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** Applications for admission pro hac vice forthcoming*

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Planned Parenthood Arizona, Inc.; William Richardson, M.D.; and William H. Richardson M.D., P.C., doing business as Tucson Women's Center, Plaintiffs, v. Will Humble, Director of the Arizona Department of Health Services, in his official capacity, Defendant.	Case No.

Plaintiffs Planned Parenthood Arizona, Inc. ("PPAZ"); William Richardson, M.D.; and William H. Richardson M.D., P.C., doing business as Tucson Women's Center (together, "Dr. Richardson"), by and through their attorneys, bring this Complaint against

the above-named Defendant, his employees, agents, delegates, and successors in office, and in support thereof state the following:

I. PRELIMINARY STATEMENT

1. Plaintiffs are Arizona health care providers who bring this civil rights action, seeking declaratory and injunctive relief, on behalf of themselves and their patients, under the United States Constitution and 42 U.S.C. § 1983, to challenge portions of Arizona House Bill 2036 of 2012 ("HB 2036"), Section 2, codified at A.R.S. § 36-449.03(E)(6) ("the Act") and its implementing regulation, A.A.C. R9-10-1508(G) ("the Regulation") (collectively, "the Arizona law") which, unless enjoined by this Court, will impair the health and safety of women seeking abortions in Arizona and violate their constitutional rights.[1]

2. If the Arizona law is allowed to stand, physicians in Arizona will not be able to care for their abortion patients according to the current standard of care recommended by the American Medical Association ("AMA") and the American College of Obstetricians and Gynecologists ("ACOG"); instead, they will be forced to practice medicine as it was practiced almost 20 years ago.

3. Under current law, Arizona women seeking to terminate an early pregnancy, like women nationwide, have the option of choosing a safe, non-surgical method of abortion using medications alone. This is referred to as "medication abortion." The medications used are mifepristone and misoprostol.

4. The U.S. Food and Drug Administration ("FDA") approved mifepristone for use in abortion in the United States in 2000. But medical research and physicians' clinical experiences do not stop after a medication is approved. Instead, as with other medications, the way that physicians prescribe abortion medications continued to evolve based on new medical research even before FDA approval, making medication abortion increasingly safer, more effective, effective until later in pregnancy, more accessible, and with fewer side effects. The practice of altering prescriptions to reflect clear, significant, generally

[1] Copies of the Act and Regulation are annexed hereto as Exhibit 1.

accepted developments in medical research is referred to as "off-label" or "evidence-based" medicine.

5. The current, evidenced-based regimen for medication abortion, which Plaintiffs offer their patients, has been recognized by the AMA and ACOG as preferable to the regimen that appears on the mifepristone label; it is safer, more effective, less expensive, less burdensome, and may be used later in pregnancy. This evidenced-based regimen is the standard of care.

6. The Arizona law, scheduled to take effect April 1, 2014, potentially bans medication abortion in Arizona altogether. At the very least, and without any medical justification, the law requires physicians to ignore decades of medical research, the opinion of leading medical organizations, and their own clinical experience, and administer medication abortion in an outdated and inferior manner.

7. Thus, however it is construed, the Arizona law unquestionably would prevent at least some of Plaintiffs' patients from obtaining a medication abortion, and any patients who could still access the procedure would be deprived of years of improvements in the standard of care. These effects would be harmful for Arizona women, particularly those with medical conditions that make medication abortion significantly safer than surgical abortion, as well as women who live outside of major metropolitan areas, low-income women, and women who are victims of rape or abuse.

8. For these reasons, the Arizona law violates the constitutional rights guaranteed to both Plaintiffs and their patients by the Fourteenth Amendment to the United States Constitution. Preliminary and permanent injunctive relief is necessary to protect the health of Arizona women and the constitutional rights of Plaintiffs and their patients.

II. JURISDICTION AND VENUE

9. Jurisdiction is conferred on this Court by 28 U.S.C. §§ 1331 and 1343(a)(3). Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202, by Rules 57 and 65 of the Federal Rules of Civil Procedure, and by the general legal and equitable powers of this Court.

10. Venue is appropriate under 28 U.S.C. §§ 1391(b)(1) and (2) because events giving rise to this action occur in this District and Defendant is located in this District.

III. THE PARTIES

A. Plaintiffs

11. Plaintiff PPAZ is a not-for-profit corporation organized under the laws of Arizona and is the largest provider of reproductive health services in Arizona, operating 11 health centers throughout the state and providing a broad range of reproductive and sexual health services, including cervical cancer screening, breast exams, testing and treatment for sexually transmitted infections, contraception, and surgical and medication abortion.

12. PPAZ has been providing medication abortions since 2001, and provides the evidence-based regimen recommended by AMA and ACOG through 63 days or nine weeks of pregnancy, measured from the first day of a woman's last menstrual period (LMP), which differs from the regimen that appears on the mifepristone label. This regimen includes screening all patients for contraindications, including ectopic pregnancies, before providing treatment. PPAZ currently provides medication abortions at four centers: Glendale Health Center, Margaret Sanger Health Center (in Tucson), Tempe Health Center, and Flagstaff Health Center. In 2013, PPAZ provided medication abortions to 2511 patients; 38 percent of eligible patients chose this procedure. PPAZ brings this action on behalf of itself, its patients, and the physicians it employs to provide services to its patients.

13. Plaintiff William Richardson, M.D., is a licensed, board-certified obstetrician-gynecologist in Tucson. He is the sole owner and director of Plaintiff Tucson Women's Center. Dr. Richardson provides comprehensive family planning and women's health services to over a thousand patients each year, from throughout southern Arizona and beyond, including pregnancy testing, prenatal care, contraception, prenatal ultrasounds, pregnancy options counseling, gynecological care, and surgical and medication abortions.

14. Dr. Richardson provides abortion services to about 900 women per year, nearly half of whom choose medication abortion. He opened Tucson Women's Center in 1999 and has been offering his patients medication abortion since 2001. He provides medication abortion using an evidence-based regimen recommended by AMA and ACOG

through 63 days LMP that differs from the regimen that appears on the mifepristone label. This regimen includes screening all patients for contraindications, including ectopic pregnancies, before providing treatment. Dr. Richardson brings this action on behalf of himself and his patients.

B. Defendant

15. Defendant Will Humble is the Director of the Arizona Department of Health Services ("DHS"). DHS promulgated the Regulation, and has the authority to enforce it as well as the Act. Defendant Humble is sued in his official capacity.

IV. FACTUAL ALLEGATIONS

A. Challenged Provisions of the Arizona Law

16. On April 10, 2012, the Arizona Legislature passed HB 2036, and on April 12, 2012, Governor Brewer signed it into law. Section 2 of that law, codified at A.R.S. § 36-449.03(E)(6), mandates that the Director of DHS adopt rules requiring "[t]hat any medication, drug or other substance used to induce an abortion is administered in compliance with the protocol that is authorized by the United States Food and Drug Administration and that is outlined in the final printing labeling instructions for that medication, drug or substance."

17. On November 21, 2013, pursuant to the legislative mandate in Section 2 of the Act, DHS posted "Draft Rules Issued for Abortion Clinics" online, and on November 29, 2013, the Secretary of State published a Notice of Public Information in the *Arizona Administrative Register*. The Online Survey was open for comments until December 19, 2013.

18. On January 27, 2014, without providing the two additional opportunities for comment that its own policy requires, *see* Office of Administrative Counsel & Rules, Rulemaking Process, Arizona Department of Health Services, Exempt Rulemaking Process, available at http://azdhs.gov/ops/oacr/rules/rulemakings/process.htm (click on "Exempt Rulemaking"), DHS promulgated the Regulation.

19. The Regulation requires the medical director of a facility licensed as an abortion clinic to "ensure that any medication, drug or other substance used to induce an abortion is administered in compliance with the protocol that is authorized by the United

States food and drug administration and that is outlined in the final printing labeling instructions for that medication, drug or substance." The Regulation's effective date is April 1, 2014.

20. Any clinic that fails to comply with these requirements is subject to a civil penalty, license suspension or revocation, or other enforcement actions by DHS. A.A.C. § R9-10-1515.

21. The medical director of any abortion clinic that is subject to such a penalty may also face disciplinary action against his or her medical license. *See* A.R.S. § 32-1401(27)(a) (defining "unprofessional conduct" as including "[v]iolating any federal or state laws, rules or regulations applicable to the practice of medicine").

22. The Arizona law applies only to abortion clinics. It does not apply to hospitals, regardless of how many abortions they perform, nor to independent physicians who perform fewer than five first-trimester abortions per month. *See* A.R.S. § 36-449.03 (setting out requirements for abortion clinics, including medication abortion restrictions); A.R.S. § 36-449.01(2) (defining "abortion clinic").

B. Existing Regulatory Framework for Abortion in Arizona

23. Abortion clinics are already heavily regulated under A.R.S. § 36-449 et seq. and A.A.C. R9-10-1501 et seq., and subject to regular inspections under A.R.S. § 36-425.

24. Women seeking an abortion, moreover, face a number of recently-enacted legislative hurdles. Under A.R.S. § 36-449.03(D)(4), § 36-2153, and § 13-3603.02, a woman must travel to a clinic at least 24 hours before her abortion, meet with a physician, undergo an ultrasound, hear a description of "the probable anatomical and physiological characteristics" of the fetus, discuss her reasons for choosing an abortion, and undergo state-directed counseling.

25. Other recent restrictions control from which health professionals a woman can obtain an abortion. Under A.R.S. § 36-449 et seq., A.R.S. § 32-2532, and A.A.C. R9-10-1501 et seq., women can only obtain an abortion from a physician, even though major medical associations have stated that physician assistants and registered nurse-practitioners ("RNPs") can safely provide this care early in pregnancy (as they were before the Arizona legislature banned these services).

26. Another provision of HB 2036, not challenged here, will require women to find, and travel to, a physician provider who has admitting privileges (or a back-up arrangement) at a hospital within 30 miles. HB 2036 § 2, codified at A.R.S. § 36-449.03(C)(3).

27. Largely as a result of these restrictions, the number of licensed abortion clinics in Arizona has shrunk over the past eight years from 16 to 10 (all of them concentrated in a few metropolitan areas), and many women must travel long distances, multiple times, to obtain an abortion.

C. Medication Abortion Background

28. Women seek abortions for a variety of medical, psychological, emotional, familial, economic, and personal reasons.

29. Approximately one in three women in the United States will have an abortion by age 45.

30. Most women having abortions (61 percent) already have at least one child, and most (66 percent) also plan to have children in the future—many when they are older, financially able to provide for them, and/or in a supportive relationship with a partner so their children will have two parents.

31. Currently, and for over a decade, Arizona women in the first nine weeks of pregnancy (through 63 days LMP) have had the option of choosing between a surgical procedure that takes place in a health center (surgical abortion) or a procedure using medications alone (medication abortion). Both are extremely safe and effective procedures.

32. A medication abortion involves a combination of two prescription drugs: mifepristone and misoprostol. Mifepristone, commonly known as "RU-486" or by its commercial name Mifeprex, works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol, sometimes known by its brand name Cytotec, causes the uterus to contract and expel its contents.

33. Under current practice, a patient takes the mifepristone at her health care facility and approximately 24 to 48 hours later, usually at home, she takes the misoprostol, thereby completing the abortion.

34. Used together, the medications mifepristone and misoprostol provide an extremely safe and effective method of abortion, one of the safest procedures in contemporary medical practice. Major complications from medication abortion are extremely rare, and far rarer than those associated with pregnancy and childbirth.

35. Nevertheless, Plaintiffs have health professionals available to speak with medication abortion patients 24 hours a day, seven days a week, if needed.

36. For some women, medication abortion offers important advantages over surgical abortion. In particular, some women have medical conditions that make medication abortion a significantly safer option, with a lower risk of both complications and failure than a surgical abortion. These conditions include extreme obesity, and anomalies of the reproductive and genital tract, such as large uterine fibroids, vaginismus, cervical stenosis, genital mutilation, or an extremely flexed uterus, which make it difficult to access the pregnancy inside the uterus as part of a surgical abortion.

37. Many women choose medication abortion because they fear any procedure with surgical instruments. Victims of rape, or women who have experienced sexual abuse or molestation, may choose medication abortion to feel more in control of the experience and to avoid the trauma of having instruments placed in their vagina.

38. Additionally, many women prefer medication abortion because it feels more natural, like a miscarriage, and/or because they can complete a medication abortion in the privacy of their homes, with the company of loved ones, and at a time of their choosing.

D. Advantages Of the Current Regimen Over the One on the Mifepristone Label

39. In 2000, the FDA approved Mifeprex for marketing as an abortion-inducing drug in the United States. As part of that approval, as with all medications, the FDA approved a Final Printed Labeling ("FPL"), which is an informational document that provides physicians with guidance about the use for which the drug sponsor requested and received FDA approval.

40. Based on the clinical trials submitted in support of the application for approval (which were completed prior to 1996 and involved fewer than 3000 women), the manufacturer proposed, and the FDA approved, an FPL for Mifeprex that reflects the regimen used in those trials. (As with most drugs, the FDA did not test the drug itself.)

41. Under this regimen, the patient takes 600 mg of mifepristone orally, returns to the health center approximately 36 to 48 hours later to take 400 µg of misoprostol orally, and then returns approximately 14 days later for a follow-up visit. Those trials found that regimen to be safe and effective through 49 days LMP, and the FPL therefore reflects that regimen and that gestational age limit.

42. Mifepristone is the only medication that has received FDA approval for marketing as an abortion-inducing drug, and therefore, the only medication with an FPL describing an abortion regimen. Misoprostol was approved for the treatment of ulcers and its FPL reflects only that use.

43. The FDA's regulatory authority with respect to drugs is limited to approving them for marketing; it does not regulate the practice of medicine. In approving mifepristone, the FDA did not authorize (or prohibit) the use of any particular regimen for administering it. It has never required that prescribers of mifepristone follow any particular regimen and has never imposed a gestational age limit on its use.

44. It is standard medical practice for physicians to prescribe FDA-approved drugs in dosages and for indications that were not specifically approved or contemplated by the FDA, particularly when supported by adequate study. The FDA has repeatedly acknowledged that use of such evidence-based regimens that vary from an FPL is common and is sometimes required by good medical practice.

45. By the time mifepristone was approved in 2000, newer research showed that a lower dose of mifepristone (200 mg instead of 600 mg) combined with a different dose and route of self-administered misoprostol was equally safe and was effective through at least 63 days LMP. This research also showed that varying the route of misoprostol administration decreased medication abortion's side effects.

46. Based on this research, from the time that mifepristone was approved, the overwhelming majority of abortion providers in the United States offered their patients a regimen different from the one on the FPL through at least 63 days LMP.

47. Today, the evidence-based regimen most commonly used across the country, including in Arizona and by Plaintiffs, involves 200 mg of mifepristone taken orally at the health center followed approximately 24 to 48 hours later by 800 micrograms ("µg") of

misoprostol which the woman self-administers buccally (dissolving the pills between her cheek and gum) at a location of her choosing, most often at home.

48. Approximately two million American women, if not more, have now safely used an alternative evidence-based mifepristone regimen to terminate their pregnancies, compared to the fewer than 3000 women who participated in the clinical trials submitted to the FDA in the mid-1990s.

49. ACOG, the AMA, the World Health Organization, and the Royal College of Obstetricians and Gynecologists have all endorsed use of this alternative regimen through 63 days LMP.

50. Medication abortion with Mifeprex and misoprostol is also increasingly prevalent, chosen by more women each year.

51. The evidence-based regimen used by Plaintiffs has been shown to have a higher rate of effectiveness and require fewer surgical interventions to complete the procedure, as compared to the FPL regimen.

52. The evidence-based regimen has a number of other advantages when compared to the FPL regimen.

53. *First*, it is effective for longer in pregnancy, allowing medication abortions to be performed through at least 63 days LMP, which in turn allows many more women to avail themselves of that method. Those additional weeks are significant because many women do not detect their pregnancies until close to 49 days LMP.

54. *Second*, self-administration of misoprostol eliminates a trip to the health center, allows the woman greater control over the timing of the procedure, and ensures that she experiences the bleeding and cramping that follow in a location of her choosing, rather than in the car on the way home from the clinic.

55. *Third*, the lower mifepristone dosage reduces the cost of the procedure significantly.

56. *Fourth*, it has a lower incidence of side effects than the regimen that appears on the FPL.

57. Arizona does not mandate any drugs be used only as described on their labels, except in the context of abortion. To the contrary, in contexts other than abortion,

Arizona law protects patients' access to evidence-based drugs regimens. *See, e.g,* A.R.S. § 20-2326(A) (prohibiting health insurers from refusing to cover evidence-based prescription of cancer drugs).

E. The Impact of the Arizona Law

58. The Arizona law prohibits the use of any abortion inducing medication except as "outlined in the final printing label instructions *for that medication*" (emphasis added).

59. As explained above, one of the drugs administered in the course of a medication abortion, misoprostol, was approved for the treatment of ulcers; its FPL does not mention any indication for abortion. Under one possible construction of the Arizona law, then, abortion clinics could not permissibly prescribe misoprostol for abortions at all, and therefore could not provide medication abortion (which requires that women take both medications).

60. However, it is unclear whether the Arizona law even applies to misoprostol in the first place. When misoprostol is taken, mifepristone has often, but by no means always, terminated the pregnancy. It is thus uncertain whether misoprostol is being "used to induce an abortion" when used following administration of mifepristone.

61. Moreover, the Arizona law requires abortion-inducing drugs to be administered "in compliance with the protocol that is authorized by the [FDA]." But because the FDA does not authorize drug protocols, it is unclear whether even mifepristone could be provided in compliance with the Arizona law.

62. A complete ban on medication abortion would substantially burden Arizona women, particularly those women described above who have important personal reasons for choosing a medication abortion or have medical conditions that make medication abortion a significantly safer option.

63. Some women with these medical conditions, moreover, could have other health complications arising out of, or exacerbated by, their being forced to continue unwanted pregnancies. Such complications could threaten the life or the health of these women.

64. The Arizona law contains no exceptions from its restrictions for abortions necessary, in appropriate medical judgment, to protect the life or health of a pregnant woman.

65. Moreover, because surgical abortion services require certain staff and facilities related to the provision of sedation and other aspects of that procedure, some clinics are only able to provide medication abortion, not surgical abortion.

66. If these clinics are banned from providing medication abortion, women will have to travel further to find an abortion provider.

67. PPAZ's clinic in Flagstaff is the only licensed abortion clinic in the Northern half of Arizona, an area that includes over 60,000 square miles (larger than most states). This clinic is only equipped to provide medication abortion services, not surgical.

68. If women cannot have an abortion in Flagstaff, the next closest clinic in Arizona is 134 miles away, in Glendale. Thus, women traveling from the northernmost parts of Arizona would be forced to travel up to 744 miles roundtrip to the next closest clinic, in Glendale, in order to obtain an abortion in Arizona. And for the average patient of the Flagstaff center, this would be a 321-mile roundtrip drive to Glendale, 202 miles more than the current average roundtrip.

69. Arizona's 24-hour waiting period will force them to make that trip two to four times, or remain away from home for an extended period.

70. Especially for low-income women, these obstacles may impose delays to arrange the necessary funds, transportation, childcare, or time off work required. This in turn may further delay their procedure, increasing the risk to their health.

71. Alternatively, the Arizona law might be construed to allow misoprostol to be used in a medication abortion, but require that both medications be used as outlined on the Mifeprex FPL.

72. This would allow medication abortion through 49 days LMP, but would deprive Arizona women of many of medication abortion's benefits by forcing physicians, against their best medical judgment, to adhere to an outdated, inferior regimen.

73. This will impose substantial obstacles for all women seeking abortion.

74. These obstacles will be particularly burdensome for women who have important personal reasons for choosing a medication abortion, and will be dangerous for women who have medical conditions that make medication abortion a significantly safer option than surgical abortion.

75. That is because, in order to have a medication abortion following the FPL regimen, a woman will be required to make four separate trips to an abortion facility over the course of two weeks: 1) for the state-mandated counseling and ultrasound at least 24-hour before she takes the mifepristone; 2) for the mifepristone; 3) for the misoprostol; and 4) for the follow-up.

76. These extra trips, over longer distances, will require additional travel and time away from home, children, and work, which will be particularly difficult for low-income women, women who live in rural areas, women who have limited access to transportation, and women who are victims of abuse.

77. Especially for low-income women, these obstacles may impose delays to arrange the necessary funds, transportation, childcare, or time off work required. This in turn may further delay their procedure, increasing the risk to their health, and possibly delay them past the 49 day LMP limit, which would prevent them from having a medication abortion altogether.

78. Moreover, requiring women to take misoprostol at the clinic forces them to bleed and cramp either at the clinic or during their journey home, rather than (as is currently the case) in a safe place with the support of family or friends.

79. The 600 mg of mifepristone required by the Mifeprex FPL, rather than the 200 mg taken under the evidence-based regimen, will be significantly more costly and again will particularly burden low-income women. Each mifepristone pill costs approximately $90, meaning that the increased cost of the procedure will be about $180, not counting the staff time need for the extra visit to the health center and the time the woman needs to take off from work or school or to get child care.

80. Also, if the Act permitted medication abortion only under the Mifeprex FPL, women 50-63 days LMP would be denied medication abortion entirely.

81. Additionally, given the new costs and burdens associated with the regimen, and the likely consequence of fewer patients choosing this treatment, PPAZ is likely to be forced to cease medication abortion services in some of its centers, including Flagstaff, under this interpretation of the Arizona law. The effect on women in Northern Arizona would thus be the same as if the Act imposed a total ban on medication abortion – even for women under 50 days LMP.

82. All of these burdens will come with no medical benefit whatsoever. To the contrary, they harm women's health by making women who choose or need medication abortion to protect their health take three times as much medication as is necessary, and follow an outdated regimen that is no longer the standard of care, is more burdensome, and has been demonstrated to be less effective and have a greater risk of needing a surgical procedure to complete the abortion.

83. These burdens will compound the severe, burdensome, and medically unnecessary restrictions *already* in place in Arizona: namely, the requirement of a separate trip for state-directed counseling and an ultrasound followed by a 24-hour waiting period, and the prohibition on the provision of medication abortion by advanced-practice nurses or by physicians through telemedicine.

V. CLAIMS FOR RELIEF

COUNT I – RIGHT TO DUE PROCESS OF LAW

(Liberty/Privacy)

84. Plaintiffs hereby reaffirm and reallege each and every allegation made in paragraphs 1-83 above as if set forth fully herein.

85. The Arizona law violates Plaintiffs' patients' rights to liberty and privacy as guaranteed by the Fourteenth Amendment to the United States Constitution by imposing an unconstitutional burden on their right to choose abortion.

COUNT II – RIGHT TO DUE PROCESS OF LAW

(Bodily Integrity)

86. Plaintiffs hereby reaffirm and reallege each and every allegation made in paragraphs 1-85 above as if set forth fully herein.

87. The Arizona law violates Plaintiffs' patients' right to bodily integrity guaranteed by the Fourteenth Amendment to the United States Constitution by depriving all women of access to a safe and medically accepted non-surgical abortion procedure.

88. Alternatively, the Arizona law violates Plaintiffs' patients' right to bodily integrity by depriving some women of access to a safe and medically accepted non-surgical abortion procedure, and by forcing others who obtain medication abortion to ingest more medication than is required by the standard of care, thereby subjecting them to increased side effects.

COUNT III – RIGHT TO DUE PROCESS OF LAW

(Vagueness)

89. Plaintiffs hereby reaffirm and reallege each and every allegation made in paragraphs 1-88 above as if set forth fully herein.

90. The Arizona law violates Plaintiffs' rights to due process as guaranteed by the Fourteenth Amendment to the United States Constitution because it is impermissibly vague, fails to give adequate notice of the procedures it proscribes, and encourages arbitrary and discriminatory enforcement.

COUNT IV – RIGHT TO EQUAL PROTECTION

91. The allegations of paragraphs 1 through 90 are incorporated as though fully set forth herein.

92. The Arizona Law violates Plaintiffs' right to equal protection of the laws guaranteed by the Fourteenth Amendment to the United States Constitution, because it discriminates between licensed abortion clinics (and their patients) and other abortion providers (and their patients), as well as between abortion providers and other health care providers, without adequate justification.

VI. REQUEST FOR RELIEF

Plaintiffs respectfully request that this Court:

93. Issue a declaratory judgment that the Act and Regulation are unconstitutional and unenforceable;

94. Issue preliminary and permanent injunctive relief restraining Defendant, and his employees, agents, and successors in office from enforcing the Act and Regulation;

95. In the alternative, issue preliminary and permanent injunctive relief restraining Defendant, and his employees, agents, and successors in office from enforcing the Act and Regulation as applied to women for whom a banned medication abortion is necessary, in appropriate medical judgment, to protect the life or health of the woman.

96. Grant Plaintiffs attorneys' fees, costs, and expenses pursuant to 42 U.S.C. § 1988; and;

97. Grant such other and further relief as this Court may deem just, proper, and equitable.

Dated: March 4, 2014

Respectfully submitted,

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