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FREEDOM NOT TO SEE A DOCTOR: THE PATH TOWARD OVER-THE-COUNTER ABORTION PILLS

LEWIS A. GROSSMAN*

American courts and lawmakers are engaged in an epic struggle over the fate of abortion pills. While some anti-abortion activists are attempting to drive the pills off the market entirely, supporters of reproductive rights are striving to make them more easily accessible. This Article advances the latter mission with a bold proposal: FDA should consider allowing abortion pills to be sold over the counter (OTC). Abortion rights supporters argue that FDA should repeal the special distribution and use restrictions it unnecessarily imposes on mifepristone, one of two drugs in the medication abortion regimen. Even if FDA removed these restrictions, however, abortion pills would still be prescription medicines—a status that, in and of itself, hinders people’s access to drugs. This Article thus advocates going further by repealing the prescription requirement for abortion pills. To support this proposal, the Article analyzes the prescription-to-OTC switch process for drugs generally, explores how prescription status impedes access, and argues that FDA should give greater weight to the benefits of improved access when considering any OTC switch. The Article discusses recent promising instances of successful switches—including naloxone and birth control pills—in which FDA emphasized the access factor more than it traditionally has. Finally, the Article considers various intermediate approaches between prescription and OTC status and explains how federal and state regulators might use these approaches to improve access to abortion pills in the absence of a complete switch.

Introduction	1042
I. The Prescription/Over-the-Counter Dichotomy	1051
A. History	1051
B. The Statutory Criteria	1056
1. “Toxicity”	1058
2. “Other Potentiality for Harmful Effect”	1060
3. “The Method of Its Use”	1060

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4. “The Collateral Measures Necessary to Its Use”	1061
II. OTC Status and the Benefits of Improved Access.....	1063
III. The Role of Access in FDA Switch Decisions.....	1070
IV. Examples of Access-Motivated OTC Switches	1079
A. Nicotine Replacement Therapy	1079
B. Hearing Aids	1081
C. Naloxone.....	1086
V. Blurring the Rx-OTC Dichotomy	1089
A. Behind the Counter: A Path Not Taken	1089
B. Pharmacist Prescribing under State Law	1092
C. Nonprescription Drug Product with Additional Condition for Safe Use	1095
VI. Toward an Over-the-Counter Reproductive Health Armamentarium.....	1099
A. Plan B Emergency Contraception	1099
B. Oral Contraceptives	1104
C. Abortion Pills	1113
1. The Mifepristone REMS.....	1115
2. Pharmacist Prescribing.....	1118
3. OTC Abortion Pills?	1120
Conclusion	1124

INTRODUCTION

The Supreme Court’s June 2022 overruling of *Roe v. Wade*¹ in *Dobbs v. Jackson Women’s Health Organization*² has focused attention on medication abortion. For over two decades, an alternative to procedural abortion has been available to people seeking to terminate a pregnancy—a two-drug regimen (mifepristone and misoprostol) approved by the Food and Drug Administration (FDA) in 2000.³ According to FDA-approved labeling, this regimen can be used safely and effectively through ten weeks into the pregnancy.⁴ *Dobbs* has already

1. 410 U.S. 113 (1973).

2. 142 S. Ct. 2228, 2242 (2022).

3. *Information About Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, FDA, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation> [https://perma.cc/GVB5-KVYT] (Mar. 23, 2023) [hereinafter *Information About Mifepristone*].

4. *Mifeprex*[®] *Prescribing Information*, FDA 2, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s0201b1.pdf [https://perma.cc/J9WY-86YN] (Mar. 2016) [hereinafter *Mifeprex Prescribing Information*]. Despite FDA labeling, about thirty-seven percent of providers in the United States now offer the use of this regimen beyond ten weeks. ADVANCING NEW STANDARDS

generated multiple lawsuits regarding abortion medication, including a case challenging the very validity of FDA's approval of mifepristone,⁵ and another asserting that the agency's approval of the abortion pill regimen with specific restrictions on distribution of mifepristone preempts a state law banning almost all medication abortion.⁶ The former lawsuit may temporarily disrupt the availability of mifepristone but is extremely unlikely to permanently end it. In any event, it will have no effect on the availability of misoprostol, which is a very effective abortion medication when used alone.⁷

Even before *Dobbs*, fifty-four percent of abortions in the United States were medication abortions.⁸ The percentage of abortions performed with pills will now likely surge, as people in anti-abortion states seek out a method that can be obtained from elsewhere, concealed, and used in the privacy of one's home. This surge would probably be steeper, however, if mifepristone were not subject to an array of regulatory requirements that hinder people's ability to obtain the drug, even in abortion-permissive states.

The FDA restrictions on mifepristone that have received the most attention are those contained in the Risk Evaluation and Mitigation Strategy (REMS) imposed on the drug.⁹ The agency uses REMS to lessen

IN REPROD. HEALTH, TRENDS IN ABORTION FACILITY GESTATIONAL LIMITS PRE- AND POST-*DOBBS* 1 (2023), <https://www.ansirh.org/sites/default/files/2023-06/Gestational%20Limits%20Brief%206-14-23%20Final.pdf> [https://perma.cc/P56E-SY6F].

5. *All. for Hippocratic Med. v. FDA*, 78 F.4th 210 (5th Cir. 2023).

6. *GenBioPro, Inc. v. Sorsaia*, No. 3:23-0058, 2023 WL 3451688 (S.D. W. Va. Apr. 21, 2023); *GenBioPro, Inc. v. Sorsaia*, No. 3:23-0058, 2023 WL 3211847 (S.D. W. Va. May 2, 2023); *GenBioPro, Inc. v. Sorsaia*, No. 3:23-0058, 2023 WL 5490179 (S.D. W. Va. Aug. 24, 2023). The West Virginia law in question prohibits abortion by any method in almost all cases, with several narrow exceptions. W. VA. CODE § 16-2R-3 (2022).

7. *See infra* pp. 1119–20.

8. Rachel K. Jones, Elizabeth Nash, Lauren Cross, Jesse Philbin & Marielle Kirstein, *Medication Abortion Now Accounts for More Than Half of All US Abortions*, GUTTMACHER INST. (Dec. 1, 2022), <https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions> [https://perma.cc/DQK3-UF5W].

9. *See, e.g.*, Greer Donley, *Medication Abortion Exceptionalism*, 107 CORNELL L. REV. 627 (2022); Lewis A. Grossman, *Pushing Back with Pills —Enhancing Access to Reproductive Health Drugs After Dobbs*, 387 NEW ENG. J. MED. 1056 (2022); Anne N. Flynn, Jade M. Shorter, Andrea H. Roe, Sarita Sonalkar & Courtney A. Schreiber, *The Burden of the Risk Evaluation and Mitigation Strategy (REMS) on Providers and Patients Experiencing Early Pregnancy Loss: A Commentary*, 104 CONTRACEPTION 29 (2021); Alexandra Thompson, Dipti Singh, Adrienne R. Ghorashi, Megan K. Donovan, Jenny Ma & Julie Rikelman, *The Disproportionate Burdens of the Mifepristone REMS*, 104 CONTRACEPTION 16 (2021); Julia Kaye, Rachel Reeves & Lorie

the risks of particularly dangerous drugs so that their benefits outweigh their risks.¹⁰ The strictest REMS, including the mifepristone REMS, regulate the drug's distribution and use by imposing "elements to assure safe use" (ETASU).¹¹ FDA recently loosened the mifepristone REMS by eliminating the most onerous ETASU—a requirement that the drug be dispensed in-person directly to the patient in a healthcare setting.¹² Under the new REMS, certified clinicians may dispense mifepristone by mail, and certified pharmacies may also dispense the drug.¹³ In ongoing litigation,¹⁴ anti-abortion physicians are challenging the legality of these revisions, as well as earlier relaxations of the ETASU. For now, however, the revised REMS remains in effect.¹⁵

Nevertheless, the remaining REMS elements (including, for example, special certification of prescribers and pharmacies) are themselves disproportionate to mifepristone's risk and needlessly complicate and burden acquisition of the drug. Many scholars and medical organizations have thus called for the mifepristone REMS to be revoked altogether.¹⁶ Seventeen abortion-permissive states have also filed

Chaiten, *The Mifepristone REMS: A Needless and Unlawful Barrier to Care*, 104 *CONTRACEPTION* 12 (2021).

10. 21 U.S.C. § 355-1; *see infra* pp. 1115–17.

11. 21 U.S.C. § 355-1(f).

12. *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, FDA, (Jan. 4, 2023), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation#TheJanuary2023REMSModification> [<https://perma.cc/TH3E-WKF7>].

13. *Information About Mifepristone, supra* note 3; FDA, RISK EVALUATION AND MITIGATION STRATEGY (REMS) SINGLE SHARED SYSTEMS FOR MIFEPRISTONE 200MG, 1–3 (Mar. 2023), https://www.accessdata.fda.gov/drugsatfda_docs/rem/s/Mifepristone_2023_03_23_REM_S_Full.pdf [<https://perma.cc/8AV5-F2GN>].

14. *See All. for Hippocratic Med. v. FDA*, 78 F.4th 210 (5th Cir. 2023).

15. In August 2023, the United States Court of Appeals for the Fifth Circuit upheld the portions of a district court decision staying the actions FDA has taken to loosen the mifepristone REMS since 2016. *Id.* However, the Fifth Circuit's decision will not go into effect pending the disposition of petitions for certiorari by the United States Supreme Court. *Danco Lab's, LLC v. All. for Hippocratic Med.*, 143 S. Ct. 1075 (2023) (mem.).

16. *Improving Access to Mifepristone for Reproductive Health Indications*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Mar. 2021), <https://www.acog.org/en/clinical-information/policy-and-position-statements/position-statements/2018/improving-access-to-mifepristone-for-reproductive-health-indications> [<https://perma.cc/T9PR-HCHY>]; Thompson, Singh, Ghorashi, Donovan, Ma & Rikelman, *supra* note 9, at 16; Laura Schummers, Elizabeth K. Darling, Sheila Dunn, Kimberlyn McGrail, Anastasia Gayowsky et al., *Abortion Safety and Use with Normally Prescribed Mifepristone in Canada*, 386 N. ENG. J. MED. 57, 58 (2022); L. Grossman, *supra* note 9, at 1057; Donley, *supra* note 9, at 681; David S. Cohen, Greer Donley &

a lawsuit contending that the remaining ETASU are unnecessary and unduly burdensome.¹⁷

Even if the entire mifepristone REMS is eliminated, however, another regulatory hurdle to easy abortion pill access will remain: the prescription requirement. FDA, appropriately in most instances, requires a drug to be sold pursuant to prescription when a medical professional's supervision is necessary to ensure that the medicine is taken safely and effectively.¹⁸ Because the agency imposes prescription status on both mifepristone and misoprostol, people seeking a medication abortion must first make an appointment with a physician or other health care provider. Even for drugs other than abortion pills, the prescription requirement can be burdensome, particularly for people who cannot take time off work, people without health insurance, people in rural communities, and people who do not have access to physicians for other reasons.¹⁹ Moreover, regardless of a person's circumstances, the obligation to make a medical appointment before obtaining a drug can delay commencement of treatment.

The prescription requirement poses unique access problems with respect to abortion pills. FDA has approved the medication abortion regime only through ten weeks of pregnancy.²⁰ Although many experts believe the regimen can be used safely and effectively at a somewhat later gestation,²¹ the time is indisputably limited. And as a practical matter, pregnant patients have even less time to obtain abortion pills, because they must know they are pregnant before seeking them. On average, American women discover they are pregnant at the gestational age of 5.5 weeks.²² About twenty percent—disproportionately younger women, poorer women, and people of color—learn past seven weeks.²³

Timely acquisition of abortion pills is especially challenging for people who must travel out of state to get them, most notably residents of the thirteen states that, post-*Dobbs*, have enacted near-total bans on

Rachel Rebouché, *Abortion Pills*, 76 STAN. L. REV. (forthcoming 2024) (manuscript at 46–47) (on file with *Stanford Law Review*) [hereinafter *Abortion Pills*]; Kaye, Reeves & Chaiten, *supra* note 9, at 12.

17. *Washington v. FDA*, No. 1:23-CV-3026-TOR, 2023 WL 2825861 (E.D. Wash. Apr. 7, 2023).

18. *See infra* pp. 1053–54.

19. *See infra* pp. 1106–07.

20. *Information About Mifepristone*, *supra* note 3.

21. *Abortion Pills*, *supra* note 16, at 48–49.

22. Amy M. Branum & Katherine A. Ahrens, *Trends in Timing of Pregnancy Awareness Among US Women*, 21 MATERNAL & CHILD HEALTH J. 715, 715 (2017).

23. *Id.*; Lauren J. Ralph, Diana Greene Foster, Rana Barar & Corinne H. Rocca, *Home Pregnancy Test Use and Timing of Pregnancy Confirmation Among People Seeking Health Care*, 107 CONTRACEPTION 10, 10–11 (2022).

abortion.²⁴ The REMS contributes to the problem, but the requirement to obtain a prescription would itself pose a significant hurdle to such people even without the REMS. Most people do not have pre-established relationships with health care providers in other states. Furthermore, even insurance plans that cover medication abortion generally do not cover nonemergency visits to out-of-state providers.²⁵

Finally, there is the issue of privacy. Even in Western nations where abortion is legal and widely available, a strong social stigma against it remains. Women obtaining abortions report experiencing guilt and shame, a fear of social judgment and reputational harm, and a need for secrecy.²⁶ Abortion patients can feel judged even by their physicians. In famously progressive Norway, women seeking abortions felt “vulnerable and exposed in relation to health care workers,” and some who had medication abortions “experienced being *sent home* by health care workers to perform the abortion as a form of punishment for being irresponsible and becoming pregnant.”²⁷

FDA’s recent revisions to the mifepristone REMS have made it possible to obtain the abortion regimen through telemedicine (that is, by mail following an online appointment with a doctor or completion of an online questionnaire reviewed by the doctor).²⁸ But even as abortion-permissive states tweak their telehealth rules to accommodate the provision of abortion care to out-of-state patients,²⁹ states with abortion

24. *Medication Abortion*, GUTTMACHER INST. (July 1, 2023), <https://www.guttmacher.org/state-policy/explore/medication-abortion> [<https://perma.cc/B3DG-HMCB>].

25. Louise Norris, *How Health Insurance Works When You Live in Multiple States*, VERYWELL HEALTH, <https://www.verywellhealth.com/health-insurance-for-multiple-states-4584359> [<https://perma.cc/QT7R-B8C3>] (July 22, 2023).

26. Kate Cockrill & Adina Nack, “*I’m Not That Type of Person*”: *Managing the Stigma of Having an Abortion*, 34 *DEVIANT BEHAV.* 973, 979–86 (2013); Idun Røseth, Eva Sommerseth, Anne Lyberg, Berit Margrethe Sandvik & Bente Dahl, *No One Needs to Know! Medical Abortion: Secrecy, Shame, and Emotional Distancing*, *HEALTH CARE FOR WOMEN INT’L*, July 2022, at 2, 3; Franz Hanschmidt, Katja Linde, Anja Hilbert, Steffi G. Reidel-Heller & Anette Kersting, *Abortion Stigma: A Systematic Review*, 48 *PERSPS. SEXUAL & REPROD. HEALTH* 169, 169–70 (2016).

27. Røseth, Sommerseth, Lyberg, Sandvik & Dahl, *supra* note 26, at 7–8, 10.

28. David S. Cohen, Greer Donley & Rachel Rebouché, *The New Abortion Battleground*, 123 *COLUM. L. REV.* 1, 89, 91–92 (2023) [hereinafter *The New Abortion Battleground*]; *Abortion Pills*, *supra* note 16, at 7–9. See UD Upadhyay, LR Koenig, J Ko, E Valladares, K Meckstroth & MA Biggs, *Safety and Effectiveness of Synchronous and Asynchronous Telehealth Medication Abortion Provided by US Virtual Clinics*, 116 *CONTRACEPTION* 69, 69–70 (2022) (demonstrating the safety and efficacy of medication abortions provided through both synchronous and asynchronous telehealth models).

29. *Abortion Pills*, *supra* note 16, at 33–37; Pam Belluck & Emily Bazelon, *New York Passes Bill to Shield Abortion Providers Sending Pills into States with Bans*,

bans may try to exercise extraterritorial criminal jurisdiction over out-of-state telehealth providers, and many providers will refuse to mail the pills to patients in these states for fear of legal exposure.³⁰ In any event, telehealth abortion remains out of reach for many (disproportionately low-income individuals, people of color, and rural residents) due to digital illiteracy and lack of access to adequate technology.³¹ And many patients may be reluctant to leave an electronic trail showing that they ordered abortion medication.

In the face of legal and practical barriers to obtaining abortion care from doctors, people have long turned to “self-managed abortion” (SMA), including through the use of abortion medication obtained from unsanctioned suppliers.³² Even before *Dobbs*, about seven percent of American women reported having attempted SMA during their lifetimes.³³ This trend seems likely to accelerate as restrictions on abortion tighten.³⁴ People acquire mifepristone and misoprostol without a prescription in various ways, such as traveling to Mexico, participating in underground distribution networks in the United States, or receiving the pills by mail from overseas providers.³⁵ Although many self-managed

N.Y. TIMES (June 20, 2023), <https://www.nytimes.com/2023/06/20/health/abortion-shield-law-new-york.html>.

30. *The New Abortion Battleground*, *supra* note 28, at 30–34; *Abortion Pills*, *supra* note 16, at 25–26.

31. *The New Abortion Battleground*, *supra* note 28, at 91–92.

32. See Yvonne Lindgren, *When Patients Are Their Own Doctors: Roe v. Wade in an Era of Self-Managed Care*, 107 CORNELL L. REV. 151, 168–69 (2021). The phrase “self-managed abortion” also covers a variety of other practices occurring outside the formal health care system, including the use of herbs and physical methods. Lisa H. Harris & Daniel Grossman, *Complications of Unsafe and Self-Managed Abortion*, 382 NEW ENG. J. MED. 1029, 1030 (2020).

33. Lauren Ralph, Diana G. Foster, Sarah Raifman, M. Antonia Biggs, Goleen Samari et al., *Prevalence of Self-Managed Abortion Among Women of Reproductive Age in the United States*, JAMA NETWORK OPEN, Dec. 18, 2020, at 1, 1, 11 (reporting results from a cross-sectional survey of over 7,000 women).

34. See Dani McClain, *As Abortion Restrictions Ramp Up, More Women Weigh Taking Matters into Their Own Hands*, NATION (Mar. 21, 2016), <https://www.thenation.com/article/archive/as-abortion-restrictions-ramp-up-more-women-weigh-taking-matters-into-their-own-hands/> [https://perma.cc/6QYH-68NA?type=image] (reporting that online searches for accomplishing a “do-it-yourself” abortion jumped forty percent the same year that ninety-two provisions restricting abortion access were enacted worldwide); Ushma D. Upadhyay, Alice F. Cartwright & Daniel Grossman, *Barriers to Abortion Care and Incidence of Attempted Self-Managed Abortion Among Individuals Searching Google for Abortion Care: A National Prospective Study*, 106 CONTRACEPTION 49 (2022) (“Attempted self-managed abortion is higher among people facing barriers to abortion care.”).

35. Lindgren, *supra* note 32, at 202–03, 212–13; Erica Hellerstein, *The Rise of the DIY Abortion in Texas*, ATLANTIC (June 27, 2014),

medication abortions using these drugs are completed successfully without serious adverse effects,³⁶ there is no assurance that pills obtained in these ways are genuine, unadulterated, or properly labeled. Further, as prescription drugs, they likely do not bear instructions and warnings directed to consumers.³⁷

Imagine a world in which a pregnant customer could buy FDA-regulated abortion medication in a pharmacy, grocery store, or other retailer without a prescription. The two components of the regimen would be sold together, in a blister pack, with clear instructions. The customer could pull the product off the shelf, purchase it at a self-checkout register, and leave the store without talking to anybody. She might live in the same neighborhood as the store, but she could also be a visitor from a state where abortion is banned.

As this Article explains, FDA could bring about this scenario (likely in cooperation with an interested manufacturer) through a mechanism known as a prescription to over-the-counter (Rx-OTC) switch. Of course, the agency should take such a step only if provided with sufficient evidence that people can take the abortion medication regimen safely and effectively without a health care professional's supervision. It would be one of the boldest switches (and most controversial actions) in the agency's history. It is unlikely to happen anytime soon; FDA has thus far been unwilling to abandon the REMS for mifepristone, let alone the prescription requirement. No drug has ever made the journey all the way from a REMS to OTC status.

Moreover, FDA has never authorized OTC sales of a drug quite like abortion medication. The regimen causes heavy uterine bleeding for a

<https://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/>; *Abortion Pills*, *supra* note 16, at 55–57.

36. See, e.g., Abigail R.A. Aiken, Evdokia P. Romanova, Julia R. Morber & Rebecca Gomperts, *Safety and Effectiveness of Self-Managed Medication Abortion Provided Using Online Telemedicine in the United States: A Population Based Study*, LANCET REG'L HEALTH – AMS., June 2022, at 1, 1.

37. *Information About Mifepristone*, *supra* note 3; FDA, WARNING LETTER TO AIDACCESS.ORG (Mar. 8, 2019), <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/aidaccessorg-575658-03082019> [<https://perma.cc/GKX6-BTWS>]; Laura J. Frye, Catherine Kilfedder, Jennifer Blum & Beverly Winikoff, *A Cross-Sectional Analysis of Mifepristone, Misoprostol, and Combination Mifepristone-Misoprostol Package Inserts Obtained in 20 Countries*, 101 CONTRACEPTION 315, 315–16, 319 (2020). *But see* Chloe Murtagh, Elisa Wells, Elizabeth G. Raymond, Francine Coeytaux & Beverly Winikoff, *Exploring the Feasibility of Obtaining Mifepristone and Misoprostol from the Internet*, 97 CONTRACEPTION 287, 287 (2018) (concluding that despite the fact that mifepristone obtained online without a prescription generally contained less active ingredient than the labeled amount, it is expected that “some people for whom clinic-based abortion is not easily available or acceptable may consider self-sourcing pills from the internet to be a rational option”).

median duration of two days.³⁸ It invariably causes abdominal pain and cramping, sometimes requiring pain medication.³⁹ Between 2.9 and 4.6 percent of women visit emergency rooms following administration of mifepristone and misoprostol,⁴⁰ and major complications occur in 0.31 percent of cases (about one in 300).⁴¹

As this Article explains, switching the medication abortion regimen to OTC status would thus require FDA to somewhat re-envision the prescription requirement and the criteria for a switch. This Article argues that the agency should give as much consideration to the *benefits* of switching a drug as to the *risks* of doing so. In the case of abortion medication, one such benefit is assuring that pregnant individuals are able to acquire the pills in time to use them safely and effectively. Another is making an FDA-approved abortion method more easily available to people who, for whatever reason, cannot obtain a prescription or procedural abortion from a health care provider in their state.⁴² Still another (and related) benefit of OTC status is to protect people from the dangers posed by the other self-managed abortion methods to which some will inevitably turn if they are unable to obtain FDA-approved mifepristone and misoprostol. These dangers include toxic exposures, sepsis, hemorrhage, and pelvic-organ injury.⁴³ A final, critical benefit of OTC status is the advancement of privacy and bodily autonomy. This benefit is implicit in any OTC switch but has greatly heightened significance for abortion pills, especially post-*Dobbs*.

Although the question of whether abortion pills should be sold over the counter may presently be little more than a thought experiment,⁴⁴ it is one well worth conducting, for various reasons. First, it may become relevant in the future. Second, as this Article explains, abortion-permissive states may be able to take steps to push abortion pills closer to OTC status even before FDA considers formally switching the pills. Through mechanisms known as statewide protocols and collaborative

38. *Mifeprex Prescribing Information*, *supra* note 4, at 5.

39. *Id.* at 3, 7.

40. *Id.* at 8.

41. Ushma D. Upadhyay, Sheila Desai, Vera Zlidar, Tracy A. Weitz, Daniel Grossman et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *OBSTETRICS & GYNECOLOGY* 175, 175 (2015).

42. Because most non-medication abortions are not technically surgeries, this Article uses the term “procedural abortion” rather than “surgical abortion.” See Ushma D. Upadhyay, Leah Coplon & Jessica M. Atrio, *Society of Family Planning Committee Statement: Abortion Nomenclature*, *CONTRACEPTION* (June 16, 2023), <https://doi.org/10.1016/j.contraception.2023.110094>.

43. Harris & D. Grossman, *supra* note 32, at 1029.

44. See *Abortion Pills*, *supra* note 16, at 45 (discussing the “many steps” that would have to be taken to make mifepristone available over the counter).

practice agreements (CPA), these states can authorize pharmacists to dispense abortion medication without an individualized prescription. In addition to facilitating access to these drugs immediately, this step would generate important data for any later OTC switch application submitted to FDA. Third, the question of OTC abortion pills raises broader issues regarding the role of access in FDA's switch decisions for other drugs, including, for example, statin drugs for cholesterol control.

Finally, *Dobbs* has magnified the importance of facilitating access not only to abortion medication, but also to contraceptive products that prevent unwanted pregnancies from occurring in the first place.⁴⁵ Although FDA may not have occasion any time soon to consider switching abortion pills to OTC status, this Article's emphasis on the benefits of access applies equally to contraceptive drugs. Until very recently, the only birth control products available without a prescription were male condoms, female condoms, sponges, spermicide, and the emergency contraceptive pill levonorgestrel (commonly known by the brand name Plan B).⁴⁶ During the production of this Article, however, FDA approved over-the-counter access to a highly effective, and thus crucial, alternative: a progestin-only daily oral contraceptive drug called Opill.⁴⁷ As described below,⁴⁸ FDA appears to have approved Opill's OTC switch application largely in response to public and expert pressure to give decisive weight to the benefits of easing access. The agency will soon have to decide whether to similarly prioritize access when it considers a pending switch application for a combination birth control pill containing estrogen as well as progestin.⁴⁹

This Article proceeds as follows. Part I discusses the history of prescription status and the criteria and procedures for switching a drug from prescription to OTC. Part II explores the ways in which OTC status

45. L. Grossman, *supra* note 9, at 1056.

46. *Birth Control Methods*, OFF. ON WOMEN'S HEALTH, <https://www.womenshealth.gov/a-z-topics/birth-control-methods> [<https://perma.cc/3VUU-UBJ4>] (Dec. 29, 2022).

47. News Release, FDA, FDA Approves First Nonprescription Daily Oral Contraceptive (July 13, 2023), <https://www.fda.gov/news-events/press-announcements/fda-approves-first-nonprescription-daily-oral-contraceptive> [<https://perma.cc/EC9K-RM3M>] [hereinafter FDA Approves First Nonprescription Daily Oral Contraceptive].

48. See *infra* pp. 1104–13.

49. *Zena*, CADENCE OTC, <https://www.cadenceotc.com/zena> [<https://perma.cc/57YK-QC23>]. FDA may also see requests to make contraceptive patches and vaginal rings available on a nonprescription basis. See, e.g., Daniel Grossman, Opinion, *The Victory for Over-the-Counter Birth Control Pills Is Just the Beginning*, N.Y. TIMES (July 19, 2023), <https://www.nytimes.com/2023/07/19/opinion/birth-control-pills-opill-over-the-counter.html>.

facilitates access to drugs and the benefits of this improved access. Part III discusses the actual role of access in FDA switch decisions, concluding that it is an underemphasized factor that the agency typically deals with in a nonexplicit and unsystematic manner.

Part IV examines three instances in which FDA has given more pronounced consideration to the benefits of access in the OTC switch context: nicotine replacement therapy, hearing aids, and naloxone. Part V describes three approaches to facilitating access short of a complete OTC switch: behind-the-counter access, state-authorized pharmacist prescribing, and a newly proposed status that FDA calls “nonprescription with an additional condition for safe use.” The latter two approaches may ultimately play a role in improving access to the abortion medication regimen.

Finally, Part VI explores the possibility of a comprehensive OTC reproductive health drug armamentarium including oral contraceptives, emergency contraceptives, and abortion pills. Part VI discusses the role that the goal of improving access played in the switch of emergency contraception and the progestin-only daily contraceptive pill. It briefly considers how this consideration might affect FDA’s forthcoming decision regarding an OTC combination birth control pill. Finally, this part examines the potential migration of abortion medication from highly restrictive REMS requirements all the way to OTC status. I argue that in the wake of *Dobbs*, both federal and state regulators should give great weight to the ease-of-access factor in deciding how to regulate the distribution and prescription of abortion pills.

I. THE PRESCRIPTION/OVER-THE-COUNTER DICHOTOMY

A. History

Until 1938, only certain narcotics listed in the Harrison Anti-Narcotics Act of 1914 were legally mandated to be sold only on prescription.⁵⁰ Otherwise, consumers could purchase any drug they desired without a physician’s intervention, unless the manufacturer chose to distribute the drug in a manner that prevented them from doing so

50. Peter Temin, *The Origin of Compulsory Drug Prescriptions*, 22 J.L. & ECON. 91, 91 (1979). The complex terms of the Harrison Act effectively banned the distribution of the listed narcotics (“opium or coca leaves or any compound, manufacture, salt, derivative, or preparation”) to consumers, but Section 2(b) of the Harrison Act said its requirements did not apply “[t]o the sale, dispensing, or distributing of any of the aforesaid drugs by a dealer to a consumer under and in pursuance of a written prescription issued by a physician, dentist, or veterinary surgeon registered under this Act.” Harrison Narcotics Act, Pub. L. No. 63-223, §§ 1, 2(b), 38 Stat. 785, 785–86 (1914).

(*i.e.*, directly to physicians).⁵¹ Before the Great Depression, only about one-quarter of drug sales from drugstores was pursuant to prescription.⁵²

The federal Food, Drug, and Cosmetic Act (FD&C Act), enacted in 1938 to replace the 1906 Pure Food and Drugs Act, formally recognized a category of “drug[s] dispensed on a written prescription” that were exempt from certain labeling requirements.⁵³ The statute left the decision of whether to distribute a particular drug in this manner entirely up to the manufacturer; however, there was no mandatory prescription status. Indeed, the House report on the bill that Congress eventually passed emphasized, “The bill is not intended to restrict in any way the availability of drugs for self-medication”—that is, use by consumers without the involvement of physicians.⁵⁴

The slow march toward mandatory prescription status is a complex story that others have told in great detail.⁵⁵ In 1938, FDA issued a regulation allowing manufacturers, at their own discretion, to market and label a drug as a prescription drug and making it a misbranding violation for anyone to sell such a drug without a prescription.⁵⁶ The regulation required prescription drug labels to state, “Caution: To be used only by or on the prescription of a [physician].”⁵⁷ In a 1944 regulation, FDA—concerned about manufacturers’ excessive use of prescription status and the confusing distribution of drugs as both prescription and nonprescription products—established a category of mandatory

51. See, *e.g.*, Temin, *supra* note 50, at 97 (noting that “less than 5% of drug advertising was directed at doctors . . . [and] almost all drug advertising [was] directed at the public”).

52. *Id.*

53. Federal Food, Drug, and Cosmetic Act, Pub. L. No. 75-717, § 503(b), 52 Stat. 1040, 1052 (1938) (codified as amended at 21 U.S.C. § 353(b)).

54. Temin, *supra* note 50, at 96; H.R. REP. NO. 75-2139, at 8 (1938).

55. See generally Temin, *supra* note 50.

56. 3 Fed. Reg. 3162, 3168 (Dec. 28, 1938). This regulation created an exemption from 21 U.S.C. § 352(f), which otherwise required adequate directions for use comprehensible by a layperson. The regulation not only exempted manufacturers of self-designated prescription drugs from providing adequate directions for use by a layperson; it also required all representations regarding conditions of use to “appear only in such medical terms as are not likely to be understood by the ordinary individual.” *Id.* Although this regulation reserved the Rx-OTC decision to the manufacturer, FDA took enforcement action under other provisions of the FD&C Act, without citing this regulation, against a drug being sold OTC that the agency concluded should have been sold only by prescription. *United States v. 62 Packages, More or Less, of Marmola Prescription Tablets.*, 48 F. Supp. 878 (W.D. Wis. 1943), *aff’d*, 142 F.2d 107 (7th Cir. 1944) (upholding FDA’s reliance on 21 U.S.C. §§ 321(n), 352(a) & (j)).

57. 3 Fed. Reg. 3162, 3168 (Dec. 28, 1938) (allowing use of the word “physician,” “dentist,” “veterinarian,” or any combination of these words).

nonprescription drugs.⁵⁸ It did so by allowing prescription status only for drugs that “because of [their] toxicity or other potentiality for harmful effect [are] not generally recognized among experts [qualified] by scientific training and experience to evaluate [their] safety and efficacy, as safe and efficacious for use except by or under the supervision of a physician, dentist or veterinarian.”⁵⁹

Finally, in 1951, Congress passed the Humphrey-Durham Amendments,⁶⁰ which amended Section 503(b)(1) of the FD&C Act to state that a drug must be dispensed upon a prescription if:

(A) [it] is a habit-forming drug [listed in another section of the Act]

(B) because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, [it] is not safe for use except under the supervision of a practitioner licensed by law to administer such drug; or

(C) [it] is limited by an approved application under section [355] to use under the professional supervision of a practitioner licensed by law to administer such drug⁶¹

The “habit-forming drug” provision was repealed in 1997,⁶² but section 503(b) remains otherwise unchanged.⁶³

The second provision of the paragraph quoted above left the decision about the prescription status of drugs already on the market to their manufacturers and limited FDA’s role to post-marketing challenges to these decisions.⁶⁴ Nevertheless, because Section 503(b) subjected manufacturers who miscategorized a drug to legal penalties for misbranding, it effectively established mandatory prescription status. More important, the third provision authorized FDA to apply the prescription requirement to any new drug as part of the new drug

58. 9 Fed. Reg. 3867, 3868 (Apr. 11, 1944). *See also* Gregory W. Reilly, The FDA and Plan B: The Legislative History of the Durham-Humphrey Amendments and the Consideration of Social Harms in the Rx-OTC Switch 13 (May 12, 2006) (on file with Harvard Library) (discussing the 1944 regulation).

59. Harry M. Marks, *Revisiting “The Origins of Compulsory Drug Prescriptions,”* 85 AM. J. PUB. HEALTH 109, 111 (1995) (quoting 9 Fed. Reg. 3867, 3868 (Apr. 11, 1944)).

60. Humphrey-Durham Amendments, Pub. L. No. 82-215, 65 Stat. 648 (1951).

61. *Id.*

62. Food and Drug Administration Modernization Act of 1997, Pub. L. No. 105-115, § 126, 111 Stat. 2296, 2327.

63. 21 U.S.C. § 353(b)(1).

64. Temin, *supra* note 50, at 102–03; Marks, *supra* note 59, at 112.

application (NDA) approval process. This provision gave FDA the power to determine the prescription status of a new drug as an initial matter, and it would turn out to be far more important than the second provision. FDA imposes prescription status on almost all NDA-approved drugs at the time of initial approval, and most prescription drugs currently on the market are subject to the prescription requirement for this reason.⁶⁵

The agency may later⁶⁶ switch a drug to OTC status through one of several regulatory mechanisms.⁶⁷ First, FDA can implement a switch through notice-and-comment rulemaking, either on its own or in response to a citizen petition.⁶⁸ This mechanism implements section 503(b)(3) of the FD&C Act, which provides that the agency may change a drug to over-the-counter status by regulation when the prescription status mandated by its NDA approval is no longer “necessary for the protection of the public health.”⁶⁹ Between 1955 and 1971, the agency transferred approximately thirty drugs to OTC status under this procedure.⁷⁰ Acetaminophen (Tylenol[®]) is probably the most prominent of the medications switched in this manner.⁷¹ FDA has never conducted a “forced switch” over the objections of an NDA-holder in response to a petition submitted by another entity, such as an insurance company.⁷² Its legal authority to do so is unclear, and the agency’s position generally seems to be that a third party cannot generate all of the data necessary to support a switch in any event.⁷³

65. Reilly, *supra* note 58, at 27 n.90; Madison Kilbride, Steven Joffe & Holly Fernandez Lynch, *Prescription Requirements and Patient Autonomy: Considering an Over-the-Counter Default*, 50 HASTINGS CTR. REP. NOV.–DEC. 2020, at 15, 16 (“Since the mid-1980s, there have been fewer than five instances in which a new molecular entity was approved first for OTC use.”).

66. FDA ordinarily will not switch a drug until at least five years after the commencement of marketing. PETER BARTON HUTT, RICHARD A. MERRILL, LEWIS A. GROSSMAN, NATHAN CORTEZ, ERIKA FISHER LIETZAN & PATRICIA J. ZETTLER, *FOOD AND DRUG LAW 1217* (5th ed. 2022).

67. Lewis A. Grossman, *FDA and the Rise of the Empowered Consumer*, 66 ADMIN. L. REV. 627, 663–64 (2014); HUTT, MERRILL, L. GROSSMAN, CORTEZ, LIETZAN & ZETTLER, *supra* note 66, at 1217–18.

68. This procedure is set forth at 21 C.F.R. § 310.200 (2022).

69. 21 U.S.C. § 353(b)(3).

70. L. Grossman, *supra* note 67, at 663.

71. *Id.*

72. See Daniel I. Gorlin, *Staving off Death: A Case Study of the Pharmaceutical Industry’s Strategies to Protect Blockbuster Franchises*, 63 FOOD & DRUG L.J. 823, 856–57 (2008) (describing how in 1998, the FDA faced, for the first time, the decision of whether to grant an OTC switch petition by a non-manufacturer).

73. *Id.* at 856–59; Kurt R. Karst, *Has FDA Already Resolved One Critical Issue Concerning Forced Rx-to-OTC Switches?*, HYMAN, PHELPS & MCNAMARA: FDA L. BLOG (Feb. 8, 2010), <https://www.thefdalawblog.com/2010/02/has-fda-already->

A switch can also occur in connection with a program called the OTC Drug Review, established in 1972.⁷⁴ Although the review was intended primarily to determine the effectiveness of drug ingredients that were already sold over-the-counter before the 1962 Drug Amendments required premarket review of effectiveness as well as safety, the resulting monographs listing legal OTC ingredients also embraced some previously Rx-only products.⁷⁵ Between the 1970s and the early 1990s, FDA switched approximately thirty-two drugs through this mechanism, including hydrocortisone and various cough and cold products.⁷⁶

In the mid-1980s, a third switch era began when FDA began converting drugs from prescription to OTC by approving supplemental NDAs (sNDAs) submitted by their manufacturers.⁷⁷ For the past few decades, virtually all switches have occurred through this mechanism, including: ibuprofen (Advil[®]) for pain and fever (1984); loperamide (Imodium[®]) for diarrhea (1988); clotrimazole (Lotrimin[®]) for athlete's foot and jock itch (1989); permethrin (Nix[®]) for head lice (1990); clotrimazole (Gyne-Lotrimin[®] and Mycelex[®]) for vaginal yeast infections (1990); famotidine (Pepcid AC[®]) for acid indigestion (1995); nicotine polacrilex (Nicorette[®]) for smoking cessation (1996); and loratadine (Claritin[®]) for seasonal allergies (2002).⁷⁸ Under this method, the holder of the prescription NDA has complete control over whether and when to seek nonprescription status.⁷⁹ Pursuant to a related procedure rarely used for switches, the "section 505(b)(2) NDA," a company may apply to market an OTC version of a drug sold as a prescription product by another company.⁸⁰

To support a switch application, a sponsor must perform various types of studies to demonstrate that consumers can use the drug safely and effectively without professional supervision. These generally include "label-comprehension" and "self-selection" studies and sometimes also include "actual use" studies (investigations of the drug's use under OTC-like conditions).⁸¹ Although patents for switched drugs are usually

resolved-one-critical-issue-concerning-forced-rxtootc-switches/
[<https://perma.cc/TVN8-EXY8>].

74. See HUTT, MERRILL, L. GROSSMAN, CORTEZ, LIETZAN & ZETTLER, *supra* note 66, at 1230-41.

75. L. Grossman, *supra* note 67, at 664.

76. *Id.*

77. *Id.*

78. *Id.*

79. See HUTT, MERRILL, L. GROSSMAN, CORTEZ, LIETZAN & ZETTLER, *supra* note 66, at 1218.

80. *Id.*

81. CTR. FOR DRUG EVALUATION & RSCH., FDA, GUIDANCE FOR INDUSTRY: LABEL COMPREHENSION STUDIES FOR NONPRESCRIPTION DRUG PRODUCTS 1, 3 (2010)

expired by the time the switch occurs, a manufacturer can get three years of statutory exclusivity on the OTC marketplace if the applicant performs new clinical investigations necessary to support the switch.⁸² Because actual use studies are “clinical investigations,” the performance of one mandated by FDA will qualify a product for OTC exclusivity.⁸³

B. The Statutory Criteria

When deciding whether to approve a switch application, FDA uses the criteria for prescription status listed in the second Durham-Humphrey provision quoted above.⁸⁴ This language echoes that of the agency’s 1944 regulation, with one notable difference: Congress eliminated any reference to the drug’s effectiveness.⁸⁵ Therefore, on the face of the statute, the line between prescription and OTC drugs seems to be based only on whether a layperson can use the drug *safely* without professional intervention. When Congress stripped references to “efficacious” from the last version of the Durham-Humphrey bill, however, it explained that “[t]his omission is not intended to mean that the only matter to be considered in applying the definition is whether or not a particular drug is poisonous.”⁸⁶ The Senate report observed that some nontoxic drugs for serious diseases may not be safe for self-medication “because their unsupervised use may indirectly cause injury or death”⁸⁷—presumably by failing to treat the diseases. Similarly, a court has observed: “the fact that a particular product may be an ineffectual remedy under some circumstances could certainly be a substantial consideration in finding that it is unsafe for self-medication.”⁸⁸

Accordingly, when deciding whether to switch a drug to OTC status, the agency has always considered whether a drug can be used safely *and effectively* without a prescription. FDA regulations provide:

[hereinafter GUIDANCE FOR INDUSTRY: LABEL COMPREHENSION STUDIES]; CTR. FOR DRUG EVALUATION & RSCH., FDA, GUIDANCE FOR INDUSTRY: SELF SELECTION STUDIES FOR NONPRESCRIPTION DRUG PRODUCTS 1 (2013).

82. 21 U.S.C. § 355(c)(E)(iii); 21 C.F.R. § 314.108 (2022).

83. See HUTT, MERRILL, L. GROSSMAN, CORTEZ, LIETZAN & ZETTLER, *supra* note 66, at 1220–21.

84. Humphrey-Durham Amendments, Pub. L. No. 82-215, 65 Stat. 648 (1951).

85. Reilly, *supra* note 58, at 37–39.

86. S. REP. NO. 82-946, at 4 (1951).

87. *Id.*

88. *United States v. Article of Drug Labeled Decholin*, 264 F. Supp. 473, 482 (E.D. Mich. 1967).

Any drug limited to prescription use under section 503(b)(1)(B) of the act shall be exempted from prescription-dispensing requirements when the Commissioner finds such requirements are not necessary for the protection of the public health by reason of the drug's toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, and he finds that the drug is safe *and effective* for use in self-medication as directed in proposed labeling.⁸⁹

The last clause seems to go further than the original legislative intent by permitting the agency to consider effectiveness totally isolated from the question of safety. For example, it would permit FDA to require a nontoxic hair growth medicine to be sold only on prescription if professional supervision is required merely to ensure that the drug is effective.⁹⁰

The FD&C Act and FDA's implementing regulation list the same four specific characteristics of a drug that the agency should consider in making Rx/OTC determinations: "toxicity," "other potentiality for harmful effect," "the method of its use," and "the collateral measures necessary to its use."⁹¹ FDA itself has never formally clarified the meaning of these terms,⁹² and only a few courts have addressed them.⁹³

89. 21 C.F.R. § 310.200(b) (emphasis added). According to its web page on Rx-OTC switches, a switch application should "contain both efficacy and safety data demonstrating that the drug product is safe to use in the nonprescription setting" and "must provide data that demonstrate consumers can understand how to use the drug safely and effectively without the supervision of a healthcare professional." *Prescription-to-Nonprescription (Rx-to-OTC) Switches*, FDA, <https://www.fda.gov/drugs/drug-application-process-nonprescription-drugs/prescription-nonprescription-rx-otc-switches> [https://perma.cc/TX4C-998E] (June 28, 2022). See also GUIDANCE FOR INDUSTRY: LABEL COMPREHENSION STUDIES, *supra* note 81, at 3 ("The goal of a label comprehension study should be to test consumer comprehension of the major communication messages that detail the safe and effective use of a nonprescription drug product.").

90. Notably, the OTC drug review was premised on the question of whether ingredients were generally recognized as safe *and effective* for lay use. 21 C.F.R. § 330.10 (2022).

91. 21 U.S.C. § 353(b)(1)(A); 21 C.F.R. § 310.200(b).

92. The Senate report issued in support of the Durham-Humphrey legislation explicitly recognized FDA's authority to issue interpretive regulations providing more precise meaning to the statutory definition of "prescription drugs," but the agency never did so. S. REP. NO. 82-946, at 4-5 (1951).

93. See *United States v. Article of Drug Labeled Decholin*, 264 F. Supp. 473 (E.D. Mich. 1967); *Nat'l Nutritional Foods Ass'n v. Weinberger*, 512 F.2d 688, 704 (2d Cir. 1975); *United States v. Gen. Nutrition, Inc.*, 638 F. Supp. 556, 559-60 (W.D.N.Y. 1986).

1. “TOXICITY”

According to Section 503(b)(1)(A), a drug should be sold only on prescription if “because of its toxicity . . . [it] is not safe for use except under the supervision of a practitioner licensed by law to administer such drug.”⁹⁴ “Toxicity” should not be read narrowly as synonymous with “poisonous.” Rather, the word refers to the “state of being a potential source of harm for any reason directly attributable to its ingredients.”⁹⁵

Conversely, in the context of the statute, “toxicity” should not be interpreted too broadly. For example, this factor cannot mean that a drug should be limited to prescription sale whenever an overdose of the drug may harm the consumer. After all, many OTC drugs—for example, Tylenol® (acetaminophen)—can be extremely dangerous when taken in more than the labeled amount.⁹⁶ The leading case interpreting the “toxicity” provision, *United States v. Article of Drug Labeled Decholin*,⁹⁷ examines its legislative history and concludes that a drug should be made a prescription drug on this basis “only if it is hazardous for the reason that there is more than a remote possibility that it will cause harm when used in a reasonable manner.”⁹⁸ The court continues: “If, in attempting to evaluate a drug, a court were to consider every contingency and take account of the immaturity or stupidity of every potential user, it would not be paying heed to the [Senate] Committee’s desire that it give to the word ‘safe’ the ordinary meaning.”⁹⁹ That said, the possibility of overdose is not wholly irrelevant to the Rx/OTC determination. Another court, assessing the status of high-dosage vitamins, rejected the contention that FDA should only consider whether a drug is toxic when taken in accordance with the labeling.¹⁰⁰ “It was reasonable for the Commissioner to recognize that the risks of toxicity are increased by over-the-counter availability of readily ingestible, high dosage forms,

94. 21 U.S.C. § 353(b)(1)(A).

95. *Decholin*, 264 F. Supp. at 476 n.2.

96. Susan E. Farrell & Michael A. Miller, *Acetaminophen Toxicity*, MEDSCAPE, <https://emedicine.medscape.com/article/820200-overview> [https://perma.cc/6S38-2K94] (Oct. 5, 2021).

97. *Decholin*, 264 F. Supp. 473.

98. *Id.* at 480.

99. *Id.* See also Peter Barton Hutt, *A Legal Framework for Future Decisions on Transferring Drugs from Prescription to Nonprescription Status*, 37 FOOD DRUG COSM. L.J. 427, 434 (1982) (“[T]he mere possibility that a drug can be misused, with toxic results, is not sufficient by itself to retain that drug in prescription status. . . . [V]irtually any drug can be misused with some toxic results.”).

100. *Nat’l Nutritional Foods Ass’n v. Weinberger*, 512 F.2d 688, 704 (2d Cir. 1975).

and therefore he could rationally conclude that these forms have a 'potential harmful effect.'"¹⁰¹

"Toxicity" also cannot mean that a drug is capable of causing *any* adverse effects or that it can cause significant adverse effects in *some* people, regardless of how few. Because almost all drugs sometimes cause side effects, such a reading would impose prescription status on most medicines currently sold over the counter. *Decholin* clarifies that the question is whether adverse effects are likely to have severe consequences for the consumer if the drug is consumed without physician oversight. This depends on "the seriousness of the effect likely to result" and the "immediacy of the harmful consequences," as well as on whether the harmful effect is noticeable enough so that the consumer "could be expected to appreciate that the drug is doing him no good and discontinue its use before real harm occurs."¹⁰² When considering whether a drug's toxicity renders it inappropriate for over-the-counter sale, FDA will ask whether the medicine's risk can be mitigated through labeling. For example, an OTC drug label can warn people with heightened susceptibility to a drug's adverse effects not to take the drug except under the advice and supervision of a physician.¹⁰³

One factor that makes a drug more likely to be classified as a prescription drug based on toxicity is a "low margin of safety."¹⁰⁴ This phrase describes situations when a drug's most effective dose is not much lower than an unacceptably toxic dose.¹⁰⁵ For example, if the optimal dose for a drug were one milligram, but a two-milligram dose were highly toxic, FDA probably would not permit the drug to be sold over-the-counter.¹⁰⁶ As Peter Barton Hutt has explained, such drugs should be prescription drugs because they have to be "titrated carefully to achieve an adequate level of effectiveness without endangering patient safety."¹⁰⁷

101. *Id.*

102. *Decholin*, 264 F. Supp. at 481.

103. Gerald M. Rachanow, *The Switch of Drugs from Prescription to Over-the-Counter Status*, 39 FOOD DRUG COSM. L.J. 201, 204-05 (1984).

104. *Id.* at 204.

105. *Id.*; Hutt, *supra* note 99, at 434.

106. See Sidney Wolfe, Dir., Pub. Citizen's Health Rsch. Grp., Statement at FDA Hearing on Over the Counter Drug Products (June 28, 2000), https://downloads.regulations.gov/FDA-2000-N-0112-0109/attachment_1.pdf [<https://perma.cc/CU66-WUTP>] ("The switch of drugs with a low margin of safety—ones where a doubling of dose may significantly increase the toxicity—should be generally opposed.")

107. Hutt, *supra* note 99, at 433.

2. “OTHER POTENTIALITY FOR HARMFUL EFFECT”

The meaning of the second section 503(b) factor, “other potentiality for harmful effect,” is uncertain. The legislative history of the Durham-Humphrey Amendment contains no discussion of the meaning of this phrase.¹⁰⁸ Hutt’s seminal article on the Rx/OTC distinction interprets it as covering nontoxic harmful risks to human health, including, for example, abuse potential, dangerous interaction with food, and reduced effectiveness of a drug due to overuse (as occurs with antibiotics).¹⁰⁹ One case seems to hold that this factor—like toxicity—is limited to harm caused by the “inherent characteristics of a drug.”¹¹⁰

3. “THE METHOD OF ITS USE”

The Durham-Humphrey legislative history is similarly silent with respect to the “method of use” factor.¹¹¹ This language presumably refers to the drug’s route of administration—for example, oral, transdermal, rectal, or parenteral (that is, by injection). Few routes of administration always require the involvement of a health professional. Consider, for example, that some types of synthetic human insulin—as opposed to insulin analogs—are available without a prescription even though they are administered by subcutaneous injection.¹¹² Perhaps the only common category of drugs that is automatically prescription status because of their “method of use” is those injected directly into the bloodstream or into other locations posing special challenges or risks, such as the eye or the bone marrow cavity.

108. Reilly, *supra* note 58, at 40.

109. Hutt, *supra* note 99, at 434–36.

110. *United States v. Gen. Nutrition, Inc.*, 638 F. Supp. 556, 559 (W.D.N.Y. 1986)

111. Reilly, *supra* note 58, at 40.

112. Sarah Gantz, *High Cost of Insulin May Be Sending Consumers to Use Over-The-Counter Version, Researchers Say*, PHILA. INQUIRER (Feb. 23, 2019), <https://www.inquirer.com/health/insulin-prices-diabetes-walmart-reunion-20190218.html>; Hutt, *supra* note 99, at 436. Because they must be stored in a refrigerator, nonprescription human insulin products are typically held by the pharmacist “behind the counter.” See Ginger Vieira, *Everything You Need to Know About Walmart Insulin*, DIABETES STRONG (Oct. 5, 2022), <https://diabetesstrong.com/walmart-insulin/> [<https://perma.cc/6WSB-6BT2>]. Notably, a growing number of prescription drugs are self-injectable; *California 3 Tier Drug List*, HEALTH NET, <https://www.healthnet.com/content/dam/centene/healthnet/pdfs/pharmacy/ca/hn-3-tier-specialty-drug-list.pdf> [<https://perma.cc/9UH7-A5AB>] (Sept. 1, 2023) (drugs listed in tier 4 are self-injectable).

4. "THE COLLATERAL MEASURES NECESSARY TO ITS USE"

"Collateral measures necessary to use" is the vaguest of the Rx/OTC factors. A federal court described this language as "a catchall provision designed to cover drugs which merit prescription-status scrutiny, but do not fit within the more precise specifications of the subsection."¹¹³ For instance, when considering a case concerning an indigestion treatment, the *Decholin* Court asked:

[D]oes the fact that Decholin may be taken by a person who, although experiencing the indications set out on the label, has an ailment which Decholin cannot cure, coupled with the fact such an individual may postpone a visit to his physician in reliance upon the over-the-counter availability of Decholin, cause the drug to be unsafe?¹¹⁴

United States v. General Nutrition,¹¹⁵ a case involving a dietary supplement promoted for use against hypertension, stated:

Collateral measures necessary to the safe use of Gammaprim in the management of hypertension means all those things which a layman, because of his or her lack of education, training, and experience, cannot do to safely manage the disease. These include taking a proper history, doing a physical exam, ordering appropriate laboratory tests, having a knowledge of the diseases that cause hypertension, integrating the results of the history, exam, and tests with this knowledge, making a diagnosis, designing a treatment plan, and carrying the plan through with proper continuing evaluation.¹¹⁶

Both *General Nutrition* and *Decholin* emphasized that a drug is not necessarily a prescription drug merely because it treats a condition that *could be* a symptom of a serious disease that laypeople cannot diagnose or treat on their own.¹¹⁷ Under such a reading, there would, in the words of the *Decholin* Court, "be few drugs left on the over-the-counter market."¹¹⁸ The precise risk of delaying a visit to a doctor is an essential

113. *General Nutrition, Inc.*, 638 F. Supp. at 559.

114. *United States v. Article of Drug Labeled Decholin*, 264 F. Supp. 473, 476 (E.D. Mich. 1967).

115. *General Nutrition, Inc.*, 638 F. Supp. 556.

116. *Id.*

117. *Id.* at 560; *Decholin*, 264 F. Supp. at 482–83.

118. *Decholin*, 264 F. Supp. at 482.

consideration.¹¹⁹ Another critical question is whether OTC labeling can adequately warn consumers to consult with a physician if certain symptoms persist or new ones emerge.¹²⁰ FDA is quite likely to conclude that clear and informative consumer labeling suffices to address this situation unless the OTC drug, by relieving symptoms, might cause users to conclude inaccurately that they are cured and thus dangerously delay visiting a doctor for treatment of a serious disease.¹²¹

In his article, Hutt explains that in factoring “method of use and collateral measures necessary to use” into a switch decision, FDA will weigh a variety of considerations, none of them dispositive in and of itself.¹²² These considerations fall within the rubrics of “self-diagnosis,” “self-treatment and self-care,” and “adequate labeling.”¹²³ Hutt emphasizes the last of these, suggesting that concerns such as inaccurate self-diagnosis, delayed consultations with medical professionals, and improper administration (as well as concerns about toxicity) can all be mitigated through proper instructions and warnings.¹²⁴ “Thus, labeling must be regarded as central to all . . . determinations of prescription/nonprescription status.”¹²⁵

Hutt further argues that “method of use and collateral measures necessary to use” has “the broadest possible scope.”¹²⁶ He contends, “There is perhaps no issue involving drug use that cannot properly be brought into consideration under this factor.”¹²⁷ Thus, Hutt argues, FDA validly considers questions of “social policy” in its Rx-OTC decisions, even though neither section 503(b) nor its legislative history makes any direct reference to such questions.¹²⁸ For example, when considering the possibility of an OTC contraceptive drug, the agency will take (and in Hutt’s eyes, apparently *should* take) “broad questions of social policy” into account.¹²⁹ Hutt also endorses the use of other “social policy” considerations, such as the costs of adequate professional care for the poor.¹³⁰ Gregory Reilly agrees that FDA may consider social harms in

119. *Id.* at 483.

120. *Id.*; *General Nutrition, Inc.*, 638 F. Supp. at 560.

121. R. William Soller, “OTCness,” 32 DRUG INFO. J. 555, 558 (1998) (“In general, OTC labeling can be considered an appropriate safeguard for such considerations . . .”); *Decholin*, 264 F. Supp. at 483.

122. Hutt, *supra* note 99, at 436–39.

123. *Id.*

124. *Id.* at 438.

125. *Id.*

126. *Id.* at 436.

127. *Id.*

128. *Id.* at 438.

129. *Id.*

130. *Id.* at 438–39.

Rx-OTC decisions, but only if they are “real costs to society” that are “quantifiable, generally recognized as harmful, and reasonably probable.”¹³¹ Reilly thus concludes that FDA’s initial refusal to switch Plan B emergency contraception to OTC status for adolescents as well as adults (discussed below)¹³² was inappropriate, because the agency considered social harms—increased promiscuity and decreased condom use—that were not “realistic probabilities” without additional evidence.¹³³

In sum, FDA always applies the explicit statutory factors set forth in section 503(b) of the FD&C Act when deciding whether to switch a drug from Rx to OTC status. The agency reads these factors broadly to sweep in a wide range of considerations. Moreover, although Section 503(b) itself refers only to the “safe” use of a drug, the agency inquires whether a drug can be used safely *and effectively* without a prescription.¹³⁴ The overarching question in any Rx-OTC switch matter is whether patient labeling can successfully ensure a positive answer to this question. Finally, as Hutt asserts, “many determinations of prescription/nonprescription status depend in large measure upon unarticulated principles of social policy.”¹³⁵

II. OTC STATUS AND THE BENEFITS OF IMPROVED ACCESS

An additional factor that FDA should consider in any Rx-OTC decision is the potential *benefits* (as well as risks) of the easier access provided by OTC status. Section 503(b) and agency regulations fail to mention this critical consideration. Thus, although FDA sometimes takes this factor into account in practice, it does so in a haphazard way and arguably gives the factor insufficient weight.

Every consumer knows that it is more convenient and less time-consuming to obtain an OTC drug than a prescription product. The purchaser of an OTC drug does not have to make an appointment with a practitioner and does not have to take time off work or away from family to visit the practitioner. Although patients who have pre-established relationships with health care providers can often obtain a prescription through a telephone call to their provider, many Americans do not have such relationships. In any event, even obtaining a prescription by telephone and then filling it takes some time, thus delaying acquisition of the drug. Furthermore, OTC drugs are available at a much wider array

131. Reilly, *supra* note 58, at 9.

132. *Infra* pp. 1101–02.

133. Reilly, *supra* note 58, at 62–64.

134. Hutt, *supra* note 99, at 432–33.

135. *Id.* at 438.

of retailers than prescription drugs. Nonprescription status also affords consumers more privacy; in the age of self-checkout, a person can purchase an OTC drug without having to interact with a practitioner, a pharmacist, or even a cashier.¹³⁶ Finally, whereas there are generally no limits on the quantity of an OTC drug that a consumer can purchase, prescribers and insurers commonly limit the amount of a prescription medicine that a patient can obtain at one time—a serious inconvenience for some patients who use a prescription drug for a prolonged period.¹³⁷

In one respect, a switch from Rx to OTC status can sometimes hinder access—by increasing out-of-pocket costs for consumers with insurance that covers prescription drugs. Until quite recently in history, few Americans had prescription drug coverage. In 1970, only 16.5 percent of retail prescription drug expenditures were paid for by any sort of insurance, government or private—most commonly by Medicaid.¹³⁸ By 2012, this number was 81.3 percent due to the enactment of Medicare Part D and the dramatic expansion of prescription drug coverage by private insurers.¹³⁹ Moreover, the out-of-pocket costs for prescription drugs covered by insurance seem to have been trending downward in recent years.¹⁴⁰ Because many public and private insurance plans cover prescription drugs but not OTC drugs,¹⁴¹ one might expect an Rx-OTC switch to shift significant costs from third-party payers to consumers.

136. Jongwha Chang, Allison Lizer, Isha Patel, Deepak Bhatia, Xi Tan & Rajesh Balkrishnan, *Prescription to Over-the-Counter Switches in the United States*, 5 J. RSCH. PHARMACY PRAC. 149, 150–51 (2016); Eric P. Brass, Ragnar Löfstedt & Ortwin Renn, *Improving the Decision-Making Process for Nonprescription Drugs: A Framework for Benefit–Risk Assessment*, 90 CLINICAL PHARMACOLOGY & THERAPEUTICS 791, 792 (2011) [hereinafter *Improving the Decision-Making Process*]; JEFFREY A. SINGER & MICHAEL F. CANNON, CATO INST., *DRUG REFORMATION: END GOVERNMENT’S POWER TO REQUIRE PRESCRIPTIONS* 4 (2020), <https://www.cato.org/sites/cato.org/files/2022-03/white-paper-drug-reformation-updated-3-7-2022.pdf> [<https://perma.cc/8UN8-U2CP>].

137. Amanda Dennis & Daniel Grossman, *Barriers to Contraception and Interest in Over-the-Counter Access Among Low-Income Women: A Qualitative Study*, 44 PERSPS. ON SEXUAL & REPROD. HEALTH 84, 87 (2012).

138. Lewis A. Grossman, *Drugs, Biologics, and Devices: FDA Regulation, Intellectual Property, and Medical Products in the American Healthcare System*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 637, 656 (2015).

139. *Id.*

140. William A. Carroll, G. Edward Miller & Steven C. Hill, *Statistical Brief #532: Out-of-Pocket Spending for Retail Prescribed Drugs by Age and Type of Prescription Drug Coverage, 2009 to 2018*, AGENCY FOR HEALTHCARE RSCH. & QUALITY (Dec. 2020), https://meps.ahrq.gov/data_files/publications/st532/stat532.pdf [<https://perma.cc/6XAX-HNT5>].

141. Frank Gianfrancesco, Beatrice Manning & Ruey-Hua Wang, *Effects of Prescription-to-OTC Switches on Out-of-Pocket Health Care Costs and Utilization*, MEDSCAPE (2002), https://www.medscape.com/viewarticle/431114_6 [<https://perma.cc/FDB4-K4HB>]; Joshua Cohen, Aurelie Millier, Slim Karray &

However, the precise financial impacts of such switches on consumers are understudied, difficult to calculate, and vary tremendously.¹⁴² Drug manufacturers typically lower their products' prices substantially when they switch them to OTC status.¹⁴³ Therefore, for people without prescription drug coverage—approximately thirteen percent of the population in 2021¹⁴⁴—a switch to OTC status invariably lowers the cost of obtaining a drug.¹⁴⁵ For insured patients, the financial impact of an Rx-OTC switch depends on the drug and the details of their insurance coverage. Even patients with prescription drug coverage can find themselves burdened with significant out-of-pocket expenses due to copays, deductibles, and coverage denials. For example, a 2018 study of the out-of-pocket costs for retail prescription drugs incurred by elderly patients found that five percent with private drug coverage paid at least \$1,011 annually and five percent with Medicare Part D coverage paid at least \$1,490 annually.¹⁴⁶ It is also important to note that these direct out-of-pocket costs do not include the indirect costs attendant to obtaining a prescription drug: physician visits, travel expenses, and time away from work.¹⁴⁷

To complicate things even further, an increasing number of private health insurers, state insurers, and Medicare Advantage plans offer OTC drug benefits, including direct coverage of some drugs that have switched

Mondher Toumi, *Assessing the Economic Impact of Rx-to-OTC Switches: Systematic Review and Guidelines for Future Development*, 16 J. MED. ECON. 835, 835 (2013).

142. *Improving the Decision-Making Process*, *supra* note 136, at 798; Cohen, Millier, Karray & Toumi, *supra* note 141, at 842.

143. Sam Peltzman, *Prescription for Lower Drug Prices: More OTC Transitions*, 41 REGUL. Spring 2018, at 2, 2.

144. Sasha Guttentag, *Survey: More Americans Uninsured Compared to Last Year, and Prescription Medication Coverage Hasn't Improved*, GOODRX (Feb. 19, 2021), <https://www.goodrx.com/insurance/health-insurance/survey-more-americans-uninsured-compared-to-last-year>.

145. *Id.* It also does so for customers with drug coverage whose insurance does not cover the particular prescription their physician has prescribed. In 2020, more than thirty percent of adults reported that they or their household members had been denied coverage for a drug prescribed by their doctor in the past year. *Life Experiences and Income Inequality in the United States*, HARVARD T.H. CHAN SCH. OF PUB. HEALTH (Jan. 2020), <https://www.hsph.harvard.edu/wp-content/uploads/sites/94/2020/01/Income-inequality-report-topline-January2020.pdf> [<https://perma.cc/LZ3T-7MK8>].

146. Carroll, Miller & Hill, *supra* note 140 (the corresponding figure for elderly patients with no drug coverage was \$1,624).

147. Chang, Lizer, Patel, Bhatia, Tan & Balkrishnan, *supra* note 136, at 151; Peltzman, *supra* note 143, at 2; SINGER & CANNON, *supra* note 136, at 24–27; Cohen, Millier, Karray & Toumi, *supra* note 141, at 843. Of course, consumers will see no such savings from a switch to OTC status if ineffective self-care, product misuse, and product substitution lead to an increase in physician visits. A 2002 study found this effect with respect to four switches. Gianfrancesco, Manning & Wang, *supra* note 141.

from Rx to OTC.¹⁴⁸ Medicaid coverage of OTC drugs varies state by state, but all states' programs cover such products to some extent, and some states have quite generous OTC benefits.¹⁴⁹ Moreover, the Affordable Care Act of 2010 requires private health plans to cover certain categories of OTC preventive medicines with no co-pays or deductibles if the patient obtains a prescription for them.¹⁵⁰ Examples include aspirin, fluoride, folic acid, vitamin D supplements, smoking cessation aids, and (critical to this article) OTC contraceptives—if an employer does not exercise an exemption for contraceptive coverage based on religious objections.¹⁵¹ As more drugs shift from prescription to OTC status, insurers may extend coverage to a greater variety of nonprescription products.¹⁵²

For all these reasons, even for insured consumers, total out-of-pocket costs are often quite similar for Rx and OTC drugs, and a switch can sometimes lower these costs.¹⁵³ FDA (taking all costs into account) estimates that the switch of a drug from prescription to nonprescription status saves insured customers between \$0 and \$53.50 per purchase, with a primary estimate of \$26.70.¹⁵⁴ Moreover, even if a drug becomes more

148. SINGER & CANNON, *supra* note 136, at 46; Jennifer McIntosh, Britt Wahlin, Kate Grindlay, Myra Batchelder & Daniel Grossman, *Insurance and Access Implications of an Over-the-Counter Switch for a Progestin-Only Pill*, 45 PERSPS. ON SEXUAL & REPROD. HEALTH 164, 165 (2013). For an example of a Medicare Advantage plan with an OTC drug allowance, see *Over-the-Counter Allowance*, BLUE CROSS BLUE SHIELD BLUE CARE NETWORK MICH., <https://www.bcbsm.com/medicare/resources/advantage-extras/over-counter-allowance/> [<https://perma.cc/67RA-HJL5>].

149. CONG. RSCH. SERV., R43778, MEDICAID PRESCRIPTION DRUG PRICING AND POLICY 10 (2014). *See, e.g., Aetna Better Health of Virginia Formulary Guide*, AETNA (Sept. 2023), https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/pdfs/formulary/Aetna_Better_Health_of_Virginia_PDL.pdf [<https://perma.cc/35T6-7F8R>].

150. *See Patient Protection and Affordable Care Act – Preventive Items and Services*, EXPRESS SCRIPTS (2018), https://www.express-scripts.com/art/open_enrollment/STB_ACAPrevMeds.pdf [<https://perma.cc/P94H-DJAZ>].

151. *Id.* In September 2022, a U.S. district court struck down a certain ACA preventive care mandate. *Braidwood Mgmt. Inc. v. Becerra*, 627 F. Supp. 3d 624 (N.D. Tex. 2022). In May 2023, the U.S. Court of Appeals for the Fifth Circuit issued an administrative stay in this case. *Braidwood Mgmt. Inc. v. Becerra*, No. 23-10326 (5th Cir. 2023). Coverage without cost sharing of some of these OTC preventive medicines will no longer be mandated if the district court's decision is ultimately upheld.

152. Kilbride, Joffe & Lynch, *supra* note 65, at 18.

153. Chang, Lizer, Patel, Bhatia, Tan & Balkrishnan, *supra* note 136, at 151; Patrick W Sullivan, *Switching Prescription Drugs to Over the Counter*, 330 BMJ 904, 905 (2005).

154. FDA, DOCKET NO. FDA-2021-N-0862, NONPRESCRIPTION DRUG PRODUCT WITH AN ADDITIONAL CONDITION FOR NONPRESCRIPTION USE (2021), at 11–12, <https://www.fda.gov/media/159311/download> [<https://perma.cc/W3QL-NSHS>].

expensive for a patient due to an OTC switch, other, similarly effective products for the same condition may remain available on prescription and thus still be covered by insurance.

In any event, studies suggest that many people are willing to pay at least a modest additional price for the convenience that OTC status offers.¹⁵⁵ This fact helps explain why even in a population in which most people have fairly comprehensive coverage for prescription drugs and limited coverage for OTC medicines, the utilization of a drug usually increases substantially after a switch—on average about thirty percent for the first drug in a class that switches.¹⁵⁶

Moreover, in some situations, the quicker access afforded by OTC status has benefits beyond mere convenience. For drugs with a very narrow time window of efficacy, the difference between prescription and nonprescription status can determine, as a practical matter, whether the drug is available for use at all. Perhaps the best example is naloxone, a drug approved to reverse opioid overdose, discussed later in this article.¹⁵⁷ Other drugs provide a slightly longer time window but lose effectiveness rapidly even during that period. For such medicines, the rapid acquisition that OTC status makes possible directly contributes to the drug's effectiveness.¹⁵⁸ A good example of this type of product is emergency contraceptive pills, also discussed below.¹⁵⁹

For any drug intended to treat a condition for which a significant portion of the population is untreated, an OTC switch “can be an important policy tool for improving public health” simply by virtue of increasing the drug's utilization.¹⁶⁰ For example, one study estimated that

155. Daniel Grossman, Kate Grindlay, Rick Li, Joseph E. Potter, James Trussell & Kelly Blanchard, *Interest in Over-the-Counter Access to Oral Contraceptives Among Women in the United States*, 88 *CONTRACEPTION* 544, 549 (2013); Michelle Long, Brittni Frederiksen, Usha Ranji, Karen Diep & Alina Salganicoff, *Interest in Using Over-the-Counter Contraceptive Pills: Findings from the 2022 KFF Women's Health Survey*, KFF (Nov. 3, 2022), <https://www.kff.org/womens-healthpolicy/issue-brief/interest-using-over-the-counter-oral-contraceptive-pills-findings-2022-kff-womens-health-survey/> [<https://perma.cc/676C-HAJP>].

156. Chris Stomberg, Tomas Philipson, Margaret Albaugh & Neeraj Sood, *Utilization Effects of Rx-OTC Switches and Implications for Future Switches*, 5 *HEALTH* 1667, 1667 (2013).

157. *See infra* pp. 1085–88.

158. One might assume that regardless of its impact on effectiveness, prescription status would always work in favor of drug safety. But an economist has studied the health effects of prescription requirements in the United States and abroad and, counterintuitively, concluded that prescription requirements may increase mortality from drug poisoning overall by shifting the population from less to more potent drugs. Sam Peltzman, *The Health Effects of Mandatory Prescriptions*, 30 *J.L. & ECON.* 207, 217 (1987).

159. *Infra* pp. 1099–103.

160. Stomberg, Philipson, Albaugh & Sood, *supra* note 156.

switching a low dose statin drug (a treatment for high cholesterol) to OTC status would avert at least 250,000 coronary heart disease events over ten years in the United States.¹⁶¹ The increase in attempts to quit smoking prompted by the 1996 switch of nicotine replacement to OTC status (discussed below¹⁶²) led to “more successful quitters, fewer smoking attributable deaths, and increased life expectancy for current smokers.”¹⁶³

A switch may also advance public health by deterring people without access to health care providers from turning to unsafe and ineffective alternatives to the prescription product. This consideration is particularly relevant in the medication abortion context, because pregnant individuals who cannot obtain the prescription pills may turn instead to more dangerous and less effective methods of self-managed abortion, whether pharmaceutical, herbal, or physical.¹⁶⁴

For some types of drugs, the privacy offered by OTC status should also weigh heavily in favor of a switch.¹⁶⁵ These include drugs for conditions involving sexuality and intimate bodily functions that some people are wary about discussing, even with a doctor.¹⁶⁶ Examples of this type of product include reproductive health drugs (including abortion medication), sexual health drugs, and treatments for urinary incontinence.¹⁶⁷

Finally, many people value the sense of autonomy and agency offered by OTC medicines. OTC switches are just one component of a broad trend toward patient “empowerment” since the 1970s.¹⁶⁸ This trend reflects various cultural developments, including an increased devotion to patients’ rights, greater education and literacy, more access to

161. *Id.* at 1677. This study built on data from Eric P. Brass, Shannon E. Allen & Jeffrey M. Melin, *Potential Impact on Cardiovascular Public Health of Over-the-Counter Statin Availability*, 97 AM. J. CARDIOLOGY 851 (2006).

162. *Infra* p. 1090.

163. Saul Shiffman & Christine T. Sweeney, *Ten Years after the Rx-to-OTC Switch of Nicotine Replacement Therapy: What Have We Learned About the Benefits and Risks of Non-Prescription Availability?*, 86 HEALTH POL’Y 17, 19 (2008). *See also* Theodore E. Keeler, Teh-wei Hu, Alison Keith, Richard Manning, Martin D. Marciniak et al., *The Benefits of Switching Smoking Cessation Drugs to Over-the-Counter Status*, 11 HEALTH ECON. 389, 389 (2002) (“[T]he resulting increase in smoking cessation generated annual net social benefits of the order of magnitude of \$1.8–2 billion, based on conservative estimates of both the number of quits achieved and the value of added quality-adjusted life years from the reduced smoking.”).

164. Harris & D. Grossman, *supra* note 32, at 1030.

165. Chang, Lizer, Patel, Bhatia, Tan & Balkrishnan, *supra* note 136, at 151.

166. *See infra* pp. 1114–15.

167. *See infra* pp. 1114–15.

168. *See, e.g.*, L. Grossman, *supra* note 67.

information about medicine (including on the internet), and rampant distrust of experts.¹⁶⁹

During the past several decades, an enormous, FDA-enabled migration of important drugs from prescription to OTC status has occurred. . . . [T]he OTC switch phenomenon represents a tidal shift of authority away from the medical profession and toward the consumer. . . . [It] . . . reflects . . . a modern vision of consumers as autonomous, capable guardians of their own health.¹⁷⁰

When a drug being considered for an OTC switch concerns women's reproductive health, the question of autonomy becomes even more salient because of a half-century of widespread commitment to the notion that women should be in control of their own bodies.

Some authors have recently invoked the value of autonomy in advocating for a broader shift away from prescription status and toward OTC status. For example, Madison Kilbride, Steven Joffe, and Holly Fernandez Lynch argue that FDA should reverse its current presumption that new drugs should initially be sold only by prescription and that existing prescription drugs should retain that status.¹⁷¹

The prescription default has substantial paternalistic tendencies, often directed at protecting competent adults from harms related to the use of pharmaceutical products. Although paternalism can sometimes be justified, uncritical acceptance of it violates respect for individual autonomy, running contrary to a core tenet of bioethics and a long-standing American value.¹⁷²

In a recent report for the conservative CATO Institute, Jeffrey Singer and Michael Cannon call for a more dramatic measure—the total elimination of FDA's power to impose prescription requirements.¹⁷³ They contend that this step would “promote greater choice, innovation,

169. *Id.* at 631, 635, 637, 640.

170. *Id.* at 663, 665. References to a “right to self-medication” have appeared in statements opposing the imposition of prescription status since soon after FDA first created a formal category of prescription drugs by regulation in 1938. Mid-century, most advocacy of this right was by representatives of the manufacturers of proprietary OTC drugs. In a 1951 House of Representatives hearing on the Durham-Humphrey Amendments, the general counsel of the Proprietary Association contended that an earlier version of Section 503(b) “jeopardize[d] the traditional right of self-medication and choice of remedies.” H.R. REP. NO. 82-700, at 31 (1951).

171. *See* Kilbride, Joffe & Lynch, *supra* note 65, at 16.

172. *Id.* at 2.

173. SINGER & CANNON, *supra* note 136, at 42.

and affordability while restoring respect for the dignity and autonomy of the individual.”¹⁷⁴ The current system, they argue, “places the judgment of perceived experts above the autonomy of the individual.”¹⁷⁵

One does not have to embrace these policy proposals in full to recognize the cogency of their recognition that considerations of patient autonomy should weigh in favor of OTC status, at least in some instances.

III. THE ROLE OF ACCESS IN FDA SWITCH DECISIONS

The FD&C Act’s prescription drug provisions do not neatly accommodate a consideration of the benefits of access. The Section 503(b) criteria explicitly require FDA to consider the potential *risks* of using a drug without physician oversight, but not the potential *benefits* of being able to obtain the drug over the counter.¹⁷⁶ The statutory language thus does not fully reflect what appears to have been Congress’s intention in passing Section 503(b): to protect the public from potent drugs *and* to “relieve . . . pharmacists and the public from burdensome and unnecessary restrictions on the dispensing of drugs that are safe for use without the supervision of a physician.”¹⁷⁷

Ideally, Congress would revise Section 503(b) to require FDA to consider, in addition to the current factors, whether prescription status for a drug unduly burdens access.¹⁷⁸ In another, related context, the FD&C Act already requires the agency, when imposing elements to assure safe use in a REMS, to ensure that, in light of the specific serious risk at issue, the “element[] to assure safe use,” is not “unduly burdensome on patient access to the drug, considering in particular . . . patients who have difficulty accessing health care (such as patients in rural or medically underserved areas).”¹⁷⁹ If such considerations are relevant in the REMS context, they should certainly also be relevant for the imposition of prescription status.

Such a revision to the FD&C Act may not be necessary, however. Peter Barton Hutt, for one, contends that the “importance of having

174. *Id.* at 2.

175. *Id.* The authors also contend that government-imposed prescription requirements have either no discernible effect on health outcomes or correlate with worse outcomes. *Id.* at 38.

176. 21 U.S.C. § 353(b)(1)(A).

177. S. REP. NO. 82-946, at 2 (1951). *See also* H.R. REP. NO. 82-700, at 2 (1951).

178. A propitious opportunity to do so might be in the legislation that Congress will likely pass in 2025 to reauthorize the Over-the-Counter Monograph Drug User Fee Program. *See* 21 U.S.C. §§ 379j-72(b)–(c) (authorizing such fees only through 2025).

179. 21 U.S.C. § 355-1(f)(2)(C)(i).

particular drugs available readily and cheaply for public use is . . . a major consideration” under the current criteria.¹⁸⁰ And as this Article demonstrates below, the agency has repeatedly taken the benefits of access into account in switch decisions, regardless of the statutory language.¹⁸¹ But the statute’s silence on the issue is nonetheless problematic. It likely causes FDA to underemphasize the benefits of access, and it definitely leads the agency to address these benefits in an ad hoc and often unarticulated manner.

In the 1990s, two FDA officials, Carl Peck and Robert DeLap, created influential sets of principles regarding OTC switches that FDA has long used to guide its decisions. “Peck’s Principles” focus on the characteristics of the drug itself, whereas DeLap’s Principles emphasize consumer understanding and the conditions of use.¹⁸² As the latter became more influential than the former, FDA increasingly stressed the importance of label comprehension, self-selection, and actual use studies. These data constitute the core of most switch applications today.¹⁸³ Notably, however, neither list of principles includes any consideration of the benefits of OTC access.¹⁸⁴

Supplemental NDAs requesting Rx-OTC switches are required to follow the same content and format regulations that govern other NDAs and supplements, and these regulations make no special provision for switch applications.¹⁸⁵ There is thus no obvious place in the application to discuss the benefits of a switch. This is not to say that switch applicants do not include such information, but they must shoehorn it into sections that talk in general terms about the “benefits” and “risks” related to the drug.¹⁸⁶

180. Hutt, *supra* note 99, at 438.

181. *Infra* p. 1116.

182. R. William Soller, *Prescription-to-over-the-Counter Switch Criteria*, 36 DRUG INFO. J. 309, 311–13 (2002); Nancy Thai Nguyen, Daniel M. Cook & Lisa A. Bero, *The Decision-Making Process of US Food and Drug Administration Advisory Committees on Switches from Prescription to Over-the-Counter Status: A Comparative Case Study*, 28 CLINICAL THERAPEUTICS 1231, 1232, 1237 (2006).

183. Soller, *supra* note 182, at 312–13.

184. Although he did not refer to the public health benefits of greater access, DeLap maintained that FDA “implicitly” considers the potential cost savings associated with an Rx-OTC switch. *Rx-to-OTC Switch Cost-Savings Are Implicitly Considered By FDA – DeLap*, in THE TAN SHEET 20 (1998) (comments of Robert DeLap).

185. 21 C.F.R. § 314.50. There is a separate regulation governing the content and format of Abbreviated New Drug Applications. 21 C.F.R. § 314.94.

186. See 21 C.F.R. § 314.50(c)(2)(ix) (requiring the mandatory summary section to include “[a] concluding discussion that presents the benefit and risk considerations related to the drug”); 21 C.F.R. § 314.50(d)(5)(viii) (requiring the clinical data section to include “[a]n integrated summary of the benefits and risks of the drug,

Before ruling on a switch application, FDA typically convenes a public hearing of the Nonprescription Drugs Advisory Committee (NDAC), a standing advisory committee composed of outside scientific experts.¹⁸⁷ NDAC meetings on switches are usually conducted jointly with another FDA advisory committee with expertise on the type of drug under review.¹⁸⁸ The committee members receive briefing materials from both FDA and the sponsor before the meeting. FDA's materials include a list of questions for the committee to discuss during the meeting and vote on at the end. The final question on the list typically asks whether the committee member recommends the switch or not.¹⁸⁹ The committee's vote on this question, while highly influential on FDA's decisions, is not binding on the agency.¹⁹⁰

The sponsor, in its presentation at the start of the meeting, often emphasizes the benefits of improved access. By contrast, FDA's opening presentation generally highlights potential problems with a switch raised by its list of questions. These questions shape the advisory committee's subsequent deliberations. The nature of the questions varies, but they focus primarily on the drug's safety and efficacy and on consumers' ability to use it safely and effectively without a physician's supervision.¹⁹¹ One researcher's examination of the transcripts of three such meetings showed that none of them included questions concerning access or cost.¹⁹² The absence of such questions in these three particular meetings is noteworthy, because they all addressed drugs (nicotine replacement therapy, statins, and the emergency oral contraceptive pill) for which the public health benefit of improved access was an obvious factor in favor of the proposed Rx-OTC switch.

Consider, for example, the two-day meeting in 2005 addressing whether a twenty-milligram dose of Merck's statin Mevacor[®] (lovastatin) should be available over the counter. Merck's presentation to the committee concluded with a cardiologists' discussion of the positive

including a discussion of why the benefits exceed the risks under the conditions stated in the labeling").

187. 21 C.F.R. § 14.100(c)(16) (listing NDAC as a standing committee); *Nonprescription Drugs Advisory Committee*, FDA, <https://www.fda.gov/advisory-committees/human-drug-advisory-committees/nonprescription-drugs-advisory-committee> [<https://perma.cc/9HDZ-V6Y3>]. The use of such advisory committees by FDA is governed by the Federal Advisory Committee Act, 5 U.S.C. App., and by FDA's own regulations at 21 C.F.R. Part 14.

188. Nguyen, Cook & Bero, *supra* note 182, at 1232.

189. *Id.*

190. Federal Advisory Committee Act, 5 U.S.C. App. § 9(b); 21 C.F.R. § 14.5(b).

191. Nguyen, Cook & Bero, *supra* note 182, at 1232, 1237.

192. *Id.* at 1240.

public health effects that would occur if a statin were made more readily available to consumers.¹⁹³ But in the follow-up discussion, when one committee member raised the question of how a switch would affect the cost of obtaining the medication, and thus access, the chair told him that “it is probably not the remit of the committee to address the financial issues.”¹⁹⁴ Another committee member replied, “I would say it is to the degree that the issue of the overall benefit to the population has been raised, which also isn’t strictly our purview.”¹⁹⁵ They then largely dropped the subject.

The second day of the meeting was dedicated to responding to FDA’s questions.¹⁹⁶ The agency’s questions addressed toxicity and whether patients could, without the supervision of a doctor, appropriately self-select for use of the statin and self-manage their high cholesterol.¹⁹⁷ Many committee members expressed concerns about self-selection, and in response to the penultimate question, *every* committee member expressed concerns about self-management.¹⁹⁸ Unsurprisingly, in light of the discussion’s emphases, the committee responded to the final question by voting 20-3 against recommending the switch.¹⁹⁹

FDA did not ask the committee about the public health benefits of wider access to statins. Consequently, the committee did not have an organized discussion about this issue. One of the three “yes” voters stated: “I vote yes for the overriding reason that there are millions of Americans in this country with no health insurance and absolutely no access to a statin . . . I think that these people deserve the right to lower their risk and prevent cardiovascular disease.”²⁰⁰ Another expressed frustration about the whole discussion’s underlying assumptions:

So I am sort of left uncomfortable . . . listening to [others] saying, well, we are not going to approve a drug for over-the-counter use because some patients who might derive relatively little benefit would take it and, for them, it might not . . . be worthwhile but, on the other hand, . . . there are other patients

193. CTR. FOR DRUG EVALUATION & RSCH., FDA, THE NONPRESCRIPTION DRUGS ADVISORY COMMITTEE IN JOINT SESSION WITH THE ENDOCRINE AND METABOLIC DRUGS ADVISORY COMMITTEE, vol. I, 120–35 (Jan. 13, 2005).

194. *Id.* at 168 (remarks by Dr. Wood).

195. *Id.* at 168–69 (remarks by Dr. Meyer).

196. *See* CTR. FOR DRUG EVALUATION & RSCH., FDA, THE NONPRESCRIPTION DRUGS ADVISORY COMMITTEE IN JOINT SESSION WITH THE ENDOCRINE AND METABOLIC DRUGS ADVISORY COMMITTEE, vol. II (Jan. 14, 2005).

197. *Id.* at 163, 298.

198. *Id.* at 307.

199. *Id.* at 307, 337.

200. *Id.* at 330–31 (remarks of Dr. Schade).

out there who might derive benefit but they should not have the opportunity to do that.²⁰¹

FDA accepted the advisory committee's recommendation and denied Merck's switch petition for lovastatin.²⁰² This decision was not necessarily *wrong*, but FDA appears to have made it without systematically considering a critical factor—the benefits of wider access.

A few stakeholders have been criticizing FDA's underemphasis of this factor for years. In 1998, a trade publication reported that Mark Gelbert, a Novartis Consumer Health vice president, advanced such an argument at a trade association meeting:

“The benefit/risk equation of [an Rx-to-OTC] switch now includes the traditional benefit/risk equation that we get from . . . the study of a drug in a clinical setting [plus] the risks of access that we pick up in the OTC usage setting,” Gelbert said. However, “if we're going to add risk to the equation, you have to add the benefit [from increased access] to the equation, otherwise you get a very biased approach [that is] typically against a switch.”²⁰³

Three years later, Eric Brass, a medical school professor and former chair of FDA's Nonprescription Drugs Advisory Committee, suggested in the *New England Journal of Medicine* that when ruling on switches, FDA should take into account the benefits that a switch would have for patients and the health care delivery system.²⁰⁴ He observed: “The need to visit a health care professional represents a substantial barrier to care for many patients because of financial, transportation, or scheduling limitations. Thus, making drugs available through direct retail sales will give patients greater access to effective therapies.”²⁰⁵ Brass also invoked the “cultural and social trends [that] have led to increased interest among patients in self-care and in control over their medical treatment” and proposed that with adequate information and support, a switch “may improve patients' knowledge and increase compliance.”²⁰⁶

Brass later elaborated on the potential health benefits of OTC access:

201. *Id.* at 315–16 (remarks of Dr. Wood).

202. Although NDA denials are not public information, lovastatin remains a prescription drug today.

203. “Benefit of Access” Data Can Balance OTC Switch Risks – Novartis's Gelbert, in THE TAN SHEET 19 (1998) (remarks of Mark Gelbert).

204. Eric P. Brass, *Changing the Status of Prescription to Over-the-Counter Availability*, 345 NEW ENG. J. MED. 810, 812 (2001).

205. *Id.*

206. *Id.* at 813.

For a consumer, there are several steps in the process of accessing a prescription drug. The consumer must contact a prescriber, be evaluated by the prescriber, obtain a prescription, proceed to a pharmacy to have the prescription filled, and then finally obtain the drug from a pharmacist. Each of these steps represents a barrier, the magnitude of which varies depending on the specific health-care system and the resources of the individual consumer. For example, for consumers without a regular physician, accessing a prescriber may be difficult, time-consuming, and expensive. . . . This contrasts with facile access to nonprescription drugs In situations that call for early intervention, such as emergency contraception, minimizing barriers to access may be particularly important.²⁰⁷

Brass observed that improved access to drugs may translate into improved clinical outcomes, based on “quicker access to the drugs or from the patient’s ability or willingness to access the nonprescription drug vs. a prescription alternative.”²⁰⁸ He also remarked that the availability of an effective nonprescription drug may divert consumers from “less effective or more dangerous alternatives, including unregulated products.”²⁰⁹ More broadly, Brass raised the possibility that “[w]hen a consumer assumes the role of a decision maker in an area that has classically belonged solely to health-care professionals, it reinforces a dynamic of increased responsibility for one’s own health,” and that this “may help catalyze a broader effort in consumer self-education and health awareness and the adoption of healthier lifestyles.”²¹⁰

Brass in no way diminishes the possibility of increased risks from the nonprescription use of a drug. Rather, he calls for these risks to be balanced against the benefits of a switch in a meaningful and systematic way.²¹¹ He proposes use of a value-tree framework that predefines product-specific benefit and risk attributes, guides the search for quantitative and qualitative data regarding each attribute, and then performs a multicriteria analysis to weigh and balance the incremental

207. *Improving the Decision-Making Process*, *supra* note 136, at 792.

208. *Id.*

209. *Id.*

210. *Id.* at 793.

211. Eric P. Brass, Ragnar Löfstedt & Ortwin Renn, *A Decision-Analysis Tool for Benefit-Risk Assessment of Nonprescription Drugs*, 53 J. CLINICAL PHARMACOLOGY 475, 478 (2013) [hereinafter *A Decision-Analysis Tool*].

benefits and risks.²¹² He acknowledges that such a benefit-risk analysis of an OTC switch raises special challenges:

Addressing data gaps for a nonprescription drug is often more challenging than in the development of a prescription drug as it is often necessary to estimate consumer behavior and dynamics in the uncontrolled marketplace. In addition, there is enormous diversity in the consumer population with respect to knowledge, attitudes, medical literacy, health status, socioeconomics and other factors that might influence the incremental benefit or risk of nonprescription status for a drug.²¹³

Brass also observes that “very little quantitative data are available to estimate the magnitude of improved clinical outcomes due to enhanced drug availability.”²¹⁴

Rather than throw up his hands, however, Brass maintains that “diverse information sources” can be used to provide estimates of consumer behavior.²¹⁵ He observes that label comprehension studies and self-selection studies can provide important data.²¹⁶ But because fully assessing the benefits of improved access can defy traditional modes of data collection, Brass emphasizes that his model is compatible with qualitative as well as quantitative assessment methods. It permits the use of “expert estimates or crude market data as inputs for the analysis if more robust data are unavailable.”²¹⁷ For example, data from other nonprescription drugs may yield “important insights” into how consumers will behave if the drug in question is converted to OTC.²¹⁸

Brass shows that an OTC switch decision taking access into account can be structured, transparent, and rational even if some inputs are estimates or assumptions. He explains that his approach is not “a panacea for uncertainty,” nor can it “yield a definite yes/no output.”²¹⁹ Instead, the tools he proposes “are designed to facilitate more fully informed judgments, with the goal of optimizing individual and public health through rational decision making.”²²⁰

212. *Improving the Decision-Making Process*, *supra* note 136, at 795–96; *A Decision-Analysis Tool*, *supra* note 211.

213. *A Decision-Analysis Tool*, *supra* note 211, at 477.

214. *Improving the Decision-Making Process*, *supra* note 136, at 793.

215. *A Decision-Analysis Tool*, *supra* note 211, at 477.

216. *Id.*

217. *Improving the Decision-Making Process*, *supra* note 136, at 800.

218. *A Decision-Analysis Tool*, *supra* note 211, at 477.

219. *Improving the Decision-Making Process*, *supra* note 136, at 802.

220. *Id.*

FDA should strongly consider adopting Brass's methodology, or something like it, for its Rx-OTC switch decisions. It already uses structured frameworks to bring rigor and transparency to other decisions that inevitably involve incomplete data and subjective judgments.²²¹ Such an approach to OTC switches might lead FDA to give appropriate consideration and weight to the benefits of increased access.

The agency does not appear to be doing so now. It is impossible to delve into FDA's reasoning when it *denies* an OTC switch application, because the agency almost never publicly explains its disapproval decisions for NDAs of any type, citing its obligation to protect confidential commercial information.²²² But FDA shares quite a bit of information with respect to *approved* drug applications,²²³ and by examining the agency's documentation for approved switch applications, we can get a sense of how much consideration it gives to the benefit of improved access. In general, the answer is surprisingly little. Consider, for example, one of the most publicized OTC switches in recent decades: the 2002 approval of a nonprescription version of Claritin® (loratadine) for hay fever.²²⁴ The word "access" does not even appear in the extensive medical review of this application.²²⁵ Similarly, there is not a single

221. See, e.g., FDA, STRUCTURED APPROACH TO BENEFIT-RISK ASSESSMENT IN DRUG REGULATORY DECISION-MAKING: DRAFT PDUFA V IMPLEMENTATION PLAN 2-3 (2013), <https://www.fda.gov/files/about%20fda/published/PDUFA-V-Implementation-Plan--Structured-Approach-to-Benefit-Risk-Assessment-in-Drug-Regulatory-Decision-Making-%28Draft%29.pdf> [<https://perma.cc/Y7MJ-DLCT>]; FDA, DRAFT GUIDANCE: BENEFIT-RISK ASSESSMENT FOR NEW DRUG AND BIOLOGICAL PRODUCTS 5-6 (2021), <https://www.fda.gov/media/152544/download> [<https://perma.cc/4PVY-BXEY>]; CTR. FOR DEVICES & RADIOLOGICAL HEALTH, FDA, GUIDANCE: CONSIDERATION OF UNCERTAINTY IN MAKING BENEFIT-RISK DETERMINATIONS IN MEDICAL DEVICE PREMARKET APPROVALS, DE NOVO CLASSIFICATIONS, AND HUMANITARIAN DEVICE EXEMPTIONS 5-10 (2019), <https://www.fda.gov/media/115672/download> [<https://perma.cc/FJZ2-S9KG>].

222. See 21 C.F.R. § 314.430 (2021); 21 C.F.R. § 20.61 (2022); Peter Lurie, Harinder S Chahal, Daniel W Sigelman, Sylvie Stacy, Joshua Sclar & Barbara Ddamulira, *Comparison of Content of FDA Letters Not Approving Applications for New Drugs and Associated Public Announcements from Sponsors: Cross Sectional Study*, *BMJ*, June 10, 2015, at 1, 1 <https://www.bmj.com/content/bmj/350/bmj.h2758.full.pdf> [<https://perma.cc/Q6QU-X9WY>].

223. See *Drugs@FDA: FDA-Approved Drugs*, <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm> [<https://perma.cc/5B9C-Y45U>].

224. Ceci Connolly, *Claritin to Be Sold over the Counter*, *WASH. POST* (Mar. 9, 2002), <https://www.washingtonpost.com/archive/politics/2002/03/09/claritin-to-be-sold-over-the-counter/119ef55d-5441-46bb-96bf-32f3d9868588>.

225. CTR. FOR DRUG EVALUATION & RSCH., FDA, NDA 19-658/S-018, 19-670/S-018, 20-470/S-016, 20-641/S-009, 20-704/S-008 MEDICAL REVIEW (2002), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2002/19-

mention of the benefits of facilitated access anywhere in the massive medical review of the successful OTC switch application for Prilosec® (omeprazole magnesium), a popular heartburn medication.²²⁶

Sometimes, the benefit of easier OTC access is such a vital justification for the proposed switch that the topic cannot be avoided. Consider, for instance, the 2014 switch of Oxytrol® (oxybutynin transdermal system) for treatment of overactive bladder (OAB) in women. At the advisory committee meeting, the sponsor stressed that OTC status would improve access, in part by averting the shame and embarrassment that prevented women with OAB from seeking prescriptions, and in part by increasing awareness of OAB as a treatable medical condition.²²⁷ One of the sponsor's representatives concluded, "I feel it would be a disservice to deny millions of women access to an effective treatment option" ²²⁸ However, the question that FDA presented to the committee ("Does the totality of the data support that consumers can appropriately self-select to use the oxybutynin transdermal system in an over-the-counter-setting?"²²⁹) did not address the benefits of access at all.

Although the committee voted "no" on this question by a 6-5 margin,²³⁰ the follow-up discussion demonstrated that the issue of improved access had, perhaps inevitably, been on the committee members' minds. Dr. Charles J. Ganley, a director at the Center for Drug Evaluation and Research and non-voting participant in the meeting, observed that a switch "may actually increase access."²³¹ A "no" voter responded, "I understand what you're saying . . . [but] the answer you need to know is whether it's going to improve access is not knowable . . . until you allow for access and then see what happens" ²³² FDA ultimately rejected the committee's

658S018_Claritin_Medr_P1.pdf [https://perma.cc/NQL7-PVXU] [hereinafter CLARITIN NDA].

226. CTR. FOR DRUG EVALUATION & RSCH., FDA, NDA 21-229 MEDICAL REVIEW (2003), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2003/21-229_Prilosec_medr.pdf [https://perma.cc/DL62-FYAF] [hereinafter PRIOSECC NDA].

227. CTR. FOR DRUG EVALUATION & RSCH., FDA, MEETING OF THE NONPRESCRIPTION DRUGS ADVISORY COMMITTEE: OXYTROL FOR WOMEN NEW DRUG APPLICATION (NDA) 202211 FOR THE PARTIAL SWITCH FROM PRESCRIPTION TO OVER-THE-COUNTER (OTC) 26-27, 68-70 (Nov. 9, 2012), <https://wayback.archive-it.org/7993/20170404152912/https://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/NonprescriptionDrugsAdvisoryCommittee/UCM336189.pdf>.

228. *Id.* at 68.

229. *Id.* at 220.

230. *Id.* at 274-75.

231. *Id.* at 299 (remarks of Dr. Ganley).

232. *Id.* (remarks of Dr. Gellad).

recommendation and approved the Oxytrol® switch application.²³³ In doing so, it followed the recommendation of its internal review team, whose risk-benefit assessment mentioned—though only briefly—that “OTC availability and increased access could be of benefit to a population in need.”²³⁴

IV. EXAMPLES OF ACCESS-MOTIVATED OTC SWITCHES

In a few instances, OTC switches have been so overwhelmingly motivated by the goal of improving access that FDA has had no choice but to tackle the issue head-on.

A. Nicotine Replacement Therapy

FDA approved Nicorette® chewing gum as a smoking cessation aid in 1984, and the NicoDerm CQ® patch in 1991.²³⁵ Like almost all newly approved drugs, these nicotine replacement therapy (NRT) medications were initially limited to prescription sale. Prescription status seemed appropriate to most experts because of the possibility of abuse, the perceived need for ongoing professional behavioral intervention, and the usefulness of instructions from a health care provider regarding the proper chewing technique for the gum.²³⁶ But as it became apparent that NRT treatments were generally safe, that prescribing physicians rarely provided comprehensive counseling, and that the medications were quite effective even without such counseling, support grew for an OTC switch. The potential public health benefit of a switch became obvious when a 1993 poll showed that fifty-seven percent of smokers were unlikely to

233. CTR. FOR DRUG EVALUATION & RSCH., FDA, NDA 202211S000 APPROVAL LETTER (2013), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2013/202211Orig1s000Approv.pdf [<https://perma.cc/9C76-E6U5>].

234. Ryan Raffaelli, Clinical Review, in CTR. FOR DRUG EVALUATION & RSCH., FDA, NDA 202211s000 MEDICAL REVIEW 67, 77 (2013), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2013/202211Orig1s000MedR.pdf [<https://perma.cc/35HZ-DSMY>].

235. *Drugs@FDA: FDA-Approved Drugs*, FDA, <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=018612> [<https://perma.cc/3NYC-WZFE>] (Nicorette®); *Drugs@FDA: FDA-Approved Drugs*, FDA, <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=020165> [<https://perma.cc/V46P-WLXQ>] (NicoDerm CQ®).

236. Saul Shiffman, Joe Gitchell, John M Pinney, Steven L Burton, Katherine E Kemper & Eduardo A Lara, *Public Health Benefit of Over-the-Counter Nicotine Medications*, 6 TOBACCO CONTROL 306, 306 (1997).

seek medicine from a physician to help them quit.²³⁷ As one scholar observed, “prescription-only status had become an access barrier to these effective treatments.”²³⁸

In 1994, Nicorette®’s manufacturer, Marion Merrell Dow, submitted an sNDA seeking a switch of Nicorette® to OTC status.²³⁹ This may have been the first-ever switch application in which the main rationale for making a medicine OTC was to improve access and thus increase use. In the application’s cover letter, the company explained,

[T]he majority of smokers who attempt to quit will not seek a physician’s help in the quit attempt. Switching Nicorette® from prescription only to an OTC product is a way to increase access to a proven smoking cessation aid. The data presented in this supplement establish that the numbers of individuals successfully quitting will significantly increase by switching Nicorette® from Rx to OTC status.²⁴⁰

Interestingly, the sNDA does not appear to have included any studies quantifying the potential public health impact of increased access to these drugs.²⁴¹ Nonetheless, “[t]he fundamental rationale for approving OTC sale of NRT was to improve access to and use of NRT products. . . .”²⁴²

The advisory committee (which voted unanimously to recommend the switch) focused, as usual, on the drugs’ effectiveness, side effects, and susceptibility to abuse rather than the benefits of improved access.²⁴³ Nonetheless, it heard testimony from former U.S. Surgeon General Koop

237. *Id.* at 306, 310 n.7.

238. *Id.*

239. CTR. FOR DRUG EVALUATION & RSCH., FDA, NDA 18-612/S022, 20-066/S004 ADMINISTRATIVE & CORRESPONDENCE DOCUMENTS (1996), https://www.accessdata.fda.gov/drugsatfda_docs/nda/96/018612s022_Nicorette_admincorres.PDF [<https://perma.cc/5YQW-SRQZ>] [hereinafter NICORETTE NDA].

240. Letter from Elaine Waller to FDA, *in* NICORETTE NDA, *supra* note 239, at 3 (emphasis omitted).

241. NICORETTE NDA, *supra* note 239 (“[T]he usage studies included with [the sNDA] . . . focus[ed] on the ability of participants to self-select, to identify and deal with treatment-emergent events, and to establish an OTC quite rate.”).

242. Shiffman, Gitchell, Pinney, Burton, Kemper & Lara, *supra* note 236, at 306.

243. *Nonprescription Gum to Fight Smoking May Win Approval*, N.Y. TIMES, Oct. 1, 1995, at 28 <https://timesmachine.nytimes.com/timesmachine/1995/10/01/issue.html>; *Government Panel Recommends SmithKline Beecham’s Nicorette® for Approval as Over-the-Counter Smoking Cessation Aid*, P.R. NEWSWIRE (Sept. 28, 1995), NEXIS UNI [hereinafter *Panel Recommends Nicorette OTC Approval*].

that “one important answer [to reducing smoking-related morbidity and mortality] is to make treatments that have been proven safe and effective in the prescription setting more widely available by shifting them to over-the-counter availability.”²⁴⁴

FDA approved the Nicorette[®] switch (for people eighteen years of age and older) in January 1996.²⁴⁵ Shortly afterward (too late to be mentioned in the sNDA), a study projected that making the gum available on a nonprescription basis would result in an additional 450,000 successful quit attempts within ten years.²⁴⁶ Later in 1996, FDA approved OTC switch applications for NicoDerm CQ[®] and Nicotrol[®], a competing patch sold by another company.²⁴⁷ Research later showed that use of nicotine replacement therapy increased by 152 percent in the year following the OTC conversions and that the number of quit attempts more than doubled.²⁴⁸

Eric Brass suggested that his decision tool would have assisted FDA’s Nicorette[®] switch decision even with the data gaps existing at the time.²⁴⁹ He explained that “increased smoking cessation attempts” could be entered into the value tree as a “benefit attribute” because “it would be reasonable to assume that use of these products would increase” based on previous switches.²⁵⁰ FDA seems to have made just such an assumption in a less structured manner when it approved the switch.

B. Hearing Aids

In one recent instance, Congress *required* FDA to switch a product to nonprescription status to improve access. That product was hearing aids.

244. *Panel Recommends Nicorette OTC Approval*, *supra* note 244.

245. CTR. FOR DRUG EVALUATION & RSCH., FDA, NDA 18-612/S022, 20-066/S004 APPROVAL LETTER (1996), https://www.accessdata.fda.gov/drugsatfda_docs/nda/96/018612s022_Nicorette_approv.PDF [<https://perma.cc/M7C3-883S>] [hereinafter NICORETTE NDA APPROVAL LETTER].

246. Gerry Oster, Thomas E. Delea, Daniel M. Huse, Meredith M. Regan & Graham A. Colditz, *The Benefits and Risks of Over-the-Counter Availability of Nicotine Polacrilex (“Nicotine Gum”)*, 34 MED. CARE 389, 389 (1996).

246. *FDA-Approved Drugs*, FDA, <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=020165> [<https://perma.cc/V46P-WLXQ>] (NicoDerm CQ[®]); *FDA-Approved Drugs*, FDA, <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=020536> [<https://perma.cc/B75U-QDQD>] (Nicotrol[®]).

248. Shiffman, Gitchell, Pinney, Burton, Kemper & Lara, *supra* note 236, at 308.

249. *A Decision-Analysis Tool*, *supra* note 211, at 479–80.

250. *Id.*

The FDA-regulated category of “hearing aids” includes any wearable device, regardless of technology, intended to compensate for impaired hearing.²⁵¹ The agency regulates hearing aids as medical devices rather than drugs, but it applies the Section 503(b)(1) factors to determine prescription status for devices as well.²⁵² The agency did not, until very recently, formally regulate any hearing aids as prescription devices. In 1977, however, it issued regulations making all hearing aids “restricted devices” subject to specified restrictions on sale, distribution, and use.²⁵³ These regulations stated that a hearing aid dispenser could not legally sell a hearing aid unless the purchaser provided a written statement signed by a licensed physician stating that the physician had evaluated the person’s hearing loss and that he or she was a candidate for a hearing aid.²⁵⁴ Alternatively, a purchaser eighteen years of age or older could sign a waiver of the medical evaluation after being advised by the dispenser that such a waiver was not in his or her “best health interest.”²⁵⁵

State laws imposed a variety of additional distribution restrictions, such as requiring the licensing of persons who sold and dispensed hearing aids and prohibiting the sale or distribution of hearing aids through the mail or via the internet.²⁵⁶ Consequently, even if they were willing to waive the medical evaluation requirement, most people seeking to obtain hearing aids had to make an in-person visit to a state-licensed individual (typically an ear, nose, and throat physician; an audiologist; or a licensed hearing-aid specialist).²⁵⁷ Although the FD&C Act expressly preempts state medical device requirements “different from, or in addition to” any

251. 21 C.F.R. § 874.3300 (2022) (air- or bone-conduction hearing aid); § 874.3305 (wireless air-conduction hearing aid); 21 C.F.R. § 874.3315 (tympanic membrane contact hearing aid); 21 C.F.R. § 874.3315 (self-fitting air-conduction hearing aid); 21 C.F.R. § 874.3950 (transcutaneous air-conduction hearing aid system).

252. 21 C.F.R. § 801.109 (prescription status applies to “[a] device which, because of any potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use is not safe except under the supervision of a practitioner licensed by law to direct the use of such device, and hence for which ‘adequate directions for use’ cannot be prepared”).

253. 42 Fed. Reg. 9286, 9286 (Feb. 15, 1977).

254. 21 C.F.R. § 801.421(a)(1), *removed at* 87 Fed. Reg. 50698, 50755 (Aug. 17, 2022).

255. 21 C.F.R. §§ 801.421(a)(1)–(2), *removed at* 87 Fed. Reg. 50698, 50755 (Aug. 17, 2022).

256. HEARING HEALTH CARE FOR ADULTS 183 (Dan G. Blazer, Sarah Domnitz & Catharyn T. Liverman eds., 2016) [hereinafter HEARING HEALTH CARE]; PRESIDENT’S COUNCIL OF ADVISORS ON SCI. & TECH., EXEC. OFF. OF THE PRESIDENT, AGING AMERICA & HEARING LOSS 4 (2015) [hereinafter AGING AMERICA & HEARING LOSS], https://obamawhitehouse.archives.gov/sites/default/files/microsites/ostp/PCAST/pcast_hearing_tech_letterreport_final3.pdf [<https://perma.cc/E5N6-8D6X>].

257. AGING AMERICA & HEARING LOSS, *supra* note 256, at 3–4.

federal requirement imposed by the Act,²⁵⁸ these state hearing aid restrictions remained in force either because FDA deemed them to be outside the scope of the statutory preemption provision or because the agency exempted them from federal preemption, as permitted by the Act.²⁵⁹

For four decades, FDA rejected the very notion of OTC hearing aids.²⁶⁰ In denying petitions seeking to revoke the medical evaluation requirement, it asserted that such an evaluation was necessary to ensure that “red flag” medical conditions that can cause hearing loss would not be undiagnosed and their treatment delayed.²⁶¹

In the mid-2010s, the federal government began to focus on the problem of underuse of hearing aids. Experts estimated that “67 to 86 percent of [American] adults who might benefit from hearing aids d[id] not use them.”²⁶² Adoption rates were especially meager for low-income and minority populations.²⁶³ Studies demonstrated that untreated hearing loss not only interferes with work, travel, and social interaction, but also is statistically associated with higher risks of depression, dementia, and injurious falls.²⁶⁴

In quick succession, two major reports highlighted this crisis—one issued in 2015 by the President’s Council of Advisors on Science and Technology (PCAST),²⁶⁵ and the other published in 2016 by the National Academies.²⁶⁶ In identifying the barriers to access for hearing aids, the reports identified federal and state distribution restrictions, along with high cost, lack of insurance coverage, and the stigma associated with hearing loss.²⁶⁷ Both reports concluded that the medical evaluation requirement posed a significant barrier to access even though a large majority of patients waived it.²⁶⁸ The reports also criticized state laws

258. 21 U.S.C. § 360k(a)(1).

259. 21 U.S.C. § 360k(b); HEARING HEALTH CARE, *supra* note 256, at 183–84.

260. HEARING HEALTH CARE, *supra* note 256, at 176–78.

261. *Id.* at 178.

262. *Id.* at 7.

263. AGING AMERICA & HEARING LOSS, *supra* note 256, at 1 (stating that use rates among lower income and racial minorities with hearing loss are less than the fifteen to thirty percent overall adoption rate among Americans with hearing loss).

264. *Id.* (citing various studies); HEARING HEALTH CARE, *supra* note 256, at 55–63.

265. AGING AMERICA & HEARING LOSS, *supra* note 256.

266. HEARING HEALTH CARE, *supra* note 256.

267. AGING AMERICA & HEARING LOSS, *supra* note 256, at 1–4; HEARING HEALTH CARE, *supra* note 256, at ix, 7–8.

268. AGING AMERICA & HEARING LOSS, *supra* note 256, at 5 (“[S]everal sources suggest[] that between 60 and 85 percent of patients now forgo the medical evaluation.”); HEARING HEALTH CARE, *supra* note 256, at 98, 102–03 (“[A]pproximately 60 to 95 percent of individuals purchasing hearing aids may be signing the waiver.”).

requiring the certification of hearing aid dispensers because they unnecessarily hindered access and limited competition and choice.²⁶⁹ To lower barriers to access, both PCAST and the National Academies recommended that FDA make certain hearing aids intended for mild to moderate hearing loss available over the counter.²⁷⁰

FDA responded quickly. In December 2016, citing these reports, the agency announced that it would increase “availability and accessibility” by immediately suspending enforcement of the medical evaluation/waiver requirement for air conduction hearing aids sold to adults.²⁷¹ This action left state regulatory barriers in place, however. The following year, in August 2017, Congress compelled the agency, within three years, to establish a category of “over-the-counter hearing aids,” defined as air conduction hearing aids used by adults age eighteen and older to compensate for perceived mild to moderate hearing impairment.²⁷² Importantly, the 2017 statute expressly preempts all state and local requirements “for the supervision, prescription, or other order, involvement, or intervention of a licensed person for consumers to access over-the-counter hearing aids.”²⁷³

FDA fulfilled its statutory duty (more than a year late) in October 2021, when it published a proposed rule establishing a new category of over-the-counter hearing aids.²⁷⁴ By now, the agency had become an enthusiastic convert to the mission of lowering burdens to hearing aid access. It observed:

Besides health benefits for individuals, more-widespread adoption of hearing aids could have broader effects. By increasing social participation, hearing aids could help to improve inclusion of individuals in family, economic, civic, and religious life. Thus, reducing barriers to hearing aid access might contribute to such improvements. This could be

269. AGING AMERICA & HEARING LOSS, *supra* note 256, at 3–4; HEARING HEALTH CARE, *supra* note 256, at 8, 153, 185.

270. PCAST suggested that the agency create a separate class of OTC “basic” hearing aids, while the National Academies recommended creating a special category of “OTC wearable hearing devices.” AGING AMERICA & HEARING LOSS, *supra* note 256, at 5–6, 8; HEARING HEALTH CARE, *supra* note 256, at 8, 190–92.

271. CTR. FOR DEVICES & RADIOLOGICAL HEALTH, FDA, IMMEDIATELY IN EFFECT GUIDANCE DOCUMENT: CONDITIONS FOR SALE FOR AIR-CONDUCTION HEARING AIDS 1–2 (2016).

272. FDA Reauthorization Act of 2017, Pub. L. No. 115-52, § 709, 131 Stat. 1005, 1065-67 (codified in part at 21 U.S.C. § 360j(q)).

273. Pub. L. No. 115-52, § 709(b)(4), 131 Stat. at 1067.

274. Medical Devices; Ear, Nose, and Throat Devices; Establishing Over-the-Counter Hearing Aids, 86 Fed. Reg. 50698, 58150 (proposed Oct. 20, 2021) (to be codified at 21 C.F.R. pts. 800, 801, 808, 874).

particularly true for people of color, rural Americans, low-income individuals, and others for whom barriers to hearing aid access may be especially burdensome.²⁷⁵

FDA finalized the rule in August 2022.²⁷⁶ The new hearing aid regulations define “over-the-counter hearing aid” as “an air-conduction hearing aid that does not require implantation or other surgical intervention, and is intended for use by a person age 18 or older to compensate for perceived mild to moderate hearing impairment.”²⁷⁷ FDA revoked the provision requiring medical evaluation or waiver prior to purchase of these products, while creating a separate category of prescription hearing aids that are subject to a nonwaivable prescription requirement.²⁷⁸ The new rules preempt “any State or local requirement for the supervision, prescription, or other order, involvement, or intervention of a licensed person for consumers to access OTC hearing aids.”²⁷⁹

FDA did not overlook the fact that misuse of hearing aids can reduce their effectiveness or even cause harm. Nor did it ignore the fact that mild to moderate hearing loss can result from treatable diseases for which people should seek professional medical attention. However, the agency addressed these issues through comprehensive patient labeling. The new rule mandates outside package labeling and a user instructional brochure inside the package that together provide detailed instructions for use of the device and various warnings and cautions, including information about “red flag” conditions that should prompt a person to see a doctor.²⁸⁰ The regulation also imposes volume limits on OTC hearing aids—a rough equivalent to limiting the dose or concentration of an OTC drug.²⁸¹

When Congress left the agency no choice, FDA wholeheartedly fulfilled its mission of providing OTC access to hearing aids while mitigating the countervailing risks.

275. *Id.* at 58152.

276. *Id.* at 50692.

277. 21 C.F.R. § 800.30(b) (2022).

278. Medical Devices; Ear, Nose, and Throat Devices; Established Over-the-Counter Hearing Aids, 87 Fed. Reg. at 50698, 50701, 50734 (citing 21 C.F.R. § 801.109 (2023)).

279. 21 C.F.R. § 800.30(h)(1).

280. 21 C.F.R. §§ 800.30(c)(1)(D), (2)(b).

281. 21 C.F.R. § 800.30(d).

C. Naloxone

During this century, America has suffered from a growing epidemic of addiction to opioids—FDA-approved prescription opioids (including oxycodone, hydrocodone, and methadone), heroin, and illegal synthetic opioids (primarily fentanyl).²⁸² Approximately 700,000 Americans have died from opioid overdoses since 1999.²⁸³ This number would have been significantly lower if more people in proximity to those experiencing an overdose had been able to easily access naloxone hydrochloride, a drug that reverses opioid overdose.²⁸⁴ Naloxone must be administered “as soon as possible . . . because prolonged respiratory depression may result in damage to the central nervous system or death.”²⁸⁵

FDA first approved naloxone in 1971 as an injectable prescription drug.²⁸⁶ Though it originally was used primarily by hospital emergency room personnel and first responders, as opioid overdoses increased in the twenty-first century, various entities established community-based programs designed to get naloxone into the hands of people at risk of overdose and their families, friends, and caregivers.²⁸⁷ In addition, in the 2010s, states began authorizing pharmacist dispensing of naloxone without a patient-specific prescription pursuant to mechanisms known as “statewide protocols” and “collaborative practice agreements,” discussed later in this article.²⁸⁸ Eventually, all fifty states and the District of Columbia passed some type of naloxone access law.²⁸⁹

Because the original naloxone injectable products were only available in glass vials and ampules, non-healthcare professionals

282. *Opioid Data Analysis and Resources*, CTR. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/opioids/data/analysis-resources.html> [https://perma.cc/SWQ9-9G45] (Aug. 8, 2023).

283. *Id.*

284. Michael A. Irvine, Declan Oller, Jesse Boggis, Brian Bishop, Daniel Coombs et al., *Estimating Naloxone Need in the USA Across Fentanyl, Heroin, and Prescription Opioid Epidemics: A Modelling Study*, 7 LANCET PUB. HEALTH e210, e216 (2022).

285. *Naloxone Hydrochloride Injection Prescribing Information*, FDA, https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/215457s000lbl.pdf [https://perma.cc/VC86-EP7E] (Feb. 2022).

286. Safety and Effectiveness of Certain Naloxone Hydrochloride Drug Products for Nonprescription Use; Request for Comments, 87 Fed. Reg. 68702, 68704 (Nov. 16, 2022).

287. See FDA, SUMMARY REPORT, EXPLORING NALOXONE UPTAKE AND USE: PUBLIC MEETING 1–3 (July 1–2, 2015) (describing multiple programs of this sort).

288. Alex J. Adams & Krystalyn K. Weaver, *The Continuum of Pharmacist Prescriptive Authority*, 50 ANNALS PHARMACOTHERAPY 778, 778 (2016). See *infra* Section V.B.

289. LEGIS. ANALYSIS AND PUB. POL’Y ASS’N, NALOXONE ACCESS: SUMMARY OF STATE LAWS 1–3 (2023).

attempting to administer the drug often had to fill syringes themselves. FDA eased this problem by approving a prefilled, auto-injector naloxone drug product (Evzio[®]) in 2014 and a prefilled, single-dose nasal spray (Narcan[®]) in 2015.²⁹⁰

Despite these developments, obstacles continued to hinder quick administration of naloxone products by a layperson. Many pharmacists were unaware of the state protocols permitting them to dispense naloxone without a prescription, and many pharmacies did not stock the drug at all.²⁹¹ Moreover, many people hesitated to seek naloxone from a physician or pharmacist because of their fears of stigma and discrimination.²⁹² A 2018 FDA advisory committee meeting highlighted these problems, and several witnesses at this event urged FDA to approve a nonprescription naloxone product to increase access.²⁹³

By this time, FDA had already taken extraordinary actions to encourage naloxone manufacturers to enter the OTC market. The agency developed a model consumer-friendly Drug Facts Label (DFL) for naloxone, with pictograms illustrating how to use the drug, and performed its own label comprehension study.²⁹⁴ Commissioner Scott Gottlieb announced, “This is the first time the FDA has proactively developed and tested a DFL for a drug to support development of an OTC product.”²⁹⁵ In November 2022, “[t]o help facilitate increased

290. Safety and Effectiveness of Naloxone Hydrochloride Drug Products for Nonprescription Use; Request for Comments, 87 Fed. Reg. at 68705.

291. See, e.g., Jenny S. Guadamuz, G. Caleb Alexander, Tanya Chaudhri, Rebecca Trotsky-Sirr & Dima M. Qato, *Availability and Cost of Naloxone Nasal Spray at Pharmacies in Philadelphia, Pennsylvania, 2017*, JAMA NETWORK, June 7, 2019, at 1, 1–2, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2735466> [https://perma.cc/9BA3-WKFY]; Talia Puzantian, James J. Gasper & Christina M. Ramirez, *Pharmacist Furnishing of Naloxone in California: A Follow-Up Analysis*, 61 J. AM. PHARMACISTS ASS’N e108 (2021).

292. Thompson, Singh, Ghorashi, Donovan, Ma & Rikelman, *supra* note 9, at 17–18 (discussing how drug regulations discourage patients from accessing care); Kendra L. Walsh & Jeffrey P. Bratberg, *Plan N: The Case for Over-the-Counter Naloxone*, HEALTH AFFAIRS (July 2, 2021), <https://www.healthaffairs.org/content/forefront/plan-n-case-over-the-counter-naloxone> (discussing “bias” toward drug users as the main concern people have about accepting or carrying naloxone).

293. Safety and Effectiveness of Naloxone Hydrochloride Drug Products for Nonprescription Use; Request for Comments, 87 Fed. Reg. at 68707.

294. Barbara R. Cohen, Karen M. Mahoney, Elande Baro, Claudia Squire, Melissa Beck et al, Special Article, *FDA Initiative for Drug Facts Label for Over-the-Counter Naloxone*, 382 NEW ENG. J. MED. 2129, 2130 (2020).

295. News Release, FDA, Statement from FDA Comm’r Scott Gottlieb, M.D., on Unprecedented New Efforts to Support Develop. Of Over-the-Counter Naloxone to Help Reduce Opioid Overdose Deaths (Jan. 17, 2019), <https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-unprecedented-new-efforts-support-development-over> [https://perma.cc/BS22-G44K].

access to and availability of . . . naloxone products,” FDA took the unusual step of announcing its “preliminary assessment that certain types of naloxone . . . may be approvable as safe and effective for nonprescription use.”²⁹⁶ Never before had the agency been so aggressive in encouraging manufacturers to apply for an OTC switch. Interestingly, FDA did not intimate any inclination to become even more aggressive by converting some naloxone products to nonprescription status on its own by rulemaking under Section 503(b)(3)—a mechanism it has not used in years.²⁹⁷ It explained, “[W]e need additional data such as product-specific data on the nonprescription user interface design . . . to make a conclusive determination”²⁹⁸

Soon afterward, several naloxone manufacturers submitted switch applications to FDA.²⁹⁹ On February 15, 2023, a joint advisory committee voted unanimously to recommend switching Narcan® Nasal Spray to OTC status.³⁰⁰ Despite acknowledging methodological flaws in the primary study supporting the switch, the committee members agreed that “the benefit of naloxone to those with opioid overdose outweighed the imperfections in the trial design.”³⁰¹ On March 29, 2023, FDA approved the switch.³⁰² FDA Commissioner Robert Califf declared: “Today’s approval of OTC naloxone nasal spray will help improve access to naloxone, increase the number of locations where it’s available and help reduce opioid overdose deaths throughout the country.”³⁰³

FDA’s approach to naloxone demonstrates how it can facilitate Rx-OTC switches critical to the public health, and it provides a model that the agency could one day use with respect to abortion medication. The

296. Safety and Effectiveness of Naloxone Hydrochloride Drug Products for Nonprescription Use; Request for Comments, 87 Fed. Reg. at 68702, 68711.

297. See Safety and Effectiveness of Naloxone Hydrochloride Drug Products for Nonprescription Use; Request for Comments, 87 Fed. Reg. at 68702; *supra* pp. 1054–55.

298. Safety and Effectiveness of Naloxone Hydrochloride Drug Products for Nonprescription Use; Request for Comments, 87 Fed. Reg. at 68702.

299. Julie Wernau, *FDA Fast-Tracks Review of Overdose Drug Naloxone For Use Without Prescription*, WALL ST. J. (Dec. 26, 2022, 9:00 AM), <https://www.wsj.com/articles/fda-fast-tracks-overdose-drug-naloxone-for-use-without-prescription-11671990592>.

300. CTR. FOR DRUG EVALUATION & RSCH., FDA, INTEGRATED REVIEW OF APP. #208411ORIG1s006, at 3–4 (2023).

301. *Id.* at 62.

302. News Release, FDA, FDA Approves First Over-the-Counter Naloxone Nasal Spray (Mar. 29, 2023), <https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray> [<https://perma.cc/HX67-4HLP>] [hereinafter FDA Approves First OTC Naloxone Nasal Spray].

303. *Id.*

naloxone switch, along with the agency's approval of a nonprescription oral contraceptive several months later,³⁰⁴ suggest that FDA may—without any official change in procedure or policy—be taking the benefits of access into greater account than it used to when making switch decisions.

V. BLURRING THE RX-OTC DICHOTOMY

Sometimes, of course, the goal of improving access to a drug by making it available over the counter is in tension with legitimate concerns about consumers' ability to use the drug safely and effectively with no professional supervision. One possible solution to this problem is creating an intermediate status between prescription and over-the-counter. As this Part discusses, the federal government has for years considered but rejected the establishment of a “behind-the-counter” (BTC) class of drugs. In the absence of federal action, states have promoted access by authorizing pharmacists to dispense certain prescription drugs without patient-specific prescriptions. Finally, last year, FDA proposed a new category of over-the-counter drug—“nonprescription drug[s] with an additional condition for nonprescription use”—that is a potential method for expediting consumer access to drugs that the agency would otherwise hesitate to authorize for OTC sale.³⁰⁵

A. Behind the Counter: A Path Not Taken

Many countries reject the United States's binary Rx-OTC approach. Instead, they also have intermediate classes of medicines that are nonprescription but must be dispensed by a pharmacist or, alternatively, sold only in pharmacies.³⁰⁶ Since shortly after passage of the Durham-Humphrey Amendments in 1951, various stakeholders have urged the U.S. government to similarly establish one or more intermediate classes of drugs, but it has not done so except in a few limited situations.³⁰⁷ In

304. See *infra* pp. 1111–12.

305. See *infra* pp. 1095–98.

306. U.S. GEN. ACCT. OFF., GAO/PEMD-95-12, NONPRESCRIPTION DRUGS: VALUE OF A PHARMACIST-CONTROLLED CLASS HAS YET TO BE DETERMINED 2 (1995).

307. *Id.* at 82–84. The most prominent example concerns products containing ephedrine, pseudoephedrine, and phenylpropanolamine, which can be used in the production of illegal methamphetamine. See Carlos Dobkin & Nancy Nicosia, *The War on Drugs: Methamphetamine, Public Health, and Crime*, AM. ECON. REV., Mar. 2009, at 324. Despite these drugs' nonprescription status, the Methamphetamine Production Prevention Act of 2008 requires them to be kept behind the counter, and they can be dispensed only by pharmacists or other trained employees, who must check identifications of purchasers and maintain records of each sale. 21 U.S.C. §§ 830(d)–(e).

1974, FDA “categorically reject[ed] the establishment of a third class of drugs,” declaring that such a step would restrict access to OTC drugs, limit competition, and raise prices with no attendant public health benefit.³⁰⁸ Ten years later, FDA rejected a petition from the National Association of Retail Druggists urging the establishment of a transitional category for drugs being switched from prescription to OTC status.³⁰⁹ In addition to asserting that public health considerations did not justify a third category, the agency also suggested that it did not have legal authority under the FD&C Act to create one.³¹⁰ In 1995, the Government Accounting Office (GAO) examined the issue and concluded, based largely on evidence from other countries, that a third class offered few if any public health benefits.³¹¹

Soon, however, FDA evinced increasing willingness to consider an intermediate status for some drugs. It conditioned approval of the 1996 Nicorette® switch on assurances from the manufacturer that to ensure compliance with the eighteen-year age requirement, the company would distribute the products only to certain types of stores and provide training to retailers.³¹² In 2006, FDA created a de facto BTC scheme when (in an episode examined further below³¹³) it approved an OTC switch of the Plan B emergency contraceptive but preserved its prescription status for those under eighteen years of age.³¹⁴ The sNDA approval required the manufacturer to distribute Plan B only to pharmacies and licensed healthcare clinics, and it compelled pharmacies to keep the drug behind the counter so they could enforce the prescription requirement for adolescents.³¹⁵

In 2007, FDA held a public meeting to explore the desirability of creating a broader class of BTC drugs that would be available without a prescription but dispensed by a pharmacist.³¹⁶ The agency’s stated ambition was to increase access to drugs that would otherwise be limited to prescription sale.³¹⁷ Witnesses from the pharmacy profession testified in favor of the idea, while the American Medical Association and the

308. Classification of Over-the-Counter (OTC) Drugs, 39 Fed. Reg. 19878, 19880–81 (proposed June 4, 1974) (to be codified at 21 C.F.R. pt. 330).

309. U.S. GEN. ACCT. OFF., *supra* note 306, at 83.

310. *Id.*

311. *Id.* at 34–35.

312. NICORETTE NDA APPROVAL LETTER, *supra* note 244.

313. *Infra* pp. 1099–104.

314. CTR. FOR DRUG EVALUATION & RSCH., FDA, APPROVAL LETTER OF APP. #21-045/S011, at 2 (2023).

315. *Id.* at 3.

316. Behind the Counter Availability of Certain Drugs; Public Meeting, 72 Fed. Reg. 56769 (Oct. 4, 2007).

317. *Id.* at 56769.

Consumer Health Products Association spoke against it.³¹⁸ One of the most prominent points of disagreement was whether the establishment of a BTC class would improve access or impede it. A proponent of an intermediate class asserted: “Pharmacist interventions to determine the clinical appropriateness of BTC medication has the potential to increase appropriate patient access to medications that would otherwise be available only by prescription.”³¹⁹ Opponents of a new tier, by contrast, contended that it would *hinder* access by slowing or preventing complete switches. “[I]t is easy to visualize the [Nonprescription Drugs Advisory Committee] retreating to [the] behind-the-counter option as the safe option, and avoiding the perceived risk of endorsing a more expanded access decision, even when the expanded access may improve public health.”³²⁰

A 2009 GAO report reexamined the question and took a cautionary stance. Based on its analysis of other countries, it stated that the impact of restricted nonprescription status on access is unclear.³²¹ It concluded that FDA should not establish a BTC drug class without first addressing some critical issues, including pharmacists’ responsibilities, pharmacists’ compensation, the data infrastructure, and cost implications.³²² In 2012, FDA held another meeting on the topic.³²³ Since then, however, the agency has taken no steps toward creating a BTC tier.

In the face of federal inaction, however, states have created their own versions of an intermediate status between Rx and OTC. In an effort to facilitate access to certain prescription drugs, states have established a variety of regimes in which consumers can obtain them directly from a pharmacist without first obtaining a prescription from a doctor.

318. FDA, PUBLIC MEETING; BEHIND THE COUNTER AVAILABILITY OF CERTAIN DRUGS (2007) (testimonies of Michael Moné, Joseph Cranston, and David Spangler) [hereinafter BEHIND THE COUNTER AVAILABILITY OF CERTAIN DRUGS]. See also GAO, NONPRESCRIPTION DRUGS: CONSIDERATIONS REGARDING A BEHIND-THE-COUNTER DRUG CLASS 1, 10, 13 (2009) [hereinafter CONSIDERATIONS REGARDING A BEHIND-THE-COUNTER DRUG CLASS]

319. BEHIND THE COUNTER AVAILABILITY OF CERTAIN DRUGS, *supra* note 318 (remarks of Michael Moné, American Pharmacists Association).

320. *Id.* (remarks of Eric Brass).

321. CONSIDERATIONS REGARDING A BEHIND-THE-COUNTER DRUG CLASS, *supra* note 318, at 5–6.

322. *Id.*

323. Meeting Notice, Using Innovative Technologies and Other Conditions of Safe Use to Expand Which Drug Products Can Be Considered Nonprescription, 77 Fed. Reg. 12059 (Feb. 28, 2012).

B. Pharmacist Prescribing under State Law

Although FDA determines whether a drug is prescription or OTC as an initial matter, states have significant power to tweak this decision. Occasionally, they *constrain* access to an OTC drug. For example, they can require that a nonprescription drug be dispensed only by a pharmacist, as many states have done with respect to human insulin.³²⁴ States can also implement complete “reverse switches,” requiring that drugs designated OTC by FDA be sold only by prescription within the state.³²⁵ Oregon, for example, took such a step in 1990 with respect to ephedrine, based on concerns that the drug was being misused as a stimulant and as a precursor substance in the manufacture of methamphetamine.³²⁶

States do not, however, have the converse power to switch a drug from Rx to OTC status.³²⁷ Nonetheless, a state can push a prescription drug significantly closer to nonprescription status by authorizing pharmacists to “prescribe” it—that is, to dispense it at their own discretion without an individualized prescription from a physician or other healthcare provider.

Under Section 503(b) of the FD&C Act, a prescription drug can be legally dispensed only upon the prescription “of a practitioner licensed by law to administer such drug.”³²⁸ State law, not federal law, dictates who is licensed to prescribe drugs, and different states give prescribing authority to different lists of professions.³²⁹ Physicians and dentists have prescribing power in every state, but states differ with respect to advanced practice nurses, physician assistants, and psychologists (for example).³³⁰

324. CONSIDERATIONS REGARDING A BEHIND-THE-COUNTER DRUG CLASS, *supra* note 318, at 45–46; OR. REV. STAT. § 475.230 (2021).

325. HUTT, MERRILL, L. GROSSMAN, CORTEZ, LIETZAN & ZETTLER, *supra* note 66, at 1222; 21 U.S.C. § 379r(c)(1)(B).

326. *Nw. Connection, Inc. v. Bd. of Pharmacy*, 814 P.2d 191, 193 (Or. Ct. App. 1991); OR. REV. STAT. § 475.230 (2021). This action by Oregon brought the state into accord with the rest of the country; as noted earlier, Congress in 2008 required ephedrine and related drugs to be sold behind-the-counter nationwide. *Supra* note 306.

327. HUTT, MERRILL, L. GROSSMAN, CORTEZ, LIETZAN & ZETTLER, *supra* note 66, at 1222.

328. 21 U.S.C. § 353(b)(1)(B).

329. HUTT, MERRILL, L. GROSSMAN, CORTEZ, LIETZAN & ZETTLER, *supra* note 66, at 1045. See *United States v. Shock*, 379 F.2d 29, 33 (8th Cir. 1967) (noting that a district court should look to state law to determine whether a chiropractor is authorized to use or direct the use of a medical device regulated under the FD&C Act).

330. HUTT, MERRILL, L. GROSSMAN, CORTEZ, LIETZAN & ZETTLER, *supra* note 66, at 1045.

Pharmacists are also medical professionals, and for the past half-century, states have experimented with different arrangements under which pharmacists can furnish designated prescription medications to people who do not have individualized prescriptions. One mechanism for doing so is known as the “collaborative practice agreement” (CPA). Under these arrangements, physicians or groups of physicians enter agreements with pharmacists or groups of pharmacists. These agreements, which must be authorized by state law, delegate to the pharmacists the authority to prescribe specified drugs or categories of drugs in accordance with defined protocols.³³¹ CPAs allow pharmacists to prescribe these drugs to either particular individuals named in the agreement (“patient-specific CPAs”) or, in some states, to defined categories of patients (“population-specific CPAs”).³³² States began to embrace CPAs in the late 1970s, first in institutional settings and then in outpatient settings as well.³³³ This approach became increasingly popular in the 1990s,³³⁴ and today every state except Delaware authorizes CPAs.³³⁵

Since the turn of this century, a second method for legalizing pharmacist prescribing has become popular: the “statewide protocol.” Under this mechanism, state law empowers a state administrative agency (such as the board of pharmacy or health department) to authorize pharmacists to prescribe specified drugs in accordance with protocols established by the agency. The agency or the legislation itself determines

331. Raymond W. Hammond, Amy H. Schwartz, Marla J. Campbell, Tami L. Remington, Susan Chuck et al., *Collaborative Drug Therapy Management by Pharmacists—2003*, 23 PHARMACOTHERAPY 1210 (2003); Adams & Weaver, *supra* note 288, at 779–81; Dale B. Christensen, *Collaborative Practice Agreements—Further Evidence of Acceptance and Success*, 41 J. AM. PHARM. ASS’N 15 (2001). To avoid political battles with other prescribers, these state laws sometimes use terms like “furnish” or “dispense without a prescription” rather than “prescribe.” Gloria Sachdev, Mary Ann Kliethermes, Veronica Vernon, Sandra Leal & George Crabtree, *Current Status of Prescriptive Authority by Pharmacists in the United States*, 3 J. AM. COLL. CLINICAL PHARMACY 807, 810–11 (2020).

332. Adams & Weaver, *supra* note 288, at 780–81. The latter type of CPA is sometimes known as a “standing order.” *Id.* at 783.

333. Jannet M. Carmichael, Mary Beth O’Connell, Beth Devine, H. William Kelly, Larry Ereshefsky et al., *Collaborative Drug Therapy Management by Pharmacists: American College of Clinical Pharmacy Position Statement*, 17 PHARMACOTHERAPY 1050, 1052 (1997); Christensen, *supra* note 331, at 15; Hammond, Schwartz, Campbell, Remington, Chuck et al., *supra* note 331, at 1213–14.

334. See U.S. GEN. ACCT. OFF., *supra* note 306, at 72 (nine states in 1995); Christensen, *supra* note 331, at 15 (finding that as of 2001, “more than half of the 50 states have [CPAs] . . . passed in most cases within the past 5 or so years”).

335. Sachdev, Kliethermes, Vernon, Leal & Crabtree, *supra* note 331, at 809.

which drugs are eligible.³³⁶ The drugs most commonly subject to statewide protocols are vaccines, tobacco cessation products, hormonal contraceptives, and naloxone.³³⁷ When both CPAs and statewide protocols are taken into account, pharmacists now have some degree of prescriptive authority in all fifty states.³³⁸

Insurance generally covers these products because they remain prescription drugs. Nevertheless, from a logistical perspective, a drug available from a pharmacist pursuant to a CPA or statewide protocol is *not* equally as accessible as an OTC medicine. It is available only in stores that employ a pharmacist. Many pharmacists are ignorant of these arrangements, and many others opt out of them because of state-specific training requirements, time burdens, and a lack of reimbursement for their services.³³⁹ Moreover, patients obtaining a drug in this manner must interact with a pharmacist whom they do not necessarily know or trust. As the U.S. Supreme Court aptly observed in 1977, when striking down a state requirement that condoms be dispensed only by pharmacists: “Limiting . . . distribution . . . to licensed pharmacists clearly imposes a significant burden [T]he restriction of distribution channels to a small fraction of the total number of possible retail outlets renders contraceptive devices less accessible to the public [and] reduces the opportunity for privacy of selection and purchase.”³⁴⁰

[Nonetheless, state pharmacist prescribing authority can enhance access to prescription drugs when their manufacturers or FDA are not ready to switch them to nonprescription status. It can also generate real-world evidence that can later be used to support a switch application. For example, when FDA recently invited submission of OTC applications for

336. Adams & Weaver, *supra* note 288, at 781–82; ALLISON ORRIS, GAYLE MAUSER, DEBORAH BACHRACH & MORGAN CRAVEN, IMPLEMENTING PHARMACIST CONTRACEPTIVE PRESCRIBING: A PLAYBOOK FOR STATES AND STAKEHOLDERS 6–7 (2021), https://www.manatt.com/Manatt/media/Documents/Articles/Implementing-Pharmacist-Contraceptive-Prescribing_v3.pdf [<https://perma.cc/4JUK-KWXV>]. Under a related approach, often known as the “statewide standing order,” a state medical official decides on his or her own to authorize pharmacists to prescribe certain drugs. ORRIS, MAUSER, BACHRACH & CRAVEN, *supra* at 6; Adams & Weaver, *supra* note 288, at 783.

337. Adams & Weaver, *supra* note 288, at 781; Kristen Engelen, *3 Questions About Pharmacist Prescribing Authority*, RXLIVE (Oct. 13, 2021) <https://rxlive.com/blog/mapping-u-s-statewide-protocols-for-pharmacist-prescriptive-authority/> [<https://perma.cc/ZRT8-DR5M?type=standard>]. FDA has rendered some of these statewide protocols partly or wholly irrelevant by authorizing OTC sales of covered products. *See, e.g., supra* pp. 1079–81 (discussing FDA’s approval of Nicorette® Nicotine Replacement Therapy’s switch to OTC status).

338. Sachdev, Kliethermes, Vernon, Leal & Crabtree, *supra* note 331, at 813.

339. *See* Lisa M. Guirguis & Damilola T. Adesanoye, *Pharmacist Prescribing: An Overnight Success, Decades in the Making*, 58 J. AM. PHARMACISTS ASS’N 589, 589 (2018); ORRIS, MAUSER, BACHRACH & CRAVEN, *supra* note 336, at 9, 17.

340. *Carey v. Population Servs. Int’l*, 431 U.S. 678, 689 (1977).

naloxone, it remarked that the many state pharmacist prescribing programs for this drug “help to inform the potential public health benefit of nonprescription naloxone use by laypersons and have factored into our initial assessment that naloxone may be used safely and effectively for nonprescription use.”³⁴¹

*C. Nonprescription Drug Product with Additional Condition
for Safe Use*

While state efforts to increase the accessibility of prescription drugs have proliferated in the last decade, FDA has taken steps to facilitate access from the other direction—by allowing drugs that otherwise would not qualify for OTC status to do so through additional conditions on their distribution.

In 2012, the agency hosted a public hearing on “Using Innovative Technologies and Other Conditions of Safe Use to Expand Which Drug Products Can Be Considered Nonprescription.”³⁴² The meeting was motivated by the agency’s concern that the prescription requirement can impede access.

Increasing the number of people who are able to obtain for the first time and those who continue on necessary drug therapy could provide improved health outcomes. The requirement to obtain a prescription for appropriate medication (and to make one or more visits to a practitioner) may contribute to undertreatment³⁴³

At the meeting, FDA sought input regarding ways in which technology could “augment the consumers’ ability to diagnose their condition, really . . . understand a drug and whether it’s right for them, and . . . assist them in understanding how to use the drug properly”³⁴⁴ Over the next fifteen months, the Brookings

341. Safety and Effectiveness of Certain Naloxone Hydrochloride Drug Products for Nonprescription Use; Request for Comments, 87 Fed. Reg. 68702, 68709 (Nov. 16, 2022).

342. Meeting Notice, 77 Fed. Reg. 12059, 12059 (February 28, 2012).

343. *Id.*

344. CTR. FOR DRUG EVALUATION & RSCH., FDA, PUBLIC HEARING: USING INNOVATIVE TECHNOLOGIES AND OTHER CONDITIONS OF SAFE USE TO EXPAND 7 (2012) (remarks of Janet Woodcock, Dir., Ctr. For Drug Evaluation & Rsch.).

Institution, in cooperation with FDA, held three expert workshops on development of a new OTC paradigm.³⁴⁵

Five years later, FDA issued a draft guidance titled “Innovative Approaches for Nonprescription Drug Products.”³⁴⁶ The guidance laid out approaches that might lead the agency to approve a wider range of nonprescription drug products and thus “improve the public health by increasing the types of drug products consumers can access and use”³⁴⁷ One such approach was providing labeling in addition to the standard “Drug Facts” label, such as leaflets, interactive displays, websites, and mobile applications.³⁴⁸ Another, more restrictive approach would impose “additional conditions for safe and effective use,” such as requiring consumers, prior to purchase, to answer questions on a self-selection test in a mobile application or affirm that they had viewed an instructional video.³⁴⁹

In 2022, FDA proposed implementing this “nonprescription drug with an additional condition for nonprescription use” (ACNU) approach through notice-and-comment rulemaking.³⁵⁰ The agency’s stated goal in promulgating this regulation is to “expand consumer access to certain drug products in a nonprescription setting.”³⁵¹

Instead of using the existing sNDA process, the proposal would establish a new type of NDA for a nonprescription drug with an ACNU.³⁵² The proposed definition of “additional condition for nonprescription use” is “one or more FDA-approved conditions that an applicant of a nonprescription drug product must implement to ensure consumers’ appropriate self-selection or appropriate actual use, or both, of the nonprescription drug product without the supervision of a healthcare practitioner”³⁵³ This definition is “intentionally broad to give applicants flexibility.”³⁵⁴ The preamble to the proposed rule provides two examples of ACNUs:

345. Nonprescription Drug Product With an Additional Condition for Nonprescription Use, 87 Fed. Reg. 38313, 38317 (June 28, 2022) (to be codified at 21 C.F.R. pts. 201, 314).

346. CTR. FOR DRUG EVALUATION & RSCH., FDA, GUIDANCE FOR INDUSTRY: INNOVATIVE APPROACHES FOR NONPRESCRIPTION DRUG PRODUCTS (2018).

347. *Id.* at 2.

348. *Id.* at 3.

349. *Id.*

350. Nonprescription Drug Product With an Additional Condition for Nonprescription Use, 87 Fed. Reg. at 38313.

351. *Id.* at 38315.

352. *Id.* at 38314–15.

353. *Id.* at 38329.

354. *Id.* at 38318.

[A]n applicant could propose an ACNU that requires a consumer, in order to purchase the nonprescription drug product, to respond with specific answers to a set of questions on a self-selection test available by either a mobile application or an automated telephone response system. An applicant may also propose that before purchasing the nonprescription drug product with an ACNU, a consumer be required to view labeling . . . that describes how to appropriately use the nonprescription drug product and to respond to questions to confirm understanding.³⁵⁵

Perhaps the most revolutionary aspect of this proposal is its allowance of simultaneous marketing of the identical drug on both a prescription³⁵⁶ and “nonprescription drug product with an ACNU” basis.³⁵⁷ FDA has long interpreted the FD&C Act to permit concurrent prescription and nonprescription sales of a drug only if there is a “meaningful difference” between the two versions, such as the indication, dosage form, or strength.³⁵⁸ Under the proposed rule, the ACNU would be deemed a “meaningful difference,” allowing simultaneous prescription and nonprescription marketing.³⁵⁹ FDA observes:

Continued access to the prescription drug product, along with availability of the nonprescription drug product approved with an ACNU, would ensure greater access to needed drugs by providing flexibility in how to obtain them. For example, if a nonprescription drug product approved with an ACNU is available through a kiosk in a pharmacy, patients who do not live near a pharmacy with such a kiosk may find it easier to obtain the drug through a prescription. Additionally, patients who prefer to continue interacting with their healthcare

355. *Id.*

356. *Id.* at 38321–22.

357. *Id.* at 38322.

358. *See, e.g.*, Drug Approvals: Circumstances Under Which an Active Ingredient May Be Simultaneously Marketed in Both a Prescription Drug Product and an Over-the-Counter Drug Product, 70 Fed. Reg. 52050 (Sept. 1, 2005) (to be codified at 21 C.F.R. pt. 310) (discussing “circumstances under which an active ingredient may be simultaneously marketed in both a prescription drug product and an over-the-counter drug product”) (cleaned up).

359. Nonprescription Drug Product With an Additional Condition for Nonprescription Use, 87 Fed. Reg. at 38330.

providers and obtain the drug by prescription would have that option.³⁶⁰

Unstated by FDA is another advantage of its proposed dual distribution system: even if the studies accompanying a switch application show that a significant number of consumers require professional supervision to use the drug safely and effectively, the agency could, instead of simply rejecting the switch, approve it with an ANCU. The additional condition would be used to deny OTC distribution to people who demonstrate they need such supervision, and these patients would continue to acquire the drug by prescription.

FDA also fails to mention yet another potential benefit of the proposed rule—one particularly relevant to abortion pills. It concerns federal preemption. Because the FD&C Act contains no express preemption provision for prescription drugs, there is much uncertainty regarding what restrictions states can impose on a prescription product in addition to any REMS imposed by FDA.³⁶¹ This question is currently being litigated in the medication abortion context.³⁶² By contrast, the Act explicitly prohibits a state from establishing any requirement for a *nonprescription* drug that is “different from or in addition to, or that is otherwise not identical with, a requirement under” drug provisions of the FD&C Act, with only a few exceptions.³⁶³ Although these exceptions permit a state to impose prescription status on an OTC drug, they do not allow it to impose additional restrictions on distribution unless FDA grants it an exemption from preemption.³⁶⁴ Consequently, if FDA were to approve medication abortion as a “nonprescription with ACNU” drug, anti-abortion states attempting to erect barriers to obtaining the pills could do no more than require a prescription.³⁶⁵

360. *Id.* at 38318–19.

361. *See infra* Section VI.C.2.

362. *See, e.g.*, Complaint at 7, *Bryant v. Stein*, 2023 WL 3477194 (M.D.N.C. May 16, 2023) (No. 1:23-cv-00077); Complaint at 1, *GenBioPro, Inc. v. Sorsaia*, 2023 WL 3451688 (S.D. W. Va. Apr. 21, 2023) (No. 3:23-cv-00058)

363. 21 U.S.C. § 379r(a)(2).

364. 21 U.S.C. § 379r. The exception for state imposition of prescription status is at 21 U.S.C. § 379r(c)(1)(B).

365. Whereas the nonprescription drug preemption provision would clearly preempt state restrictions on the distribution of OTC abortion medication beyond the imposition of a prescription requirement, it is possible—depending on how the courts apply preemption principles—that states would retain the power to ban all abortions, including those performed with medication. Patricia J. Zettler, Annamarie Beckmeyer, Beatrice L Brown & Ameet Sarpatwari, *Mifepristone, Preemption, and Public Health Federalism*, 9 J.L. & BIOSCIENCES 1, 23–25 (2022).

VI. TOWARD AN OVER-THE-COUNTER REPRODUCTIVE HEALTH ARMAMENTARIUM

This Part will discuss three categories of drugs essential to allowing women to control their reproductive choices: emergency contraceptives, oral contraceptives, and abortion medication. Until recently, only one of these (emergency contraception) was available over the counter.³⁶⁶ As described below, however, FDA granted an OTC switch application for a progestin-only birth control pill shortly before the publication of this article.³⁶⁷ Combination oral contraceptives containing both estrogen and progestin remain available by prescription only, but the agency may soon consider a switch application for a drug in that category, as well.³⁶⁸ Abortion medication, by contrast, is nowhere near gaining OTC status. Nevertheless, this Part imagines what such a transition might look like and what advantages it would offer.

A. Plan B Emergency Contraception

Plan B (levonorgestrel) is a synthetic progestin that prevents or delays ovulation (the release of an egg by the ovary) and thus reduces the chance of pregnancy if taken within seventy-two hours after unprotected sex.³⁶⁹ Levonorgestrel is also an active ingredient in two types of multiple-hormone (“combined”) oral contraceptives.³⁷⁰ Since the 1960s, people have used high doses of oral contraceptives as “morning after

366. Other contraceptive products currently available over the counter include sponges with spermicide, male condoms, female (internal) condoms, and spermicide alone. *Birth Control*, FDA, <https://www.fda.gov/consumers/free-publications-women/birth-control> (July 13, 2023) [<https://perma.cc/RF92-3ESB>]. The only one of these other products that FDA regulates as a drug is spermicide alone. 21 C.F.R. § 201.325 (“Over-the-counter drugs for vaginal contraceptive and spermicide use containing nonoxynol 9 as the active ingredient.”). The agency regulates the others as medical devices.

367. FDA Approves First Nonprescription Daily Oral Contraceptive, *supra* note 47.

368. *See infra* p. 1113.

369. *Plan B One-Step (1.5 mg levonorgestrel) Information*, FDA, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/plan-b-one-step-15-mg-levonorgestrel-information> [<https://perma.cc/YPC8-9AQF>]. In 2022, FDA approved a labeling supplement to modify the description of Plan B’s mechanism of action, clarifying that the drug does not have any direct effect on postovulatory processes, such as fertilization or implantation. *Id.*

370. *Birth Control Pills Brands: What Options Are There?*, MEDICALNEWSTODAY, <https://www.medicalnewstoday.com/articles/what-are-the-best-birth-control-pill-brands#how-do-pills-work> (Nov. 2022). The two types are levonorgestrel/ethinylestradiol combination pills and extended cycle birth control pills. *Id.*

pills” following unprotected intercourse.³⁷¹ In 1997, FDA Commissioner David Kessler took the unusual step of announcing that high dose regimens of oral contraceptives combining ethinyl estradiol (an estrogen) with either levonorgestrel or norgestrel (another progestin) were effective off-label as emergency contraceptives.³⁷² He invited manufacturers to submit NDAs for formal approval of this use based on published literature cited in the notice, and he implicitly guaranteed that the agency would approve such applications.³⁷³

In 1998, FDA approved the first emergency contraceptive pill, Preven, which combined ethinyl estradiol and levonorgestrel.³⁷⁴ The next year it approved the levonorgestrel-only Plan B.³⁷⁵ As is typical, the agency subjected both of these newly approved products to the prescription requirement. Immediately, some expressed concern that this requirement might delay acquisition of these drugs and thus reduce or negate their effectiveness.³⁷⁶ To address this very problem, in 1998 (before the approval of Preven), Washington State had authorized and encouraged collaborative practice agreements (CPAs) between prescribers and community pharmacists for off-label use of high-dose oral contraceptives as emergency contraceptives.³⁷⁷ (This program generated epidemiological evidence that was later used to support the Plan B switch application.³⁷⁸) In 2001, the California legislature

371. Prescription Drug Products; Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception, 62 Fed. Reg. 8610, 8610 (Feb. 25, 1997).

372. *Id.* at 8611-12.

373. *Id.*

374. *Drugs@FDA: FDA-Approved Drugs*, FDA, <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&AppNo=020946> [<https://perma.cc/EY2N-2TSL>] (Preven Emergency Contraceptive Kit).

375. *Drugs@FDA: FDA-Approved Drugs*, FDA, <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&AppNo=021045> [<https://perma.cc/7KTP-37NK>] (Plan B) [hereinafter Plan B].

376. *See, e.g.*, Kirsten Moore, Dir., Reprod. Health Techs. Project, Statement at FDA Hearing on Over the Counter Drug Products (June 28-29, 2000), https://downloads.regulations.gov/FDA-2000-N-0112-0120/attachment_1.pdf [<https://perma.cc/D4KN-HXP2>] (“Recent clinical evidence . . . tells us that this pill is more effective the sooner it’s taken, and for this reason, the project is strongly in favor of moving emergency contraception . . . over the counter.”).

377. Jane Hutchings, Jennifer Winkler, Tim Fuller, Jacqueline S. Gardner, Elisa Wells et al., *When the Morning After Is Sunday: Pharmacist Prescribing of Emergency Contraceptive Pills*, 53 J. AM. MED. WOMEN’S ASS’N 230, 230-31 (1998); Sunshine D. Sommers, Nathan Chaiyakunapruk, Jacqueline S. Gardner & Jennifer Winkler, *The Emergency Contraception Collaborative Prescribing Experience in Washington State*, 41 J. AM. PHARM. ASS’N 60, 60-61 (2001).

378. CTR. FOR DRUG EVALUATION & RSCH., FDA, APPLICATION NUMBER 21-045/S011: MEDICAL REVIEW (2006),

authorized pharmacists to dispense emergency contraception without a patient-specific prescription pursuant to collaborative physician protocols.³⁷⁹ Eventually, at least seven additional states permitted pharmacists to distribute emergency contraception pursuant to either a collaborative practice agreement or statewide protocol.³⁸⁰ These programs appear to have had only modest impact on access, however, because the majority of pharmacies did not participate.³⁸¹

In 2001, the Center for Reproductive Rights and other public health groups filed a citizen petition seeking to make Plan B and Preven available OTC. In 2003 the Women's Capital Corporation, Plan B's sponsor at the time, submitted an sNDA seeking a switch for that drug.³⁸² Thus commenced the tortured saga of Plan B's journey from prescription to nonprescription status, a story that has been detailed elsewhere.³⁸³ The process was characterized by administrative irregularities and political interference in FDA processes.³⁸⁴

Switching Plan B to nonprescription status for *adults* did not meet any significant resistance within the government. The hot button issue, from a political standpoint, was providing OTC access to adolescents, as well. In 2004, Steven Galson, the acting director of FDA's Center for Drug Evaluation and Research (CDER), rejected the recommendations of a joint advisory committee and the agency's own review staff and denied Plan B's switch application.³⁸⁵ He asserted that OTC availability

https://www.accessdata.fda.gov/drugsatfda_docs/nda/2006/021045s011_Plan_B_Med_R.pdf [<https://perma.cc/MAP4-EJJ2>] [hereinafter PLAN B NDA].

379. S.B. 1169, 2001–02 Leg., Reg. Sess. (Cal. 2001).

380. *State Contraception Policies*, NAT'L CONF. STATE LEGISLATURES <https://www.ncsl.org/health/state-contraception-policies> (July 28, 2023) [<https://perma.cc/7VJT-S2QY>].

381. CTR. FOR DRUG EVALUATION & RSCH., FDA, NONPRESCRIPTION DRUGS ADVISORY COMMITTEE (NDAC) IN JOINT SESSION WITH THE ADVISORY COMMITTEE FOR REPRODUCTIVE HEALTH DRUGS (ACRHD) 70–71 (2003) (remarks of Dr. Carole Ben-Maimon) (noting that only “14 percent of pharmacies and pharmacists participate[d]” two years after California's legislation went into effect) [hereinafter 2003 NDAC ADVISORY COMMITTEE].

382. Lisa Heinzerling, *The FDA's Plan B Fiasco: Lessons for Administrative Law*, 102 GEO. L.J. 927, 940 (2014).

383. *See generally id.*; Roseann B. Termini & Miranda Lee, *Sex, Politics, and Lessons Learned from Plan B: A Review of the FDA's Actions and Future Direction*, 36 OKLA. CITY U. L. REV. 351 (2011).

384. GAO, GAO-06-109, FOOD AND DRUG ADMINISTRATION DECISION PROCESS TO DENY INITIAL APPLICATION FOR OVER-THE-COUNTER MARKETING OF THE EMERGENCY CONTRACEPTIVE DRUG PLAN B WAS UNUSUAL 11 (2005) [hereinafter FDA DECISION PROCESS DENYING APPLICATION WAS UNUSUAL]; *Tummino v. Hamburg*, 936 F. Supp. 2d 162, 165–66 (E.D.N.Y. 2013); Heinzerling, *supra* note 382, at 929.

385. FDA DECISION PROCESS DENYING APPLICATION WAS UNUSUAL, *supra* note 384, at 375.

of Plan B would lead adolescents, who are more prone to risky behaviors, to engage in unsafe sexual activity, resulting in an increase in unintended pregnancies, abortions, and sexually transmitted disease.³⁸⁶ The manufacturer overcame this objection by revising the sNDA to provide OTC access only for women eighteen years of age and older, as discussed earlier.³⁸⁷ FDA approved this amended sNDA in 2006.³⁸⁸ Subsequent efforts by manufacturers and a reproductive rights group to extend nonprescription status to people of all ages were stymied by political interference until finally, in 2013, a judge ordered the agency to make Plan B available over the counter without age restrictions.³⁸⁹

For purposes of this Article, the Plan B switch was noteworthy for a reason other than its fraught procedural history: the emphasis given throughout the process to the public health benefits of improved access to the drug. With the arguable exception of the Nicorette[®] switch in 1996, no previous switch had ever been justified so explicitly and predominantly on the need to increase a drug's utilization and efficacy by making it more readily accessible.³⁹⁰

In 2003, the FDA—atypically—presented the advisory committee considering the original Plan B switch application with a question explicitly focused on access.³⁹¹ The committee voted 22-5 in favor of OTC access for people of all ages, rejecting the possibility of behind-the-counter status.³⁹² As one member remarked: “[T]he least [sic] thing I would want is a pharmacist and I to hold a conversation about my sex life in front of my 30 neighbors standing behind me very impatient waiting for their prescriptions.”³⁹³ FDA officials ranking below Galson agreed that Plan B should be OTC for all. The director of the OTC Drugs Review Division declared: “Any system that creates barriers to access . . . would defeat the purpose of the drug and lessen its public health potential.”³⁹⁴ The director of the Office of New Drugs agreed.

386. *Id.* at 23.

387. *Supra* p. 1090.

388. Plan B, *supra* note 375.

389. *Tummino*, 936 F. Supp. 2d at 197; *Tummino v. Hamburg*, No. 12-CV-763, 2013 WL 2631163, at *1 (E.D.N.Y. June 12, 2013).

390. PLAN B NDA, *supra* note 378, at 49 (describing purpose of sNDA as “to facilitate timely access”).

391. 2003 NDAC ADVISORY COMMITTEE, *supra* note 381, at 364 (“Question No. 5: are the plans for introduction of Plan B into the non-Rx setting adequate with respect to consumer access and safe use?”).

392. *Id.* at 398.

393. *Id.* at 384 (remarks of Dr. Lorraine Tulman).

394. Memo-Addendum from Division Director Curtis J. Rosebraugh (Mar. 23, 2004), in PLAN B NDA, *supra* note 378, at 178 (2006).

I believe that greater access to this drug will have a significant positive impact on the public health by reducing the number of unplanned pregnancies and the number of abortions. . . . An agency decision to approve Plan B as a “dual” product may have the paradoxical effect of decreasing access to and use of the product if pharmacies and pharmacists choose not to stock the product due to an unwillingness to participate in verifying the age of women who present to the pharmacy requesting Plan B or based on liability concerns.³⁹⁵

Galson rejected these recommendations when he approved the partial switch of Plan B (for adults only) in 2006. He observed that even if the dual approach had “the unintended public health consequence of limiting access to women of all ages” by forcing Plan B behind the counter, “[t]his is not a factor FDA would normally consider in making a switch decision, as it is not in the criteria for non-prescription status in the statute or FDA’s implementing regulations.”³⁹⁶ By contrast, in 2013, when U.S. District Judge Edward Korman finally ordered the agency to make the drug available OTC to people of all ages, he clearly thought that the benefit of access *was* a valid consideration in a switch decision. He observed: “The regime . . . requir[ing] that the product be sold only at pharmacies and health clinics and that it be kept behind the counter at pharmacies . . . not only limits young adolescents’ access to Plan B, it limits the access of individuals 17 and older to the product.”³⁹⁷

Even the complete OTC switch of Plan B and its generic equivalents has not guaranteed unhindered access to everyone. Many pharmacies continue to stock the drug behind the counter to enforce the (nonexistent) age limit, to guard against theft, or both.³⁹⁸ Many stores continue to demand proof of age based on the misconception that an age restriction remains in place. The product remains prohibitively expensive for some. Furthermore, *Dobbs* has raised alarms that conservative states may ban

395. Memorandum from Office of New Drugs Director, John K. Jenkins (Jan. 14, 2005), in PLAN B NDA, *supra* note 378, at 30 (2006).

396. Memorandum from Center for Drug Evaluation & Research Director, Steven Galson (Aug. 26, 2005), in PLAN B NDA, *supra* note 378, at 17 (2006).

397. *Tummino v. Hamburg*, 936 F. Supp. 2d 162, 179 (E.D.N.Y. 2013).

398. Kelly Cleland, Jamie Bass, Florida Doci & Angel M. Foster, *Access to Emergency Contraception in the Over-the-Counter Era*, 26 WOMEN’S HEALTH ISSUES 622, 624 (2016); Tracey A Wilkinson, Porsche Clark, Sally Rafie, Aaron E. Carrol & Elizabeth Miller, *Access to Emergency Contraception After Removal of Age Restrictions*, 140 PEDIATRICS 1, 3 (2017); Kelly Cleland, Bhavik Kumar, Nikita Kakkad, Jasmine Shabazz, Nicola R Brogan et al., *Now Is the Time to Safeguard Access to Emergency Contraception as Abortion Restrictions Sweep the United States*, 114 CONTRACEPTION 6, 7 (2022).

emergency contraceptive pills along with abortion on the erroneous grounds that they can prevent a fertilized egg from implant in the womb.³⁹⁹ For now, however, Plan B remains a pillar of the OTC reproductive health armamentarium.

B. Oral Contraceptives

In 1960, FDA approved the first hormonal birth control pill, Enovid, a combination of synthetic estrogen and progestin.⁴⁰⁰ By the end of 1964, three competitors had entered the market, and the “pill” was the most popular contraceptive in the country.⁴⁰¹ The pill constituted both a medical and social revolution. It separated the act of contraception from the act of sex and was nearly 100 percent effective. In addition, in the words of historian Elaine Tyler May, the pill “became a major player in many of the most dramatic and contentious issues of the last half of the twentieth century: the quest for reproductive rights; challenges to the authority of medical, pharmaceutical, religious, and political institutions; changing sexual mores and behaviors . . . and women’s emancipation.”⁴⁰²

As early as 1962, reports emerged linking Enovid to thromboembolism, a potentially fatal blood clotting disorder.⁴⁰³ Concerns also arose about a possible increased risk of breast, cervical, and uterine cancer.⁴⁰⁴ By the late 1960s, the safety of oral contraceptives (OCs) had become a matter of widespread concern. In 1969, FDA reported that users of OCs were 4.4 times more likely to develop thromboembolism.⁴⁰⁵ In 1969, Barbara Seaman, a journalist and one of the founders of the women’s health movement, detailed the risks of combination oral

399. Pam Belluck, *F.D.A. Takes Action to Say It Plainly: Morning-After Pills Are Not Abortion Pills*, N.Y. TIMES, Dec. 24, 2022, at A17. In December 2022, FDA revised the labeling of Plan B One-Step to remove wording suggesting that the drug could work by preventing fertilization or implantation. *Plan B One-Step (1.5 mg levonorgestrel) Information*, FDA, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/plan-b-one-step-15-mg-levonorgestrel-information> [<https://perma.cc/F9FA-3CHQ>].

400. ELIZABETH SIEGAL WATKINS, *ON THE PILL: A SOCIAL HISTORY OF ORAL CONTRACEPTIVES* 32 (1998); JONATHAN EIG, *THE BIRTH OF THE PILL: HOW FOUR CRUSADERS REINVENTED SEX AND LAUNCHED A REVOLUTION* 299 (2014). FDA first approved Enovid in 1957 as a treatment for menstrual disorders. *Id.* at 256–57.

401. WATKINS, *supra* note 400, at 38; ELAINE TYLER MAY, *AMERICA AND THE PILL: A HISTORY OF PERIL, PROMISE, AND LIBERATION* 2 (2010).

402. MAY, *supra* note 401, at 6.

403. WATKINS, *supra* note 400, at 38.

404. *Id.* at 77.

405. ANDREA TONE, *DEVICES AND DESIRES: A HISTORY OF CONTRACEPTIVES IN AMERICA* 244 (2001).

contraceptives in her book, the *Doctors' Case Against the Pill*.⁴⁰⁶ This volume inspired U.S. Senator Gaylord Nelson to hold hearings on the safety of the pill in 1970.⁴⁰⁷ An estimated eighty-seven percent of women between the ages of twenty-one and forty-five followed these hearings.⁴⁰⁸

In fact, OCs had become significantly safer drugs with fewer side effects by the early 1970s, as manufacturers had lowered the level of hormones in them to a small fraction of the original amounts.⁴⁰⁹ Hormone doses, particularly the amount of estrogen, continued to fall in subsequent decades.⁴¹⁰ Today, combination pills are thus far safer than they were in 1960. Nonetheless, vascular and cardiovascular risks (and other risks) remain, and combination pills are thus contraindicated for smokers and women at high risk of thrombotic disease (as well as for breast cancer survivors and others).⁴¹¹ Since 1973, however, an even safer alternative has been available: the progestin-only pill (or “minipill”), containing no estrogen.⁴¹² Although it is slightly less effective than combination pills, it does not similarly increase thromboembolic risks.⁴¹³

The birth control pill also represented a revolution in drug labeling. For three decades after FDA first created formal prescription status by regulation in 1938, the agency had maintained that prescription drug information should be directed only to physicians and other medical professionals.⁴¹⁴ In this view, patients should not learn about the benefits and risks of their prescription drugs from the labeling but should instead rely on the judgment and advice of their physicians. The rise of the women’s health and patient’s rights movements in the late 1960s and early 1970s began to change this assumption, and consumer-directed OC labeling was an early tangible result. In 1970, following the Nelson hearings, FDA required OC manufactures to provide a “patient package information” with the pill.⁴¹⁵ This insert disclosed side effects and risks,

406. BARBARA SEAMAN, *THE DOCTOR’S CASE AGAINST THE PILL* (1969); MAY, *supra* note 401, at 130–31; TONE, *supra* note 405, at 245; WATKINS, *supra* note 400, at 103–05.

407. TONE, *supra* note 405, at 248.

408. WATKINS, *supra* note 400, at 115.

409. TONE, *supra* note 405, at 245–46; MAY, *supra* note 401, at 168.

410. TONE, *supra* note 405, at 246.

411. See, e.g., *YAZ (drospirenon/ethinyl estradiol) Tablets Prescribing Information*, FDA 1 (Apr. 2012), https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/021676s012lbl.pdf.

412. *Mini-Pill Approved by FDA*, 7 IPPF MED. BULL. 3, 3 (1973).

413. *Id.*; Naomi K. Tepper, Maura K. Whiteman, Polly A. Marchbanks, Andra H. James & Kathryn M. Curtis, *Progestin-Only Contraception and Thromboembolism: A Systematic Review*, 94 CONTRACEPTION 678, 678 (2016).

414. L. Grossman, *supra* note 67, at 652.

415. Statement of Policy Concerning Oral Contraceptive Labeling Directed to Users, 35 Fed. Reg. 9001–02 (June 11, 1970).

including potentially fatal abnormal blood clotting, and told the patient of the availability of a booklet containing more information.⁴¹⁶ This was the first significant direct-to-patient labeling for a prescription drug and the genesis of a now-common phenomenon.⁴¹⁷

Thereafter, the pill was the paradigmatic patient-controlled prescription drug, with doctors playing a relatively passive role in its use. Patients generally drove the decision about whether to use OCs, reviewed the labeling themselves, and renewed their prescriptions only once a year. Because of these “peculiar characteristics,” courts in tort cases forged an exception to the learned intermediary doctrine for OCs, requiring manufacturers to warn patients about their risks directly.⁴¹⁸ Today, birth control pills are perhaps more like OTC drugs than any other prescription medication.

But they are still available only by prescription in the United States, even though many countries around the world permit nonprescription sales.⁴¹⁹ And the requirement to obtain a prescription burdens access. Surveys of American women have found that between forty and sixty percent of those who currently use no contraception or a less effective method than the pill would be more likely to use OCs if they were available without a prescription.⁴²⁰ Women are interested in OTC oral contraceptives for various reasons: to save time, to avoid pelvic exams, to quickly start taking the pill when needed, to preserve confidentiality, and to save money.⁴²¹ One survey showed that about thirty percent of American women who have ever tried to obtain an oral contraceptive

416. *Id.* at 9001–03.

417. L. Grossman, *supra* note 67, at 652–56 (“Almost 200 REMs with patient-directed MedGuide requirements have been established since 2007.”).

418. *MacDonald v. Ortho Pharm. Corp.*, 475 N.E.2d 65, 69–70 (Mass. 1985); Teresa Moran Schwartz, *Consumer Warnings for Oral Contraceptives: A New Exception to the Prescription Drug Rule*, 41 FOOD, DRUG, COSM. L.J. 241, 253–54 (1986).

419. Kate Grindlay, Bridgit Burns & Daniel Grossman, *Prescription Requirements and Over-the-Counter Access to Oral Contraceptives: A Global Review*, 88 CONTRACEPTION 91, 93–95 (2013); *OTC Access World Map*, FREE THE PILL, <https://freethepill.org/otc-access-world-map> [<https://perma.cc/8K8Y-EGYX>] (July 12, 2022) (“Birth control pills are . . . available over the counter in more than 100 countries around the world.”).

420. *See, e.g.*, Joseph E. Potter, Sarah McKinnon, Kristine Hopkins, Jon Amastae, Michele G. Shedlin et al., *Continuation of Prescribed Compared with Over-the-Counter Oral Contraceptives*, 117 OBSTETRICS & GYNECOLOGY 551, 551 (2011); D. Grossman, Grindlay, Li, Potter, Trussell & Blanchard, *supra* note 155, at 545–46, 548–49; *A National Survey of US Women’s Interest in Over-the-Counter Access to a Progestin-Only Pill*, IBIS REPROD. HEALTH (Feb. 2018), https://www.ibisreproductivehealth.org/sites/default/files/files/publications/POP%20survey%20brief_0.pdf [<https://perma.cc/5DPG-AGV6>].

421. IBIS REPROD. HEALTH, *supra* note 420; Long, Frederiksen, Ranji, Diep & Salganicoff, *supra* note 155.

prescription have had difficulty doing so at least once.⁴²² Another found that nearly half of prescription contraceptive users at risk for unintended pregnancy had experienced a gap in contraceptive use in the previous year, often because of a lack of time for medical visits or difficulty paying.⁴²³

The notion of an OTC oral contraceptive pill has thus been in the air for decades. In 1992, after multiple companies approached FDA to discuss the possibility of selling the pill without a prescription, the agency scheduled an advisory committee meeting on the topic.⁴²⁴ In January 1993, however, FDA abruptly cancelled the meeting, explaining that the agenda focused too narrowly on the science and neglected the “social implications” of such a move.⁴²⁵ The resistance to an OTC pill—or even a discussion about it—came primarily not from conservative groups, but from some family planning advocates, consumer protection advocates, and doctors.⁴²⁶ These opponents warned that women at high risk for thromboembolism and cancer would use the pill without a physician’s oversight.⁴²⁷ They asserted that absent a need to renew their OC prescriptions, women would skip their annual doctors’ visits and thus miss important health screenings and reproductive health advice.⁴²⁸ They also predicted that improper use of an OTC birth control pill would lead to more unintended pregnancies and abortions.⁴²⁹

Attitudes began to evolve in the 2000s. At FDA hearings in 2000 and 2007, Amy Allina of the National Women’s Health Network, though opposing OTC oral contraceptives, spoke in favor of behind-the-counter access.⁴³⁰ A crucial development occurred in 2012, when an American

422. Kate Grindlay & Daniel Grossman, *Prescription Birth Control Access Among U.S. Women at Risk of Unintended Pregnancy*, 25 J. WOMEN’S HEALTH 249, 250, 252 (2016).

423. Jennifer J. Frost, Susheela Singh & Lawrence B. Finer, *U.S. Women’s One-Year Contraceptive Use Patterns, 2004*, 39 PERSPS. ON SEXUAL & REPROD. HEALTH 48, 52 (2007). See also Potter, McKinnon, Hopkins, Amastae, Shedlin et al., *supra* note 420, at 555 (reporting lower incidence of discontinuance of oral contraceptive use among users who obtained them OTC than among those who obtained them at a clinic).

424. Elizabeth Neus, *No-Prescription Birth Control Pills Raise Furor*, CHI. SUN-TIMES, Feb. 21, 1993, at 27; Elyse Tanouye & Rose Gutfeld, *Talks Canceled on Making “Pill” Nonprescription*, WALL ST. J., Jan. 28, 1993, at B1.

425. Neus, *supra* note 424; Tanouye & Gutfeld, *supra* note 424, at B1.

426. Tanouye & Gutfeld, *supra* note 424.

427. *Id.*

428. *Id.*

429. *Id.*; Mary Rainwater & Susan Mandel, Editorial, *Don’t Sell the Pill Over the Counter*, ST. LOUIS POST-DISPATCH, Sept. 27, 1993, at 7B.

430. NAT’L WOMEN’S HEALTH NETWORK, COMMENTS AT FDA PUBLIC HEARING ON OTC DRUG PRODUCTS 2–3 (2000), <https://www.regulations.gov/document/FDA-2000-N-0112-0111> (remarks of Amy Allina, National Women’s Health Network

College of Obstetricians and Gynecologists (ACOG) committee issued an opinion calling for OTC access to oral contraceptives.⁴³¹ The committee cited the need to eliminate the logistical barriers that contributed to unintended pregnancies; the low rate of venous thromboembolism in OC users (and the much higher rate during pregnancy); and women's demonstrated ability to self-screen for contraindications.⁴³² While recognizing the value of annual health assessments, the ACOG opinion maintained that "cervical cancer screening and sexually transmitted infection screening are not required before initiating [OC] use and should not be used as . . . [barriers] to access."⁴³³

In the absence of federal action, states stepped into the breach. In 2013, the California legislature authorized the creation of a statewide protocol for pharmacist prescribing of oral contraceptives,⁴³⁴ and Oregon followed two years later.⁴³⁵ Today, about sixteen states have such statewide protocols or CPAs.⁴³⁶ Pharmacy participation in these programs is uneven and far from universal.⁴³⁷ Where available, however, younger, less educated, uninsured, rural, and African American individuals use these programs at disproportionate rates.⁴³⁸

In recent years, interest in a complete Rx-OTC switch at the federal level has increased. Since 2015, Republicans in Congress have repeatedly introduced bills that would require FDA to give priority review to any application seeking to switch an oral contraceptive to OTC status.⁴³⁹

Program & Policy Director); BEHIND THE COUNTER AVAILABILITY OF CERTAIN DRUGS, *supra* note 318.

431. *Over-the-Counter Access to Oral Contraceptives*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, at e96 (2019).

432. *Id.*

433. *Id.*

434. CAL. BUS. & PROF. CODE. § 4052.3 (2013).

435. OR. REV. STAT. § 689.689 (2015).

436. *Pharmacist-Prescribed Contraceptives*, GUTTMACHER INST. (July 1, 2023), <https://www.gutmacher.org/state-policy/explore/pharmacist-prescribed-contraceptives> [<https://perma.cc/LB6Q-EGA5>]; ORRIS, MAUSER, BACHRACH & CRAVEN, *supra* note 336, at 8.

437. For example, approximately 46% of pharmacies in Oregon participate, about 31% in Hawai'i, and about 28% in Utah. *Pharmacies Prescribing Birth Control in Oregon*, POWER TO DECIDE, <https://powertodecide.org/what-we-do/information/resource-library/pharmacies-prescribing-birth-control-oregon> [<https://perma.cc/DKE6-477D>] (Jan. 20, 2021); Hannah Collins-Doijode, Julia Oehlers, Jasmine Tyson, Maria Isabel Rodriguez & Bliss Kaneshiro, *Availability of Pharmacist-Prescribed Contraception in Hawai'i*, 81 HAW. J. HEALTH & SOC. WELFARE 215, 218 (2022); Emma Freestone, *Pharmacy-Prescribed Contraceptives in Utah*, BYU: PUB. HEALTH (Nov. 9, 2021, 9:15 AM), <https://ph.byu.edu/pharmacy-prescribed-contraceptives-in-utah> [<https://perma.cc/B2RA-6VCC>].

438. ORRIS, MAUSER, BACHRACH & CRAVEN, *supra* note 336, at 5.

439. *See, e.g.*, S. 1438, 114th Cong. (2015); S. 4638, 117th Cong. (2022).

Democrats, for their part, have introduced bills requiring cost-free insurance coverage of any nonprescription OC that FDA might approve.⁴⁴⁰ In 2021, the *New York Times* reported that two OC manufacturers had been in communication with FDA for at least five years about switching their products (one a minipill and the other a combination product) to OTC status, but that the agency had responded with unusual caution and hesitation.⁴⁴¹

In 2022, as the expected overturning of *Roe v. Wade* loomed, a sense of urgency gripped supporters of OTC oral contraception. Shortly after his appointment in March, FDA Commissioner Robert Califf received a letter from fifty-nine Democratic members of Congress urging him to give “timely review” to the imminent OTC switch applications.⁴⁴² They contended that an OTC birth pill would lower the “immense barriers to getting birth control due to systemic inequities in our healthcare system” and “provide individuals greater control over their reproductive lives and health.”⁴⁴³ In June 2022, the American Medical Association endorsed “removing the prescription access barrier” to oral contraceptives, noting that it was “an easy call from a public health perspective as the risks of pregnancy vastly outweigh those of oral contraceptive use.”⁴⁴⁴

Finally, in July 2022—just weeks after the Supreme Court issued its decision in *Dobbs*—HRA Pharma announced that it had submitted an sNDA seeking to switch its progestin-only Opill to OTC status.⁴⁴⁵ After a delay to allow the agency to “review new information,”⁴⁴⁶ an advisory

440. See, e.g., S. 1532, 114th Cong. § 2 (2015); S. 4347, 117th Cong. § 2 (2022).

441. Kate Kelly, *Firms Push to Make Birth Control Pills Available Without Prescriptions*, N.Y. TIMES (Dec. 14, 2021), <https://www.nytimes.com/2021/12/14/business/birth-control-pill-over-counter.html>.

442. Letter from Democratic Members of Cong. to FDA Comm’r Robert Califf (Mar. 7, 2022) (on file with *Wisconsin Law Review*).

443. *Id.*

444. Press Release, Am. Med. Ass’n., AMA Urges FDA to Make Oral Contraceptive Available Over-the-Counter (June 15, 2022), <https://www.ama-assn.org/press-center/press-releases/ama-urges-fda-make-oral-contraceptive-available-over-counter> [<https://perma.cc/3AQ8-MMLJ?type=image>].

445. Perrigo Co. plc, *Perrigo’s HRA Pharma Submits Application to FDA for First-Ever OTC Birth Control Pill*, CISION PR NEWSWIRE (July 11, 2022, 6:00 AM), <https://www.prnewswire.com/news-releases/perrigos-hra-pharma-submits-application-to-fda-for-first-ever-otc-birth-control-pill-301583602.html> [<https://perma.cc/XP8G-E7BP>] (press release from Perrigo Co. plc).

446. *POSTPONED: November 18, 2022 Joint Meeting of the Nonprescription Drugs Advisory Committee and the Obstetrics, Reproductive and Urological Drugs Advisory Committee Meeting: Updated Information*, FDA (Oct. 26, 2022), <https://www.fda.gov/advisory-committees/advisory-committee-calendar/postponed-november-18-2022-joint-meeting-nonprescription-drugs-advisory-committee-and-obstetrics> [<https://perma.cc/MAQ7-WDHE>].

committee finally met to consider the application in May 2023.⁴⁴⁷ FDA’s briefing document and its presentation on the first day of the meeting focused on its concerns about the methodology and results of the studies the manufacturer had conducted to support the switch.⁴⁴⁸ The agency virtually ignored the benefits of improved access while emphasizing flaws in the evidentiary record. By the time the last FDA presenter finished talking, the application seemed dead in the water.⁴⁴⁹

But then the open public hearing commenced. Thirty-seven speakers testified—all but two supported the switch.⁴⁵⁰ Many were medical professionals, but many others were laypeople pleading for OTC access based on their personal experiences and those of their communities.⁴⁵¹ These speakers highlighted the barriers to obtaining contraception confronted by poor and working-class women, rural residents, youth from conservative religious families, immigrants, African Americans, Latinas, and Native Americans.⁴⁵² Their testimony was replete with passionate pleas for “access,” “autonomy,” and “reproductive justice.”⁴⁵³

On the second day, the committee addressed the agency’s formal questions.⁴⁵⁴ The first three queries (“discussion questions” not subject

447. *May 9-10, 2023: Joint Meeting of the Nonprescription Drugs Advisory Committee and the Obstetrics, Reproductive and Urologic Drugs Advisory Committee Meeting Announcement*, FDA, <https://www.fda.gov/advisory-committees/advisory-committee-calendar/may-9-10-2023-joint-meeting-nonprescription-drugs-advisory-committee-and-obstetrics-reproductive-and#event-materials> [https://perma.cc/42AZ-2QDB] (July 25, 2023).

448. FDA, FDA BRIEFING DOC., JOINT MEETING OF THE NONPRESCRIPTION DRUGS ADVISORY COMMITTEE AND THE OBSTETRICS, REPRODUCTIVE, AND UROLOGIC DRUGS ADVISORY COMMITTEE, MAY 9, 2023 – MAY 10, 2023 (2023); CTR. FOR DRUG EVALUATION & RSCH., FDA, JOINT MEETING OF THE NONPRESCRIPTION DRUGS ADVISORY COMMITTEE (NDAC) AND THE OBSTETRICS, REPRODUCTIVE, AND UROLOGIC DRUGS ADVISORY COMMITTEE (ORUDAC) 150–255 (2023) (Day 1: May 9, 2023), <https://www.fda.gov/media/170525/download> [https://perma.cc/M3NR-5589] [hereinafter JOINT MEETING, MAY 9, 2023].

449. JOINT MEETING, MAY 9, 2023, *supra* note 448.

450. *See id.* at 282–400.

451. *Id.*

452. *See, e.g., id.* at 304–05 (remarks of Ms. Rebecca Heimbrock) (poor, working-class women and rural residents); *id.* at 367–70 (remarks of Ms. Dyvia Huitron) (youth from conservative religious families); *id.* at 382–85 (remarks of Candace Gibson) (immigrant Latinas); *id.* at 385–88 (remarks of Dr. Cherie Priya Dhar) (immigrants, African Americans, and Native Americans).

453. *Id.* at 282–400.

454. CTR. FOR DRUG EVALUATION & RSCH., FDA, JOINT MEETING OF THE NONPRESCRIPTION DRUGS ADVISORY COMMITTEE (NDAC) AND THE OBSTETRICS, REPRODUCTIVE, AND UROLOGIC DRUGS ADVISORY COMMITTEE (ORUDAC) 87–186 (2023) (Day 2: May 10, 2023), <https://www.fda.gov/media/170526/download> [https://perma.cc/9RVG-9FC4] [hereinafter JOINT MEETING, MAY 10, 2023].

to a vote) focused on flaws in the actual use study and the potential *risks* of switching Opill to nonprescription status.⁴⁵⁵ Atypically, however, the final question—the “voting” question—explicitly invoked the *benefits* of improved access and asked the committee whether these benefits outweighed the risks of OTC status.⁴⁵⁶ Perhaps to FDA’s dismay, this fourth question shaped the committee’s deliberations about the first three. From the moment the committee began discussing the first question, its members uniformly began opining that the imperative for immediate OTC access to an oral contraceptive outweighed any concerns they had about the evidentiary record.⁴⁵⁷ Following discussion of the third question, an FDA representative defensively asserted:

I just want to emphasize . . . that we really realize how important it is that U.S. women have increased access to effective contraception, and I don’t want . . . our pointing out of the deficiencies of the development program to take away from that message. . . . [We] realize how very important women’s health is.⁴⁵⁸

In response to the fourth question, the committee then voted 17-0 that the benefits of the OTC switch would outweigh its risks.⁴⁵⁹ During the committee members’ explanations of their votes, the same themes arose again and again. They pointed out that even if consumers followed Opill’s labeled directions imperfectly, it would still be more effective than existing OTC contraceptive methods.⁴⁶⁰ They observed that the risks of pregnancy in America far outweigh any risks posed by the drug

455. *Id.* at 88–120 (first discussion question); *id.* at 120–41 (second discussion question); *id.* at 141–59 (third discussion question).

456. The voting question asked:

Is there adequate information to conclude that consumers will be likely to use norgestrel tablet properly, such that the benefits of making this available for nonprescription use (access without needing to interact with a healthcare professional), exceed the risks (such as inadequate adherence leading to contraceptive failure with unintended pregnancy, use of the medication by consumers with a contraindication to its use, failure to see a health care professional when appropriate)?

CTR. FOR DRUG EVALUATION & RSCH., FDA, QUESTIONS, JOINT MEETING OF THE NONPRESCRIPTION DRUGS ADVISORY COMMITTEE (NDAC) AND THE OBSTETRICS, REPRODUCTIVE, AND UROLOGIC DRUGS ADVISORY COMMITTEE (ORDUDAC), MAY 9-10, 2023, <https://www.fda.gov/media/167977/download> [<https://perma.cc/CK9B-NZYF>].

457. JOINT MEETING, MAY 10, 2023, *supra* note 454, at 88–120

458. *Id.* at 154–55.

459. *Id.* at 161.

460. *Id.* at 161–86.

itself.⁴⁶¹ And most emphatically, the committee members proclaimed the need to remove inequitable barriers to contraceptive access and to support reproductive autonomy.⁴⁶² Numerous members suggested that the preceding day's public testimony had influenced their votes.⁴⁶³

Interestingly, however, none of the committee members directly mentioned *Dobbs*. This was a curious omission. After all, in the growing number of states that have virtually banned abortion since the issuance of that decision, the risk-benefit assessment of a switch has changed dramatically.⁴⁶⁴ In those jurisdictions, an easily accessible oral contraceptive will now prevent not only pregnancy, but also state-compelled childbearing. Only a few eloquent young lay witnesses participating in the public hearing portion of the meeting explicitly addressed this vital consideration.⁴⁶⁵

Two months later, on July 13, 2023, FDA announced that it had approved Opill for nonprescription use.⁴⁶⁶ The agency declared: "Nonprescription availability of Opill may reduce barriers to access by allowing individuals to obtain an oral contraceptive without the need to first see a health care provider. . . . Availability of nonprescription Opill may help reduce the number of unintended pregnancies and their potential negative impacts."⁴⁶⁷

The switch of Opill to OTC status represents a historic advance in the expansion of birth control access in this country. The precise extent of its impact will depend on the drug's cost to consumers when it becomes available in early 2024.⁴⁶⁸ Some promising signs exist. Although the drug's manufacturer has not announced its price, the company has provided assurance that the pill will be "accessible and affordable to

461. *Id.*

462. *Id.*

463. *Id.*

464. *Tracking Abortion Bans Across the Country*, N.Y. TIMES (Aug. 23, 2023, 11:30 AM), <https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html>.

465. *See Joint Meeting, May 10, 2023, supra* note 454, at 325 (remarks of Ms. Bo Nelson, college student) ("[N]ow more than ever, bodily autonomy and the right to prevent and decide when and if one gets pregnant is one that we face so many barriers to, especially after the overturn of *Roe v. Wade* . . .").

466. FDA Approves First Nonprescription Daily Oral Contraceptive, *supra* note 47.

467. *Id.*

468. *See* D. Grossman, *supra* note 49 (describing price sensitivity of demand for the pill); Sabrina Malhi, *What to Know About Opill, the First U.S. Over-the-Counter Birth Control Pill*, WASH. POST (July 13, 2023, 6:37 PM), <https://www.washingtonpost.com/health/2023/07/13/what-know-about-opill-first-us-over-the-counter-birth-control-pill/> [<https://perma.cc/P3EA-N9MY>] (projecting availability in January or February 2024).

women and people of all ages.”⁴⁶⁹ A growing number of states—now twelve plus the District of Columbia—already require coverage of at least some methods of over-the-counter birth control.⁴⁷⁰ Thirty-five Democratic senators have cosponsored the Affordability is Access Act, which would require private health plans to cover FDA-approved over-the-counter contraceptives without any out-of-pocket costs to the patient.⁴⁷¹

FDA will probably soon receive an OTC switch application for a combination estrogen-progestin birth control pill.⁴⁷² Combination pills are more popular and slightly more effective—but also somewhat riskier—than the progestin-only Opill.⁴⁷³ If the agency’s new emphasis on access leads it to approve this application as well, the full array of different types of oral contraceptive drugs will be available without a prescription.

C. Abortion Pills

By approving the Opill switch application, FDA has likely significantly reduced the number of unintended pregnancies and thus the number of abortions in the United States.⁴⁷⁴ However, even readily available birth control pills will not eliminate all unintended pregnancies. Therefore, we must also consider ways to make abortion pills more accessible. This Article thus ends where it started—with the possibility of OTC abortion medication.

Even before *Dobbs*, sixty-five percent of people seeking an abortion were personally interested in OTC medication abortion, citing privacy,

469. Malhi, *supra* note 468 (quoting a statement made by Frédérique Welgryn, Perrigo’s global vice president for women’s health).

470. *State Requirements for Insurance Coverage of Contraceptives, in Abortion & Health Coverage/Access for Families & Children*, KFF, <https://www.kff.org/other/state-indicator/state-requirements-for-insurance-coverage-of-contraceptives/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (May 1, 2022) [<https://perma.cc/6LMF-BYJY>]. Some of these states, however, require a prescription for over-the-counter methods to be eligible for coverage, and Nevada currently appears to require coverage only of over-the-counter condoms. *Id.*

471. Affordability is Access Act, S. 4347, 117th Cong. (2021–22).

472. CADENCE OTC, *supra* note 49.

473. Stephanie Teal & Alison Edelman, *Contraception Selection, Effectiveness, and Adverse Effects: A Review*, 326 JAMA 2507 (2021).

474. One might think that abortion opponents would thus support the switch. Nevertheless, during the public hearing portion of the advisory committee meeting, a representative of a conservative group opposed OTC status for Opill on the grounds that it would promote sexual promiscuity. See *Joint Meeting, May 10, 2023, supra* note 454, at 340–41 (remarks of Susan Musckett).

earlier access, and convenience as the main advantages.⁴⁷⁵ Now that abortion is banned or highly restricted in many states,⁴⁷⁶ interest in a nonprescription option is likely increasing, particularly among people traveling to other states for abortion care.

The regimen that FDA has approved for abortion through ten weeks of gestation comprises two drugs: 200 milligrams (one tablet) of mifepristone taken orally, followed twenty-four to forty-eight hours later by 800 micrograms (four 200-microgram tablets) of misoprostol taken buccally (between the cheek and gum).⁴⁷⁷ Mifepristone blocks body's production of the hormone progesterone and thus causes the embryo to detach from the uterine wall.⁴⁷⁸ Misoprostol then causes the uterus to contract and expel the embryo.⁴⁷⁹ The combined regimen is over ninety-five percent effective with an extremely low rate of major complications (0.31 percent according to one study).⁴⁸⁰

Two versions of mifepristone for abortion are currently on the market: the brand name product Mifeprex, manufactured by Danco, and a generic version, manufactured by GenBioPro. Clinicians frequently also use mifepristone off-label for miscarriage management, and in October 2022, ACOG and other organizations petitioned FDA to request Danco to submit an sNDA adding this indication to the labeling.⁴⁸¹ A different company, Corcept, sells a 300-milligram version of

475. M. Antonia Biggs, Lauren Ralph, Natalie Morris, Katherine Ehrenreich, Jamila Perritt et al., *A Cross-Sectional Survey of U.S. Abortion Patients' Interest in Obtaining Medication Abortion Over the Counter*, 109 *CONTRACEPTION* 25, 25 (2022) (surveying people seeking abortion from October 2019 to March 2020).

476. *Id.* at 26.

477. *Mifeprex Prescribing Information*, *supra* note 4. FDA originally approved a 600mg/800mg combined regimen through seven weeks gestation but changed both the mifepristone dosage and the approved period of use in 2016. *Compare Mifeprex™ Prescribing Information*, FDA, https://www.accessdata.fda.gov/drugsatfda_docs/label/2000/206871bl.pdf [<https://perma.cc/RRF9-SH52>], with *Mifeprex Prescribing Information*, *supra* note 4 (revised approval as of March 2016).

478. *Medical Abortion: What Is It, Types, Risks & Recovery*, CLEV. CLINIC, <https://my.clevelandclinic.org/health/treatments/21899-medical-abortion> [<https://perma.cc/E7RC-2LGR>].

479. *Id.*

480. IPAS, *CLINICAL UPDATES IN REPROD. HEALTH*, (Nathalie Kapp ed., 2021), <https://www.ipas.org/wp-content/uploads/2021/06/Clinical-Updates-in-Reproductive-Health-CURHE21.pdf> [<https://perma.cc/Q5B4-L96C>]; Upadhyay, Desai, Zlidar, Weitz, D. Grossman et al., *supra* note 41.

481. Citizen Petition to FDA (Oct. 4, 2022), <https://emaaproject.org/wp-content/uploads/2022/10/Citizen-Petition-from-the-American-College-of-Obstetrician-and-Gynecologists-et-al-10.3.22-EMAA-website.pdf> [<https://perma.cc/JX5L-UNUW>].

mifepristone under the brand name Korlym for use against hyperglycemia in patients with the rare disorder Cushing’s Syndrome.⁴⁸²

FDA approved misoprostol in 1988 for reduction of the risk of NSAID (nonsteroidal anti-inflammatory drug)-induced gastric ulcers in patients at high risk of complications from ulcers.⁴⁸³ Pfizer makes the brand name version, Cytotec, and the drug is also available in generic versions. Neither Pfizer nor any other manufacturer has ever sought approval of misoprostol for use for abortion, and misoprostol’s labeling itself says nothing about abortion. Instead, mifepristone’s labeling approves the mifepristone/misoprostol abortion regimen (an FDA practice known as “cross labeling”).⁴⁸⁴

1. THE MIFEPRISTONE REMS

From the time of its approval, mifepristone has been subject to strict distribution restrictions pursuant to a Risk Evaluation and Mitigation Strategy.⁴⁸⁵ REMS are permitted only when they are “necessary to ensure that the benefits of the drug outweigh the risks of the drug.”⁴⁸⁶ Many REMS include only mandatory communications to health care providers and patients.⁴⁸⁷ When additional measures are needed to mitigate a specific serious risk, however, FDA may impose “elements to assure safe use,” such as requiring prescribers to have particular training or experience, requiring prescribing physicians and dispensing pharmacists to be specially certified, requiring that the drug be administered only in specified health care settings, or requiring that the drug be dispensed only to patients with laboratory test results demonstrating safe-use conditions.⁴⁸⁸

When FDA approved the abortion medication regimen in 2000, it mandated that mifepristone be administered in-person in the prescribing physician’s office or healthcare facility; that misoprostol be administered

482. *Korlym*[®] *Prescribing Information*, FDA, https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/202107s0001bl.pdf [<https://perma.cc/AE4N-Q5J6>].

483. *Cytotec*[®] *Prescribing Information*, FDA, https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/019268s0511bl.pdf [<https://perma.cc/2ELT-GK5X>]. NSAIDs are drugs used to relieve and reduce inflammation and fever. Common examples include aspirin, ibuprofen, and naproxen.

484. Cross-labeling is most common in the oncology area. *See* CTR. FOR DRUG EVALUATION & RSCH., FDA, GUIDANCE FOR INDUSTRY: CROSS LABELING ONCOLOGY DRUGS IN COMBINATION REGIMENS (Nov. 2022).

485. 21 U.S.C. § 355-1.

486. 21 U.S.C. § 355-1(1)(a)(1).

487. 21 U.S.C. § 355-1(e)(3).

488. 21 U.S.C. § 355-1(f).

in-person three days later; and that the patient also make a third, follow-up office visit approximately fourteen days after the first visit.⁴⁸⁹ The agency required the prescribing physician and patient to jointly review and sign a patient agreement form.⁴⁹⁰ The agency further required, among other things, that prescribers certify their ability to assess the duration of a pregnancy, to diagnose ectopic pregnancies, and to provide or refer for follow-up surgical intervention when needed.⁴⁹¹ Because FDA did not yet have statutory authority to impose such restrictions in 2000, it did so pursuant to a regulation known as “Subpart H” that allowed approvals “with restrictions to assure safe use.”⁴⁹²

In 2007, Congress gave FDA express statutory authority to impose such use and distribution restrictions in the form of REMS,⁴⁹³ and in 2011, the agency converted mifepristone’s Subpart H restrictions into a REMS.⁴⁹⁴ FDA subsequently approved two sNDAs loosening the strictures of the REMS. In 2016, it eliminated the requirement that the regimen be administered in a healthcare setting (requiring only in-person *dispensing* of mifepristone), allowed healthcare providers other than physicians to become certified to prescribe and dispense mifepristone, and eliminated any requirements for in-person visits other than the initial visit.⁴⁹⁵ In 2023, FDA removed the requirement that mifepristone be dispensed in a health care setting, allowing prescribers to mail it or certified pharmacies to dispense it.⁴⁹⁶

489. Letter from Ctr. for Drug Evaluation & Rsch., FDA, to Sandra P. Arnold, Vice President, Corp. Affs., Population Council (Sept. 28, 2000), https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2000/20687appltr.pdf [<https://perma.cc/3ZHR-VB3Y>] [hereinafter Letter from FDA to Sandra P. Arnold].

490. *Id.*

491. *Id.*

492. 21 C.F.R. § 314.520 (2022).

493. FDA Amendments Act of 2007, Pub. L. No. 110-85, § 901, 121 Stat. 823, 922–43 (2007) (codified as amended at 21 U.S.C. § 355-1).

494. Letter from Ctr. for Drug Evaluation & Rsch., FDA, to Danco Laboratories, LLC (June 08, 2011), https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2011/020687s014ltr.pdf [<https://perma.cc/2TLN-7T5N>].

495. *Risk Assessment and Risk Mitigation Reviews(s), No. 020687Orig1s020*, FDA (Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020RiskR.pdf [<https://perma.cc/9FWZ-DR2T>].

496. CTR. FOR DRUG EVALUATION & RSCH., FDA, *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation> [<https://perma.cc/3D99-HEUE>] [hereinafter *Questions and Answers*]; *Risk Evaluation & Mitigation Strategy (REMS) Single Shared System for Mifepristone* 200 MG, FDA, 3,

Mifepristone's labeling says that the drug remains available only through the current, less-stringent REMS program because of the "very rare[]" incidence of serious and sometimes fatal infections and bleeding following medical abortions.⁴⁹⁷ The requirement that the provider certify an ability to diagnose ectopic pregnancies shows that FDA is also particularly concerned about the risk that initiation of a medication abortion might mask and delay treatment of an undiagnosed ruptured ectopic pregnancy, which has similar symptoms to a medication abortion.⁴⁹⁸

Numerous medical and legal experts and reproductive rights advocates have asserted that mifepristone's risk profile does not justify imposition of the REMS, even in its reduced form.⁴⁹⁹ They also argue that the REMS imposes unacceptable burdens on people trying to access the drug, especially poor people, people of color, and rural residents.⁵⁰⁰ The costs to providers of complying with the REMS likely drive up the procedure's price (a median of \$560 in 2020), an amount frequently not covered by insurance.⁵⁰¹ Finally, as discussed below, the REMS creates an obstacle to other state and federal efforts to make abortion medication more accessible.

https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2023_03_23_REMS_Full.pdf [<https://perma.cc/5V37-XZ5S>] (Mar. 2023). In 2021, before formally revising the REMS, FDA stopped enforcing the in-person dispensing requirement as an exercise of enforcement discretion during the COVID-19 pandemic. *Questions and Answers, supra*. For more details on the history of the mifepristone REMS, see Donley, *supra* note 9, and Julie Dohm & Mingham Ji, *An Introduction to Risk Evaluation and Mitigation Strategies*, 104 *CONTRACEPTION* 4 (2021).

497. *Mifeprex Prescribing Information, supra* note 4.

498. Letter from FDA to Sandra P. Arnold, *supra* note 489, at 2–3; *Mifeprex Prescribing Information, supra* note 4; *Patient Agreement Form*, FOOD & DRUG ADMIN. (Jan. 2023), https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2023_01_03_Patient_Agreement_Form.pdf [<https://perma.cc/JE7G-8WQ3>].

499. Jane E. Henney & Helene D. Gayle, *Time to Reevaluate U.S. Mifepristone Restrictions*, 381 *NEW ENG. J. MED.* 597, 597 (2019); Donley, *supra* note 9, at 655; *Abortion Pills, supra* note 16, at 6–7.

500. *See, e.g.*, Thompson, Singh, Ghorashi, Donovan, Ma & Rikelman *supra* note 9, at 17; AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, *supra* note 16; Henney & Gayle, *supra* note 499, at 597; Donley, *supra* note 9, at 655; *Abortion Pills, supra* note 16, at 43; L. Grossman, *supra* note 9, at 1057; Press Release, Am. Civ. Liberties Union, Comment on FDA's Updated Restrictions for Mifepristone (Jan. 3, 2023), <https://www.aclu.org/press-releases/aclu-comment-fdas-updated-restrictions-mifepristone> [<https://perma.cc/J23X-6JGF>].

501. Ushma D. Upadhyay, Chris Ahlback, Shelly Kaller, Clara Cook & Isabel Muñoz, *Trends in Self-Pay Charges and Insurance Acceptance for Abortion in the United States, 2017–20*, 41 *HEALTH AFFS.* 507, 510 (2022).

2. PHARMACIST PRESCRIBING

Abortion-permissive states should consider easing access to medication abortion by authorizing pharmacist prescribing through collaborative practice agreements or statewide protocols. One possible obstacle to doing so is the mifepristone REMS. States could designate pharmacists as “healthcare providers” eligible to prescribe mifepristone under the REMS.⁵⁰² Moreover, the 2023 revision to the REMS authorizes pharmacies to dispense mifepristone—although they must become specially certified to do so.⁵⁰³ But pharmacists could become certified prescribers only if they attested to their ability to “assess the duration of pregnancy accurately” and “diagnose ectopic pregnancies.”⁵⁰⁴ The most accurate method for each of these determinations involves use of an ultrasound, a procedure that few, if any, pharmacists are equipped to provide.⁵⁰⁵ However, FDA’s abandonment of the in-person dispensing requirement for mifepristone demonstrates that the agency does not intend to require prescribers to use an ultrasound on a patient before prescribing the drug. Indeed, many medication abortions are administered without prior ultrasound examination, and research suggests that such an examination is unnecessary to ensure patient safety.⁵⁰⁶ The REMS thus probably only requires prescribers to know

502. The mifepristone REMS also requires prescribers to confirm their “[a]bility to provide surgical intervention in cases of incomplete abortion or severe bleeding, or to have made plans to provide such care through others, and ability to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.” *Risk Evaluation & Mitigation Strategy (REMS) Single Shared System for Mifepristone* 200 MG, FDA, 1, https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2023_03_23_REM_S_Full.pdf [<https://perma.cc/37U9-7ZZD>] (Mar. 2023). Because pharmacists cannot provide surgical intervention and do not have admitting privileges to hospitals, they would have to make prior arrangements with physicians to satisfy this REMS provision.

503. *Id.* at 3.

504. *Id.* at 1.

505. John A. Morgan & Danielle B. Cooper, *Pregnancy Dating*, STATPEARLS, <http://www.ncbi.nlm.nih.gov/books/NBK442018/> [<https://perma.cc/KU4J-MUUZ>] (Sept. 12, 2022); Krelin Naidu & Katherine L. Fredlund, *Gestational Age Assessment*, STATPEARLS, <http://www.ncbi.nlm.nih.gov/books/NBK526000/> [<https://perma.cc/XP2T-825H>] (July 24, 2023); Anne-Marie Lozeau & Beth Potter, *Diagnosis and Management of Ectopic Pregnancy*, AM. FAM. PHYSICIAN, 2005, at 1707, 1707.

506. Ushma D. Upadhyay, Elizabeth G. Raymond, Leah R. Koenig, Leah Coplon, Marji Gold et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 JAMA INTERNAL MED. 482, 489 (2022); *Medication Abortion Up to 70 Days of Gestation*, ACOG (Oct. 2020), <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation> [<https://perma.cc/MB6D-EJAD>]; Elizabeth G. Raymond & Hillary Bracken, *Early*

how to estimate the gestational age and the risk of ectopic pregnancy by asking the patient certain relevant questions. Pharmacists could be trained to do so.⁵⁰⁷

Even if the mifepristone REMS proves to be an unsurmountable obstacle, states should consider authorizing pharmacist prescribing of a misoprostol-only abortion regimen. Though misoprostol alone is not quite as effective for abortion as the combination regimen,⁵⁰⁸ studies have generally demonstrated it to be between eighty and eighty-five percent effective, and some researchers have reported success rates of over ninety percent.⁵⁰⁹ The World Health Organization recommends misoprostol-alone as an alternative regimen.⁵¹⁰ It is likely the most common method of medication abortion worldwide, because in many nations (particularly low- and middle-income countries) misoprostol is available at an affordable price over the counter, whereas mifepristone is either unapproved or prohibitively expensive to obtain.⁵¹¹

Medical Abortion Without Prior Ultrasound, 92 *CONTRACEPTION* 212, 212 (2015); Elizabeth G. Raymond, Daniel Grossman, Ellen Wiebe & Beverly Winikoff, *Reaching Women Where They Are: Eliminating the Initial In-Person Medical Abortion Visit*, 92 *CONTRACEPTION* 190, 191 (2015); Holly A. Anger, Elizabeth G. Raymond, Melissa Grant, Sue Haskell, Christy Boraas et al., *Clinical and Service Delivery Implications of Omitting Ultrasound before Medication Abortion Provided Via Direct-to-Patient Telemedicine and Mail in the U.S.*, 104 *CONTRACEPTION* 659, 664 (2021).

507. The mifepristone REMS also requires prescribers to confirm their “[a]bility to provide surgical intervention in cases of incomplete abortion or severe bleeding, or to have made plans to provide such care through others, and ability to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.” *Risk Evaluation and Mitigation Strategy (REMS) Single Shared System For Mifepristone 200MG*, FDA (Mar. 2019), <https://www.fda.gov/media/164650/download> [<https://perma.cc/CCH9-FVAD>]. Because pharmacists cannot provide surgical intervention and do not have admitting privileges to hospitals, they would have to make prior arrangements with physicians to satisfy this REMS provision.

508. Nguyen Thi Nhu Ngoc, Jennifer Blum, Sheila Raghavan, Nguyen Thi Bach Nga, Rasha Dabash et al., *Comparing Two Early Medical Abortion Regimens: Mifepristone + Misoprostol vs. Misoprostol Alone*, 83 *CONTRACEPTION* 410, 415 (2011).

509. Elizabeth G. Raymond, Alice Mark, Daniel Grossman, Anitra Beasley, Kristyn Brandi et al., *Medication Abortion with Misoprostol-Only: A Sample Protocol*, *CONTRACEPTION* (Feb. 25, 2023), [https://www.contraceptionjournal.org/article/S0010-7824\(23\)00060-4/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(23)00060-4/fulltext); Elizabeth G. Raymond, Margo S. Harrison & Mark A. Weaver, *Efficacy of Misoprostol Alone for First-Trimester Medical Abortion: A Systematic Review*, *OBSTETRICS & GYNECOLOGY*, Jan. 2019, at 137, 143; Linda Speer, *Misoprostol Alone Is Associated with a High Rate of Successful First-Trimester Abortion*, *AM. FAM. PHYSICIAN*, July 15, 2019, at 119, 119; IPAS, *supra* note 480, at 119.

510. *Abortion Care Guideline*, WHO, at xxix, (2022) <https://iris.who.int/bitstream/handle/10665/349316/9789240039483-eng.pdf?sequence=1> [<https://perma.cc/6RS9-KGQR>].

511. *Misoprostol-Alone Medication Abortion Is Safe and Effective*, IBIS REPROD. HEALTH (Nov. 2021), <https://www.ibisreproductivehealth.org/publications/misoprostol->

Because misoprostol is not subject to a REMS, states could immediately authorize pharmacist prescribing of it for use in abortion. They might hesitate to do so because misoprostol is currently approved as a solo therapy only for ulcer prevention, and the drug's own labeling says nothing about abortion. There is, however, a precedent for state-authorized off-label prescribing by pharmacists in the reproductive health area: the Oregon emergency contraception program (using high doses of oral contraceptive pills) discussed earlier.⁵¹²

By authorizing pharmacist prescribing of either the full abortion regimen or of misoprostol alone, states would not only be facilitating access to these drugs; they would also be generating evidence that an applicant could eventually use in support of a full Rx-OTC switch.

3. OTC ABORTION PILLS?

So long as any REMS remains in effect for mifepristone, the possibility of FDA switching the abortion regimen to OTC status remains, at best, a distant prospect. FDA would not consider an OTC switch for the regimen while a mifepristone REMS is in effect.⁵¹³ Moreover, even if FDA were to remove the REMS, the agency almost certainly would not consider making the regimen OTC without an interim period of conventional prescription sales.⁵¹⁴

Nonetheless, on the assumption that FDA may someday remove the mifepristone REMS, it is worth considering whether the abortion medication regimen might be a credible candidate for an OTC switch.⁵¹⁵

alone-medication-abortion-safe-and-effective [https://perma.cc/AEV7-M7K3]; Katharine Footman, Katherine Keenan, Kate Reiss, Barbara Reichwein, Pritha Biswas & Kathryn Church, *Medical Abortion Provision by Pharmacies and Drug Sellers in Low- and Middle-Income Countries: A Systematic Review*, 49 *STUD. FAM. PLANNING* 57, 58 (2018); Cynthia C. Harper, Kelly Blanchard, Daniel Grossman, Jillian T. Henderson & Philip D. Darney, *Reducing Maternal Mortality Due to Elective Abortion: Potential Impact of Misoprostol in Low-Resource Settings*, 98 *INT'L J. GYNECOLOGY & OBSTETRICS* 66, 66–67 (2007).

512. *Supra* p. 1108.

513. Although 21 U.S.C. § 355-1, the section of the FD&C Act authorizing REMS, does not explicitly require a drug to also have prescription status, the entire REMS scheme is premised on this assumption. *See, e.g., Frequently Asked Questions (FAQs) About REMS*, FDA, <https://www.fda.gov/drugs/risk-evaluation-and-mitigation-strategies-rems/frequently-asked-questions-faqs-about-rems> [https://perma.cc/BL37-4X69] (“FDA can require a REMS for prescription drugs REMS do not apply to over-the-counter (OTC) medications.”).

514. *Abortion Pills*, *supra* note 16, at 45.

515. FDA could also, even with the mifepristone REMS in place, consider making misoprostol a nonprescription for use in a misoprostol-only abortion regimen. The agency could not do so, however, unless misoprostol itself were approved for this use. For this to happen, somebody would have to perform extensive studies on

The idea is plausible enough that researchers have begun to consider the question.⁵¹⁶

A group of researchers recently published a label comprehension study for nonprescription medication abortion, using an OTC “Drug Facts” label prototype they developed. The study, which showed high levels of comprehension among people of all ages and literacy levels, might need a follow up to assess the effectiveness of certain revisions.⁵¹⁷ To support an OTC switch of medication abortion, somebody will also have to perform self-selection studies demonstrating that women do not take the regimen too late in their pregnancy⁵¹⁸ or if they have any of the listed contraindications (for example, a history of ectopic pregnancy or bleeding disorders). Finally, actual use studies will have to be performed to show that people correctly self-administer the regimen in accordance with the labeled instructions and seek medical help in the situations listed on the label.⁵¹⁹

No self-selection or actual use studies of a nonprescription mifepristone-misoprostol regimen have been performed yet in the United States.⁵²⁰ But if these studies are eventually conducted and have positive

misoprostol-only abortion and then submit a successful sNDA changing the labeling of misoprostol to include this indication. Even if this were to occur, the FDA would likely approve misoprostol for abortion as a prescription drug before it even considered approving at a nonprescription product. Because approving and switching misoprostol for abortion would itself be a lengthy and fraught process—and because the combined regimen is more effective in any event—this article focuses on making the entire regimen OTC.

516. Nathalie Kapp, Daniel Grossman, Erin Jackson, Laura Castleman & Dalia Brahmī, *A Research Agenda for Moving Early Medical Pregnancy Termination Over the Counter*, 124 *BJOG: INT’L J. GYNECOLOGY & OBSTETRICS* 1646 (2017).

517. M. Antonia Biggs, Katherine Ehrenreich, Natalie Morris, Kelly Blanchard, Claudie Kiti Bustamante et al., *Comprehension of an Over-the-Counter Drug Facts Label Prototype for a Mifepristone and Misoprostol Medication Abortion Product*, 139 *OBSTETRICS & GYNECOLOGY* 1111, 1111–12, 1118–120 (2022). The authors stated that the only primary communication objective that did not meet its target threshold “related to understanding that lack of bleeding soon after taking misoprostol could indicate that the medication is not working and requires contacting a health professional.” *Id.* at 1118.

518. Kapp, D. Grossman, Jackson, Castleman & Brahmī, *supra* note 516, at 1650; Biggs, Ehrenreich, Morris, Blanchard, Bustamante et al., *supra* note 517, at 1120 (suggesting that screening questions for determining pregnancy duration could be integrated into future versions of the label).

519. Biggs, Ehrenreich, Morris, Blanchard, Bustamante et al., *supra* note 517, at 1120; Kapp, D. Grossman, Jackson, Castleman & Brahmī, *supra* note 516, at 1650.

520. Biggs, Ehrenreich, Morris, Blanchard, Bustamante et al., *supra* note 517, at 1116. A small observational study of unsupervised medical abortion in India showed an increase in maternal morbidity and mortality, but it is unclear what labeling and information, if any, the users received. Nivedita Krishnamoorthy & Fatima Shanthini, *Is It Safe to Provide Abortion Pills Over the Counter? A Study on Outcome Following Self-Medication with Abortion Pills*, *CLINICAL & DIAGNOSTIC RSCH.*, Jan. 2015, at 1.

results, FDA should seriously consider authorizing over-the-counter sales of the medication abortion regimen. In addition to reducing logistical obstacles to acquiring the medicine, an OTC switch might also defeat anti-abortion states' efforts to obstruct access. Under the FD&C Act's nonprescription drug preemption provision, discussed earlier, a state could require that an OTC regimen be sold only on prescription, but it apparently could not impose any additional restrictions on it.⁵²¹ Furthermore, switching the drugs to nonprescription status might substantially reduce the cost of obtaining a medical abortion; under the current system, the cost of the pills themselves represents only a small portion of the total cost.⁵²²

An OTC switch would likely be consistent with the Section 503(b) criteria discussed earlier.⁵²³ The *toxicity* factor does not disqualify abortion medication from OTC status. The regimen usually requires the use of only one dose of each drug,⁵²⁴ and it does not have a particularly narrow margin of safety.⁵²⁵ The most pronounced bodily effects caused by the regimen—cramping and bleeding—are not “side effects” or “adverse reactions,” but rather the intended results of using a drug for termination of a pregnancy.⁵²⁶ Moreover, abortion medication poses no obvious *other potentiality for harmful effect*: it is unlikely to be abused, for example. Its *method of use* is relatively simple: one oral administration of mifepristone followed twenty-four to forty-eight hours by one buccal administration of misoprostol.

Finally, there is the question of *collateral measures necessary to its use*. This factor encompasses some potential problems posed by OTC

521. 21 U.S.C. § 379r.

522. Emma McGowan, *A Generic Abortion Pill Is Now Available But What Does That Mean?*, BUSTLE (Sept. 3, 2019), <https://www.bustle.com/p/whatgeneric-mifepristone-means-for-people-seeking-abortions-according-to-expertsadvocates-18704261> [<https://perma.cc/RR4X-DGVD?type=standard>]. If FDA mandates an actual use study for the switch, the applicant would receive three-year exclusivity, which would limit the cost-savings of an OTC medication abortion regimen for that period. *See supra* notes 82–83 and accompanying text.

523. *Supra* pp. 1056–63.

524. NAT'L ABORTION FED'N, 2022 CLINICAL POLICY GUIDELINES FOR ABORTION CARE 19–20 (2022), <https://prochoice.org/wp-content/uploads/2022-CPGs.pdf> [<https://perma.cc/22XL-NPR5>]. These guidelines state that a second dose of misoprostol may be used from 64–70 days gestation and should be used from 71–77 days gestation. *Id.*

525. The original dose for mifepristone was 600 mg; now it is 200 mg. *See supra* note 477 and accompanying text.

526. *Mifeprex Prescribing Information*, *supra* note 4, at 7 (“Abdominal pain/cramping is expected in all medical abortion patients. . . . Treatment with Mifeprex and misoprostol is designed to induce uterine bleeding and cramping to cause termination of an intrauterine pregnancy.”).

availability of the abortion medication regimen, including the possibilities of inappropriate self-selection and that users will fail to seek medical attention for side effects and serious underlying conditions. But as *Decholin* made clear, the main inquiry when considering such issues is whether they can be mitigated through clear and informative labeling.⁵²⁷ Additional studies will establish whether this is case for medication abortion.

Even if FDA ultimately concludes that conventional OTC labeling is inadequate to ensure safe and effective use of the abortion regimen, it might consider using its proposed “nonprescription with an additional condition for nonprescription use” status.⁵²⁸ Through the use of a cell phone app or other technology, customers could be required to answer questions that demonstrate they are eligible to take the regimen, understand how to distinguish between a normal and abnormal course of symptoms, and know when to seek medical help. The mandatory use of such technology might raise confidentiality and privacy concerns if not properly designed. But the “nonprescription with ACNU approach” would also have a notable benefit over traditional OTC status; it would allow abortion medication to be sold simultaneously as a prescription and nonprescription product. Thus, people with insurance that covers medication abortion could still elect to get a prescription and get reimbursed.

Finally, when considering either a traditional OTC switch or a “nonprescription with ACNU” application for medication abortion, the agency should follow this Article’s recommendation to give considerable weight to the benefits of greater access. The public health benefits of facilitating access are particularly compelling in this context. People seeking abortion drugs have always confronted higher barriers than users of other prescription drugs—even other REMS drugs—because of widespread opprobrium and the unwillingness of many providers to prescribe them. Post-*Dobbs*, the hurdles to acquiring abortion pills have gotten even higher, as many states have banned them or highly restricted their use.⁵²⁹ Americans should be able to look forward to a day when they can obtain abortion pills over the counter—along with birth control pills and emergency contraceptive pills—and easily build their personal reproductive health armamentarium.

527. *United States v. Article of Drug Labeled Decholin*, 264 F. Supp. 473, 483 (E.D. Mich. 1967).

528. *See supra* Section V.C.

529. *Abortion Pills*, *supra* note 16, at 60.

CONCLUSION

Advocating for over-the-counter abortion pills may seem overly optimistic at a moment when anti-abortion advocates have recently persuaded the United States Court of Appeals for the Fifth Circuit preliminarily to increase the REMS restrictions on prescription mifepristone.⁵³⁰ The ultimate resolution of this litigation, *Alliance for Hippocratic Medicine v. FDA*,⁵³¹ is uncertain; the plaintiffs might even succeed in their attempt to withdraw mifepristone from the market altogether. But even if the plaintiffs prevail in whole or in part, FDA will likely be able to correct any procedural deficiencies identified by the court and eventually make mifepristone available again under the same conditions as today. In other words, mifepristone is almost certainly here to stay, and FDA might well have an opportunity, sooner or later, to consider improving access to the abortion regimen by switching it to OTC status. And even if FDA is unwilling to do so, states can nudge medication abortion closer to OTC status with statewide protocols and collaborative practice agreements. Finally, regardless of the fate of abortion pills, this Article's examination of how OTC switches can promote public health and other values by easing access to drugs may inspire regulators to reevaluate their approach to the switch process more generally.

530. See *All. for Hippocratic Med. v. FDA*, 78 F.4th 210 (5th Cir. 2023). As explained above, this decision is stayed while the Supreme Court considers whether to take on the matter. *Supra* note 15.

531. *All. for Hippocratic Med.*, 78 F.4th 210.