Exhibit J

Declaration of Joey Banks, M.D.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF HAWAII

GRAHAM T. CHELIUS, M.D., *et al.*,

Plaintiffs,

vs.

XAVIER BECERRA, J.D., *in his official capacity as* SECRETARY, U.S. D.H.H.S., *et al.*,

Defendants.

CIV. NO. 1:17-cv-00493-JAO-RT

[CIVIL RIGHTS ACTION]

DECLARATION OF JOEY BANKS, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Judge: Hon. Jill A. Otake
Hearing Date: Vacated per Dkt. 107
Trial Date: Vacated per Dkt. 82

Joey Banks, M.D. declares and states as follows:

1. I make this declaration based on my own personal knowledge. If called to testify, I could and would do so competently as follows.

2. I am a family medicine physician. I work at Blue Mountain Clinic in Missoula, Montana, where I have been providing care since 2011. I currently provide and train residents in reproductive health care, including abortion, at the Blue Mountain Clinic and also provide such care at a clinic in Tulsa, Oklahoma.

3. In addition, I serve as the Chief Medical Officer for Planned Parenthood of Montana, a position I have held since 2019. In this capacity, I supervise the medical staff at all Planned Parenthood sites statewide and also provide reproductive health care to patients.

4. In my practice I prescribe mifepristone (brand name Mifeprex®) to my patients both for pregnancy termination and in cases of pregnancy loss (where mifepristone assists in safely and efficiently completing the miscarriage). I have provided abortion and miscarriage care to patients for 20 years and, over the years, have provided such care to many people who lived in areas where care is difficult to obtain—including in Alaska, Maine, Montana, and, most recently, in Oklahoma.

5. I am a member of the National Abortion Federation, the American Academy of Family Physicians, and the Montana Academy of Family Physicians. I am also a member of the Society of Family Planning ("SFP"). I understand that

SFP is a plaintiff in litigation challenging FDA's imposition of a Risk Evaluation and Mitigation Strategy ("REMS") for mifepristone, and write this declaration in support of SFP's Motion for Summary Judgment. I do so in my individual capacity and as an SFP member, and do not speak on behalf of Blue Mountain Clinic, Planned Parenthood, or any other institution.

6. Until a couple of years ago, Blue Mountain Clinic was the only clinic in Missoula where patients could access abortion care. The Blue Mountain Clinic is located near a perinatologist's office. A perinatologist is an obstetrician who specializes in maternal-fetal medicine and has special training in high-risk pregnancy care. Perinatologists sometimes use mifepristone to induce labor in late pregnancy.

7. The perinatologist near my clinic did not stock mifepristone, but occasionally wanted to administer it to his patients to induce labor in late pregnancy. Knowing that I stocked and provided mifepristone to my patients, in 2018 the perinatologist approached me about whether I would be amenable to his sending his patients to see me just to obtain the mifepristone, and then he would re-assume care after the patient left my clinic.

8. When I asked the perinatologist why he didn't stock mifepristone himself, he said it was because he was worried that by stocking mifepristone he would unwittingly be placed on a list of abortion providers. The perinatologist was

aware of the history of violence and harassment by anti-abortion activists and was concerned that if the list of mifepristone prescribers required by the REMS were somehow made public, it would put him in danger.

9. The perinatologist was affiliated with and provides services at a local hospital in Missoula, Montana. When I asked why he didn't just ask the hospital to stock mifepristone in its formulary, he said that he did not want anyone in the hospital to presume he was pro-choice.

10. This is not the only instance in which I have encountered clinicians who are unwilling to stock mifepristone even though it would benefit their patients. For instance, since 2013, I have been providing reproductive health care training to family medicine residents at Blue Mountain Clinic. My training includes, among other things, medication abortion, procedural (sometimes called "surgical") abortion, and miscarriage management. For many years, I have taught residents to treat patients seeking medication abortion with a regimen of 200mg of mifepristone followed by 800mg of misoprostol; and, since 2018, based on new, high-quality medical research, I also began teaching them this two-drug regimen for the medical management of miscarriages. Although both can be accomplished with misoprostol alone, evidence supports the two-drug regimen as the superior regimen.

11. On numerous occasions, I have been contacted by physicians I

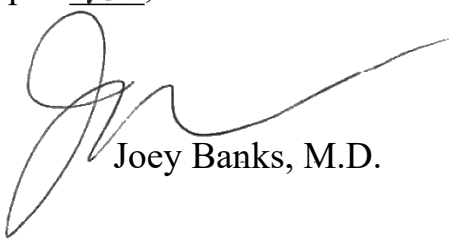
previously trained, telling me that the health care facility where they work does not stock mifepristone, and that they felt uncomfortable asking leadership at their health care facility to begin stocking mifepristone, or that they knew their clinic simply would not stock mifepristone. They all wanted to know whether they could still care for patients who sought a medication abortion or suffered a miscarriage, even without mifepristone. In light of these conversations, I now explain to the residents I train that if their health care facility does not stock mifepristone, they can consider prescribing misoprostol alone for either early abortion or miscarriage treatment, but that it is less effective and that the two-drug regimen, including mifepristone, is the superior regimen

12. In my experience, the mifepristone REMS is interfering with practitioners' provision of evidence-based medicine. Some clinicians fear professional repercussions if they try to persuade their colleagues to stock and dispense mifepristone onsite. And some are so concerned about the stigma and threat of violence surrounding the provision of abortion that they are unwilling to register their names and addresses with the mifepristone distributer, as required by the REMS. The prospect of this "abortion provider list" being leaked to the public is enough to prevent clinicians from providing what they deem the best medicine for their patients.

13. In sum, the mifepristone REMS prevents clinicians from providing

solid evidence-based medicine due to the stigma and fear associated with having to register with the drug manufacturer and stock the medication onsite.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed on April 12, 2021.



Joey Banks, M.D.