patterns-american-adults-disabilities-updated-01-03-22.pdf [*hereinafter* Brumbaugh, *Travel Patterns*].

[17] *See* Biggs, *Access to Reproductive Health*, *supra* note 13, at 10.

B. Mail And Pharmacy Dispensing Of Mifepristone Mitigates Pervasive Physical Barriers To In-Person Care, Including Inaccessible Facilities And Medical Equipment.

Physical barriers to in-person health care remain pervasive[18] despite decades of federal legal obligations.[19] Inaccessible medical buildings, examination rooms, and equipment routinely result in denials of care. In a recent study, every physician surveyed acknowledged that their practice contained physical barriers to care, including inaccessible facilities or equipment.[20] A separate study inspecting 2,389 primary care offices found that only 53% met all exterior access criteria and just 34.3% met interior office and restroom accessibility standards.[21]

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[18] *See* Nat'l Council on Disability, *The Current State of Health Care for People with Disabilities* 1, 49–50 (2009) [*hereinafter* NCD, *Current State of Health Care*]; Tara Lagu et al., *'I Am Not the Doctor for You': Physicians' Attitudes About Caring for People with Disabilities*, 41 Health Aff. 1387, 1389–90 (2022) [*hereinafter* Lagu, *Not the Doctor for You*], https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00475; Nancy R. Mudrick et al., *Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews*, 5 Disability & Health J. 159 (2012) [*hereinafter* Mudrick, *Physical Accessibility in Primary Settings*], https://dredf.org/wp-content/uploads/2015/02/Mudrick-Breslin-Liang-Yee-DHJO-article-V5-No3-2012.pdf; Nancy R. Mudrick et al., *Change Is Slow: Acquisition of Disability Accessible Medical Diagnostic Equipment in Primary Care Offices over Time*, 8 Health Equity 157 (2024); Lagu, *Access to Subspecialty Care*, *supra* note 13, at 443.

[19] 42 U.S.C. § 12182(a), (b); 42 U.S.C. § 12132; 29 U.S.C. § 794(a). *See also* U.S. Dep't of Justice Civil Rights Div., *Access to Medical Care for Individuals with Mobility Disabilities*, ADA.gov (last updated Jun. 26, 2020) [*hereinafter* DOJ, *Access to Medical Care*], https://www.ada.gov/resources/medical-care-mobility/ (summarizing U.S. Dep't of Just., *ADA Standards for Accessible Design* (Sept. 15, 2010)).

[20] Lagu, *Not the Doctor for You*, *supra* note 18, at 1389.

[21] Mudrick, *Physical Accessibility in Primary Settings*, *supra* note 18, at 163-64.

Inaccessible medical equipment is a particular barrier for people with mobility disabilities.[22] Adjustable exam tables, accessible weight scales, and accessible diagnostic equipment are essential to providing safe and equitable care,[23] yet remain rare in clinical settings. One study found that only 8.4% of primary care offices had an adjustable-height exam table and only 3.6% had an accessible weight scale.[24] A separate study of subspecialty practices found that gynecology offices reported the highest rates of inaccessibility—44%—primarily due to inaccessible equipment.[25]

Although HHS codified standards for accessible medical diagnostic equipment in 2024, providers are not required to have even a single accessible exam table until July 2026.[26] This prolonged regulatory gap has left many providers unprepared and unequipped to serve disabled patients. Some physicians report sending wheelchair users to grocery stores, zoos, or industrial facilities to obtain a weight measurement.[27]

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[22] *See* NCD, *Current State of Health Care*, *supra* note 18, at 49–50; *see also* Nat'l Council on Disability, *Enforceable Accessible Medical Equipment Standards* 1, 29–32 (2021).

[23] *See* DOJ, *Access to Medical Care*, *supra* note 19 (adjustable height exam tables allow wheelchair users to independently transfer onto an exam table without the risk of injury posed by assisted transfer and include features that support the person once on the table; accessible weight scales allow a wheelchair user to wheel their chair onto the scale and be weighed in their chair; and accessible diagnostic machines are designed to accommodate different types of body positions or allow a wheelchair user to utilize the machine while in their chair).

[24] Mudrick, *Physical Accessibility in Primary Settings, supra* note 18, at 164.

[25] *See* Lagu, *Access to Subspecialty Care, supra* note 13, at 444.

[26] 89 Fed. Reg. 40066, 40165 (May 9, 2024) (codified at 45 C.F.R. § 84.90 et seq.).

[27] Lagu, *Not the Doctor for You*, *supra* note 18, at 1389.

These experiences are not merely degrading—they are powerfully deterrent. Physical barriers cause disabled people to delay or avoid care, with consequences that can be medically catastrophic in the context of time-sensitive reproductive health decisions.

The current REMS allows disabled patients to avoid these physical and equipment-related barriers by accessing mifepristone through telemedicine and filling prescriptions by mail or at a local pharmacy. Reinstatement of the in-person requirement will eliminate this accessible alternative, forcing disabled people back into medical environments where physical barriers will predictably prevent or deter access to this essential medication.

C. Mail And Pharmacy Dispensing Of Mifepristone Alleviates Transportation And Logistical Barriers That Exclude Disabled People From Care.

Transportation barriers prevent millions of disabled people from accessing health care. Approximately 25.5 million people have disabilities that make travel difficult—including 3.6 million who do not leave their homes at all[28]— and nearly thirty percent of disabled people report difficulty accessing transportation.[29] Disabled people between the ages of eighteen and sixty-four are less likely to own or drive a vehicle[30] and more likely to rely on public transit or paratransit systems that are

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[28] Brumbaugh, *Travel Patterns*, *supra* note 16, at 1.

[29] U.S. Gen. Acct. Off., *Transportation – Disadvantaged Populations: Some Coordination Efforts Among Programs Providing Transportation Services, but Obstacles Persist* 6 (2003), http://tinyurl.com/6zzvbtuh.

[30] Brumbaugh, *Travel Patterns, supra* note 16, at 3.

unreliable, inaccessible, or unavailable.[31] In the context of time-sensitive reproductive health care, where delays can foreclose options entirely, these barriers are not merely inconvenient—they are determinative of access.[32]

Mail and pharmacy dispensing of mifepristone is critical for overcoming transportation and logistical barriers to reproductive care.[33] Where transportation would otherwise foreclose access, the ability to receive mifepristone by mail is a critical equalizer. Reinstating the in-person dispensing requirement would reintroduce transportation and logistical barriers to reproductive care, undoing the access that the 2023 REMS modification effectively secured.

D. Mail And Pharmacy Dispensing Of Mifepristone Reduces Financial Barriers That Prevent Disabled People From Accessing Care.

Disabled people face compounding financial barriers to health care. They are more than twice as likely to live in poverty, significantly more likely to be unemployed, and incur substantially higher costs of living due to disability-related expenses.[34] Mail and pharmacy dispensing of mifepristone mitigate these financial

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[31] NCD, *Current State of Health Care*, *supra* note 18, at 56, 77 (common transportation barriers for disabled people include "lack of public transportation in suburban and rural areas, difficulty scheduling rides, and difficulty relying on paratransit to get to appointments on time").

[32] *Id. See also* Brumbaugh, *Travel Patterns, supra* note 16, at 6.

[33] *See* Leah R. Koenig, *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, JMIR Pub. Health & Surveillance, July 11, 2023, https://doi.org/10.2196/45671.

[34] *See* Inst. on Disability, Univ. of N.H., Annual Disability Statistics Compendium 2026, tbl. 6.1 (2026), https://www.researchondisability.org/resource/2026-disability-statistics-compendium-adsc/section-6-poverty-compendium-2026 (reporting that in 2024, 23.6% of working-age people with disabilities lived in poverty, compared to 9.6%

burdens by eliminating travel costs, reducing time off work, and avoiding the need to arrange and pay for personal assistance to attend in-person appointments. Reinstatement of the in-person requirement will revive these financial barriers, resulting in the practical impossibility of equal access to mifepristone.

E. Mail And Pharmacy Dispensing Of Mifepristone Reduces Exposure To Discrimination And Medical Mistreatment That Deter Disabled People From Seeking Care.

Disabled people face widespread discrimination and mistreatment in reproductive health care settings, as well as heightened medical risk during pregnancy. These realities, combined with structural access barriers, can make it extraordinarily difficult for disabled people to seek and receive necessary care.[35] Reinstatement of the in-person dispensing requirement for mifepristone will exacerbate these harms by forcing disabled people into medical environments where discrimination and mistreatment remain pervasive.

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of people without disabilities); Bureau of Labor Statistics, U.S. Dep't of Labor, People with a Disability: Labor Force Characteristics — 2025, tbl. 1 (Mar. 2026), https://www.bls.gov/news.release/pdf/disabl.pdf (reporting that only 22.8% of people with a disability were employed in 2025, compared to 65.2% of people without a disability, and that approximately 75% of disabled people were not in the labor force at all, compared with roughly 32% of nondisabled people); Zofsha Merchant, Erin Troland & Douglas Webber, The Hidden Costs of Disability, FEDS Notes (Bd. of Governors of the Fed. Reserve Sys., Jan. 10, 2025), https://doi.org/10.17016/2380-7172.3686 (finding that the hidden financial costs of disability — those beyond the direct earnings penalty — are equivalent to a reduction in annual household income of approximately $25,000 for a two-adult household).

[35] Ctrs. for Disease Control & Prevention, *Disability Barriers to Inclusion* (Apr. 3, 2025), https://www.cdc.gov/disability-inclusion/barriers/.

It is disturbingly common for disabled people to report receiving fair or poor-quality care from their regular physicians and to experience medical mistreatment when seeking reproductive health services.[36] Physicians are often ill-equipped to provide disability-competent reproductive care and fail to dedicate the resources necessary to understand disability-related pregnancy risks.[37] Nearly half of disabled people report mistreatment in reproductive health care settings, including ridicule or humiliation by providers, dismissal of symptoms, or minimization of health concerns.[38] Consistent with these experiences, disabled adults are almost twice as likely to report unmet health care needs due to barriers to accessing care,[39] and women with disabilities frequently report negative or dismissive reactions from health care providers in response to their pregnancies.[40]

Physicians themselves acknowledge these deficiencies. Studies document a lack of education at all levels of medical training regarding pregnancy and disability,

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[36] Biggs, *Access to Reproductive Health*, *supra* note 13, at 6.

[37] Autistic Self Advocacy Network, *Access, Autonomy & Dignity: People with Disabilities and the Right to Parent* 9 (2021), https://nationalpartnership.org/wp-content/uploads/2023/02/repro-disability-parenting.pdf [*hereinafter* ASAN, *Right to Parent*].

[38] Biggs, *Access to Reproductive Health*, *supra* note 13, at 6 (36.5% reported medical mistreatment generally; 19.4% reported being ridiculed or humiliated; and 32.6% reported being made to feel like their symptoms were not real or important).

[39] ASAN, *Right to Parent, supra* note 37.

[40] Jessica L. Gleason et al., *Risk of Adverse Maternal Outcomes in Pregnant Women With Disabilities*, JAMA Network Open, Dec. 15, 2021, at e2138414, 8, https://doi.org/10.1001/jamanetworkopen.2021.38414 [*hereinafter* Gleason, *Risk of Adverse Maternal Outcomes*]; *see also* ASAN, *Right to Parent*, *supra* note 37, at 8.

as well as explicit bias against disabled patients.[41] Some providers report attempting to discharge disabled patients from their practices due to concerns about accommodating disabilities, insufficient reimbursement, or staff time constraints.[42] These attitudes directly affect clinical decision-making and patient treatment, resulting in delayed care, substandard care, or outright denial of services.[43]

Mail and pharmacy dispensing of mifepristone can reduce exposure to these discriminatory dynamics by allowing patients to access reproductive care in a setting that is more private, controlled, and—critically—less likely to subject them to bias based on visible disability. Reinstatement of the in-person dispensing requirement will needlessly re-expose disabled people to discriminatory medical environments, compounding their risk of harm and deterring them from seeking care altogether.

III. MAIL AND PHARMACY DISPENSED MIFEPRISTONE IS ESSENTIAL LIFE-PRESERVING HEALTH CARE FOR DISABLED PEOPLE WHO FACE ELEVATED RISKS OF COMPLICATIONS, INCLUDING DEATH.

Mifepristone is essential, and in many cases life-saving, health care for people with disabilities. Disabled people become pregnant at similar rates as nondisabled people yet they face dramatically elevated risks of severe pregnancy-related complications and maternal mortality.[44] Pregnant people with physical, intellectual,

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[41] Gleason, *Risk of Adverse Maternal Outcomes*, *supra* note 40, at 8.

[42] Lagu, *Not the Doctor for You*, *supra* note 18, at 1392–93.

[43] *See, e.g.,* Gleason, *Risk of Adverse Maternal Outcomes*, *supra* note 40, at 9.

[44] Lisa I. Iezzoni et al., *Prevalence of Current Pregnancy Among U.S. Women with and without Chronic Physical Disabilities*, 51 Med. Care 555, 562 (2013) (disabled people become pregnant at similar rates as people without disabilities); Gleason, *Risk of Adverse Maternal Outcomes*, *supra* note 40, at 2, 4–7 (finding that women with

and sensory disabilities experience significantly higher rates of nearly all adverse maternal outcomes, including sepsis, thromboembolism, severe cardiovascular events, infection, and hemorrhage.[45] These risks are not marginal; pregnant disabled people are approximately eleven times more likely to die during childbirth than nondisabled people.[46]

Certain disabilities, including epilepsy, diabetes, and achondroplasia, are associated with particularly elevated pregnancy risks.[47] Pregnancy may also exacerbate existing disabilities or require discontinuation of medications essential to managing conditions such as multiple sclerosis or bipolar disorder, leading to serious and avoidable health consequences.[48]

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disabilities had a higher risk of gestational diabetes, placenta previa, premature rupture of membranes, preterm premature rupture of membranes, and postpartum fever as well as maternal death).

[45] *Id.*

[46] Gleason, *Risk of Adverse Maternal Outcomes*, *supra* note 40, at 2, 4–7.

[47] *See* Sima I. Patel & Page B. Pennel, *Management of Epilepsy During Pregnancy: An Update*, 9 Therapeutic Advances in Neurological Disorders 118, 124 (2016) (showing people with epilepsy may be at higher risk of death, preeclampsia, premature rupture of membranes (PPROM), and chorioamnionitis (an infection of the placenta and the amniotic fluid) during pregnancy); Am. Diabetes Ass'n, *Standards of Care in Diabetes—2023 Abridged for Primary Care Providers*, 41 Clinical Diabetes 4, 28 (2022) (people with diabetes may be more likely to face complications including preeclampsia and miscarriage); Rauf Melekoglu et al., *Successful Obstetric and Anaesthetic Management of a Pregnant Woman With Achondroplasia*, BMJ Case Rep., Oct. 25, 2017, at bcr2017221238. (people with achondroplasia, the most common type of dwarfism, may face a higher risk of cardiac abnormalities, recurrent respiratory infections, complications involving anesthetics, increased caesarean delivery rates, and preterm birth).

[48] *See, e.g.,* Kerstin Hellwig et al., *Multiple Sclerosis Disease Activity and Disability Following Discontinuation of Natalizumab for Pregnancy*, JAMA Network Open, Jan.

These medical realities compound the systemic barriers to care that disabled people routinely face. For some, timely access to mifepristone is the only medically appropriate means of preventing catastrophic harm or death.[49]

Reinstatement of the in-person dispensing requirement will predictably delay or prevent access to care for precisely those patients who face the greatest medical risk. The harm is concrete and irreversible. The disabled people who depend on mail and pharmacy access to mifepristone face the complete loss of access if an in-person requirement is reinstated. For some, that loss carries life-threatening consequences.

CONCLUSION

24, 2022, at e2144750, 11, https://doi.org/10.1001/jamanetworkopen.2021.44750 (finding that ceasing treatment of natalizumab (a highly effective and frequently prescribed treatment for multiple sclerosis) directly before or during pregnancy resulted in MS relapses during pregnancy or postpartum, which were potentially life-threatening in one percent of the pregnancies); Adele C. Viguera et al., *Risk of Recurrence in Women with Bipolar Disorder During Pregnancy: Prospective Study of Mood Stabilizer Discontinuation*, 164 Am. J. Psychiatry 1817, 1818–21 (2007) (finding that pregnant women with bipolar disorder were significantly more likely to experience at least one mood episode when they had discontinued treatment with mood stabilizers (85.5%) than those who maintained treatment (37.0%)); *see also* Mayo Clinic, *Heart Conditions and Pregnancy: Know the Risks* (Aug. 10, 2023), https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/pregnancy/art-20045977.

[49] Kavitha Surana, *Afraid to Seek Care Amid Georgia's Abortion Ban, She Stayed at Home and Died*, ProPublica (Sept. 18, 2024) (woman with lupus and diabetes died because she was forced to order abortion pills online after Georgia abortion ban prevented her from getting legitimate prescription), https://www.propublica.org/article/candi-miller-abortion-ban-death-georgia; Jamie Ducharme, *For People With Disabilities, Losing Abortion Access Can Be a Matter of Life or Death*, Time (Jan. 25, 2023) (woman with connective-tissue disorder in Oklahoma forced to stockpile "morning-after pills" because pregnancy could cause her organ rupture and Oklahoma abortion ban prevents her from obtaining other means of abortion), https://time.com/6248104/abortion-access-people-with-disabilities/.

The 2023 REMS appropriately eliminated a medically unnecessary in-person dispensing requirement, opening accessible pathways to essential reproductive health care for people with disabilities. Reinstatement violates the FDAAA and Section 504, obstructs providers and pharmacies from fulfilling their ADA obligations, excludes disabled people from care they cannot obtain any other way, and exposes the most medically vulnerable to preventable harm, including death.

The Fifth Circuit's order does not advance patient safety. It does not serve the public health. It will dismantle an accessible, functioning system that protects the health, autonomy, and lives of millions of disabled people. For these reasons, Amici respectfully urge this Court to stay or vacate it.

Respectfully submitted,

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