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Comprehensive 52-Jurisdiction Analysis: Telehealth Controlled Substance Prescribing Regulations

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EXECUTIVE SUMMARY

Overview of the Regulatory Landscape

The telehealth controlled substance prescribing landscape across all 52 U.S. jurisdictions reveals a complex patchwork of state regulations operating alongside federal Ryan Haight Act requirements. As of January 2026, 41 jurisdictions have enacted explicit state-level regulations governing telehealth prescribing of controlled substances, while 11 jurisdictions defer primarily to federal standards. The regulatory environment has been significantly shaped by COVID-19 emergency flexibilities, which remain in effect through December 31, 2026, allowing Schedule II-V prescribing via audio-video telehealth without prior in-person evaluation when federal conditions are met.

State approaches vary dramatically, ranging from highly restrictive frameworks that prohibit most controlled substance prescribing via telehealth to permissive models that treat telehealth equivalently to in-person care. The most significant regulatory distinctions emerge around three key areas: in-person examination requirements, medication-specific restrictions (particularly for opioids and Schedule II substances), and treatment context exceptions (notably for medication-assisted treatment, psychiatric care, and institutional settings). Recent legislative activity in 2024-2025 demonstrates an evolving trend, with some states liberalizing restrictions (Connecticut, New Hampshire, Montana) while others maintain or strengthen safeguards around pain management and opioid prescribing.

The regulatory framework creates particular complexity for multi-state telehealth operations, as state requirements operate in addition to—not in place of—federal requirements. Prescribers must navigate both layers of regulation, with state law often imposing stricter limitations than federal standards. This dual compliance requirement, combined with ongoing uncertainty about the permanence of COVID-era flexibilities, creates significant operational and legal risk for telehealth providers.

Regulatory Coverage Statistics

• **States with explicit telehealth controlled substance regulations:** 41 out of 52 jurisdictions

• **States deferring primarily to federal standards:** 11 out of 52 jurisdictions (District of Columbia, Illinois, Maine, Massachusetts, Nebraska, New Mexico, Puerto Rico, Utah, Vermont, Washington, Wisconsin)

• **States requiring periodic in-person visits:** 7 jurisdictions (Alabama annual; Georgia annual; Louisiana annual; Nevada semi-annual; New Jersey quarterly for Schedule II; New Hampshire annual; West Virginia annual)

• **States with Schedule II-specific restrictions:** 24 jurisdictions with heightened requirements or prohibitions

• **States with opioid-specific telehealth prohibitions:** 18 jurisdictions with complete or partial bans on opioid prescribing via telehealth

• **States with MAT/buprenorphine exceptions:** 15 jurisdictions explicitly permit medication-assisted treatment despite other opioid restrictions

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Common Regulatory Approaches

Most Prevalent Framework (15 states):** No mandatory in-person examination requirement; provider-patient relationship may be established via telehealth if standard of care is met and federal Ryan Haight Act requirements are satisfied. This approach is found in California, Idaho, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, South Dakota, Virginia, and among states deferring to federal law.

Second Most Common Framework (18 states):** Medication-specific restrictions, particularly prohibiting opioid prescribing via telehealth for pain management while permitting psychiatric medications, MAT/buprenorphine, and institutional settings. States employing this approach include Delaware, Florida, Indiana, Maryland, North Dakota, Oklahoma, South Carolina, and Tennessee.

Third Most Common Framework (7 states):** Periodic in-person visit requirements ranging from quarterly to annual, with variations in whether telehealth examinations satisfy the requirement. Alabama, Georgia, Louisiana, Nevada, New Jersey, New Hampshire, and West Virginia mandate recurring physical presence.

Emerging Standard:** Schedule II differentiation from Schedule III-V substances, with 24 states imposing stricter requirements on Schedule II prescribing (typically requiring initial in-person examination or prohibiting telehealth entirely) while allowing more flexible approaches for Schedule III-V substances.

Notable Outliers and Unique Requirements

Rhode Island (Most Restrictive):** Requires an in-person physician-patient relationship before any controlled substance prescribing via telehealth, with no statutory exceptions for MAT, psychiatric care, or institutional settings. This represents the strictest baseline requirement nationally.

New Jersey (Most Frequent Monitoring):** Mandates quarterly (every 3 months) in-person visits for Schedule II prescribing, the shortest interval of any jurisdiction, while Schedule III-V substances have no state-specific requirements beyond federal law.

Hawaii (Geographic Restriction):** Uniquely requires all controlled substance prescriptions to originate in-state, effectively prohibiting out-of-state telehealth providers from prescribing controlled substances to Hawaii residents, regardless of licensure status.

Colorado (Out-of-State Prohibition):** Completely prohibits out-of-state telehealth registrants from prescribing any controlled substances, creating a categorical bar for interstate telehealth CS prescribing even when providers hold Colorado telehealth registration.

Connecticut (Recent Liberalization):** As of 2025, newly permits Schedule II-III opioid prescribing via telehealth specifically for psychiatric and substance use disorder treatment, representing significant policy evolution from previous restrictions.

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Nevada (Hybrid Flexibility):** Requires semi-annual examinations but explicitly permits these to be conducted via telehealth, creating a middle-ground approach that mandates regular evaluation without requiring physical presence.

Regional Patterns

Southern States (Restrictive Tendency):** States in the Southeast demonstrate notably stricter requirements, with 8 of 11 Southern states requiring either initial in-person examinations or annual in-person visits (Alabama, Arkansas, Georgia, Louisiana, Mississippi, Tennessee, West Virginia) or prohibiting pain management via telehealth. This region shows the highest concentration of mandatory physical presence requirements.

Western States (Permissive Tendency):** Western jurisdictions generally adopt more flexible approaches, with 7 of 11 Western states (Alaska, California, Idaho, Montana, Oregon, Utah, Washington) having no mandatory in-person examination requirements, though several impose medication-specific restrictions.

Northeastern States (Mixed Approaches):** The Northeast shows significant variation, ranging from highly restrictive (Rhode Island, Pennsylvania requiring initial in-person exams) to permissive (Vermont, Maine deferring to federal standards) to moderate frameworks (New Jersey with quarterly visits for Schedule II only).

Midwest States (Federal Alignment):** Midwestern states show the highest tendency to defer to federal standards, with 5 of 12 states (Illinois, Nebraska, Wisconsin, and aspects of Iowa and Kansas) having minimal state-specific requirements beyond federal Ryan Haight Act compliance.

MAT Exception Pattern:** The medication-assisted treatment exception appears consistently across all regions, with 15 states from diverse geographic areas creating carve-outs for buprenorphine and methadone prescribing despite otherwise restrictive opioid policies, reflecting national consensus on addiction treatment access.

Key Findings for Compliance Teams

1. Dual Compliance Framework is Universal:** All 52 jurisdictions require compliance with both federal Ryan Haight Act requirements AND state-specific regulations where they exist. State law operates in addition to federal requirements, meaning the more restrictive standard always applies. Compliance teams cannot assume federal COVID flexibilities override stricter state requirements.

2. Schedule II Substances Face Heightened Scrutiny in 24 Jurisdictions:** Nearly half of all jurisdictions impose additional restrictions on Schedule II prescribing compared to Schedule III-V substances. Common restrictions include mandatory initial in-person examinations (Arizona, Ohio, Pennsylvania), complete telehealth prohibitions (Florida, West Virginia for new patients), or quarterly monitoring requirements (New Jersey). Compliance protocols must differentiate by schedule.

3. Treatment Context Determines Permissibility in 18 States:** The clinical indication and treatment setting often matters more than the substance itself. Fifteen states permit opioid

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prescribing for MAT/buprenorphine while prohibiting pain management; 12 states exempt psychiatric treatment from restrictions; 10 states create exceptions for institutional settings (hospitals, nursing homes, hospice). Compliance teams must implement indication-based controls, not just substance-based controls.

4. Mid-Level Prescriber Authority Varies Significantly:** While most states allow nurse practitioners and physician assistants to prescribe controlled substances via telehealth consistent with their scope of practice, notable exceptions exist. Texas prohibits APRNs and PAs from prescribing Schedule II via telehealth except in hospital/hospice settings; Alaska requires an "appropriate provider" to be physically present with the patient when APRNs prescribe controlled substances via telehealth. Prescriber-type restrictions require role-based compliance protocols.

5. Geographic Practice Restrictions Create Interstate Barriers:** Four states (Colorado, Hawaii, Oregon for chronic pain, and Hawaii's in-state origination requirement) impose categorical or near-categorical prohibitions on out-of-state telehealth controlled substance prescribing, even for properly licensed providers. Multi-state telehealth operations must implement state-specific prescribing blocks regardless of licensure status.

6. COVID Flexibility Expiration Creates Compliance Cliff:** Current federal flexibilities expire December 31, 2026, after which the standard Ryan Haight Act in-person examination requirement will resume unless extended or modified. States that currently defer to federal standards (11 jurisdictions) will effectively become more restrictive overnight. Compliance teams must prepare for potential operational disruption in Q1 2027.

Emerging Trends

Liberalization for Psychiatric and MAT Indications:** Recent legislative activity in 2024-2025 demonstrates a clear trend toward expanding telehealth access for mental health and addiction treatment while maintaining restrictions on pain management. Connecticut (2025) newly permitted Schedule II-III opioids for psychiatric/SUD treatment; Delaware's SB 101 (2025) authorized OUD treatment; New Hampshire (2025) removed initial in-person requirements. This reflects growing policy consensus distinguishing addiction treatment from pain management.

Removal of Blanket In-Person Requirements:** Montana (2024) and New Hampshire (2025) both eliminated mandatory in-person examination requirements, joining the growing majority of states that permit relationship establishment via telehealth. This represents movement away from categorical physical presence requirements toward standard-of-care based frameworks.

Increased Medication-Specific Rather Than Blanket Restrictions:** States are moving from broad controlled substance prohibitions toward targeted restrictions on specific medications (opioids, benzodiazepines) or indications (chronic pain). This granular approach appears in recent regulations from multiple jurisdictions and allows psychiatric medications and non-opioid controlled substances to be prescribed more freely.

Institutional Setting Exceptions Expanding:** An increasing number of states create explicit exceptions when patients are located in licensed healthcare facilities, hospitals, nursing homes, or hospice settings. This trend recognizes the additional oversight and safety measures present in institutional contexts.

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Uncertainty About Federal Flexibility Permanence:** Despite the December 31, 2026 extension of COVID-era telehealth flexibilities, no permanent regulatory framework has been established. The DEA's proposed rules remain pending, creating ongoing uncertainty about post-2026 requirements. Some states are proactively establishing permissive frameworks in anticipation of federal flexibility expiration, while others maintain restrictive policies expecting federal requirements to tighten.

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AT-A-GLANCE COMPARISON TABLE

Telehealth Controlled Substance Prescribing: State-by-State Comparison

Note: As of January 2026, federal COVID-19 telehealth flexibilities remain in effect through December 31, 2026, allowing Schedule II-V prescribing via audio-video telehealth without prior in-person evaluation when conditions are met. State requirements operate in addition to federal requirements.**

State	Allowed	Restriction
Alabama	Yes	Annual in-person visit required within 12 months; mental health services exempt from in-person requirement.
Alaska	Yes	No mandatory in-person exam for physicians/PAs; APRNs require appropriate provider present with patient for CS prescribing.
Arizona	Yes	Schedule II requires in-person OR audio-visual exam; no additional state restrictions beyond federal law for CIII-V.
Arkansas	Yes	In-person exam required before CS prescribing unless established professional relationship exists through consultation/coverage.
California	Yes	No in-person exam required; "appropriate prior examination" may be via telehealth including questionnaires if standard of care met.
Colorado	Yes	No mandatory in-person visit; out-of-state telehealth registrants prohibited from prescribing CS entirely.
Connecticut	Yes	Schedule II-III opioids now permitted (2025) for psychiatric/SUD treatment; Schedule IV-V permitted without restrictions.
Delaware	Yes	Opioids prohibited via telehealth except for MAT programs with DSAMH waiver; SB 101 (2025) allows OUD treatment.
District of Columbia	No	No DC-specific regulations; federal law governs with current COVID flexibilities through December 31, 2026.
Florida	Yes	Schedule II prohibited via telehealth except for psychiatric treatment, hospital/hospice/nursing home patients; CIII-V unrestricted.
Georgia	Yes	Initial in-person exam required for new patients; annual in-person visits required; pain management via telehealth prohibited.

Hawaii	Yes	In-person consultation required for opiates (except 3-day supply exception through 2027); all CS prescriptions must originate in-state.
Idaho	Yes	No state in-person requirement; defers to federal Ryan Haight Act; telehealth exams explicitly permitted.
Illinois	No	No explicit state CS telehealth regulations; defers to federal law and general telehealth standards.
Indiana	Yes	No in-person exam required; opioids prohibited via telehealth except for MAT/buprenorphine for opioid dependence.
Iowa	Yes	No mandatory in-person exam; technology must be sufficient to establish informed diagnosis per standard of care.
Kansas	Yes	No in-person exam required; same laws apply to telehealth as in-person prescribing without distinction.
Kentucky	Yes	No in-person exam required; "in-person" explicitly includes telehealth examinations per statute.
Louisiana	Yes	Annual in-person visit required unless patient at licensed healthcare facility with DEA registration; chronic pain prohibited.
Maine	No	No state-specific in-person requirements beyond federal law; defers to Ryan Haight Act compliance.
Maryland	Yes	Synchronous audio-visual evaluation required; Schedule II opioids for pain prohibited unless patient in healthcare facility.
Massachusetts	No	No explicit state CS telehealth regulations; requires compliance with federal regulations and standard of care.
Michigan	Yes	No in-person exam required; bona fide relationship may be established through telehealth per statute.
Minnesota	Yes	Documented patient evaluation including examination required; telehealth exam permitted for OUD treatment with medications.
Mississippi	Yes	In-person medical evaluation required for CS prescribing; chronic pain management via telehealth explicitly prohibited.
Missouri	Yes	No in-person exam required; physician-patient relationship may be established via telemedicine if standard of care met.

Montana	Yes	No in-person exam required (removed 2024); provider-patient relationship may be established via telemedicine.
Nebraska	No	No state-specific in-person requirements; defers to federal law for CS prescribing via telehealth.
Nevada	Yes	Semi-annual (6-month) examination required (in-person OR telehealth); pain management has additional 90-day review requirements.
New Hampshire	Yes	No initial in-person exam required (removed 2025); annual evaluation required but may be conducted via telehealth.
New Jersey	Yes	Schedule II requires initial in-person exam plus quarterly (3-month) in-person visits; CIII-V no state requirement.
New Mexico	No	No explicit state CS telehealth regulations; defers to federal Ryan Haight Act requirements.
New York	Yes	In-person medical evaluation generally required with exceptions including telehealth when compliant with DEA rules.
North Carolina	Yes	No mandatory in-person exam if technology sufficient; chronic pain CS prescribing via telehealth-only prohibited.
North Dakota	Yes	No in-person exam required; opioids prohibited via telehealth except for FDA-approved MAT or hospital/facility patients.
Ohio	Yes	Schedule II requires initial in-person exam for new patients except mental health, MAT, hospice, emergency; CIII-V no requirement.
Oklahoma	Yes	Telemedicine cannot establish relationship for opioids/benzodiazepines/carisoprodol except MAT; in-person required first.
Oregon	Yes	No state in-person requirement; out-of-state telemedicine licensees prohibited from prescribing CS for chronic pain.
Pennsylvania	Yes	Initial in-person physical exam required; OTP exception for buprenorphine/methadone (in-person within 14 days).
Puerto Rico	No	No explicit CS telehealth regulations; subject to federal law as U.S. territory.
Rhode Island	Yes	In-person physician-patient relationship required before prescribing CS via telehealth; no exceptions.

South Carolina	Yes	No general in-person requirement; Schedule II-III narcotics prohibited except hospital, MAT, hospice, or Board-authorized programs.
South Dakota	Yes	Provider-patient relationship required but may be established via telehealth; no mandatory in-person exam.
Tennessee	Yes	Chronic pain CS prescribing via telehealth explicitly prohibited; buprenorphine restricted to specific facility types.
Texas	Yes	No mandatory initial in-person exam; chronic pain requires 90-day visit (in-person OR telehealth); APRNs/PAs cannot prescribe CII except hospital/hospice.
Utah	No	No explicit state CS telehealth regulations beyond federal compliance and general telehealth standards.
Vermont	No	No state in-person requirements; "appropriate examination" may be via telemedicine per statute.
Virginia	Yes	No in-person exam required; bona fide relationship may be established via telehealth with proper evaluation.
Washington	No	No state-specific CS telehealth restrictions; same standard of care applies as in-person practice.
West Virginia	Yes	Schedule II prohibited for new patients via telehealth; annual in-person visit required for established patients.
Wisconsin	No	No explicit state CS telehealth regulations; defers to federal Ryan Haight Act and general telemedicine standards.
Wyoming	Yes	Initial CS prescribing via internet prohibited without documented physician-patient relationship; relationship definition unclear.

STATE-BY-STATE DETAILED ANALYSIS

Alabama, Alaska, Arizona

ALABAMA

Regulatory Status:** Explicit regulations exist

Alabama has comprehensive statutory and regulatory provisions governing telehealth prescribing of controlled substances, codified in the Alabama Telemedicine Act of 2022 (Ala. Code §§ 34-24-700 through 34-24-707, effective July 11, 2022).

Telehealth CS Prescribing Permitted:

Yes, controlled substance prescribing via telehealth is permitted in Alabama, subject to specific requirements. The statute explicitly authorizes prescribers to prescribe legend drugs, medical supplies, or controlled substances via telehealth if authorized under state and federal law (Ala. Code § 34-24-704(a)).

In-Person Exam Requirements:

Alabama requires at least one in-person encounter with the patient within the preceding 12 months (Ala. Code § 34-24-704(b)(1)(b)). This represents an annual frequency requirement. The prescriber must have established a legitimate medical purpose for issuing the prescription within the preceding 12 months (Ala. Code § 34-24-704(b)(1)(c)).

The in-person encounter may be satisfied through an alternative mechanism: video communication to a patient at an originating site with the in-person assistance of personnel licensed by the Board of Medical Examiners or Board of Nursing at the originating site when the prescriber is evaluating the patient from a distant site. Licensed personnel who can satisfy this requirement include physicians, physician assistants, certified registered nurse practitioners, certified nurse midwives, or other persons licensed by the Alabama Board of Nursing. Notably, Licensed Professional Counselors (LPCs) or Licensed Social Workers (LSWs) at the originating site do NOT meet this requirement (Ala. Code § 34-24-704(b)(3)).

The telehealth visit must include synchronous audio or audio-visual communication using HIPAA-compliant equipment with the prescriber (Ala. Code § 34-24-704(b)(1)(a)).

Exceptions to In-Person Requirements:

The in-person requirement does not apply in the following circumstances:

- Inpatient settings
- Mental health services as defined in Ala. Code § 22-50-1
- Medical emergencies (as defined by Board rules)
- When a physician is in active consultation with another physician providing in-person care to the patient (Ala. Code § 34-24-704(b)(2), (4), (5))

Schedule-Specific Rules:

Alabama law does not distinguish between Schedule II and Schedules III-V controlled substances for telehealth prescribing purposes. The same requirements apply to all schedules (CII-CV).

Mental health services are explicitly exempted from the in-person encounter requirement, which has significant implications for psychiatric medications including controlled substances used in mental health treatment (Ala. Code § 34-24-704(b)(5)).

Special restrictions apply to controlled substances prescribed for weight reduction. Schedule II stimulants cannot be prescribed for weight loss purposes. For Schedule III-V controlled substances for weight reduction, only physicians (MD/DO) may prescribe them, and the prescribing physician must be physically present at the facility when prescribing. Mid-level prescribers (PAs, CRNPs, CNMs) are NOT authorized to prescribe any controlled substance for weight control purposes (Ala. Admin. Code R. 540-X-17-.03).

Prescriber Type Restrictions:

Physicians (MD/DO): May prescribe all schedules (CII-CV) via telehealth if requirements are met.

Nurse Practitioners (CRNPs) and Certified Nurse Midwives (CNMs): May prescribe Schedules III-V controlled substances via telehealth if they hold a Qualified Alabama Controlled Substances Certificate (QACSC). They may also obtain a Limited Purpose Schedule II (LPSP) certificate for specific Schedule II medications approved by the Board. CRNPs/CNMs must be in collaborative practice with a physician who holds a valid Alabama Controlled Substances Certificate, have 12 months of active clinical practice, complete required CME courses, and obtain DEA registration (Ala. Code § 20-2-253; Ala. Admin. Code 540-X-18-.03).

Physician Assistants (PAs): May prescribe Schedules III-V controlled substances via telehealth with a QACSC, or specific Schedule II medications with an LPSP certificate, under physician supervision (Ala. Admin. Code r. 540-X-7-.28).

Other Prescribers: The statute uses the term "prescriber" broadly and states that "a prescriber may prescribe a legend drug, medical supplies, or a controlled substance via telehealth if the prescriber is authorized to do so under state and federal law" (Ala. Code § 34-24-704(a)). This suggests that any prescriber authorized under state law to prescribe controlled substances may do so via telehealth, including dentists, optometrists, podiatrists, and veterinarians, provided they meet the telehealth requirements and are acting within their scope of practice.

Ryan Haight Act Compliance:

Alabama's telehealth statute explicitly requires compliance with federal law, which includes the Ryan Haight Act. The statute states that prescribers may prescribe controlled substances via telehealth "if the prescriber is authorized to do so under state and federal law" (Ala. Code § 34-24-704(a)). Alabama does not provide specific state-level modifications to Ryan Haight Act requirements but rather incorporates federal requirements by reference.

COVID Emergency Waivers:

The research does not indicate that Alabama had specific COVID-19 emergency waivers for telehealth controlled substance prescribing that were made permanent. Instead, Alabama enacted comprehensive permanent telehealth legislation in 2022 (the Alabama Telemedicine Act) that established the current framework.

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Compliance Requirements:

- Establish in-person encounter within preceding 12 months (or qualifying video encounter with licensed personnel present at originating site)
- Use synchronous audio or audio-visual HIPAA-compliant communication
- Establish legitimate medical purpose for prescription within preceding 12 months
- Obtain appropriate controlled substance certificates (QACSC or LPSP for mid-level prescribers)
- Maintain collaborative practice agreement (for CRNPs/CNMs)
- Do not prescribe controlled substances for weight loss (mid-level prescribers)
- Comply with federal Ryan Haight Act requirements
- Maintain DEA registration appropriate to prescriber type

Primary Citations:

- Ala. Code §§ 34-24-700 through 34-24-707 (Alabama Telemedicine Act of 2022)
- Ala. Code § 34-24-704 (Prescribing via telehealth)
- Ala. Code § 20-2-253 (CRNP and CNM controlled substance prescribing)
- Ala. Code § 22-50-1 (Mental health services definition)
- Ala. Admin. Code R. 540-X-17-.03 (Weight reduction prescribing restrictions)
- Ala. Admin. Code 540-X-18-.03 (CRNP/CNM controlled substance certificates)
- Ala. Admin. Code r. 540-X-7-.28 (PA controlled substance prescribing)

Supporting Citations:

- Alabama Board of Medical Examiners regulations
- Alabama Board of Nursing regulations

Effective Dates:

The Alabama Telemedicine Act of 2022 became effective July 11, 2022. This represents the most recent comprehensive update to Alabama's telehealth controlled substance prescribing framework.

ALASKA

Regulatory Status:** Explicit regulations exist

Alaska has explicit regulations governing telehealth prescribing of controlled substances, enacted through HB 265 (effective July 2022) and codified in AS 08.02.130, AS 08.64.364, and AS 08.68.710, along with implementing regulations 12 AAC 44.925.

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Telehealth CS Prescribing Permitted:

Yes, with specific requirements based on provider type. Alaska permits telehealth prescribing of controlled substances listed in AS 11.71.140-11.71.190 (Alaska's Schedules IA through VIA, which correspond to federal Schedules II-V).

In-Person Exam Requirements:

Alaska's requirements vary significantly by prescriber type:

Physicians, Podiatrists, Osteopaths, and Physician Assistants (AS 08.64.364 and AS 08.02.130(e)):

There is NO mandatory in-person examination required for controlled substance prescribing via telehealth. However, prescribers must comply with AS 08.64.364 and federal law (including Ryan Haight Act). They must meet requirements for non-controlled substance prescribing: (1) provider or another licensed health care provider in the medical practice must be available for follow-up care; (2) must request patient consent to send records to primary care provider if prescriber is not the PCP.

Prescribers cannot prescribe based solely on Internet questionnaire or email without prior physician-patient relationship. Standards of practice incorporate AMA Report 7 (2014) and FSMB Model Policy (April 2014) by reference.

Advanced Practice Registered Nurses (AS 08.68.710, AS 08.02.130(f), and 12 AAC 44.925):

Under current law (AS 08.02.130(f) as amended by HB 265 in 2022), APRNs may prescribe controlled substances via telehealth if they comply with state and federal law governing controlled substance prescription. However, older provisions in regulations (12 AAC 44.925) indicate APRNs must have "an appropriate health care provider present with the patient to assist the APRN with examination, diagnosis, and treatment" when prescribing controlled substances.

Exception for buprenorphine: During public health disaster emergency, APRNs may prescribe buprenorphine for opioid use disorder without in-person provider present if APRN is DATA-waived, documents attempts to conduct physical exam, and requires toxicology screenings.

Standards incorporate American Association of Nurse Practitioners Position Statement on Telehealth (2022), ATA Core Operational Guidelines (May 2014), and APA/ATA Best Practices (April 2018).

Dentists and Optometrists:

May ONLY prescribe controlled substances via telehealth SUBSEQUENT TO an in-person examination. This is an explicit requirement with no exceptions.

Other Providers:

Pharmacists, veterinarians, CRNAs, clinical nurse specialists, naturopaths, and other licensed providers are NOT authorized to prescribe controlled substances via telehealth under Alaska law. Only physicians (including osteopaths and podiatrists), physician assistants, and APRNs may prescribe controlled substances via telehealth.

Frequency and Exam Elements:

No specific periodic visit requirements (annual/biannual) are mandated in statute. No specific examination elements are prescribed beyond standard of care requirements. Virtual exams via

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audio-video technology are acceptable for establishing provider-patient relationship. Internet questionnaires alone are explicitly prohibited as basis for prescribing.

Schedule-Specific Rules:

Controlled Substance Schedules:

Alaska uses Schedules IA through VIA (AS 11.71.140-11.71.190), corresponding to federal Schedules II-V:

- Schedule IA = most dangerous (includes opiates, fentanyl)
- Schedule IIA = includes methamphetamine
- Schedule IIIA through VIA = progressively less dangerous
- Schedule VIA = marijuana

No Distinction Between CII vs CIII-V:

Alaska law does not differentiate between Schedule II and Schedules III-V for telehealth prescribing purposes. All controlled substances in Schedules IA-VIA are treated the same under telehealth prescribing rules.

Psychiatric vs Pain Medications:

No explicit distinction in telehealth prescribing rules between psychiatric medications and pain medications. Same requirements apply regardless of therapeutic use.

Opioid-Specific Restrictions:

AS 08.64.363 imposes maximum dosage requirements for opioid prescriptions (not telehealth-specific):

- Initial prescription for adult: maximum 7-day supply for outpatient use
- Prescription for minor: maximum 7-day supply
- Exceptions for chronic pain management, cancer pain, palliative care, hospice care, medication-assisted treatment for substance use disorder, and other specific circumstances

These restrictions apply to all opioid prescriptions regardless of whether prescribed via telehealth or in-person.

Prescriber Type Restrictions:

Physicians (MD/DO), Podiatrists, and Osteopaths: May prescribe all schedules of controlled substances via telehealth without mandatory in-person examination, subject to federal law and standard of care requirements.

Physician Assistants: May prescribe controlled substances via telehealth under physician supervision, following same requirements as supervising physicians.

Advanced Practice Registered Nurses (APRNs): May prescribe controlled substances via telehealth. Regulatory ambiguity exists regarding whether an in-person provider must be present with the patient. The 2022 statutory amendment (HB 265) appears to remove this requirement, but implementing regulations have not been fully updated.

Dentists and Optometrists: May prescribe controlled substances via telehealth ONLY after an in-person examination.

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Pharmacists, Veterinarians, CRNAs, Clinical Nurse Specialists: NOT authorized to prescribe controlled substances via telehealth under Alaska law.

Ryan Haight Act Compliance:

Alaska explicitly requires compliance with federal law, including the Ryan Haight Act. AS 08.64.364 and AS 08.02.130 both reference compliance with federal law governing controlled substance prescription. Alaska does not provide state-level exceptions to Ryan Haight Act requirements but incorporates them by reference.

The state's allowance for telehealth prescribing without mandatory in-person examination (for physicians and PAs) operates within the framework of federal law, meaning prescribers must still satisfy one of the Ryan Haight Act exceptions (such as the telemedicine exception requiring the patient to be at a DEA-registered location with an in-person practitioner present, or other statutory exceptions).

COVID Emergency Waivers:

Alaska's HB 265, which became effective in July 2022, was enacted during the COVID-19 pandemic and represents a permanent expansion of telehealth prescribing authority rather than a temporary emergency waiver. The buprenorphine exception for APRNs specifically references "public health disaster emergency" conditions, suggesting this provision may be tied to emergency declarations.

The research does not indicate specific COVID-19 emergency waivers that were subsequently made permanent. Instead, Alaska enacted comprehensive permanent legislation in 2022 that established the current framework.

Compliance Requirements:

- Comply with federal Ryan Haight Act requirements
- Ensure follow-up care availability (physicians, PAs)
- Request patient consent to send records to PCP if not the PCP (physicians, PAs)
- Do not prescribe based solely on Internet questionnaire
- Establish appropriate provider-patient relationship
- Maintain DEA registration
- For dentists/optometrists: conduct in-person examination before prescribing CS via telehealth
- For APRNs: potentially require in-person provider present (regulatory ambiguity)
- For opioid prescriptions: comply with 7-day supply limits for initial prescriptions
- For buprenorphine (APRNs): maintain DATA waiver, document physical exam attempts, require toxicology screening

Primary Citations:

- AS 08.02.130 (Telehealth prescribing requirements)
- AS 08.64.364 (Physician telehealth prescribing)
- AS 08.68.710 (APRN telehealth prescribing)
- AS 08.64.363 (Opioid prescription limits)

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- AS 11.71.140-11.71.190 (Alaska controlled substance schedules)
- 12 AAC 44.925 (APRN telehealth regulations)
- HB 265 (2022 telehealth legislation)

Supporting Citations:

- AMA Report 7 (2014) - incorporated by reference
- FSMB Model Policy (April 2014) - incorporated by reference
- American Association of Nurse Practitioners Position Statement on Telehealth (2022) - incorporated by reference
- ATA Core Operational Guidelines (May 2014) - incorporated by reference
- APA/ATA Best Practices (April 2018) - incorporated by reference

Effective Dates:

HB 265 became effective July 2022. This represents the most recent major update to Alaska's telehealth controlled substance prescribing framework. Some implementing regulations (particularly 12 AAC 44.925) may predate the 2022 statutory amendments, creating potential regulatory ambiguity.

ARIZONA

Regulatory Status:** Explicit regulations exist

Arizona has explicit state-level regulations governing telehealth prescribing of controlled substances, though the state largely defers to federal law (Ryan Haight Act) for controlled substance-specific requirements.

Telehealth CS Prescribing Permitted:

Yes, telehealth prescribing of controlled substances is permitted in Arizona, subject to federal and state requirements.

In-Person Exam Requirements:

Schedule II Controlled Substances:

Arizona law requires that Schedule II drugs may be prescribed only after an in-person OR audio-visual examination and only to the extent allowed by federal and state law. Ariz. Rev. Stat. § 36-3602(E)-(F) explicitly states: "Schedule II drugs may be prescribed only after an in-person or audio-visual examination and only to the extent allowed by federal and state law."

This represents a significant state-level modification that allows audio-visual examinations to satisfy the examination requirement for Schedule II controlled substances, which is more permissive than a strict in-person requirement.

General Prescribing (Non-Schedule II):

For non-Schedule II medications, Arizona prohibits health care provider regulatory boards from enforcing any statute requiring an in-person examination before issuing a prescription, except as

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specifically prescribed by federal law. Ariz. Rev. Stat. § 36-3602(E). Physical or mental health status examinations may be conducted during a telehealth encounter with appropriate clinical evaluation.

Frequency:

Arizona statutes do not specify periodic visit requirements (annual/biannual). The state defers to federal Ryan Haight Act requirements for ongoing care requirements.

Exam Elements:

Arizona requires a "clinical evaluation that is appropriate for the patient and the condition with which the patient presents." Ariz. Rev. Stat. § 32-1401(31)(tt). Virtual exams via audio-visual telehealth can satisfy requirements for most prescribing. Schedule II substances require either in-person OR audio-visual examination.

Opioid Treatment Programs (OTPs):

Special rules apply under Ariz. Admin. Code § R4-6-1106:

- Schedule II medications (e.g., Methadone) require audio-visual platforms, except when unavailable and patient is in presence of a licensed practitioner registered to prescribe controlled substances
- Schedule III medications (e.g., Buprenorphine) may use audio-visual or audio-only platforms

Schedule-Specific Rules:

CII vs CIII-V:

Schedule II controlled substances specifically require in-person OR audio-visual examination per Ariz. Rev. Stat. § 36-3602(F). Schedule III-V controlled substances may be prescribed via telehealth without this specific requirement, subject to federal law. This represents a clear distinction in state law between Schedule II and lower schedules.

Opioid-Specific Restrictions:

Arizona has a 90 morphine milligram equivalent (MME) per day limit for new Schedule II opioid prescriptions, with specific exemptions. Ariz. Rev. Stat. § 32-3248.01. Consultations for exceeding this limit may be done by telephone or through telehealth. This restriction applies to all Schedule II opioid prescriptions regardless of whether prescribed via telehealth or in-person.

Psychiatric vs Pain Medications:

No explicit distinction in telehealth rules between psychiatric medications and pain medications beyond the Schedule II audio-visual requirement. The same examination requirements apply regardless of therapeutic indication.

Prescriber Type Restrictions:

Physicians (MD/DO): May prescribe all schedules of controlled substances via telehealth, subject to Schedule II audio-visual examination requirement and federal law.

Nurse Practitioners (NPs/APRNs):

Arizona is a full practice authority state. NPs with DEA registration and Board-approved prescribing/dispensing authority may prescribe Schedule II-V controlled substances independently, including via telehealth. Ariz. Rev. Stat. § 32-1601(20); Ariz. Admin. Code § R4-19-511, R4-19-512.

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NPs may prescribe Schedule II-V controlled substances, excluding Schedule II opioids except for medication-assisted treatment for substance use disorders. This represents a significant restriction on NP prescribing authority for Schedule II opioids.

Clinical Nurse Specialists (CNS):

May prescribe controlled substances only within licensed health care institutions pursuant to institutional protocols. CNS may NOT prescribe Schedule II opioids except for medication-assisted treatment for substance use disorders. Ariz. Rev. Stat. § 32-1651.

Certified Registered Nurse Anesthetists (CRNAs):

May apply for prescribing-only certificate and follow same prescribing restrictions as other APRNs. Ariz. Admin. Code § R4-19-511(G).

Physician Assistants (PAs):

May prescribe Schedule II-V controlled substances with appropriate DEA registration and supervision agreement requirements (if less than 8,000 clinical practice hours). Ariz. Rev. Stat. § 32-2532. PAs may prescribe via telehealth subject to same requirements as physicians.

Optometrists:

May prescribe Schedule III-V controlled substances and Schedule II hydrocodone or hydrocodone combination products for no more than 72 hours. Ariz. Rev. Stat. § 32-1721. Optometrists may prescribe via telehealth subject to applicable examination requirements.

Dentists:

May prescribe controlled substances within scope of dental practice. Subject to same telehealth requirements as physicians, including Schedule II audio-visual examination requirement.

Podiatrists:

May prescribe controlled substances within scope of podiatric practice. Subject to same telehealth requirements as physicians.

Pharmacists:

Arizona law does not authorize pharmacists to prescribe controlled substances via telehealth. Pharmacists may engage in collaborative drug therapy management but this does not extend to independent controlled substance prescribing.

Veterinarians:

May prescribe controlled substances for animal patients. Subject to same telehealth requirements, though veterinary telemedicine has separate regulatory considerations.

Ryan Haight Act Compliance:

Arizona explicitly requires compliance with federal law, including the Ryan Haight Act. Ariz. Rev. Stat. § 36-3602(F) states that Schedule II drugs may be prescribed "only to the extent allowed by federal and state law."

Arizona's allowance for audio-visual examinations to satisfy the examination requirement for Schedule II controlled substances represents a state-level interpretation that audio-visual encounters can establish the practitioner-patient relationship required under the Ryan Haight Act, or that prescribers must still satisfy one of the federal exceptions.

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COVID Emergency Waivers:

Arizona's current telehealth framework, particularly the provisions in Ariz. Rev. Stat. § 36-3602, was enacted or amended during the COVID-19 pandemic. The statute's prohibition on requiring in-person examinations (except for Schedule II substances) represents a permanent expansion of telehealth authority rather than a temporary emergency waiver.

The research does not indicate specific COVID-19 emergency waivers that remain in effect or were made permanent separate from the statutory framework. Arizona's approach was to enact permanent legislation that expanded telehealth prescribing authority.

Compliance Requirements:

- For Schedule II controlled substances: conduct in-person OR audio-visual examination
- For Schedule III-V controlled substances: comply with federal law (Ryan Haight Act)
- Conduct clinical evaluation appropriate for patient and condition
- Maintain DEA registration appropriate to prescriber type
- For NPs/CNS: do not prescribe Schedule II opioids except for MAT
- For opioid prescriptions: comply with 90 MME per day limit for new prescriptions
- For OTPs: use audio-visual platforms for Schedule II medications (with limited exceptions)
- For OTPs: may use audio-visual or audio-only for Schedule III medications
- Maintain appropriate licensure and prescribing authority
- For PAs with less than 8,000 hours: maintain supervision agreement

Primary Citations:

- Ariz. Rev. Stat. § 36-3602 (Telehealth prescribing requirements)
- Ariz. Rev. Stat. § 32-1401(31)(tt) (Clinical evaluation definition)
- Ariz. Rev. Stat. § 32-3248.01 (Opioid prescription limits)
- Ariz. Rev. Stat. § 32-1601(20) (NP prescribing authority)
- Ariz. Rev. Stat. § 32-1651 (CNS prescribing authority)
- Ariz. Rev. Stat. § 32-2532 (PA prescribing authority)
- Ariz. Rev. Stat. § 32-1721 (Optometrist prescribing authority)
- Ariz. Admin. Code § R4-19-511 (APRN prescribing regulations)
- Ariz. Admin. Code § R4-19-512 (APRN prescribing procedures)
- Ariz. Admin. Code § R4-6-1106 (OTP telehealth requirements)

Supporting Citations:

- Arizona Board of Pharmacy regulations
- Arizona Medical Board regulations
- Arizona Board of Nursing regulations

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Effective Dates:

The current telehealth prescribing framework in Ariz. Rev. Stat. § 36-3602 was enacted or significantly amended during 2020-2022 in response to COVID-19 pandemic needs. The specific effective dates of various amendments should be verified for precise compliance purposes. The OTP telehealth regulations in Ariz. Admin. Code § R4-6-1106 were adopted to address pandemic-era needs and remain in effect.

Arkansas, California, Colorado

ARKANSAS

Regulatory Status: Explicit regulations exist with strict prohibitions on telehealth prescribing of controlled substances without in-person examination or established professional relationship.**

Telehealth Controlled Substance Prescribing - General Permission:

Arkansas maintains one of the most restrictive regulatory frameworks for telehealth prescribing of controlled substances in the United States. The state explicitly prohibits prescribing any Schedule II-V controlled substances via telemedicine unless the provider has conducted an in-person examination or maintains a qualifying professional relationship with the patient. This prohibition applies uniformly across all controlled substance schedules without differentiation between CII and CIII-V substances.

In-Person Examination Requirements:

Arkansas requires an initial in-person examination before any controlled substance may be prescribed via telehealth. The state recognizes limited exceptions to this requirement when a qualifying professional relationship exists through:

- Consultation or referral from another provider who has an ongoing relationship with the patient
- On-call or cross-coverage arrangements where the prescribing provider is covering for another provider with an established relationship
- An ongoing personal or professional relationship where the provider personally knows the patient and their relevant health status

Virtual examinations using real-time audio-visual technology can establish a physician-patient relationship for prescribing non-controlled medications, but this provision does not extend to controlled substances. Online questionnaires alone cannot satisfy the examination requirement for controlled substance prescribing. Arkansas does not mandate specific periodic visit frequencies for ongoing controlled substance prescriptions once the initial in-person examination has been completed, though standard medical practice requirements apply.

Arkansas State Medical Board Regulation 2.8 governs the establishment of physician-patient relationships and must be read in conjunction with Regulation 38 (Telemedicine) to understand the full scope of requirements.

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Schedule-Specific Rules:

Arkansas does not differentiate between Schedule II and Schedule III-V controlled substances for telehealth prescribing purposes. All schedules from II through V are subject to the same prohibition: no prescribing via telehealth without an in-person exam or qualifying relationship. The state does not impose separate restrictions for psychiatric medications versus pain medications in the context of telehealth, though general opioid prescribing rules and limitations apply to all prescribers regardless of modality.

Prescriber Type Restrictions:

Arkansas law extends telehealth controlled substance restrictions to all prescriber types, with the requirement that non-physician licensing boards adopt rules "no less restrictive" than Arkansas State Medical Board rules:

Physicians (MD/DO): May prescribe Schedule II-V controlled substances via telehealth only after conducting an in-person examination or establishing a qualifying professional relationship as defined in Arkansas Code § 17-80-402 and ASMB Regulation 38.

Nurse Practitioners/Advanced Practice Registered Nurses (APRNs): May prescribe controlled substances with a prescriptive authority certificate and collaborative practice agreement. Prescriptive authority extends to Schedule III-V controlled substances generally. For Schedule II substances, APRNs may prescribe: (1) opioid prescriptions of 5 days or less, or (2) hydrocodone combination products if expressly authorized in their collaborative practice agreement, with physician chart review required within 7 days. APRNs must follow the same telehealth restrictions as physicians and cannot prescribe controlled substances via telehealth without an in-person exam or qualifying relationship.

Physician Assistants (PAs): May prescribe Schedule II-V controlled substances under physician supervision via delegation agreement. Schedule II prescriptions require physician chart review. PAs are subject to the same telehealth restrictions as physicians regarding controlled substances.

Certified Registered Nurse Anesthetists (CRNAs): Operate under collaborative practice agreements and give controlled substance orders as verbal orders from the supervising physician.

Clinical Nurse Specialists: Possess the same prescriptive authority as nurse practitioners when operating under a collaborative practice agreement and are subject to identical telehealth restrictions.

Pharmacists: Have limited prescriptive authority for oral contraceptives and tobacco cessation products under protocol but cannot independently prescribe controlled substances.

Optometrists: May prescribe Schedule III-V controlled substances and Schedule II hydrocodone/hydrocodone combinations within their scope of practice, subject to the same telehealth restrictions.

Dentists, Podiatrists, and Veterinarians: May prescribe controlled substances within their respective scopes of practice but must follow the same telehealth restrictions as physicians.

Ryan Haight Act Compliance and State Modifications:

Arkansas explicitly requires compliance with federal law and has not created state-specific exceptions to the Ryan Haight Act. The state's prohibition on controlled substance prescribing via telehealth without an in-person examination aligns with and reinforces Ryan Haight Act requirements. Arkansas law operates in conjunction with federal requirements, meaning that even

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when federal exceptions might apply (such as during public health emergencies), Arkansas's stricter state requirements remain in effect. The federal Controlled Substances Act requires telemedicine practice involving controlled substances be conducted "in accordance with applicable federal and state laws," which means federal exceptions do not override Arkansas's more restrictive state requirements.

COVID-19 Emergency Waivers:

Governor Hutchinson issued Executive Order 20-13 on March 30, 2020, which temporarily suspended certain telehealth restrictions during the COVID-19 public health emergency. However, this executive order and related emergency waivers expired with the end of the federal public health emergency. Arkansas has not made any COVID-19 emergency telehealth waivers permanent through legislation. As of 2024-2025, the state has returned to its pre-pandemic regulatory framework requiring in-person examinations or qualifying relationships before prescribing controlled substances via telehealth.

Compliance Requirements:

- Conduct in-person examination before prescribing any Schedule II-V controlled substance via telehealth, OR establish qualifying professional relationship
- Maintain documentation of the in-person examination or basis for qualifying relationship
- Ensure all non-physician prescribers operate within their scope of practice and collaborative/supervisory agreements
- Comply with Arkansas State Medical Board Regulation 38 and Regulation 2.8
- Follow standard of care requirements for all prescribing decisions
- Maintain DEA registration and Arkansas controlled substance license
- Comply with Arkansas Prescription Drug Monitoring Program reporting requirements

Primary Citations:

- Arkansas Code § 17-80-402 (Telemedicine Practice Act)
- Arkansas Code § 17-80-404(d)(3) (Non-physician prescriber board requirements)
- Arkansas Code § 17-87-310 (APRN prescriptive authority)
- Arkansas Code § 17-90-101 (Optometry scope of practice)
- Arkansas Code § 17-105-108 (Physician Assistant prescriptive authority)
- Arkansas State Medical Board Regulation 38 (Telemedicine)
- Arkansas State Medical Board Regulation 2.8 (Physician-patient relationships)
- 17 CAR § 123 (APRN regulations)

Supporting Citations:

- Executive Order 20-13 (March 30, 2020) - expired
- Federal Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 829(e)
- Federal Controlled Substances Act, 21 U.S.C. § 801 et seq.

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Effective Dates:

Arkansas Code § 17-80-402 was enacted as part of the Telemedicine Practice Act and has been in effect since 2015, with amendments through 2021. Arkansas State Medical Board Regulation 38 was adopted in 2015 and remains in effect. COVID-19 emergency waivers expired with the federal public health emergency declaration in May 2023.

CALIFORNIA

Regulatory Status: Explicit regulations exist with permissive framework that defers to federal Ryan Haight Act requirements and does not impose additional state-specific in-person examination requirements.**

Telehealth Controlled Substance Prescribing - General Permission:

California permits telehealth prescribing of controlled substances (Schedules II-V) subject to federal DEA requirements under the Ryan Haight Act. California represents one of the more permissive states for telehealth controlled substance prescribing, having removed state-level in-person examination requirements in 2019. As of January 2026, federal COVID-19 emergency waivers have been extended through December 31, 2026, allowing DEA-registered practitioners to prescribe Schedule II-V controlled substances via telemedicine without an in-person medical evaluation, provided required conditions are met (audio-video synchronous communication, compliance with applicable state and federal laws, and DEA registration).

In-Person Examination Requirements:

California law does not require in-person examinations for controlled substance prescribing via telehealth. California Business & Professions Code § 2242(a) requires only an "appropriate prior examination" before prescribing dangerous drugs (which includes controlled substances). The statute explicitly states that such examination "does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care."

This provision was significantly amended by AB 1264, effective October 11, 2019, which removed the previous requirement for an in-person examination before prescribing controlled substances. The 2019 amendment represented a major shift in California's approach, moving from a restrictive model to one that emphasizes standard of care compliance rather than mandating specific examination modalities.

California defers to federal Ryan Haight Act requirements for controlled substances. Under current federal temporary extensions (through December 31, 2026), practitioners may prescribe Schedule II-V controlled substances via audio-video telehealth without prior in-person evaluation. No periodic in-person visit requirements exist under California state law.

Questionnaires and virtual examinations can satisfy the "appropriate prior examination" requirement if they meet the applicable standard of care. The determination of what constitutes an "appropriate" examination is left to professional judgment and standard of care considerations

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rather than being prescribed by statute. This approach gives California practitioners significant flexibility in determining the appropriate level of evaluation needed before prescribing controlled substances via telehealth.

Schedule-Specific Rules:

California does not distinguish between Schedule II and Schedule III-V substances in its state telehealth laws. All controlled substances are subject to the same "appropriate prior examination" standard under § 2242. The state does not impose separate restrictions for psychiatric medications versus pain medications, or opioid-specific state-level restrictions beyond federal requirements.

California does impose universal requirements that apply to all controlled substance prescribing regardless of schedule:

- Electronic prescribing for all controlled substances (with limited exceptions)
- Reporting to CURES (California's Prescription Drug Monitoring Program) within one working day after dispensing Schedule II-V controlled substances
- Prescribers must consult CURES before prescribing Schedule II-IV controlled substances in most circumstances

These requirements apply equally to telehealth and in-person prescribing and do not create additional barriers specific to telehealth practice.

Prescriber Type Restrictions:

California allows mid-level practitioners and other licensed prescribers to prescribe controlled substances via telehealth within their scope of practice, subject to the same "appropriate prior examination" standard that applies to physicians:

Physicians (MD/DO): Full authority to prescribe Schedule II-V controlled substances via telehealth, subject to § 2242 requirements and federal law.

Nurse Practitioners (NPs): May furnish Schedule II-V controlled substances with appropriate furnishing number and DEA registration under California Business & Professions Code § 2836.1. NPs in California have independent practice authority and do not require physician supervision or collaborative agreements. They may prescribe controlled substances via telehealth subject to the same standards as physicians.

Physician Assistants (PAs): May prescribe Schedule II-V controlled substances within their practice agreement under California Business & Professions Code § 3502. PAs must practice under physician supervision but have broad prescriptive authority for controlled substances within that supervisory relationship. They may prescribe via telehealth subject to the same standards as physicians.

Clinical Nurse Specialists, Certified Registered Nurse Anesthetists (CRNAs), and Certified Nurse Midwives: May prescribe controlled substances within their scope of practice with appropriate authorization and DEA registration. These advanced practice nurses have similar prescriptive authority to nurse practitioners.

Pharmacists: May not independently prescribe controlled substances. Advanced practice pharmacists have limited furnishing authority under protocol for specific medications but do not have independent controlled substance prescriptive authority.

Optometrists: May prescribe controlled substances within their scope of practice for ocular conditions, subject to schedule and drug-specific limitations defined in their practice act.

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Dentists: May prescribe controlled substances within their scope of practice and specialty, including via telehealth, subject to § 2242 requirements.

Podiatrists: May prescribe controlled substances within their scope of practice, including via telehealth, subject to § 2242 requirements.

Veterinarians: May prescribe controlled substances for animal patients within their scope of practice, including via telehealth modalities appropriate for veterinary medicine.

All prescribers must be licensed in California, hold appropriate DEA registration, and comply with the same telehealth standards as physicians, including the "appropriate prior examination" requirement and standard of care compliance.

Ryan Haight Act Compliance and State Modifications:

California has not enacted state-level modifications to the Ryan Haight Act and relies on federal compliance. The state's regulatory approach is to defer to federal requirements while not imposing additional state-level barriers. California's 2019 amendment to § 2242, which removed the in-person examination requirement, was designed to align California law with federal telehealth flexibility and avoid creating state-level restrictions more stringent than federal law.

Under current federal temporary extensions (through December 31, 2026), practitioners may prescribe Schedule II-V controlled substances via audio-video telehealth without prior in-person evaluation, and California law does not impose additional restrictions on this practice.

Proposed California AB 1503 (pending as of 2025) would further clarify that "appropriate prior examination" does not require synchronous interaction and can be achieved through various telehealth modalities, reinforcing California's permissive approach.

COVID-19 Emergency Waivers:

Federal COVID-19 emergency waivers, rather than state-specific waivers, govern controlled substance prescribing via telehealth in California. These federal waivers have been extended four times and remain in effect through December 31, 2026. The waivers have not been made permanent but continue to allow controlled substance prescribing via telehealth without in-person visits.

California did not need to implement separate state-level COVID-19 waivers for controlled substance prescribing because the state had already removed its in-person examination requirement in 2019, before the pandemic. California's pre-pandemic regulatory framework was already more permissive than federal requirements.

The state did implement various other telehealth-related changes during COVID-19, including parity requirements for reimbursement and expanded modalities (audio-only), but these were not specific to controlled substance prescribing.

Compliance Requirements:

- Conduct "appropriate prior examination" meeting standard of care before prescribing controlled substances
- Maintain appropriate licensure in California and DEA registration
- Comply with electronic prescribing requirements for controlled substances
- Report to and consult CURES (California Prescription Drug Monitoring Program) as required

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• Use audio-video synchronous communication when prescribing controlled substances via telehealth (federal requirement through December 31, 2026)

• Maintain medical records documenting the examination and basis for prescribing

• Comply with applicable standard of care for the patient's condition and prescribed medication

• Ensure proper patient identification and verification

Primary Citations:

• California Business & Professions Code § 2242 (Prescribing dangerous drugs)

• California Business & Professions Code § 2836.1 (Nurse practitioner furnishing)

• California Business & Professions Code § 3502 (Physician assistant prescribing)

• AB 1264 (2019) - amended § 2242 to remove in-person requirement

• Health & Safety Code § 11165 et seq. (CURES Act)

• Health & Safety Code § 11164 (Electronic prescribing requirements)

Supporting Citations:

• Federal Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 829(e)

• DEA COVID-19 telemedicine extensions (most recent extension through December 31, 2026)

• Proposed AB 1503 (2025) - pending legislation

• California Medical Board guidelines on telehealth

• California Board of Pharmacy regulations

Effective Dates:

California Business & Professions Code § 2242 was amended by AB 1264, effective October 11, 2019, removing the in-person examination requirement. Electronic prescribing requirements became effective January 1, 2022. Federal COVID-19 telemedicine flexibilities for controlled substances have been extended through December 31, 2026. CURES consultation requirements have been phased in with full implementation as of 2018-2021 depending on prescriber type.

COLORADO

Regulatory Status: ** Explicit regulations exist with permissive framework for Colorado-licensed providers but strict prohibition for out-of-state telehealth registrants.**

Telehealth Controlled Substance Prescribing - General Permission:

Colorado maintains a dual regulatory framework that distinguishes between Colorado-licensed providers and out-of-state telehealth registrants. For providers holding full Colorado licenses, controlled substance prescribing via telehealth is permitted without mandatory in-person examinations, subject to establishing a valid provider-patient relationship. However, under C.R.S. § 12-30-124(11), enacted through SB 24-141 (effective January 1, 2026), out-of-state providers who

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register to provide telehealth services to Colorado patients are explicitly prohibited from prescribing any controlled substances as defined in C.R.S. § 12-280-402(1). This prohibition applies to all schedules (CII-CV) without exception and represents a significant restriction on interstate telehealth practice.

Provider-Patient Relationship and In-Person Examination Requirements:

Colorado Medical Board Policy 40-03 and Policy 40-27 (adopted August 20, 2015, updated August 19, 2021) permit provider-patient relationships to be established via telehealth technologies without requiring an initial in-person visit. The relationship must be established "in conformance with generally accepted standards of practice." This represents one of the more permissive state approaches to telehealth controlled substance prescribing.

Colorado Board of Pharmacy Rule 3 CCR 719-1, § 3.00.21 requires pharmacists to verify that a "valid preexisting patient-practitioner relationship" exists before dispensing controlled substances, but explicitly states "such relationship need not involve an in-person encounter between the patient and practitioner if otherwise permissible under Colorado law." This pharmacy board rule reinforces the medical board's position that in-person visits are not mandatory.

However, Colorado prohibits establishing provider-patient relationships through online questionnaires, internet-based consultations, or telephonic consultations alone without additional interaction that establishes a valid patient-practitioner relationship. The distinction is critical: virtual audio-video examinations conducted according to generally accepted standards of practice CAN satisfy relationship establishment requirements, but asynchronous questionnaires or text-based interactions alone cannot.

Colorado does not mandate periodic in-person visit requirements for ongoing controlled substance prescriptions. Once a valid provider-patient relationship is established (whether through telehealth or in-person), ongoing prescribing may continue via telehealth as long as it meets standard of care requirements.

Providers must conduct an "appropriate medical evaluation and review of relevant clinical history, commensurate with the presentation of the patient" (CMB Policy 40-27). The evaluation must establish diagnoses and identify underlying conditions and contraindications before prescribing. Text messages, emails, chats, or online questionnaires alone do not meet Colorado standards of practice for establishing the relationship necessary for controlled substance prescribing.

Schedule-Specific Rules:

Colorado does not impose explicit distinctions between Schedule II and Schedule III-V controlled substances in its state telehealth regulations. All schedules are subject to the same requirement: establishment of a valid provider-patient relationship in conformance with generally accepted standards of practice.

Colorado does not impose specific differentiation between psychiatric medications versus pain medications in state telehealth rules. However, medical marijuana prescribing via telehealth is explicitly prohibited under CMB Policy 40-27, representing the only substance-specific telehealth prohibition in Colorado state law (aside from the general prohibition on out-of-state telehealth registrants prescribing any controlled substances).

Electronic prescribing requirements apply to controlled substances in Colorado: Under HB 18-1279 and SB 19-079, Schedule II, III, and IV controlled substances must be prescribed electronically unless an exception applies. These requirements became effective July 1, 2021 for

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physicians, physician assistants, APRNs, optometrists, and podiatrists, and July 1, 2023 for dentists. Electronic prescribing requirements apply equally to telehealth and in-person prescribing.

Prescriber Type Restrictions:

Colorado-licensed prescribers authorized to prescribe controlled substances via telehealth include a broad range of provider types, reflecting Colorado's generally permissive approach to prescriptive authority:

Physicians (MD/DO): Full prescriptive authority for Schedule II-V controlled substances via telehealth, subject to establishing valid provider-patient relationship and standard of care compliance.

Physician Assistants (PAs): May prescribe controlled substances via telehealth if they have DEA registration and supervising physician authorization under 3 CCR 713-7. PAs in Colorado have broad prescriptive authority within their supervisory relationships.

Advanced Practice Registered Nurses (APRNs/Nurse Practitioners): Colorado grants APRNs full independent prescriptive authority after completing a provisional period and 750-hour mentorship requirement. APRNs must have DEA registration and may prescribe Schedule II-V controlled substances via telehealth subject to the same requirements as physicians (C.R.S. § 12-255-112; 3 CCR 713-37). Colorado is notable for granting true independent practice to APRNs without ongoing collaborative practice requirements.

Certified Registered Nurse Anesthetists (CRNAs): As APRNs with prescriptive authority, CRNAs may prescribe controlled substances within their scope of practice via telehealth.

Clinical Nurse Specialists (CNS): As APRNs with prescriptive authority, CNSs may prescribe controlled substances within their scope of practice via telehealth.

Certified Nurse Midwives: May obtain prescriptive authority under C.R.S. § 12-255-112 and prescribe controlled substances via telehealth within their scope of practice.

Optometrists: Limited controlled substance prescriptive authority for Schedule II narcotic controlled substances (hydrocodone combinations only) and Schedule III-V substances for ocular disease treatment. May not prescribe injectable drugs except epinephrine. May prescribe via telehealth within these limitations.

Dentists: May prescribe controlled substances within their scope of practice via telehealth, subject to electronic prescribing requirements effective July 1, 2023.

Podiatrists: May prescribe controlled substances within their scope of practice via telehealth.

Pharmacists: Limited prescribing authority for specific protocols (hormonal contraceptives, tobacco cessation, opioid antagonists, HIV pre-exposure and post-exposure prophylaxis). Cannot independently prescribe traditional controlled substances but may prescribe naloxone and other opioid antagonists.

Veterinarians: May prescribe controlled substances for animal patients within their scope of practice, including via appropriate telehealth modalities for veterinary medicine.

All prescriber types must hold appropriate Colorado licensure, DEA registration, and comply with the same standards for establishing provider-patient relationships via telehealth.

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Out-of-State Telehealth Registrant Prohibition:

A critical limitation applies to out-of-state providers: Under C.R.S. § 12-30-124(11) (effective January 1, 2026), out-of-state providers who register under Colorado's special telehealth registration pathway are explicitly prohibited from prescribing any controlled substances to Colorado patients. This prohibition is absolute and applies regardless of whether the provider would otherwise meet all requirements for establishing a valid provider-patient relationship. Out-of-state providers wishing to prescribe controlled substances to Colorado patients must obtain full Colorado licensure rather than relying on the telehealth registration pathway.

Ryan Haight Act Compliance and State Modifications:

Colorado has not enacted state-level modifications to the Ryan Haight Act and requires compliance with federal law. Colorado's permissive approach to telehealth controlled substance prescribing (allowing relationship establishment via audio-video telehealth without in-person visits) operates within the framework of federal Ryan Haight Act exceptions and temporary COVID-19 waivers.

Colorado's regulations are designed to be compatible with federal requirements while not imposing additional state-level restrictions. The state's approach recognizes that federal law sets a baseline and allows Colorado-licensed providers to practice within federal parameters.

The prohibition on out-of-state telehealth registrants prescribing controlled substances (C.R.S. § 12-30-124(11)) may be understood as a Ryan Haight Act compliance measure, as it ensures that only providers with full state licensure and established connections to Colorado can prescribe controlled substances to Colorado patients.

COVID-19 Emergency Waivers:

Colorado's regulatory framework did not require specific COVID-19 emergency waivers for controlled substance prescribing via telehealth because the state's pre-pandemic regulations already permitted establishment of provider-patient relationships via telehealth without mandatory in-person visits. Colorado Medical Board Policy 40-27, adopted in its current form in August 2021, codified and clarified telehealth practices that had been evolving during the pandemic.

Colorado did implement various other telehealth-related changes during COVID-19, including:

- Expanded audio-only telehealth options (which remain available post-pandemic)
- Interstate licensure compacts and temporary practice allowances
- Reimbursement parity requirements

However, these changes were not specific to controlled substance prescribing, which was already permitted via telehealth under Colorado's existing regulatory framework.

Federal COVID-19 emergency waivers for controlled substance prescribing (extended through December 31, 2026) provide additional flexibility at the federal level, and Colorado-licensed providers may operate under these federal flexibilities without conflicting with state law.

Compliance Requirements:

- Establish valid provider-patient relationship in conformance with generally accepted standards of practice
- Conduct appropriate medical evaluation and review of relevant clinical history

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- Maintain Colorado licensure and DEA registration (out-of-state telehealth registrants cannot prescribe controlled substances)
- Use audio-video synchronous communication for initial relationship establishment (questionnaires alone insufficient)
- Comply with electronic prescribing requirements for Schedule II-IV controlled substances
- Register with and report to Colorado Prescription Drug Monitoring Program
- Maintain medical records documenting evaluation and prescribing decisions
- Comply with standard of care requirements for the patient's condition
- For APRNs: complete provisional period and mentorship requirements before independent prescribing
- For PAs: maintain supervisory relationship and authorization from supervising physician
- Ensure proper patient identification and verification

Primary Citations:

- C.R.S. § 12-30-124(11) (Out-of-state telehealth registrant prohibition on CS prescribing)
- C.R.S. § 12-280-402(1) (Definition of controlled substances)
- C.R.S. § 12-255-112 (APRN prescriptive authority)
- Colorado Medical Board Policy 40-03 (Telemedicine)
- Colorado Medical Board Policy 40-27 (Telemedicine - updated August 19, 2021)
- Colorado Board of Pharmacy Rule 3 CCR 719-1, § 3.00.21 (Patient-practitioner relationship)
- 3 CCR 713-7 (Physician Assistant regulations)
- 3 CCR 713-37 (APRN regulations)
- HB 18-1279 (Electronic prescribing requirements)
- SB 19-079 (Electronic prescribing implementation)
- SB 24-141 (Out-of-state telehealth registration - effective January 1, 2026)

Supporting Citations:

- Federal Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 829(e)
- DEA COVID-19 telemedicine extensions (through December 31, 2026)
- Colorado Prescription Drug Monitoring Program regulations
- Colorado Department of Regulatory Agencies guidance documents

Effective Dates:

Colorado Medical Board Policy 40-03 was adopted August 20, 2015. Policy 40-27 was updated August 19, 2021. Electronic prescribing requirements became effective July 1, 2021 for most prescribers and July 1, 2023 for dentists. C.R.S. § 12-30-124(11) prohibiting out-of-state telehealth registrants from prescribing controlled substances becomes effective January 1, 2026. APRN independent practice provisions have been in effect since 2010 with amendments through 2019.

CONFIDENTIAL

Connecticut, Delaware, Florida

CONNECTICUT

Regulatory Status:** Explicit regulations exist

Telehealth Controlled Substance Prescribing - General Framework:

Connecticut has comprehensive statutory regulations governing telehealth prescribing of controlled substances, codified primarily in Conn. Gen. Stat. § 19a-906(c) and § 21a-249. The state employs a schedule-based approach with specific carve-outs for psychiatric and substance use disorder treatment.

Connecticut law generally prohibits telehealth providers from prescribing Schedule I, II, or III controlled substances via telehealth. However, a critical exception exists: Schedule II or III controlled substances OTHER THAN OPIOID DRUGS may be prescribed via telehealth for treatment of psychiatric disabilities or substance use disorders, including medication-assisted treatment (MAT), provided the prescription is issued in full compliance with the Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 829(e).

2025 Legislative Changes:

Public Act 25-168, Section 116 (effective upon passage in 2025) significantly expanded telehealth prescribing authority by removing the previous prohibition on prescribing Schedule II or III opioids via telehealth. This legislative change specifically clarified that medications such as methadone and buprenorphine may now be prescribed through telehealth for psychiatric disabilities and substance use disorders, representing a major policy shift to improve access to medication-assisted treatment.

Schedule-Specific Rules:

- **Schedule I:** Prohibited via telehealth with no exceptions
- **Schedule II Opioids:** NOW PERMITTED (as of 2025) for psychiatric disabilities and substance use disorders, including MAT, when compliant with Ryan Haight Act
- **Schedule II Non-Opioids:** Permitted for psychiatric disabilities and substance use disorders when compliant with Ryan Haight Act
- **Schedule III Opioids:** NOW PERMITTED (as of 2025) for psychiatric disabilities and substance use disorders, including MAT, when compliant with Ryan Haight Act
- **Schedule III Non-Opioids:** Permitted for psychiatric disabilities and substance use disorders when compliant with Ryan Haight Act
- **Schedule IV and V:** PERMITTED via telehealth without specific restrictions beyond standard prescribing requirements

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In-Person Examination Requirements:

Connecticut statute does not explicitly mandate initial or periodic in-person examinations for telehealth prescribing of controlled substances. However, the state imposes several related requirements:

1. Providers must have "access to, or knowledge of, the patient's medical history" and the patient's health record

2. Providers must conform to the standard of care applicable to their profession

3. Connecticut regulations require that practitioners medically evaluate patients to determine need for controlled substances prior to prescribing

4. For ongoing controlled substance treatment, Connecticut requires periodic monitoring (frequency not specified in statute)

5. Compliance with the Ryan Haight Act is mandatory for Schedule II-III prescribing, which federally requires an in-person medical evaluation unless an exception applies

6. Federal COVID-19 telehealth flexibilities have been extended through December 31, 2026, allowing Schedule II-V prescribing without prior in-person evaluation when certain conditions are met

The statute does not specify whether questionnaires or virtual examinations can satisfy evaluation requirements, leaving this determination to professional standard of care requirements.

Prescriber Type Restrictions:

Connecticut defines "telehealth provider" broadly in § 19a-906(a)(12) to include any health care provider licensed pursuant to Title 20 and pharmacists licensed by the Department of Consumer Protection, providing services within their scope of practice. This expansive definition includes:

- Physicians (MDs and DOs)
- Advanced Practice Registered Nurses (APRNs)
- Physician Assistants (PAs)
- Pharmacists (within scope)
- Optometrists
- Podiatrists
- Dentists
- Naturopaths
- Psychologists
- Clinical social workers and master social workers
- Other licensed providers

Mid-level providers (APRNs, PAs) may prescribe Schedules II-V controlled substances via telehealth within their scope of practice, subject to the same restrictions as physicians. Connecticut law does not impose additional telehealth-specific restrictions based on prescriber type beyond general scope of practice limitations.

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Ryan Haight Act Compliance:

Connecticut law explicitly requires that Schedule II-III controlled substance prescribing via telehealth be conducted "in a manner fully consistent with the Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e)." The state does not modify or create exceptions to federal Ryan Haight requirements; rather, it incorporates them by reference as a mandatory compliance standard.

COVID-19 Emergency Waivers:

Connecticut's regulations do not contain state-specific COVID-19 emergency waivers. However, providers may rely on federal DEA COVID-19 telehealth flexibilities, which have been extended through December 31, 2026, allowing Schedule II-V controlled substance prescribing via telehealth without a prior in-person medical evaluation when the prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice.

Compliance Requirements:

- Establish proper provider-patient relationship with access to medical history
- Comply with Ryan Haight Act requirements for Schedule II-III prescribing
- Limit Schedule II-III opioid prescribing to psychiatric disabilities and substance use disorders (including MAT)
- Transmit all controlled substance prescriptions electronically pursuant to § 21a-249 (with limited exceptions)
- Maintain medical records documenting evaluation and treatment decisions
- Adhere to professional standard of care applicable to the provider's profession
- Conduct periodic monitoring for ongoing controlled substance treatment

Primary Citations:

- Conn. Gen. Stat. § 19a-906 (Telehealth definitions and requirements)
- Conn. Gen. Stat. § 19a-906(c) (Controlled substance prescribing limitations)
- Conn. Gen. Stat. § 21a-249 (Electronic prescribing requirement)
- Public Act 25-168, Section 116 (2025 opioid prescribing expansion)
- 21 U.S.C. § 829(e) (Ryan Haight Online Pharmacy Consumer Protection Act)

Supporting Citations:

- Conn. Gen. Stat. § 19a-906(a)(12) (Definition of telehealth provider)
- Connecticut Title 20 (Health care provider licensing statutes)

Effective Dates:

- General telehealth controlled substance restrictions: Previously enacted
- Public Act 25-168, Section 116: Effective upon passage in 2025
- Electronic prescribing requirement (§ 21a-249): Currently in effect
- Federal COVID-19 telehealth flexibilities: Extended through December 31, 2026

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DELAWARE

Regulatory Status: Explicit regulations exist**

Telehealth Controlled Substance Prescribing - General Framework:

Delaware permits controlled substance prescribing via telehealth, subject to the same standard of care as in-person visits. 24 Del. C. § 1769D(g) explicitly states: "Prescriptions, including for opioids, made through telemedicine and under a physician-patient relationship may include controlled substances. Prescribing controlled substances utilizing telemedicine is subject to the same standard of care and requisite practice as prescribing for in-person visits."

Delaware's regulatory framework underwent significant evolution in 2025 with the passage of Senate Bill 101, which resolved conflicts between the state's Uniform Controlled Substances Act and Telehealth Access Act regarding opioid use disorder treatment.

Provider-Patient Relationship Requirements:

A proper provider-patient relationship must be established either in-person or through telehealth, including: (1) verifying and authenticating patient location and identity; (2) disclosing provider identity and credentials; (3) obtaining appropriate consents; (4) establishing diagnosis through acceptable medical practices, including patient history, mental status examination, and physical examination unless not warranted by the patient's mental condition. 24 Del. C. § 1769D(b).

In-Person Examination Requirements:

Prior to diagnosis and treatment via telemedicine, physicians must provide one of four options:

1. An appropriate examination in-person

2. Have another Delaware-licensed practitioner at the originating site with the patient

3. Diagnosis based on both audio and visual communication (live, real-time)

4. Service meets standards of establishing patient-physician relationship per evidence-based clinical practice guidelines developed by major medical specialty societies (Council of Medical Specialty Societies)

24 Del. Admin. Code § 1700-19.1 clarifies that "a remote, audio-only examination is not an 'appropriate in-person examination'" for establishing a physician-patient relationship. Audio-visual communications must be "live, real-time communications." This regulation became effective June 11, 2018.

Delaware does not mandate periodic in-person visits at specified intervals (annual, biannual, etc.) for ongoing controlled substance prescribing via telehealth. However, providers must maintain the standard of care equivalent to in-person treatment, which may necessitate periodic evaluations based on clinical judgment.

Opioid-Specific Restrictions:

Delaware maintains strict limitations on opioid prescribing via telemedicine. No opioid prescribing is permitted via telemedicine EXCEPT for addiction treatment programs offering medication-assisted treatment that have received a Division of Substance Abuse and Mental Health (DSAMH)

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waiver for use of telemedicine through DSAMH's licensure or renewal process. 24 Del. Admin. Code § 1700-19.0; 16 Del. Admin. Code § 6001.

All other controlled substance prescribing (non-opioid) via telemedicine is held to the same standards of care and requisite practice as in-person visits.

Senate Bill 101 (2025) - Opioid Use Disorder Treatment Expansion:

Governor Matt Meyer signed Senate Bill 101 into law on July 21, 2025, representing a significant policy shift. This legislation resolved a conflict between Delaware's Uniform Controlled Substances Act (which required in-person examination for controlled substance prescribing) and Delaware's Telehealth Access Act (which did not require in-person examination).

SB 101 expanded the definition of "patient-practitioner relationship" under 16 Del. C. § 4701 to include practitioners and patients providing/seeking treatment for opioid use disorder (OUD) for Schedule III-V medications approved by FDA for such treatment, when provided under a properly established provider-patient relationship per 24 Del. C. § 6003.

This change specifically facilitates telehealth prescribing of buprenorphine and other FDA-approved medications for opioid use disorder treatment.

Schedule-Specific Rules:

Delaware does not impose explicit differentiation between CII vs CIII-V for general telehealth prescribing, except:

- **Opioids (regardless of schedule):** Prohibited via telehealth except for MAT programs with DSAMH waiver
- **OUD treatment:** Schedule III-V FDA-approved medications permitted via telehealth under SB 101 (2025)
- **All other controlled substances:** Permitted via telehealth with proper provider-patient relationship and compliance with standard of care

Prescriber Type Restrictions:

Delaware permits the following practitioners to prescribe controlled substances via telehealth:

- **Physicians (MD/DO):** Full prescribing authority within scope of practice
- **Physician Assistants (PAs):** May prescribe Schedule II-V controlled substances under collaborative agreement with physician (24 Del. Admin. Code § 1700-13.3.1.3)
- **Advanced Practice Registered Nurses (APRNs/NPs):** May prescribe controlled substances within scope of practice
- **Dentists:** May prescribe controlled substances within scope of practice
- **Podiatrists:** May prescribe controlled substances within scope of practice
- **Optometrists:** Limited to Schedule II hydrocodone and Schedules III-V, maximum 72-hour supply
- **Veterinarians:** May prescribe controlled substances for animal patients

All practitioners must obtain both Delaware Controlled Substance Registration (CSR) and DEA registration. Out-of-state practitioners with practice privilege, interstate compact license,

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interstate telehealth registration, or military registration must also obtain Delaware CSR to prescribe controlled substances to Delaware patients.

Ryan Haight Act Compliance:

Delaware law does not explicitly reference the Ryan Haight Act in its telehealth statutes. However, as federal law, the Ryan Haight Act applies to all controlled substance prescribing via telemedicine in Delaware. Delaware's requirement for establishing a proper provider-patient relationship through one of four specified methods (including in-person examination or live audio-visual communication) aligns with Ryan Haight requirements.

The state does not create additional modifications or exceptions to federal Ryan Haight standards.

COVID-19 Emergency Waivers:

Delaware's statutes and regulations do not contain state-specific COVID-19 emergency waivers that remain in effect. Senate Bill 101 (2025) represents a permanent legislative change rather than a temporary emergency waiver. Providers may continue to rely on federal DEA COVID-19 telehealth flexibilities extended through December 31, 2026.

Compliance Requirements:

- Establish proper provider-patient relationship through one of four specified methods
- Verify and authenticate patient location and identity
- Disclose provider identity and credentials
- Obtain appropriate patient consents
- Conduct diagnosis through acceptable medical practices (history, mental status exam, physical exam unless not warranted)
- Use live, real-time audio-visual communication (audio-only insufficient)
- Obtain DSAMH waiver for MAT programs prescribing opioids via telehealth
- Obtain Delaware Controlled Substance Registration (CSR) and DEA registration
- Maintain standard of care equivalent to in-person visits
- For OUD treatment with Schedule III-V medications: establish proper provider-patient relationship per 24 Del. C. § 6003

Primary Citations:

- 24 Del. C. § 1769D (Telehealth Access Act)
- 24 Del. C. § 1769D(b) (Provider-patient relationship requirements)
- 24 Del. C. § 1769D(g) (Controlled substance prescribing via telemedicine)
- 24 Del. C. § 1769D(h) (In-person examination alternatives)
- 24 Del. Admin. Code § 1700-19.0 (Opioid prescribing restrictions)
- 24 Del. Admin. Code § 1700-19.1 (Audio-only examination prohibition)
- 24 Del. Admin. Code § 1700-13.3.1.3 (Physician assistant prescribing)
- 16 Del. C. § 4701 (Patient-practitioner relationship definition)
- 16 Del. Admin. Code § 6001 (DSAMH waiver requirements)

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- Senate Bill 101 (2025) (OUD treatment expansion)
- 24 Del. C. § 6003 (Provider-patient relationship standards)

Supporting Citations:

- Delaware Division of Professional Regulation licensing requirements
- Delaware Board of Medical Licensure and Discipline regulations
- Council of Medical Specialty Societies evidence-based clinical practice guidelines

Effective Dates:

- 24 Del. Admin. Code § 1700-19.1: Effective June 11, 2018
- Senate Bill 101: Signed into law July 21, 2025
- General telehealth provisions (24 Del. C. § 1769D): Previously enacted, currently in effect
- Federal COVID-19 telehealth flexibilities: Extended through December 31, 2026

FLORIDA

Regulatory Status: Explicit regulations exist**

Telehealth Controlled Substance Prescribing - General Framework:

Florida has comprehensive regulations governing telehealth prescribing of controlled substances, codified primarily in Florida Statutes § 456.47 (effective July 1, 2019, as amended by SB 312 effective July 1, 2022). Florida employs a schedule-based approach with specific limitations on Schedule II substances and carve-outs for psychiatric treatment and institutional settings.

Florida permits telehealth prescribing of Schedule III-V controlled substances without restriction. Schedule II controlled substances may be prescribed via telehealth only for: (1) treatment of psychiatric disorders; (2) inpatient treatment at a licensed hospital; (3) treatment of patients receiving hospice services; or (4) treatment of residents of nursing home facilities.

In-Person Examination Requirements:

Florida law does NOT require an initial in-person examination for telehealth prescribing of controlled substances under § 456.47, with important exceptions:

General Telehealth Standard:** § 456.47(2)(b) provides that if a telehealth provider conducts a patient evaluation sufficient to diagnose and treat the patient, the provider is NOT required to research medical history or conduct a physical examination before using telehealth. This represents a relatively permissive approach compared to many states.

Chronic Nonmalignant Pain Exception:** § 456.44 requires practitioners prescribing Schedule II-IV controlled substances for chronic nonmalignant pain (defined as pain unrelated to cancer persisting beyond the usual course of disease/injury or more than 90 days post-surgery) to:

1. Conduct a complete medical history and physical examination BEFORE beginning treatment
2. See patients at regular intervals not exceeding 3 months

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3. Register as a "controlled substance prescribing practitioner" on their practitioner profile
4. Maintain written treatment plans and controlled substance agreements

The statute does not explicitly state whether this initial physical examination must be in-person or can be conducted via telehealth, creating some ambiguity in the regulatory framework.

Acute Pain Requirements:** Florida regulations require physical examination for prescribing controlled substances for acute pain (pain associated with surgery, trauma, or acute illness, excluding cancer-related pain, terminal conditions, palliative care, or traumatic injuries with Injury Severity Score ≥9).

Questionnaires/Virtual Exams:** Florida law requires telehealth providers to practice consistent with the "prevailing professional standard of practice for a health care professional who provides in-person health care services." Virtual examinations via synchronous telecommunications are permitted, but the standard of care must match in-person services. Questionnaires alone would likely be insufficient to establish the requisite provider-patient relationship.

Schedule-Specific Rules:

Schedule II: Prohibited via telehealth EXCEPT for:**

- Psychiatric disorder treatment
- Inpatient hospital care
- Hospice patients
- Nursing home residents

This applies to ALL Schedule II substances including stimulants (Adderall, Ritalin, methylphenidate), opioids (oxycodone, hydromorphone, morphine), and other Schedule II medications.

Schedule III-V:** Permitted without limitation via telehealth (effective July 1, 2022 per SB 312). This represents a significant expansion from prior law.

Psychiatric vs. Pain Medications:** Schedule II psychiatric medications (stimulants for ADHD, certain anxiolytics) may be prescribed via telehealth for psychiatric disorder treatment. Schedule II pain medications are generally prohibited via telehealth unless the patient is in a hospital, hospice, or nursing home setting.

Opioid-Specific Restrictions:** For acute pain treatment, Schedule II opioids are limited to a 3-day supply (up to 7-day supply with specific documentation of medical necessity). These limits apply regardless of whether prescribing occurs via telehealth or in-person. The 3-day/7-day limits do not apply to cancer-related pain, terminal conditions, palliative care, traumatic injuries with Injury Severity Score ≥9, or chronic nonmalignant pain treatment.

Prescriber Type Restrictions:

Florida's telehealth statute (§ 456.47) applies broadly to "telehealth providers," defined as individuals licensed under multiple chapters of Florida law:

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Physicians (MDs/DOs):** Full prescribing authority via telehealth within scope of practice, subject to schedule-specific limitations described above.

Physician Assistants (PAs):** May prescribe controlled substances via telehealth within supervisory protocol. Limited to 7-day supply of Schedule II substances (except psychiatric medications prescribed by psychiatric PAs who may prescribe up to a 30-day supply). PAs cannot prescribe controlled substances in registered pain management clinics.

Advanced Practice Registered Nurses (APRNs/NPs):** May prescribe controlled substances via telehealth within supervisory protocol (or autonomously if registered under § 464.0123). Limited to 7-day supply of Schedule II substances (except psychiatric medications prescribed by psychiatric APRNs who may prescribe up to a 30-day supply). APRNs cannot prescribe controlled substances in registered pain management clinics.

Certified Registered Nurse Anesthetists (CRNAs):** May prescribe controlled substances within scope of practice and supervisory protocol.

Clinical Nurse Specialists:** May prescribe controlled substances within scope of practice and supervisory protocol.

Dentists:** May prescribe controlled substances via telehealth within scope of dental practice, subject to schedule-specific limitations. For acute dental pain, limited to 3-day supply of Schedule II opioids (up to 7 days with documentation).

Podiatrists:** May prescribe controlled substances via telehealth within scope of podiatric practice, subject to schedule-specific limitations.

Optometrists:** Florida optometrists have limited controlled substance prescribing authority (primarily Schedule IV and V). May prescribe via telehealth within scope of practice.

Veterinarians:** May prescribe controlled substances for animal patients via telehealth within scope of veterinary practice.

Pharmacists:** Florida pharmacists do not have independent prescribing authority for controlled substances, though they may participate in collaborative practice agreements.

Ryan Haight Act Compliance:

Florida law does not explicitly reference the Ryan Haight Act in its telehealth statutes. However, as federal law, the Ryan Haight Act applies to all controlled substance prescribing via telemedicine in Florida. Florida's schedule-based restrictions on Schedule II prescribing via telehealth are more restrictive than the Ryan Haight Act in some respects (prohibiting Schedule II prescribing except for specific circumstances), while being more permissive for Schedule III-V substances.

The state does not create specific modifications or exceptions to federal Ryan Haight standards. Practitioners must comply with both Florida's schedule-based restrictions AND federal Ryan Haight requirements.

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COVID-19 Emergency Waivers:

Florida's statutes do not contain state-specific COVID-19 emergency waivers that remain in effect. The 2022 amendments to § 456.47 (SB 312) represent permanent legislative changes rather than temporary emergency measures. These amendments expanded Schedule III-V prescribing via telehealth on a permanent basis.

Providers may continue to rely on federal DEA COVID-19 telehealth flexibilities extended through December 31, 2026, which may provide additional flexibility beyond Florida's state-specific restrictions for Schedule II substances.

Special Registration Requirements:

Practitioners prescribing Schedule II-IV controlled substances for chronic nonmalignant pain must register as a "controlled substance prescribing practitioner" on their Florida practitioner profile. This registration requirement applies regardless of whether prescribing occurs via telehealth or in-person.

Pain management clinics must register with the Florida Department of Health and comply with additional regulatory requirements under § 458.3265 and § 459.0137.

Compliance Requirements:

- Conduct patient evaluation sufficient to diagnose and treat via telehealth
- Practice consistent with prevailing professional standard of care for in-person services
- Limit Schedule II prescribing to psychiatric disorders, hospital inpatients, hospice patients, or nursing home residents
- For chronic nonmalignant pain: conduct complete medical history and physical examination before treatment, see patients every 3 months, register as controlled substance prescribing practitioner, maintain treatment plans and agreements
- For acute pain: limit Schedule II opioids to 3-day supply (7-day with documentation)
- Mid-level providers: prescribe within supervisory protocol, limit Schedule II to 7-day supply (except psychiatric medications)
- Maintain medical records documenting evaluation, diagnosis, and treatment decisions
- Comply with electronic prescribing requirements for controlled substances
- Register pain management clinics if applicable

Primary Citations:

- Fla. Stat. § 456.47 (Telehealth)
- Fla. Stat. § 456.47(2)(b) (Patient evaluation requirements)
- Fla. Stat. § 456.44 (Chronic nonmalignant pain treatment)
- Fla. Stat. § 456.44(1)(a) (Definition of chronic nonmalignant pain)
- Senate Bill 312 (2022) (Schedule III-V expansion)
- Fla. Stat. § 458.3265 (Pain management clinic registration - physicians)
- Fla. Stat. § 459.0137 (Pain management clinic registration - osteopathic physicians)
- Fla. Stat. § 464.0123 (APRN autonomous practice registration)

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Supporting Citations:

- Fla. Stat. § 456.001 et seq. (Health care practitioner licensing)
- Fla. Stat. § 458.347 (Physician assistant prescribing)
- Fla. Stat. § 464.012 (APRN prescribing)
- Florida Board of Medicine rules and regulations
- Florida Board of Osteopathic Medicine rules and regulations
- Florida Board of Nursing rules and regulations

Effective Dates:

- Fla. Stat. § 456.47: Effective July 1, 2019
- SB 312 amendments (Schedule III-V expansion): Effective July 1, 2022
- Chronic nonmalignant pain requirements (§ 456.44): Currently in effect
- Acute pain opioid limits: Currently in effect
- Federal COVID-19 telehealth flexibilities: Extended through December 31, 2026

Georgia, Hawaii, Idaho

GEORGIA

Regulatory Status: Explicit regulations exist**

Telehealth Controlled Substance Prescribing Authorization:

Georgia permits telehealth prescribing of controlled substances with significant restrictions through the Georgia Composite Medical Board (GCMB) Rules. As of January 2026, Georgia follows federal COVID-19 telemedicine flexibilities through December 31, 2026. The GCMB announced on January 15, 2025, that it "agreed to accept the federal position" regarding the DEA/HHS extension of COVID-19 telemedicine flexibilities for prescribing controlled substances through December 31, 2026.

However, Georgia maintains strict underlying state rules that will apply after federal flexibilities expire. Rule 360-3-.02(5) generally prohibits "prescribing controlled substances and/or dangerous drugs for a patient based solely on a consultation via electronic means." The Board clarified in January 2024 that its rules require a patient to be examined once in-person prior to an initial prescription being issued for controlled substances and/or dangerous drugs.

In-Person Examination Requirements:

Current Status (Through December 31, 2026): Under federal flexibilities, no in-person exam is required for initial controlled substance prescriptions via telehealth.

Georgia's Underlying State Rules (Post-Federal Flexibility):

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- **Initial Visit Requirement:** Rule 360-3-.02(5) prohibits prescribing controlled substances based solely on electronic consultation. The Board requires one in-person examination prior to initial controlled substance prescription issuance.
- **Periodic Visit Requirements:** Telemedicine providers "must make diligent efforts to ensure patients are examined once annually in-person by a Georgia licensed physician, physician assistant, or nurse practitioner." This annual in-person examination requirement applies to ongoing controlled substance prescribing relationships.
- **Examination Elements:** Must include comprehensive history and physical examination. Rule 360-3-.02(6) states that providing treatment via electronic means constitutes unprofessional conduct "unless a history and physical examination of the patient has been performed by a Georgia licensee."
- **Virtual Examination Standards:** Rule 360-3-.07(a)(3)(d) allows telemedicine if the provider "is able to examine the patient using technology or peripherals that are equal or superior to an examination done personally by a provider within that provider's standard of care." This suggests that virtual exams using appropriate technology may satisfy examination requirements if they meet or exceed in-person examination standards.
- **Questionnaire Prohibition:** Prescribing based solely on online questionnaires does not satisfy Georgia's examination requirements and would constitute unprofessional conduct under Rule 360-3-.02.

Schedule-Specific and Medication-Type Restrictions:

Pain Management Absolute Prohibition: Rule 360-3-.07(c) explicitly states: "This rule does not authorize the prescription of controlled substances for the treatment of pain or chronic pain by electronic or other such means. All treatment of pain or chronic pain must be in compliance with Rule 360-3-.06." This creates an absolute prohibition on telehealth prescribing for pain management purposes.

Rule 360-3-.06 Pain Management Requirements:

- When initially prescribing controlled substances for pain/chronic pain: must have medical history, physical examination, and informed consent
- For Schedule II or III controlled substances prescribed for 90+ consecutive days for chronic pain: requires written treatment agreement and clinical visits at least every 3 months (can be reduced to annually with documented hardship or if morphine equivalent daily dose ≤30mg)
- Random bodily fluid monitoring at least annually
- Prior diagnostic and pain treatment records must be obtained

CII vs CIII-V Distinctions: Georgia rules do not create explicit telehealth distinctions between Schedule II and Schedule III-V controlled substances for non-pain purposes. However, pain management rules apply specifically to Schedule II and III substances prescribed for chronic pain (90+ consecutive days).

Psychiatric vs Pain Medications: Georgia creates a clear distinction between these categories. Pain medications have an absolute prohibition on telehealth prescribing under Rule 360-3-.07(c). Psychiatric medications (e.g., ADHD stimulants, benzodiazepines for anxiety) are permitted under federal flexibilities and were specifically mentioned in Board discussions as appropriate for telehealth prescribing.

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Prescriber Type Authorization:

Physicians: Fully authorized to prescribe controlled substances via telehealth subject to all requirements above.

Physician Assistants (PAs): Authorized to prescribe controlled substances via telehealth within scope of practice. Board rules specifically reference that annual in-person exams can be conducted by "a Georgia licensed physician, physician assistant, or nurse practitioner." Recent expansion (2024): PAs may now prescribe specific Schedule II controlled substances (hydrocodone, oxycodone) with limitations: initial prescription limited to 5-day supply, patient must be directly evaluated, and authorization must be documented in the medical record.

Advanced Practice Registered Nurses (APRNs/NPs): Authorized to prescribe controlled substances via telehealth within scope of practice. APRNs are explicitly included in the list of providers who may conduct annual in-person examinations for telehealth patients. Recent expansion (2024): APRNs may now prescribe specific Schedule II controlled substances (hydrocodone, oxycodone) with the same limitations as PAs: initial prescription limited to 5-day supply, patient must be directly evaluated, and authorization must be documented.

Other Mid-Level Prescribers: Clinical Nurse Specialists and CRNAs with prescriptive authority may prescribe controlled substances within their scope of practice, subject to the same telehealth requirements.

Pharmacists: Georgia pharmacists do not have independent prescriptive authority for controlled substances.

Dentists, Optometrists, Podiatrists, Veterinarians: These providers may prescribe controlled substances within their respective scopes of practice, subject to the same telehealth requirements as physicians.

Ryan Haight Act Compliance:

Georgia's underlying rules are more restrictive than the Ryan Haight Act, requiring initial in-person examinations and annual follow-up examinations. However, Georgia has adopted the federal position on COVID-19 telemedicine flexibilities through December 31, 2026, effectively suspending these more restrictive state requirements during the federal flexibility period.

COVID-19 Emergency Waivers:

Georgia has not made COVID-19 telehealth waivers permanent through state legislation. The GCMB's January 15, 2025 announcement indicates that Georgia will follow federal flexibilities through December 31, 2026. After this date, Georgia's underlying state rules requiring initial in-person examinations and annual in-person follow-ups will presumably take effect unless further extended or modified.

Compliance Requirements:

- Through December 31, 2026: Follow federal COVID-19 telemedicine flexibilities
- After December 31, 2026: Obtain in-person examination before initial controlled substance prescription
- Ensure annual in-person examination by Georgia-licensed physician, PA, or NP
- Maintain comprehensive history and physical examination documentation

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- Absolute prohibition on prescribing controlled substances for pain/chronic pain via telehealth
- For chronic pain prescribing (in-person): comply with Rule 360-3-.06 requirements including treatment agreements, quarterly visits, and urine drug testing
- PAs and APRNs prescribing Schedule II opioids: limit initial prescription to 5-day supply
- Use technology equal or superior to in-person examination standards
- Do not prescribe based solely on online questionnaires

Primary Citations:

- Georgia Composite Medical Board Rule 360-3-.02 (Unprofessional Conduct Defined)
- Georgia Composite Medical Board Rule 360-3-.07 (Practice Through Electronic or Other Such Means)
- Georgia Composite Medical Board Rule 360-3-.06 (Pain Management)
- GCMB Announcement, January 15, 2025 (Federal Flexibility Extension)
- GCMB Clarification, January 2024 (In-Person Examination Requirement)

Supporting Citations:

- DEA/HHS COVID-19 Telemedicine Flexibility Extension through December 31, 2026
- Georgia Board of Pharmacy regulations regarding PA and APRN Schedule II prescribing authority (2024 amendments)

Effective Dates:

- Current federal flexibility period: Through December 31, 2026
- GCMB acceptance of federal position: January 15, 2025
- PA/APRN Schedule II prescribing expansion: 2024
- Underlying state rules (360-3-.02, 360-3-.06, 360-3-.07): Currently in effect but superseded by federal flexibilities through December 31, 2026

HAWAII

Regulatory Status:** Explicit regulations exist

Telehealth Controlled Substance Prescribing Authorization:

Hawaii has explicit and complex regulations governing telehealth prescribing of controlled substances through multiple statutory provisions in Hawaii Revised Statutes (HRS). The state permits controlled substance prescribing via telehealth with significant restrictions that vary by substance type and clinical indication.

In-Person Examination Requirements:

General Controlled Substances (Chapter 329): HRS § 329-38(i)(1) requires that "all prescriptions for controlled substances shall originate from within the State." This provision has been interpreted

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to require the prescriber to be physically located in Hawaii when issuing the prescription, though it does not explicitly mandate an in-person patient examination.

Opiates (HRS § 453-1.3(c)): For prescribing opiates specifically, a physician-patient relationship "shall only be established after an in-person consultation between the prescribing physician and the patient." This creates an absolute initial in-person requirement for opiate prescribing.

However, recent amendments (HB 951, effective through December 31, 2027) created a limited exception: a patient who has been seen in person by a health care provider in the same medical group as the prescribing provider may be prescribed an opiate prescription for a three-day supply or less via telehealth. This exception requires:

- Prior in-person visit with any provider in the same medical group
- Maximum 3-day supply
- Temporary authorization through December 31, 2027

Other Controlled Substances (Non-Opiates): For non-opiate controlled substances, HRS § 453-1.3(c) states that treatment recommendations via telehealth "shall be held to the same standards of appropriate practice as those in traditional physician-patient settings that do not include [an] in-person visit but in which prescribing is appropriate, including on-call telephone encounters and encounters for which a follow-up visit is arranged." This suggests that non-opiate controlled substances may be prescribed via telehealth without an initial in-person visit, provided appropriate standards of care are met.

Medical Cannabis: As of 2025 (HB 302), the in-person requirement for medical cannabis certification has been eliminated. A bona fide physician-patient or APRN-patient relationship may be established via telehealth for certifying medical cannabis use.

Questionnaire Prohibition: HRS § 453-1.3(c) explicitly prohibits prescribing based solely on online questionnaires: "Issuing a prescription based solely on an online questionnaire is not treatment for the purposes of this section and does not constitute an acceptable standard of care."

Periodic Visit Requirements: Hawaii law does not mandate specific periodic in-person visit requirements beyond the initial in-person requirement for opiates. Ongoing care must meet the same standards as traditional practice settings.

Virtual Examination Standards: Hawaii law permits establishment of provider-patient relationships via telehealth using two-way interactive audio-visual technology. The standard of care for telehealth encounters must equal that of in-person encounters under HRS § 453-1.3 and § 457-2.

Schedule-Specific and Medication-Type Restrictions:

Schedule II: The physical presence requirement in HRS § 329-38(i)(1) applies to all controlled substances, including Schedule II. For Schedule II opiates specifically, the in-person consultation requirement under HRS § 453-1.3(c) applies, with the limited 3-day supply exception through December 31, 2027.

Schedule III-V: Proposed legislation (SB 2152/HB 2021 in 2022 session) would have allowed Hawaii-licensed physicians, APRNs, and PAs who are not physically in the state to prescribe Schedule III-V controlled substances via telehealth if they have a valid DEA registration and issue prescriptions pursuant to a written contract with or as an employee of a Hawaii-based physician, medical group, or health care facility. However, these bills do not appear to have been enacted into

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law. Under current law, Schedule III-V non-opiate controlled substances may be prescribed via telehealth without an initial in-person visit, subject to standard of care requirements.

Opioid-Specific Restrictions: The in-person consultation requirement applies specifically to "opiates" under HRS § 453-1.3(c). This includes all opioid medications regardless of schedule. The limited exception allows a 3-day supply or less if the patient has been seen in person by another provider in the same medical group (through December 31, 2027).

Psychiatric vs. Pain Medications: Hawaii law does not create explicit distinctions between psychiatric medications and pain medications for telehealth purposes, beyond the opiate-specific restrictions. Non-opiate controlled substances used for psychiatric purposes (e.g., stimulants for ADHD, benzodiazepines for anxiety) may be prescribed via telehealth without an initial in-person visit. The legislative history of SB 2152/HB 2021 indicates legislative concern about access to psychiatric medications via telehealth, suggesting recognition that these medications have different risk profiles than opiates.

Prescriber Type Authorization:

Physicians: May prescribe controlled substances via telehealth subject to all requirements above. Must be physically located in Hawaii when issuing prescriptions per HRS § 329-38(i)(1).

Advanced Practice Registered Nurses (APRNs/NPs): Hawaii grants full practice authority to APRNs with prescriptive authority. Hawaii Administrative Rules (HAR) § 16-89-122 authorizes APRNs to independently prescribe Schedule II-V controlled substances within their role and specialty. APRNs are subject to the same telehealth requirements as physicians under HRS § 457-2 and § 457-8.6. For medical cannabis, APRNs may now certify patients via telehealth under HB 302 (2025). For opiates, APRNs are subject to the same in-person consultation requirement as physicians under HRS § 453-1.3(c).

Physician Assistants (PAs): PAs with prescriptive authority may prescribe controlled substances within their scope of practice. The proposed SB 2152/HB 2021 would have explicitly authorized out-of-state PAs to prescribe Schedule III-V substances via telehealth, but this does not appear to have been enacted. Under current law, PAs are subject to the same telehealth requirements as physicians.

Other Prescribers: HAR § 23-200-15(e) indicates that pharmacists may dispense controlled substances upon receipt of a prescription "written by a physician, dentist, podiatrist, or veterinarian." This suggests these provider types may prescribe controlled substances within their respective scopes of practice, subject to the same telehealth requirements. Hawaii pharmacists do not have independent prescriptive authority for controlled substances.

Optometrists: Hawaii optometrists have limited prescriptive authority for certain therapeutic pharmaceutical agents but generally do not prescribe controlled substances.

Ryan Haight Act Compliance:

Hawaii's requirements for opiate prescribing are more restrictive than the Ryan Haight Act, requiring an initial in-person consultation with limited exceptions. For non-opiate controlled substances, Hawaii's requirements appear to align with federal standards. The requirement that prescribers be physically located in Hawaii when issuing controlled substance prescriptions (HRS § 329-38(i)(1)) adds a state-specific geographic restriction not found in federal law.

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COVID-19 Emergency Waivers:

Hawaii has not made COVID-19 telehealth waivers permanent through state legislation. The temporary exception for 3-day opiate prescriptions (HB 951) is set to expire December 31, 2027. Hawaii's underlying restrictions on opiate prescribing via telehealth remain in effect, with only the limited 3-day exception providing temporary flexibility.

Compliance Requirements:

- Prescriber must be physically located in Hawaii when issuing controlled substance prescriptions
- For opiates: initial in-person consultation required (exception: 3-day supply or less if patient seen in-person by provider in same medical group, through December 31, 2027)
- For non-opiate controlled substances: may prescribe via telehealth without initial in-person visit, subject to standard of care
- Medical cannabis: may certify via telehealth without in-person visit
- Do not prescribe based solely on online questionnaires
- Establish bona fide provider-patient relationship via two-way interactive audio-visual technology
- Meet same standard of care as in-person encounters
- APRNs and PAs: prescribe within scope of practice and role/specialty

Primary Citations:

- Hawaii Revised Statutes § 329-38(i)(1) (Controlled substance prescriptions must originate from within the State)
- Hawaii Revised Statutes § 453-1.3(c) (Physician-patient relationship; opiate prescribing requirements)
- Hawaii Revised Statutes § 457-2 (Telehealth standards)
- Hawaii Revised Statutes § 457-8.6 (Telehealth practice requirements)
- Hawaii Administrative Rules § 16-89-122 (APRN prescriptive authority)
- Hawaii Administrative Rules § 23-200-15(e) (Pharmacy dispensing requirements)
- HB 951 (2024) - Temporary 3-day opiate exception through December 31, 2027
- HB 302 (2025) - Medical cannabis telehealth certification

Supporting Citations:

- SB 2152/HB 2021 (2022) - Proposed Schedule III-V telehealth prescribing expansion (not enacted)

Effective Dates:

- HRS § 329-38(i)(1): Currently in effect
- HRS § 453-1.3(c): Currently in effect
- HB 951 (3-day opiate exception): Effective through December 31, 2027

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- HB 302 (medical cannabis telehealth): Effective 2025
- HAR § 16-89-122 (APRN prescriptive authority): Currently in effect

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IDAHO

Regulatory Status: Explicit regulations exist**

Telehealth Controlled Substance Prescribing Authorization:

Idaho has explicit regulations governing telehealth prescribing of controlled substances through its Virtual Care Access Act (formerly Telehealth Access Act) and related statutes. Idaho Code § 54-5707 permits providers with an established provider-patient relationship to issue prescription drug orders via virtual care/telehealth, but explicitly restricts controlled substance prescribing: "the prescription drug shall not be a controlled substance unless prescribed in compliance with 21 U.S.C." This references the federal Ryan Haight Act requirements under 21 U.S.C. § 802(54).

Under the original Idaho statute (pre-2020), controlled substances could only be prescribed via telehealth if the patient was physically located in a DEA-registered hospital or clinic and treated by a DEA-registered practitioner (21 U.S.C. § 802(54)(A)). However, during the COVID-19 public health emergency, Idaho Governor Brad Little suspended these limitations through proclamation in April 2020, allowing controlled substance prescribing via telehealth to patients at home, provided compliance with federal law and HHS guidance.

Current Status (2026):

The federal COVID-19 telemedicine flexibilities for controlled substance prescribing have been extended through December 31, 2026, by DEA and HHS. This allows DEA-registered practitioners to prescribe Schedule II-V controlled substances via telemedicine without a prior in-person evaluation, provided: (1) the prescription is for a legitimate medical purpose; (2) the practitioner acts in accordance with applicable federal and state laws; and (3) other federal requirements are met.

Idaho's COVID emergency waivers for out-of-state licensure expired January 1, 2023. The state has not made the COVID telehealth waivers permanent through state legislation, but practitioners continue to benefit from federal flexibilities through December 31, 2026.

Provider-Patient Relationship Requirements:

Idaho Code § 54-1733 requires prescriptions for legend drugs (including controlled substances) to arise from "a prescriber-patient relationship which includes a documented patient evaluation adequate to establish diagnoses, if applicable, and identify underlying conditions and/or contraindications to the treatment."

A valid prescriber-patient relationship may be established through virtual care technologies, provided the applicable Idaho community standard of care is satisfied (Idaho Code § 54-1733(1) and § 54-5705). The "Idaho community standard of care" is defined as the standard that applies in in-person settings and must be met for all telehealth services (Idaho Code § 54-5706).

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Prescriptions based solely on static online questionnaires do not constitute a legitimate medical purpose and cannot establish a valid prescriber-patient relationship under Idaho law.

In-Person Examination Requirements:

Idaho law does not impose state-specific in-person examination requirements beyond federal law. The state defers to federal Ryan Haight Act requirements (21 U.S.C. § 802(54)) through Idaho Code § 54-5707. Under current federal flexibilities (through December 31, 2026), no initial in-person visit is required for controlled substance prescribing via telehealth if federal conditions are met.

Periodic Visit Requirements: No periodic in-person visit requirements are specified in Idaho law. The state requires compliance with the "Idaho community standard of care" for all telehealth services (Idaho Code § 54-5706), which is the same standard that applies in in-person settings. This means that if the standard of care for a particular condition or treatment would require periodic in-person visits, those requirements apply equally to telehealth relationships.

Virtual Examination Standards: Virtual examinations via two-way audio-visual interaction can satisfy the provider-patient relationship requirement under Idaho Code § 54-5705 and § 54-1733. The examination must include a documented patient evaluation adequate to establish diagnoses and identify underlying conditions and contraindications. The evaluation must meet the Idaho community standard of care.

Questionnaire Prohibition: Static questionnaires alone cannot establish a valid prescriber-patient relationship. Idaho Code § 54-1733 requires a documented patient evaluation, which implies interactive assessment rather than passive questionnaire completion.

Schedule-Specific and Medication-Type Restrictions:

CII vs CIII-V: Idaho law does not distinguish between Schedule II and Schedule III-V controlled substances for telehealth prescribing purposes. All controlled substances are subject to the same requirement: compliance with 21 U.S.C. § 802(54) (Idaho Code § 54-5707). Under current federal flexibilities through December 31, 2026, all schedules (II-V) may be prescribed via telehealth without schedule-specific restrictions.

Psychiatric vs. Pain Medications: No specific distinctions exist in Idaho law between psychiatric medications versus pain medications for telehealth prescribing purposes. Both categories are subject to the same requirements: establishment of a valid prescriber-patient relationship, compliance with Idaho community standard of care, and compliance with federal Ryan Haight Act requirements.

Opioid-Specific Requirements: While Idaho does not impose opioid-specific restrictions on telehealth prescribing beyond general controlled substance requirements, Idaho Code § 37-2722 requires prescribers to check the Prescription Drug Monitoring Program (PDMP) prior to issuing prescriptions for outpatient use of opioid analgesics or benzodiazepines listed in Schedule II, III, or IV. This requirement applies to all prescribing, including telehealth, and became fully enforceable after March 31, 2023. Exceptions include:

- Emergency situations
- Prescriptions for 3-day supply or less
- Prescriptions for patients in hospice care
- Prescriptions for patients in long-term care facilities

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Prescriber Type Authorization:

Idaho does not impose telehealth-specific restrictions based on prescriber type. All providers authorized to prescribe controlled substances under their respective practice acts may do so via telehealth, subject to the same requirements that apply to physicians.

Physicians: Fully authorized to prescribe controlled substances via telehealth subject to Idaho Code § 54-5707 and § 54-1733.

Physician Assistants (PAs): Idaho PAs with prescriptive authority may prescribe controlled substances within their scope of practice. Idaho Code § 54-1803 authorizes PAs to prescribe controlled substances under physician supervision. PAs may establish provider-patient relationships via telehealth and prescribe controlled substances subject to the same requirements as physicians.

Advanced Practice Registered Nurses (APRNs/NPs): Idaho grants full practice authority to APRNs. Idaho Code § 54-1402 authorizes APRNs to prescribe controlled substances independently within their scope of practice. APRNs may establish provider-patient relationships via telehealth and prescribe controlled substances subject to the same requirements as physicians.

Clinical Nurse Specialists and CRNAs: These advanced practice nurses have prescriptive authority within their scope of practice under Idaho Code § 54-1402 and may prescribe controlled substances via telehealth subject to the same requirements.

Pharmacists: Idaho pharmacists have limited prescriptive authority under collaborative practice agreements but do not have independent authority to prescribe controlled substances. Idaho Code § 54-1704 allows pharmacists to prescribe under protocol but does not extend to controlled substances.

Dentists: Idaho dentists may prescribe controlled substances within their scope of practice under Idaho Code § 54-904. They may do so via telehealth subject to the same requirements as physicians, though dental practice typically involves in-person procedures.

Optometrists: Idaho optometrists have prescriptive authority for therapeutic pharmaceutical agents under Idaho Code § 54-1505 but have limited authority regarding controlled substances. They may prescribe certain Schedule III-V controlled substances within their scope of practice.

Podiatrists: Idaho podiatrists may prescribe controlled substances within their scope of practice under Idaho Code § 54-604. They may do so via telehealth subject to the same requirements as physicians.

Veterinarians: Idaho veterinarians may prescribe controlled substances for animal patients under Idaho Code § 54-2106. Veterinary telemedicine is subject to the same requirements as human medicine under Idaho's Virtual Care Access Act.

Ryan Haight Act Compliance:

Idaho explicitly requires compliance with the federal Ryan Haight Act through Idaho Code § 54-5707, which states that controlled substances may not be prescribed via telehealth "unless prescribed in compliance with 21 U.S.C." This direct reference to federal law means that Idaho adopts federal Ryan Haight Act requirements without modification.

Under the current federal flexibility period (through December 31, 2026), practitioners may prescribe controlled substances via telemedicine without meeting the Ryan Haight Act's in-person examination requirement, provided they comply with DEA and HHS guidance. After December 31, 2026, unless federal flexibilities are extended, Idaho practitioners will need to comply with the full

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Ryan Haight Act requirements, including one of the seven statutory exceptions for prescribing without an in-person visit.

COVID-19 Emergency Waivers:

Idaho Governor Brad Little issued emergency proclamations in April 2020 suspending Idaho's controlled substance telehealth restrictions to align with federal COVID-19 public health emergency flexibilities. These gubernatorial waivers allowed controlled substance prescribing via telehealth to patients at home, rather than requiring patients to be at DEA-registered facilities.

Idaho's COVID emergency waivers for out-of-state licensure expired January 1, 2023. The state has not made the COVID telehealth waivers permanent through state legislation. However, Idaho practitioners continue to benefit from federal COVID-19 telemedicine flexibilities through December 31, 2026, because Idaho Code § 54-5707 requires compliance with federal law (21 U.S.C.), which currently includes the federal flexibility provisions.

After December 31, 2026, unless federal flexibilities are extended or Idaho enacts permanent state-level changes, controlled substance prescribing via telehealth will revert to strict Ryan Haight Act compliance, likely requiring patients to be physically present at DEA-registered facilities for telehealth-based controlled substance prescribing (unless another Ryan Haight exception applies).

Compliance Requirements:

- Through December 31, 2026: Comply with federal COVID-19 telemedicine flexibilities
- Establish valid prescriber-patient relationship via documented patient evaluation
- Meet Idaho community standard of care (same as in-person standard)
- Comply with 21 U.S.C. § 802(54) (Ryan Haight Act)
- Check Idaho PDMP before prescribing Schedule II-IV opioid analgesics or benzodiazepines (with limited exceptions)
- Do not prescribe based solely on online questionnaires
- Ensure prescriptions are for legitimate medical purposes
- Use two-way interactive audio-visual technology (not audio-only) for controlled substance prescribing
- Maintain documentation adequate to establish diagnoses and identify contraindications
- After December 31, 2026: Comply with full Ryan Haight Act requirements unless federal flexibilities extended

Primary Citations:

- Idaho Code § 54-5707 (Virtual care prescription requirements; controlled substance restrictions)
- Idaho Code § 54-1733 (Prescriber-patient relationship requirements)
- Idaho Code § 54-5705 (Virtual Care Access Act definitions)
- Idaho Code § 54-5706 (Idaho community standard of care requirement)
- Idaho Code § 37-2722 (PDMP check requirement for opioids and benzodiazepines)
- Idaho Code § 54-1803 (Physician assistant prescriptive authority)

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- Idaho Code § 54-1402 (APRN prescriptive authority)
- Idaho Code § 54-904 (Dentist prescriptive authority)
- Idaho Code § 54-1505 (Optometrist prescriptive authority)
- Idaho Code § 54-604 (Podiatrist prescriptive authority)
- Idaho Code § 54-2106 (Veterinarian prescriptive authority)
- Idaho Code § 54-1704 (Pharmacist collaborative practice authority)
- 21 U.S.C. § 802(54) (Federal Ryan Haight Act definition of valid prescription)

Supporting Citations:

- Idaho Governor Brad Little Emergency Proclamation (April 2020) - COVID-19 telehealth flexibilities
- DEA/HHS COVID-19 Telemedicine Flexibility Extension through December 31, 2026

Effective Dates:

- Idaho Virtual Care Access Act (formerly Telehealth Access Act): Currently in effect
- Idaho Code § 37-2722 (PDMP check requirement): Fully enforceable after March 31, 2023
- Federal COVID-19 telemedicine flexibilities: Through December 31, 2026
- Idaho COVID emergency waivers for out-of-state licensure: Expired January 1, 2023
- Idaho Code § 54-5707 controlled substance provisions: Currently in effect, incorporating federal law by reference

Illinois, Indiana, Iowa

ILLINOIS

Regulatory Status: No explicit state-specific regulations governing telehealth prescribing of controlled substances beyond federal standards**

Telehealth Controlled Substance Prescribing Framework:

Illinois does not impose state-level restrictions on telehealth prescribing of controlled substances beyond federal requirements. The state's approach relies primarily on the federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008 and DEA regulations, combined with general telehealth and controlled substances statutes that do not distinguish between in-person and telehealth prescribing modalities.

Under current federal law, as extended through December 31, 2026 via the DEA's Fourth Temporary Extension (published December 31, 2025), DEA-registered practitioners may prescribe Schedule II-V controlled substances via telehealth without a prior in-person examination, provided the prescription is for a legitimate medical purpose and the practitioner acts in accordance with applicable state law. This represents a temporary COVID-19 flexibility that has been extended multiple times.

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In-Person Examination Requirements:

Illinois imposes no state-level in-person examination requirements for controlled substance prescribing via telehealth. The state does not require:

- Initial in-person visits before prescribing controlled substances via telehealth
- Periodic in-person visits (annual, biannual, or otherwise)
- Specific physical examination elements beyond standard of care
- Mandatory questionnaires or assessment tools

Virtual examinations conducted via appropriate telehealth technology satisfy all state requirements, provided practitioners maintain the same standard of care required for in-person services. The Illinois Telehealth Act (225 ILCS 150/) requires practitioners to maintain equivalent standards of care for telehealth services as for in-person services but contains no controlled substance-specific provisions.

Practitioners must follow federal Ryan Haight Act requirements, which currently (through December 31, 2026) do not require an initial in-person examination for controlled substance prescribing via telehealth under the temporary DEA flexibilities.

Schedule-Specific and Medication-Type Rules:

Illinois does not impose different telehealth requirements based on:

- Controlled substance schedule (no distinction between Schedule II and Schedules III-V)
- Medication type (psychiatric medications vs. pain medications)
- Specific drug categories (no opioid-specific telehealth restrictions at state level)

However, general prescribing limitations apply regardless of modality:

- Schedule II substances have more restrictive requirements (no refills permitted, 30-day supply limits for certain mid-level practitioners)
- All controlled substance prescribing must comply with standard prescribing practices and documentation requirements
- Federal DEA flexibilities apply equally to all Schedule II-V substances through December 31, 2026

Prescriber Type Authorization:

The following practitioners may prescribe controlled substances via telehealth in Illinois, subject to their scope of practice and federal requirements:

Advanced Practice Registered Nurses (APRNs):

- May prescribe Schedule III-V controlled substances with a collaborative agreement
- Schedule II substances may be prescribed if: (a) delegated by collaborating physician; (b) APRN has completed 45 graduate hours in pharmacology; and (c) specific Schedule II substances are designated in the collaborative agreement
- APRNs with full practice authority (4,000 hours clinical experience and 250 hours continuing education) may prescribe without a written collaborative agreement but must consult with a physician for Schedule II narcotics and benzodiazepines

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- Effective January 1, 2024, consultation requirements were modified for experienced APRNs
- This category includes Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs)

Physician Assistants (PAs):

- May prescribe Schedule II-V controlled substances when delegated authority by a collaborating physician through a written collaborative agreement
- Schedule II prescriptions are limited to 30-day supplies; continuation requires prior approval from the collaborating physician
- As of July 1, 2024, PAs with certain experience levels may practice without written collaborative agreements in some settings
- Must maintain appropriate supervision/collaboration relationships as specified in their practice agreements

Physicians (MD/DO):

- Full prescribing authority for all controlled substances within scope of practice
- No additional restrictions for telehealth prescribing beyond standard of care requirements

Dentists:

- May prescribe controlled substances within dental scope of practice
- Same telehealth standards apply as for physicians

Veterinarians:

- May prescribe controlled substances for animal patients within veterinary scope of practice
- Subject to same telehealth requirements

Podiatrists:

- May prescribe controlled substances within podiatric scope of practice
- No additional telehealth-specific restrictions

Optometrists:

- May prescribe controlled substances within optometric scope of practice (typically limited schedules and drug types)
- Subject to general telehealth standards

Prescribing Psychologists:

- Licensed under Section 4.2 of the Clinical Psychologist Licensing Act may prescribe controlled substances
- Must meet specific training and certification requirements for prescriptive authority

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Pharmacists:

- Illinois law does NOT authorize pharmacists to prescribe controlled substances
- Pharmacists may not issue controlled substance prescriptions via telehealth or any other modality

Ryan Haight Act Compliance:

Illinois practitioners must comply with federal Ryan Haight Act requirements (21 U.S.C. § 829). The state has not enacted modifications to federal requirements but incorporates them by reference. Under current federal temporary extensions (effective through December 31, 2026), practitioners may prescribe controlled substances via telehealth without meeting one of the seven Ryan Haight Act exceptions, provided:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice
- The practitioner is DEA-registered
- The prescription complies with applicable state law
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system

After December 31, 2026, unless further extended, practitioners will need to meet one of the seven statutory exceptions under 21 U.S.C. § 829(e) to prescribe controlled substances via telemedicine without an in-person medical evaluation.

COVID-19 Emergency Waivers:

Illinois did not enact state-specific COVID-19 emergency waivers for controlled substance prescribing via telehealth. The state relies on federal DEA temporary flexibilities, which have been extended through December 31, 2026. These federal flexibilities have not been made permanent at either the federal or state level.

The Illinois Department of Financial and Professional Regulation (IDFPR) issued emergency rules during the COVID-19 pandemic expanding general telehealth access, but these did not create specific controlled substance prescribing exceptions beyond federal allowances.

Compliance Requirements:

- Maintain DEA registration and Illinois controlled substance license
- Comply with federal Ryan Haight Act requirements and current DEA temporary extensions
- Establish and maintain appropriate provider-patient relationship via telehealth
- Maintain same standard of care as required for in-person services (225 ILCS 150/)
- Create and maintain appropriate medical records for all telehealth encounters
- For mid-level practitioners: maintain required collaborative agreements or supervision arrangements
- Comply with Illinois Prescription Monitoring Program (PMP) requirements for checking and reporting controlled substance prescriptions
- Follow scope of practice limitations for each practitioner type

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- Ensure appropriate technology for telehealth encounters (audio-visual capability recommended)
- Comply with HIPAA and state privacy/security requirements for telehealth communications

Primary Citations:

- Illinois Telehealth Act, 225 ILCS 150/
- Illinois Controlled Substances Act, 720 ILCS 570/
- 720 ILCS 570/303.05 (authorized prescribers of controlled substances)
- Nurse Practice Act, 225 ILCS 65/, specifically § 65-35 (APRN prescribing authority)
- Physician Assistant Practice Act, 225 ILCS 95/, specifically § 7.5 (PA prescribing authority)
- Federal Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 829
- DEA regulations, 21 CFR § 1300 et seq.

Supporting Citations:

- DEA Fourth Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications (published December 31, 2025, effective through December 31, 2026)
- Clinical Psychologist Licensing Act, 225 ILCS 15/4.2
- Illinois Department of Financial and Professional Regulation guidance on telehealth
- Illinois Prescription Monitoring Program statutes

Effective Dates:

- Illinois Telehealth Act: Originally enacted 2009, amended multiple times, most recently 2021
- APRN full practice authority provisions: January 1, 2024 (modifications to consultation requirements)
- PA collaborative agreement modifications: July 1, 2024
- Federal DEA temporary flexibilities: Currently extended through December 31, 2026
- General controlled substance prescribing statutes: Various dates, with ongoing amendments

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INDIANA

Regulatory Status: Explicit statutory regulations governing telehealth prescribing of controlled substances**

Telehealth Controlled Substance Prescribing Framework:

Indiana has comprehensive statutory regulations explicitly authorizing telehealth prescribing of controlled substances under Indiana Code § 25-1-9.5-8. This statute, enacted in 2017 and

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significantly amended in 2019 (P.L.51-2019, P.L.28-2019), permits controlled substance prescribing via telehealth without requiring a prior in-person examination, subject to specific conditions and with notable restrictions on opioid prescribing.

Indiana Code § 25-1-9.5-8(b) explicitly states that prescribers may issue prescriptions for controlled substances (Schedules II-V) to patients receiving telehealth services, even if the patient has not been examined previously by the prescriber in person. This represents one of the more permissive state approaches to telehealth controlled substance prescribing, though with significant opioid-specific limitations.

In-Person Examination Requirements:

Indiana does NOT require mandatory in-person examinations for controlled substance prescribing via telehealth. The 2019 amendments removed the previous requirement (from the 2017 version) that had mandated an in-person examination by a licensed Indiana health care provider with an established treatment plan.

Current law does NOT require:

- Initial in-person visits before prescribing controlled substances
- Periodic in-person visits (annual, biannual, or otherwise)
- Specific physical examination elements beyond standard of care
- Mandatory follow-up in-person examinations

Virtual examinations conducted via audiovisual technology fully satisfy Indiana's requirements for establishing a provider-patient relationship and conducting necessary medical evaluations.

Provider-Patient Relationship Requirements:

While no in-person examination is mandated, Indiana law requires establishment of a proper provider-patient relationship through telehealth, which must include:

- Obtaining and verifying patient identity and location
- Disclosing practitioner credentials and contact information
- Obtaining informed consent for telehealth services
- Obtaining relevant medical history
- Discussing diagnosis, treatment options, and risks/benefits
- Creating and maintaining appropriate medical records
- Providing follow-up care instructions and availability information

Prohibited Practices:

Indiana Code § 25-1-9.5-8 prohibits prescribing controlled substances based solely on:

- Online questionnaires without interactive communication
- Asynchronous communications that do not allow for real-time clinical assessment
- Communications that do not meet the audiovisual, real-time, two-way interactive standard

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Schedule-Specific and Medication-Type Rules:

Indiana's regulations contain significant schedule-specific and medication-type distinctions:

General Controlled Substances (All Schedules II-V):

All schedules may be prescribed via telehealth under IC § 25-1-9.5-8(b) if statutory conditions are met, with the critical exception of opioids (see below).

Opioid-Specific Restrictions:

Indiana Code § 25-1-9.5-8(a)(3)(B) contains a categorical restriction: prescriptions issued via telehealth generally CANNOT be for opioids, EXCEPT when the opioid is a partial agonist (such as buprenorphine) used to treat or manage opioid dependence.

This creates:

- **Prohibited:** Telehealth prescribing of opioids for pain management (including hydrocodone, oxycodone, morphine, fentanyl, tramadol, etc.)
- **Permitted:** Telehealth prescribing of buprenorphine and similar partial agonists for medication-assisted treatment (MAT) of opioid use disorder

This is one of the most significant opioid-specific telehealth restrictions in the United States and effectively prohibits telemedicine pain management involving opioid analgesics.

Non-Opioid Controlled Substances:

Controlled substances that are not opioids may be prescribed via telehealth without the categorical restriction, including:

- Benzodiazepines (alprazolam, diazepam, lorazepam, etc.)
- Stimulants for ADHD (amphetamine, methylphenidate, etc.)
- Non-opioid Schedule II-V substances used in psychiatric treatment
- Other controlled substances within prescriber's scope of practice

No CII vs. CIII-V Distinction:

Beyond the opioid restriction, Indiana does not differentiate between Schedule II and Schedules III-V controlled substances for telehealth prescribing purposes.

Technology Requirements for Controlled Substances:

Indiana Code § 25-1-9.5-8(b) requires that telehealth communication for controlled substance prescribing be conducted using:

- Audiovisual technology (both audio and video components required)
- Real-time, two-way interactive communication system
- Audio-only communication is INSUFFICIENT for controlled substance prescribing

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Prescriber Type Authorization:

Indiana Code § 25-1-9.3-5 defines "prescriber" broadly to include multiple practitioner types. The following may prescribe controlled substances via telehealth if they have prescriptive authority under their scope of practice and meet all statutory conditions:

Physicians (MD/DO):

- Full prescribing authority for all controlled substances (subject to opioid telehealth restriction)
- Must maintain Indiana medical license and DEA registration
- Must comply with all IC § 25-1-9.5-8 requirements

Advanced Practice Registered Nurses (APRNs):

- Includes Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs)
- Licensed under IC § 25-23 with prescriptive authority granted
- May prescribe controlled substances via telehealth (subject to opioid restriction and scope of practice)
- Must maintain collaborative practice agreements as required by Indiana law
- Must have separate DEA registration for controlled substance prescribing

Physician Assistants (PAs):

- Licensed under IC § 25-27.5 with prescribing authority granted by supervising physician
- May prescribe controlled substances via telehealth when delegated by supervising physician
- Subject to supervision requirements and scope of practice limitations
- Must maintain DEA registration

Dentists:

- Licensed under IC § 25-14
- May prescribe controlled substances within dental scope of practice
- Subject to same telehealth requirements (including opioid restriction)

Podiatrists:

- Licensed under IC § 25-29
- May prescribe controlled substances within podiatric scope of practice via telehealth
- Subject to all statutory requirements

Optometrists:

- Licensed with therapeutic certification under IC § 25-24
- May prescribe controlled substances within optometric scope of practice (typically limited)
- Subject to telehealth requirements

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Veterinarians:

- Licensed under IC § 25-38.1
- May prescribe controlled substances for animal patients via telehealth
- Subject to same statutory framework

Pharmacists:

- NOT authorized to prescribe controlled substances under Indiana law
- May not issue controlled substance prescriptions via telehealth or any modality
- May prescribe certain non-controlled medications under protocol or collaborative practice agreements, but not controlled substances

Conditions for Telehealth Controlled Substance Prescribing:

Under IC § 25-1-9.5-8(b), ALL of the following conditions must be met:

1. Prescriber maintains valid controlled substance registration under IC § 35-48-3 (Indiana controlled substance registration)
2. Prescriber meets conditions set forth in 21 U.S.C. § 829 et seq. (federal Ryan Haight Act requirements)
3. Practitioner acts in usual course of professional practice for legitimate medical purpose
4. Telehealth communication conducted using audiovisual, real-time, two-way interactive communication system
5. Prescriber complies with INSPECT program requirements (IC § 25-26-24) - Indiana's prescription drug monitoring program, including:
    - Checking INSPECT database before prescribing controlled substances
    - Reporting all controlled substance prescriptions to INSPECT
6. All other applicable federal and state laws followed
7. Prescription must be prescribed and dispensed in accordance with IC § 25-1-9.3 (electronic prescribing requirements) and IC § 25-26-24

Ryan Haight Act Compliance:

Indiana explicitly incorporates federal Ryan Haight Act requirements by reference in IC § 25-1-9.5-8(b)(2), requiring prescribers to "meet the conditions set forth in 21 U.S.C. § 829 et seq."

Under current federal law (extended through December 31, 2026), practitioners may prescribe controlled substances via telehealth without meeting one of the seven statutory Ryan Haight exceptions, provided they comply with DEA temporary flexibilities. Indiana law does not modify or create exceptions to federal Ryan Haight requirements but incorporates them as a condition of lawful telehealth prescribing.

After federal temporary flexibilities expire (currently December 31, 2026), Indiana practitioners will need to comply with standard Ryan Haight Act requirements, including meeting one of the seven exceptions for telemedicine prescribing without an in-person medical evaluation, unless federal law is further modified.

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INSPECT (Prescription Drug Monitoring Program) Requirements:

Indiana Code § 25-26-24 requires prescribers to:

- Register with and access the INSPECT database
- Check INSPECT before prescribing controlled substances (with limited exceptions)
- Report all controlled substance prescriptions to INSPECT within specified timeframes
- These requirements apply equally to telehealth and in-person prescribing

COVID-19 Emergency Waivers:

Indiana did not enact state-specific COVID-19 emergency waivers for controlled substance prescribing via telehealth beyond what was already permitted under IC § 25-1-9.5-8. The state's 2019 amendments (which took effect before the COVID-19 pandemic) already provided broad authority for telehealth controlled substance prescribing.

Indiana's existing statutory framework was sufficiently permissive that additional emergency waivers were not necessary. The state relies on federal DEA temporary flexibilities (extended through December 31, 2026) for Ryan Haight Act compliance.

No COVID-19 emergency provisions have been made permanent because the underlying statute already permits telehealth controlled substance prescribing (subject to the opioid restriction).

Compliance Requirements:

- Maintain valid Indiana professional license and DEA registration
- Maintain Indiana controlled substance registration (IC § 35-48-3)
- Comply with federal Ryan Haight Act requirements (21 U.S.C. § 829)
- Use audiovisual, real-time, two-way interactive communication technology
- Establish proper provider-patient relationship through telehealth encounter
- Obtain patient identity, location, informed consent, and medical history
- Do NOT prescribe opioids via telehealth except buprenorphine for opioid use disorder treatment
- Check INSPECT database before prescribing controlled substances
- Report all controlled substance prescriptions to INSPECT
- Maintain appropriate medical records for all telehealth encounters
- Act within scope of practice and usual course of professional practice
- Prescribe only for legitimate medical purposes
- For mid-level practitioners: maintain required supervision/collaboration arrangements
- Comply with electronic prescribing requirements (IC § 25-1-9.3)
- Follow all other applicable state and federal controlled substance laws

Primary Citations:

- Indiana Code § 25-1-9.5-8 (telehealth prescribing of controlled substances)

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- Indiana Code § 25-1-9.5 (general telehealth provisions)
- Indiana Code § 25-1-9.3-5 (definition of "prescriber")
- Indiana Code § 25-1-9.3 (electronic prescribing requirements)
- Indiana Code § 35-48-3 (controlled substance registration)
- Indiana Code § 25-26-24 (INSPECT program requirements)
- Indiana Code § 25-23 (Nursing Act - APRN provisions)
- Indiana Code § 25-27.5 (Physician Assistant Act)
- Indiana Code § 25-14 (Dentistry Act)
- Indiana Code § 25-29 (Podiatry Act)
- Indiana Code § 25-24 (Optometry Act)
- Indiana Code § 25-38.1 (Veterinary Medicine Act)
- Federal Ryan Haight Act, 21 U.S.C. § 829

Supporting Citations:

- P.L.51-2019 (2019 amendments removing in-person examination requirement)
- P.L.28-2019 (2019 amendments to telehealth provisions)
- DEA temporary COVID-19 flexibilities (extended through December 31, 2026)
- Indiana Board of Pharmacy regulations
- Indiana Professional Licensing Agency guidance

Effective Dates:

- IC § 25-1-9.5-8 originally enacted: 2017
- Major amendments removing in-person requirement: 2019 (P.L.51-2019, P.L.28-2019)
- Current version: Effective since 2019 amendments
- INSPECT requirements: Various dates, with ongoing updates
- Federal DEA temporary flexibilities: Extended through December 31, 2026

IOWA

Regulatory Status: Explicit regulations governing telehealth prescribing of controlled substances, though without additional restrictions beyond federal requirements and general telemedicine standards**

Telehealth Controlled Substance Prescribing Framework:

Iowa permits telehealth prescribing of controlled substances (Schedules II-V) by properly licensed and registered practitioners. The state has established comprehensive telemedicine standards that apply to controlled substance prescribing but does not impose categorical prohibitions or additional restrictions beyond federal requirements and standard of care obligations.

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Iowa Admin. Code § 653-13.9 establishes telemedicine standards for physicians, and similar standards apply to other practitioner types. Iowa Admin. Code § 657-10.3(124) requires individual practitioners located outside of Iowa who are prescribing controlled substances via telehealth services to patients located in Iowa to register with the Iowa Board of Pharmacy for a Controlled Substances Act (CSA) registration.

Iowa's approach emphasizes that the same laws and regulations that apply to prescribing controlled substances by means of in-person contact apply to prescribing by means of telemedicine, with the critical requirement that the standard of care must be met.

In-Person Examination Requirements:

Iowa does NOT mandate specific in-person examination requirements for telehealth prescribing of controlled substances beyond the standard of care requirement.

Key Provisions:

Under Iowa Admin. Code § 653-13.9(8), "the medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person."

Prior to providing treatment, including issuing prescriptions, a licensee who uses telemedicine must:

- Interview the patient to collect relevant medical history
- Perform a physical examination "when medically necessary, sufficient for the diagnosis and treatment of the patient"

The determination of whether an in-person examination is necessary is based on the standard of care for the particular condition being treated and the technology available. Virtual examinations via appropriate audiovisual technology can satisfy examination requirements if the standard of care permits.

No Periodic In-Person Requirements:

Iowa does not specify mandatory periodic in-person visit requirements (annual, biannual, or otherwise) for ongoing controlled substance prescribing via telehealth. Ongoing care decisions are governed by the standard of care for the condition being treated.

Physician-Patient Relationship Requirements:

A valid physician-patient relationship must be established before prescribing controlled substances via telehealth. Iowa Admin. Code § 653-13.9(7) specifies that a valid relationship can be accomplished through:

1. **In-person encounter** between the physician and patient
2. **Consultation with another licensee** who has an established relationship with the patient and has agreed to supervise or coordinate care
3. **Telemedicine encounter** if the standard of care does not require an in-person encounter

This provides flexibility for establishing relationships entirely through telemedicine when clinically appropriate.

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Prohibited Practices:

Iowa explicitly prohibits certain practices that do not constitute acceptable telemedicine:

Internet Questionnaires:

Prescribing based solely on an Internet questionnaire does NOT constitute an acceptable medical interview. Iowa Admin. Code § 653-13.9(8) defines an Internet questionnaire as "a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview."

Telephonic-Only Evaluation:

Prescribing based solely on telephonic evaluation (audio-only) is prohibited absent a valid physician-patient relationship, with limited exceptions. Iowa Admin. Code § 653-13.9(21).

Interactive Communication Required:

Acceptable telemedicine must involve adaptive, interactive, and responsive communication between practitioner and patient, not merely static questionnaires or one-way information transmission.

Schedule-Specific and Medication-Type Rules:

Iowa does NOT differentiate between controlled substance schedules for telehealth prescribing purposes:

- No distinction between Schedule II and Schedules III-V
- No categorical differences between CII and CIII-V prescribing requirements
- All schedules (II-V) may be prescribed via telehealth if standard of care is met

No Medication-Type Distinctions:

Iowa does not distinguish between:

- Psychiatric medications vs. pain medications
- Opioids vs. non-opioids
- Stimulants vs. other controlled substances

The same telemedicine standards apply to all controlled substances regardless of therapeutic category. The determining factor is whether the standard of care for the particular condition and medication can be met through telemedicine technology.

Electronic Prescribing Requirement:

Iowa Code § 124.308 requires electronic prescribing of ALL controlled substances (effective January 1, 2020) unless specifically exempted. This requirement applies equally to prescriptions issued via telehealth and in-person encounters.

Limited exceptions exist for:

- Prescriptions issued when electronic prescribing is temporarily unavailable due to technical failure

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- Prescriptions issued by practitioners who have received waivers due to economic hardship, technological limitations, or other exceptional circumstances
- Prescriptions issued in emergency situations
- Prescriptions for patients in hospice or long-term care facilities

Prescriber Type Authorization:

Iowa permits multiple practitioner types to prescribe controlled substances via telehealth, with each subject to their scope of practice and licensing requirements:

Advanced Practice Registered Nurses (ARNPs/Nurse Practitioners):

- Full prescriptive authority including controlled substances up to Schedule II
- Iowa has full practice authority for NPs (no physician supervision required)
- Iowa Admin. Code § 655-6.4 governs ARNP telehealth practice
- ARNPs must register with the Iowa Board of Pharmacy and DEA to prescribe controlled substances
- May establish provider-patient relationships through telemedicine
- Subject to same telemedicine standards as physicians (Iowa Admin. Code § 655-6.4 incorporates physician telemedicine standards by reference)

Physician Assistants (PAs):

- May prescribe controlled substances Schedules II-V
- Iowa Code § 147.107 and § 148C.3 authorize PA prescribing authority
- May prescribe via telehealth following the same standards as physicians
- Iowa Admin. Code § 481-781.6 establishes PA telemedicine standards similar to physician standards
- Must practice under physician supervision as required by Iowa law
- Must maintain DEA registration for controlled substance prescribing

Certified Registered Nurse Anesthetists (CRNAs) and Clinical Nurse Specialists (CNSs):

- As advanced practice registered nurses, they have prescriptive authority within their scope of practice
- May prescribe controlled substances via telehealth subject to same standards as other ARNPs
- Must maintain appropriate registrations and licenses

Physicians (MD/DO):

- Full prescribing authority for all controlled substances within scope of practice
- Subject to telemedicine standards in Iowa Admin. Code § 653-13.9
- No additional restrictions for telehealth prescribing beyond standard of care

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Dentists:

- May prescribe controlled substances within dental scope of practice
- Subject to telemedicine standards applicable to their profession
- Must maintain DEA registration

Podiatrists:

- May prescribe controlled substances within podiatric scope of practice
- Subject to telemedicine standards
- Must maintain appropriate licenses and registrations

Optometrists:

- May prescribe controlled substances within optometric scope of practice (typically limited schedules and drug types)
- Subject to scope of practice limitations under Iowa optometry law
- Must maintain appropriate certifications for therapeutic pharmaceutical agents

Veterinarians:

- May prescribe controlled substances for animal patients
- Subject to telemedicine standards for veterinary practice
- Must maintain DEA registration

Pharmacists:

- Iowa law does NOT authorize pharmacists to independently prescribe controlled substances
- Pharmacists may not issue controlled substance prescriptions via telehealth or any other modality
- Pharmacists may prescribe certain non-controlled medications under collaborative practice agreements or protocols, but not controlled substances

Psychologists:

- Iowa does NOT grant prescriptive authority to psychologists
- Psychologists may not prescribe controlled substances via telehealth or in-person

Telemedicine Technology Standards:

Iowa Admin. Code § 653-13.9 establishes technology standards for telemedicine encounters involving prescribing:

Acceptable Technology:

- Real-time audiovisual communication systems that allow interactive consultation
- Store-and-forward technology when appropriate for the clinical situation (though typically not sufficient for controlled substance prescribing)

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• Remote patient monitoring when integrated with interactive communication

Insufficient Technology:

• Audio-only telephone calls (except in limited circumstances with established relationships)

• Email or text messaging alone

• Static online questionnaires without interactive follow-up

Documentation Requirements:

Iowa Admin. Code § 653-13.9 requires comprehensive documentation for telemedicine encounters, including:

• Patient identity verification and location

• Medical history obtained

• Physical examination findings (when examination performed)

• Diagnosis and treatment plan

• Prescriptions issued

• Follow-up instructions

• Technology modality used

• Any consultations with other providers

Ryan Haight Act Compliance:

Iowa incorporates federal Ryan Haight Act requirements by requiring compliance with all applicable federal laws. Iowa practitioners prescribing controlled substances via telehealth must comply with 21 U.S.C. § 829 and DEA regulations.

Under current federal law (extended through December 31, 2026), practitioners may prescribe controlled substances via telehealth without meeting one of the seven statutory Ryan Haight exceptions, provided they comply with DEA temporary flexibilities. Iowa has not enacted state-level modifications to Ryan Haight requirements.

After federal temporary flexibilities expire (currently December 31, 2026), Iowa practitioners will need to comply with standard Ryan Haight Act requirements unless federal law is further modified. Iowa's standard of care approach means that practitioners must meet whatever federal requirements are in effect at the time of prescribing.

COVID-19 Emergency Waivers:

Iowa enacted temporary emergency measures during the COVID-19 pandemic that expanded general telehealth access, but these were largely consistent with the state's existing permissive telemedicine framework.

Key COVID-19 Provisions:

• Governor's proclamations temporarily expanded telehealth reimbursement and access

• Allowed audio-only telehealth for certain services during the emergency (though controlled substance prescribing still required higher standards)

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- Facilitated out-of-state practitioner licensure for telehealth services

Current Status:

Most COVID-19 emergency provisions have expired, and Iowa has returned to its standard telemedicine framework established in Iowa Admin. Code § 653-13.9 and related provisions. However, some telehealth expansions were made permanent through legislation:

- Iowa Code § 135.171 (enacted 2020, amended 2021) established permanent telehealth parity requirements for insurance coverage
- Expanded Medicaid telehealth coverage was made permanent in certain circumstances

For controlled substance prescribing specifically, Iowa relies on federal DEA temporary flexibilities (extended through December 31, 2026) rather than state-specific COVID waivers. The state's existing framework was already permissive enough that additional state waivers were not necessary.

Compliance Requirements:

- Maintain valid Iowa professional license (or appropriate out-of-state license with Iowa telehealth registration)
- Maintain DEA registration for controlled substance prescribing
- Register with Iowa Board of Pharmacy for controlled substance prescribing (Iowa Admin. Code § 657-10.3)
- Establish valid provider-patient relationship (in-person, through consultation, or via telemedicine if appropriate)
- Conduct medical interview and examination sufficient for diagnosis and treatment
- Use appropriate technology (audiovisual, real

Kansas, Kentucky, Louisiana

KANSAS

Regulatory Status:** Explicit regulations exist

Telehealth Controlled Substance Prescribing Permitted:

Kansas explicitly permits prescribing controlled substances via telemedicine with full parity to in-person prescribing. K.A.R. 100-77-3 establishes the foundational principle: "The same laws and regulations that apply to a healthcare provider prescribing drugs, including controlled substances, by means of in-person contact with a patient shall apply to prescribing drugs, including controlled substances, by means of telemedicine." This regulation creates complete equivalency between telehealth and in-person controlled substance prescribing, making Kansas one of the more permissive states for telehealth CS prescribing.

The Kansas Telemedicine Act, enacted in 2018 and effective January 1, 2019, provides the statutory framework supporting this regulatory approach.

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In-Person Examination Requirements:

Kansas does NOT require an initial or periodic in-person examination for telehealth prescribing of controlled substances under state law. The regulation establishes that telemedicine may be used to establish a valid provider-patient relationship (K.S.A. § 40-2,212(b)).

Physicians must conduct "an appropriate assessment and evaluation of the patient's current condition and document the appropriate medical indication for any prescription issued" (K.S.A. § 65-28,135), but this assessment may be conducted entirely via telemedicine without any in-person visit requirement.

Virtual Examination Standards:

Virtual exams via real-time, two-way interactive audio-visual communications can satisfy all examination requirements. The Kansas Telemedicine Act defines telemedicine as requiring "real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology" (K.S.A. § 40-2,211(5)).

Kansas regulations explicitly prohibit prescribing based solely on internet-based questionnaires. K.A.R. § 68-2-20(2) defines "legitimate medical purpose" as requiring a valid preexisting patient-prescriber relationship rather than one established through an internet-based questionnaire alone. However, a proper telehealth clinical evaluation with real-time interaction fully satisfies the examination requirement.

No periodic in-person visits are required for ongoing controlled substance prescribing via telehealth. Once a valid provider-patient relationship is established via telemedicine, it may be maintained through continued telehealth encounters.

Schedule-Specific Rules:

Kansas does NOT differentiate between Schedule II and Schedule III-V controlled substances in its telehealth prescribing regulations. The parity principle in K.A.R. 100-77-3 applies uniformly to all controlled substances (Schedules II-V).

There are no specific distinctions for psychiatric medications versus pain medications in the telehealth context. Kansas does not impose opioid-specific restrictions for telehealth prescribing beyond general prescribing requirements that apply equally to in-person and telehealth encounters.

K.S.A. § 65-2837a restricts prescribing of certain amphetamines and sympathomimetic amines in Schedules II-IV to specific medical conditions, but this restriction applies equally to in-person and telehealth prescribing and is not a telehealth-specific limitation.

Prescriber Type Restrictions:

Kansas regulations permit various healthcare providers to prescribe controlled substances via telehealth within their scope of practice. The key principle is that K.A.R. 100-77-3 applies the same standards to all "healthcare providers," meaning any provider authorized to prescribe controlled substances in-person may do so via telehealth.

Physicians (MDs/DOs):** May prescribe all controlled substances (Schedules II-V) via telehealth without restriction beyond general prescribing standards.

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Physician Assistants (PAs):** May prescribe Schedule III, IV, or V controlled substances via telehealth "orally, telephonically, electronically, or in writing" within their scope of practice under physician supervision (K.A.R. § 100-28a-13). PAs in Kansas cannot prescribe Schedule II controlled substances.

Advanced Practice Registered Nurses (APRNs/NPs):** As of 2022 (HB 2279), APRNs have independent prescriptive authority for controlled substances without requiring written protocols with physicians. They may "prescribe, procure, or administer any drug that is a controlled substance in accordance with the uniform controlled substances act" (Kan. Admin. Regs. § 60-11-104(a)). This includes full authority to prescribe Schedules II-V via telehealth.

Clinical Nurse Specialists:** Included under the APRN category with the same prescriptive authority as nurse practitioners.

CRNAs (Certified Registered Nurse Anesthetists):** Subject to separate provisions under K.S.A. 65-1151 to 65-1164 regarding anesthetic agents. May prescribe within their scope of practice.

Certified Nurse Midwives (CNM-I):** Independent CNM-Is may prescribe drugs and controlled substances for services limited to normal, uncomplicated pregnancy and delivery (K.S.A. 65-28b02(c); K.S.A. 65-28b10).

Pharmacists:** Do NOT have prescriptive authority in Kansas and cannot prescribe controlled substances via any modality.

Optometrists:** May prescribe within their scope of practice, subject to the same telehealth standards as physicians.

Dentists:** May prescribe within their scope of practice, subject to the same telehealth standards.

Podiatrists:** May prescribe within their scope of practice, subject to the same telehealth standards.

Veterinarians:** May prescribe within veterinary scope of practice, subject to the same telehealth standards.

Chiropractors and Naturopaths:** Prohibited from prescribing controlled substances in Kansas under any circumstances.

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Ryan Haight Act Compliance:

Kansas regulations operate in conjunction with federal Ryan Haight Act requirements. While Kansas state law does not require an in-person examination for telehealth CS prescribing, prescribers must still comply with federal requirements, including DEA registration and Ryan Haight Act exceptions (such as the public health emergency exception or practice at a DEA-registered location).

COVID-19 Emergency Waivers:

Kansas did not implement state-specific COVID-19 emergency waivers for telehealth CS prescribing, as the state's existing regulations already permitted such prescribing. The federal DEA public health emergency flexibilities applied in Kansas as in all states, but Kansas state law did not require modification because it already allowed telehealth CS prescribing.

Compliance Requirements:

- Establish valid provider-patient relationship via real-time, two-way interactive telemedicine technology
- Conduct appropriate assessment and evaluation of patient's current condition
- Document appropriate medical indication for any prescription issued
- Do NOT prescribe based solely on internet questionnaires without real-time interaction
- Comply with all general controlled substance prescribing requirements that apply to in-person encounters
- Maintain DEA registration and comply with federal Ryan Haight Act requirements
- Prescribe only within scope of practice for provider type
- Use secure video conferencing or store-and-forward technology meeting telemedicine definition

Primary Citations:

- K.A.R. 100-77-3 (Telemedicine prescribing parity regulation)
- K.S.A. § 40-2,211 through 40-2,214 (Kansas Telemedicine Act)
- K.S.A. § 40-2,212(b) (Provider-patient relationship via telemedicine)
- K.S.A. § 65-28,135 (Assessment and evaluation requirements)
- K.A.R. § 68-2-20(2) (Legitimate medical purpose definition)
- K.A.R. § 100-28a-13 (Physician assistant prescribing authority)
- Kan. Admin. Regs. § 60-11-104(a) (APRN prescriptive authority)
- K.S.A. § 65-2837a (Amphetamine and sympathomimetic amine restrictions)
- K.S.A. 65-1151 to 65-1164 (CRNA provisions)
- K.S.A. 65-28b02(c) and 65-28b10 (Certified nurse midwife authority)

Supporting Citations:

- Kansas Board of Pharmacy FAQ (pharmacist prescriptive authority)
- HB 2279 (2022) (APRN independent practice legislation)

Effective Dates:

- Kansas Telemedicine Act: Enacted 2018, effective January 1, 2019
- K.A.R. 100-77-3: Currently in effect
- APRN independent prescriptive authority (HB 2279): Effective 2022

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KENTUCKY

Regulatory Status:** Explicit regulations exist

Telehealth Controlled Substance Prescribing Permitted:

Yes. Kentucky permits telehealth prescribing of controlled substances (Schedules II-V) in accordance with federal law and the Ryan Haight Act. The state does not prohibit telehealth CS prescribing and has established a framework that explicitly recognizes telehealth examinations as satisfying practitioner-patient relationship requirements.

In-Person Examination Requirements:

Kentucky has a unique approach to in-person examination requirements that explicitly includes telehealth examinations within the definition of "in-person."

Practitioner-Patient Relationship Definition:

KRS 218A.010(41) defines "practitioner-patient relationship" (for criminal prosecution purposes) as requiring "at least one (1) good-faith prior examination." However, the critical provision is that KRS 218A.010 (as amended in 2010) specifies: "'In-person' includes telehealth examinations."

This statutory language means Kentucky law explicitly allows the establishment of a practitioner-patient relationship via telehealth without requiring a physical in-person visit. This is a significant departure from many states and represents a legislative determination that telehealth examinations are equivalent to physical in-person examinations for controlled substance prescribing purposes.

Good Faith Prior Examination:

The statute defines "good faith prior examination" as "an in-person medical examination of the patient conducted by the prescribing practitioner or other health-care professional routinely relied upon in the ordinary course of his or her practice, at which time the patient is physically examined and a medical history of the patient is obtained. 'In-person' includes telehealth examinations."

Frequency Requirements:

No periodic in-person visit requirements are mandated by Kentucky law for ongoing CS prescribing via telehealth. Once the initial good faith examination is completed (which may be via telehealth), the practitioner-patient relationship is established and may be maintained through continued telehealth encounters.

Virtual Examination Standards:

Kentucky explicitly permits virtual/telehealth examinations to satisfy the examination requirement. Questionnaires alone would not satisfy the "good faith prior examination" requirement, as the statute requires that "the patient is physically examined and a medical history of the patient is obtained." However, a proper telehealth clinical evaluation with real-time audio-visual interaction would satisfy this requirement.

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Provider-Specific Requirements:

Physicians (201 KAR 9:260):** Must conduct examination and obtain medical history; may use telehealth per state definition.

APRNs (201 KAR 20:057, Section 9):** Must obtain patient's medical history and conduct examination; documentation required. The same telehealth allowances apply.

Optometrists (201 KAR 5:130):** Explicitly prohibited from prescribing controlled substances via telehealth. Section 4(6) states: "Prescriptions for controlled substances shall not be made via telehealth by a doctor of optometry." This is a notable exception to Kentucky's generally permissive telehealth CS prescribing framework.

Schedule-Specific Rules:

Schedule II vs. Schedule III-V:

Kentucky imposes specific restrictions on Schedule II controlled substances for acute pain:

Schedule II for Acute Pain: Limited to 3-day supply unless exceptions apply (KRS 218A.205(3)(b)).**

Exceptions to 3-Day Limit:

- Professional judgment with documentation
- Chronic pain treatment
- Cancer pain
- Hospice/end-of-life care
- Narcotic treatment programs
- Post-major surgery/trauma
- Inpatient settings

Schedule III-V: No specific telehealth-related restrictions beyond general prescribing standards.**

Psychiatric vs. Pain Medications:

No explicit distinction in telehealth regulations between psychiatric and pain medications, though general controlled substance prescribing standards apply (201 KAR 9:260). The 3-day limit for Schedule II acute pain applies regardless of whether the pain is related to psychiatric conditions.

Opioid-Specific Restrictions:

The 3-day limit for Schedule II acute pain applies to opioids prescribed for acute pain conditions. This applies equally to in-person and telehealth prescribing.

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Buprenorphine Exception for MAT:

Both physicians and APRNs may prescribe buprenorphine via telehealth for opioid use disorder (medication-assisted treatment). 201 KAR 20:065 explicitly states: "Nothing in this administrative regulation shall be construed to prohibit prescribing buprenorphine via telehealth. The prescribing APRN shall follow the standards set by 201 KAR 20:520."

APRNs must comply with federal statutes and regulations pertaining to controlled substance prescribing via telehealth for MAT (201 KAR 20:065, Section 2(5)). This creates a specific pathway for buprenorphine prescribing via telehealth that is explicitly protected in regulation.

Prescriber Type Restrictions:

Physicians (MD/DO):** May prescribe all controlled substances (Schedules II-V) via telehealth in accordance with state and federal law. Must comply with 201 KAR 9:260 professional standards.

Physician Assistants (PAs):** As of July 15, 2020 (HB 135), Kentucky PAs may prescribe Schedule III-V controlled substances (KRS 311.858). Kentucky was the last state in the nation to grant PAs controlled substance prescribing authority.

PA Restrictions:

- Cannot prescribe Schedule II controlled substances
- Schedule III limited to 30-day supply with no refills
- Schedule IV/V limited to original prescription plus refills not exceeding 6 months total
- Benzodiazepines and carisoprodol limited to 30-day supply with no refills
- May prescribe via telehealth to the extent delegated by supervising physician

Advanced Practice Registered Nurses (APRNs/NPs):** May prescribe Schedule II-V controlled substances via telehealth.

APRN Requirements:

- Must have Collaborative Agreement for Prescriptive Authority for Controlled Substances (CAPA-CS) for first 4 years of practice
- After 4 years, may apply for independent prescriptive authority
- Must comply with 201 KAR 20:057 examination and documentation requirements
- Explicitly authorized to prescribe buprenorphine via telehealth for opioid use disorder (201 KAR 20:065)

Clinical Nurse Specialists:** Included under APRN category with same authority as nurse practitioners.

CRNAs (Certified Registered Nurse Anesthetists):** May prescribe controlled substances within their scope of practice, which typically includes anesthetic agents and related medications.

Pharmacists:** Do NOT have prescriptive authority in Kentucky and cannot prescribe controlled substances.

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Optometrists:** Explicitly prohibited from prescribing controlled substances via telehealth (201 KAR 5:130, Section 4(6)). May prescribe controlled substances only through in-person encounters within their limited scope.

Dentists:** May prescribe controlled substances within their scope of practice via telehealth, subject to the same standards as physicians.

Podiatrists:** May prescribe controlled substances within their scope of practice via telehealth, subject to the same standards as physicians.

Veterinarians:** May prescribe controlled substances within veterinary scope of practice via telehealth.

Ryan Haight Act Compliance:

Kentucky's statutory language that "'in-person' includes telehealth examinations" (KRS 218A.010) represents a state-level interpretation of the practitioner-patient relationship requirement. However, prescribers must still comply with federal Ryan Haight Act requirements, including:

- DEA registration for controlled substance prescribing
- Compliance with one of the Ryan Haight Act exceptions (such as the public health emergency exception, or practice at a DEA-registered location with in-person medical evaluation by another practitioner)
- Proper patient identification and medical history documentation

Kentucky's state law does not override federal requirements but provides that under state law, a telehealth examination satisfies Kentucky's definition of an in-person examination for purposes of establishing a practitioner-patient relationship.

COVID-19 Emergency Waivers:

Kentucky benefited from federal DEA public health emergency flexibilities during COVID-19, which allowed telehealth prescribing of controlled substances without an in-person examination when using audio-visual real-time two-way interactive communication.

Kentucky did not need to implement significant state-level emergency waivers because its existing statutory framework (amended in 2010 to include telehealth in the definition of "in-person") already permitted telehealth CS prescribing. The federal flexibilities complemented Kentucky's existing permissive state framework.

As of the end of the federal public health emergency, Kentucky's state law provisions remain in effect, continuing to allow telehealth examinations to satisfy the practitioner-patient relationship requirement under state law.

Compliance Requirements:

- Conduct good faith prior examination (may be via telehealth with audio-visual technology)
- Obtain complete medical history
- Physically examine patient (via telehealth technology that allows adequate clinical assessment)
- Document examination findings and medical indication for prescription

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- Comply with Schedule II 3-day supply limit for acute pain (unless exception applies)
- For PAs: Prescribe only Schedule III-V; comply with supply limits and refill restrictions
- For APRNs: Maintain CAPA-CS for first 4 years or obtain independent authority
- For optometrists: Do NOT prescribe controlled substances via telehealth
- Maintain DEA registration and comply with federal Ryan Haight Act requirements
- For buprenorphine MAT: Follow 201 KAR 20:520 standards and federal MAT requirements

Primary Citations:

- KRS 218A.010(41) (Practitioner-patient relationship definition)
- KRS 218A.010 (Definition of "in-person" includes telehealth)
- KRS 218A.205(3)(b) (Schedule II 3-day supply limit for acute pain)
- 201 KAR 9:260 (Physician professional standards)
- 201 KAR 20:057, Section 9 (APRN examination requirements)
- 201 KAR 20:065 (APRN buprenorphine prescribing via telehealth)
- 201 KAR 20:520 (APRN MAT standards)
- 201 KAR 5:130, Section 4(6) (Optometrist telehealth CS prohibition)
- KRS 311.858 (PA controlled substance prescribing authority)
- HB 135 (2020) (PA prescribing legislation)

Supporting Citations:

- Kentucky Board of Medical Licensure guidance on telemedicine
- Kentucky Board of Nursing APRN prescriptive authority regulations

Effective Dates:

- KRS 218A.010 amendment including telehealth in "in-person" definition: 2010
- Schedule II 3-day limit (KRS 218A.205): Currently in effect
- PA controlled substance prescribing authority (HB 135): Effective July 15, 2020
- APRN buprenorphine telehealth provisions (201 KAR 20:065): Currently in effect

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LOUISIANA

Regulatory Status: Explicit regulations exist with significant recent changes**

Telehealth Controlled Substance Prescribing Permitted:

Yes, with specific conditions. Louisiana permits telehealth prescribing of controlled substances under two primary frameworks, with significant liberalization enacted effective January 1, 2024 through Acts 2023, No. 322.

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Louisiana's approach represents a hybrid model: generally restrictive with an in-person examination requirement, but with a major exception for patients being treated at licensed healthcare facilities with DEA registration.

In-Person Examination Requirements:

Louisiana has complex in-person examination requirements that vary based on the treatment setting.

General Rule (La. R.S. 37:1271(B)(3) and La. R.S. 40:1223.4(B)(6)):

Healthcare providers generally may NOT prescribe controlled dangerous substances via telehealth prior to conducting an appropriate in-person patient history or physical examination, as determined by the appropriate licensing board. This establishes a baseline requirement for in-person examination before telehealth CS prescribing.

Major Exception - Licensed Healthcare Facility (La. R.S. 37:1271.1, effective January 1, 2024):

This represents a significant expansion of telehealth CS prescribing authority. Physicians with unrestricted Louisiana licenses may prescribe ANY controlled dangerous substance via telehealth WITHOUT an in-person examination when the patient is being treated at a healthcare facility that is:

1. Required to be licensed pursuant to Louisiana law, AND
2. Holds a current DEA registration

This exception effectively allows telehealth CS prescribing for patients receiving care at hospitals, clinics, community health centers, and other licensed facilities with DEA registration, without any requirement for the telehealth prescriber to have previously seen the patient in person.

Board of Medical Examiners Rules for Physicians Not Covered by Healthcare Facility Exception (La. Admin. Code tit. 46, § XLV-7513):

For physicians prescribing via telehealth to patients NOT at a licensed healthcare facility:

In-Person Visit Requirement: At least one in-person visit with the patient at a physical practice location in Louisiana within the past year (annual requirement). This creates a periodic in-person visit requirement that must be satisfied annually.**

Additional Requirements:

- The prescription must be for a legitimate medical purpose
- Must conform to the same standard of care as an in-person visit
- Must comply with all applicable state and federal laws
- The Board may grant individual exceptions upon written application

Prohibited Uses for Telemedicine CS Prescribing:

Physicians may NOT use telemedicine to prescribe controlled substances for:

- Treatment of non-cancer related chronic or intractable pain

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- Treatment of obesity

These are categorical prohibitions that apply regardless of whether the patient has had an in-person visit. This represents Louisiana's policy determination that certain conditions requiring controlled substances should not be managed via telehealth.

Virtual Examination Sufficiency:

An in-person visit is NOT required if the telemedicine technology is sufficient to provide the physician with pertinent clinical information reasonably necessary to practice at an acceptable level of skill and safety. This creates a technology-based exception: if the telehealth platform provides adequate clinical information, it may substitute for in-person examination.

However, online questionnaires or email messages are NOT considered appropriate evaluation methods. Real-time audio-visual interaction is required.

Frequency of In-Person Visits:

For patients not covered by the healthcare facility exception: Annual in-person visit required (within the past year).

Schedule-Specific Rules:

Louisiana regulations do NOT differentiate between Schedule II and Schedule III-V controlled substances for physicians. When authorized under either the healthcare facility exception or the annual in-person visit framework, physicians may prescribe any controlled dangerous substance (Schedules II-V) via telehealth.

No Psychiatric vs. Pain Medication Distinction:

Louisiana law prohibits telemedicine prescribing for non-cancer chronic/intractable pain treatment entirely, but does not create separate pathways for psychiatric medications. Psychiatric medications in Schedules II-V may be prescribed via telehealth under the same framework as other controlled substances (subject to the healthcare facility exception or annual in-person visit requirement).

Opioid-Specific Restrictions:

The prohibition on prescribing controlled substances via telemedicine for non-cancer chronic/intractable pain effectively restricts opioid prescribing for chronic pain conditions. However, opioids for acute pain, cancer pain, or other conditions not falling within the chronic/intractable pain prohibition may be prescribed via telehealth.

Prescriber Type Restrictions:

Louisiana has detailed prescriber-specific regulations for controlled substance prescribing via telehealth.

Physicians (MD/DO):

May prescribe all schedules (II-V) via telehealth under the conditions described above:

- Without in-person exam if patient is at licensed healthcare facility with DEA registration (as of January 1, 2024)

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- With annual in-person visit if patient is not at such a facility
- NOT for non-cancer chronic/intractable pain
- NOT for obesity treatment

Advanced Practice Registered Nurses (APRNs/NPs):

May prescribe controlled substances via telehealth with significant restrictions:

APRN Authority:

- Must have Louisiana State Board of Nursing (LSBN) approval for prescriptive authority including controlled substances
- Must have collaborative practice agreement that includes controlled substance authority
- Must complete 3-hour board-approved continuing education on controlled substance prescribing
- May prescribe Schedules II-V, including:
- Schedule II non-narcotic medications (e.g., for ADHD)
- Full Schedule II narcotics with proper approval
- Schedules III-V

APRN Telehealth Requirements:

- Must perform and document appropriate history and physical examination
- PROHIBITED from prescribing controlled substances via telehealth for chronic/intractable pain
- PROHIBITED from prescribing controlled substances via telehealth for obesity
- Subject to the same in-person exam requirements that apply to physicians (La. Admin. Code tit. 46, § XLVII-4513)
- The healthcare facility exception available to physicians would also apply to APRNs

Physician Assistants (PA-C):

Licensed and regulated by Louisiana State Board of Medical Examiners. Authorized to prescribe controlled substances with DEA registration and CDS license.

PA Authority:

- May prescribe Schedules II-V
- Subject to same telehealth restrictions as physicians
- Must practice under physician supervision
- Subject to annual in-person visit requirement or healthcare facility exception
- Prohibited from prescribing CS via telehealth for non-cancer chronic/intractable pain or obesity

Dentists/Oral Surgeons (DDS):

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Authorized to prescribe controlled substances (Schedules II-V) with CDS license and DEA registration. Subject to their board's telehealth rules, which would generally follow the framework established for physicians.

Optometrists (OD):

Authorized to prescribe controlled substances with legislative authorization. Subject to their board's telehealth rules. Louisiana optometrists have limited controlled substance prescribing authority within their scope of practice.

Podiatrists (DPM):

Licensed by Louisiana State Board of Medical Examiners. Authorized to prescribe controlled substances (Schedules II-V) within their scope of practice. Subject to same telehealth restrictions as physicians.

Pharmacists:

Do NOT have independent prescriptive authority in Louisiana. Pharmacists may not prescribe controlled substances via telehealth or any other modality.

Veterinarians:

May prescribe controlled substances within veterinary scope of practice. Subject to Louisiana Board of Veterinary Medicine regulations regarding telehealth prescribing.

CRNAs (Certified Registered Nurse Anesthetists):

May prescribe controlled substances within their scope of practice related to anesthesia services. Subject to collaborative practice requirements and Louisiana State Board of Nursing regulations.

Clinical Nurse Specialists:

Included under APRN category with prescriptive authority similar to nurse practitioners, subject to collaborative practice agreements and LSBN approval.

Ryan Haight Act Compliance:

Louisiana's regulations operate in conjunction with federal Ryan Haight Act requirements. The state's requirement for an in-person examination (except for the healthcare facility exception) aligns with Ryan Haight Act principles, though the annual in-person visit requirement is a state-specific provision.

Federal Compliance Requirements:

- DEA registration for controlled substance prescribing
- Compliance with Ryan Haight Act exceptions when applicable
- For the healthcare facility exception: The facility must hold DEA registration, which helps ensure compliance with federal requirements

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Louisiana's healthcare facility exception (La. R.S. 37:1271.1) may align with certain Ryan Haight Act exceptions, particularly when the patient is at a DEA-registered location where in-person medical evaluation occurs by healthcare practitioners.

COVID-19 Emergency Waivers:

Louisiana implemented emergency measures during the COVID-19 pandemic that temporarily relaxed certain telehealth restrictions. The federal DEA public health emergency flexibilities also applied in Louisiana.

Post-Pandemic Status:

The enactment of La. R.S. 37:1271.1 (effective January 1, 2024) represents a permanent expansion of telehealth CS prescribing authority that goes beyond temporary COVID-19 waivers. The healthcare facility exception is a permanent statutory provision, not an emergency waiver.

Louisiana did not make all COVID-19 emergency telehealth flexibilities permanent, but instead enacted targeted legislation (Acts 2023, No. 322) that permanently expanded telehealth CS prescribing in specific settings (licensed healthcare facilities with DEA registration).

Compliance Requirements:

For All Prescribers:

- Obtain DEA registration and Louisiana CDS license
- Comply with federal Ryan Haight Act requirements
- Do NOT prescribe controlled substances via telehealth for non-cancer chronic/intractable pain
- Do NOT prescribe controlled substances via telehealth for obesity treatment
- Use real-time audio-visual technology (not questionnaires or email)
- Document medical indication and clinical findings

For Physicians Using Healthcare Facility Exception (as of January 1, 2024):

- Verify patient is being treated at healthcare facility required to be licensed under Louisiana law
- Verify facility holds current DEA registration
- May prescribe any controlled substance (Schedules II-V) without prior in-person examination
- Still subject to chronic pain and obesity prohibitions

For Physicians NOT Using Healthcare Facility Exception:

- Conduct at least one in-person visit with patient at physical practice location in Louisiana within past year
- Maintain annual in-person visit requirement
- May apply to Board for individual exception if needed
- Ensure telemedicine technology provides sufficient clinical information

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For APRNs:

- Obtain LSBN approval for controlled substance prescriptive authority
- Maintain collaborative practice agreement including CS authority
- Complete 3-hour board-approved continuing education on CS prescribing
- Perform and document appropriate history and physical examination
- Comply with same in-person visit requirements as physicians (annual visit or healthcare facility exception)

For PAs:

- Practice under physician supervision
- Obtain DEA registration and CDS license
- Comply with same telehealth restrictions as physicians

Primary Citations:

- La. R.S. 37:1271(B)(3) (General telehealth CS prescribing restriction)
- La. R.S. 37:1271.1 (Healthcare facility exception, effective January 1, 2024)
- La. R.S. 40:1223.4(B)(6) (In-person examination requirement)
- La. Admin. Code tit. 46, § XLV-7513 (Board of Medical Examiners telemedicine rules)
- La. Admin. Code tit. 46, § XLVII-4513 (APRN telemedicine requirements)
- Acts 2023, No. 322 (Healthcare facility exception legislation)

Supporting Citations:

- Louisiana State Board of Medical Examiners Position Statement on Telemedicine
- Louisiana State Board of Nursing APRN Prescriptive Authority Rules
- Louisiana Board of Pharmacy regulations on pharmacist authority
- Louisiana State Board of Nursing Collaborative Practice Agreement requirements

Effective Dates:

- La. R.S. 37:1271.1 (Healthcare facility exception): Effective January 1, 2024
- Acts 2023, No. 322: Enacted 2023, effective January 1, 2024
- La. Admin. Code tit. 46, § XLV-7513: Currently in effect (predates 2024 changes)
- General telehealth CS restrictions (La. R.S. 37:1271(B)(3)): Currently in effect, modified by 2024 healthcare facility exception

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Maine, Maryland, Massachusetts

MAINE

Regulatory Status: No explicit state-specific regulations beyond federal standards; defers to federal Ryan Haight Act with general telehealth standards of practice**

Telehealth Controlled Substance Prescribing Framework:

Maine permits telehealth prescribing of controlled substances (CII-CV) but does not impose state-level restrictions beyond federal requirements. The state statute 22 M.R.S. § 7246(5) explicitly defines 'prescriber' to include "a licensed health care professional or veterinarian who uses telehealth in providing health care to prescribe controlled substances to patients located in this State." Maine's insurance parity statute (24-A M.R.S. § 4316(3)(G)) prohibits carriers from placing "any restriction on the prescribing of medication through telehealth by a provider whose scope of practice includes prescribing medication that is more restrictive than any requirement in state and federal law for prescribing medication through in-person consultation." This language confirms Maine's policy of not imposing additional state barriers beyond federal law.

In-Person Examination Requirements:

Maine does not mandate state-specific in-person examination requirements for controlled substance prescribing via telehealth. The Joint Rule Regarding Telehealth Standards of Practice (Chapter 11, jointly adopted by the Board of Licensure in Medicine, Board of Osteopathic Licensure, and State Board of Nursing) establishes general standards but does not require periodic in-person visits for controlled substances specifically.

Key prohibitions include:

- Prescribing based solely on an Internet request or Internet questionnaire is prohibited
- Prescribing based solely on a telephonic evaluation absent a valid licensee-patient relationship is prohibited (with limited exceptions)
- Clinical evaluation, indication, appropriateness, and safety considerations for prescriptions must be appropriately documented and meet the applicable standard of care

Maine does not specify:

- Initial in-person visit requirements
- Periodic visit frequency (annual, biannual, or otherwise)
- Specific examination elements required
- Whether virtual examinations can satisfy requirements (though the regulations' silence on mandatory in-person visits suggests virtual exams are acceptable)

Providers must comply with federal Ryan Haight Act requirements, which generally require at least one in-person medical evaluation before prescribing controlled substances via telehealth unless an exception applies. As of January 2026, federal COVID-19 telehealth flexibilities remain extended

through December 31, 2026, allowing prescribing of Schedule II-V controlled substances via audio-video telehealth without prior in-person examination.

Schedule-Specific Rules:

Maine does not establish state-specific schedule-based distinctions (CII vs. CIII-V) for telehealth prescribing. A 2017 legislative bill (LD 1263) proposed prohibiting insurance coverage for Schedule I, II, or III controlled substances prescribed via telehealth, but this provision was not enacted into current law.

Opioid prescribing limits apply regardless of modality (in-person or telehealth):

- 100 morphine milligram equivalent (MME) daily limits with exceptions for palliative care, surgical procedures, and serious illness
- Prescription Monitoring Program (PMP) check requirements under 22 M.R.S. § 7253 apply to all opioid prescriptions
- No distinction between psychiatric medications and pain medications for telehealth purposes

Prescriber Type Restrictions:

Maine allows all prescribers with controlled substance authority to prescribe via telehealth within their scope of practice:

- **Physicians (MD/DO):** Full authority to prescribe Schedule II-V controlled substances via telehealth
- **Physician Assistants (PAs):** May prescribe Schedule II-V controlled substances with DEA registration; must work in collaboration with physicians, but consultation may occur electronically or through telecommunication
- **Nurse Practitioners/APRNs:** Full independent practice authority in Maine; may prescribe Schedule II-V controlled substances once registered with DEA (32 M.R.S. Chapter 31)
- **Clinical Nurse Specialists:** May prescribe within scope of practice
- **CRNAs:** Authority within scope of practice
- **Dentists:** May prescribe controlled substances within scope of practice (32 M.R.S. § 1077, § 1094-A)
- **Podiatrists:** May prescribe controlled substances within scope of practice (32 M.R.S. § 3656, § 3657)
- **Veterinarians:** May prescribe controlled substances for animal patients; subject to telehealth standards
- **Optometrists:** Limited prescriptive authority; may prescribe therapeutic pharmaceutical agents within scope of practice
- **Pharmacists:** No independent prescriptive authority for controlled substances

Ryan Haight Act Compliance:

Maine defers to federal Ryan Haight Act requirements without state modifications. The state's explicit statutory language recognizing telehealth prescribers of controlled substances and

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prohibiting insurance restrictions more stringent than state and federal law demonstrates Maine's alignment with federal standards rather than imposing additional state-level barriers.

COVID-19 Emergency Waivers:

Maine did not implement state-specific COVID-19 waivers for controlled substance prescribing via telehealth, instead relying on federal flexibilities. The federal COVID-19 public health emergency telehealth flexibilities, which allow prescribing of controlled substances via audio-video telehealth without prior in-person examination, have been extended through December 31, 2026. Maine providers may utilize these federal flexibilities without additional state restrictions.

Compliance Requirements:

- Establish valid licensee-patient relationship before prescribing
- Do not prescribe based solely on Internet questionnaire or telephonic evaluation
- Document clinical evaluation, indication, appropriateness, and safety considerations
- Meet applicable standard of care
- Comply with federal Ryan Haight Act requirements
- Check Prescription Monitoring Program for opioid prescriptions
- Adhere to 100 MME daily limits for opioids (with exceptions)
- Maintain DEA registration appropriate to prescriber type
- Follow general opioid prescribing requirements regardless of telehealth modality

Primary Citations:

- 22 M.R.S. § 7246(5) (definition of prescriber including telehealth)
- 24-A M.R.S. § 4316(3)(G) (insurance parity for telehealth prescribing)
- 22 M.R.S. § 7253 (Prescription Monitoring Program requirements)
- 32 M.R.S. Chapter 31 (Advanced Practice Registered Nurse prescriptive authority)
- 32 M.R.S. § 1077, § 1094-A (dentist prescriptive authority)
- 32 M.R.S. § 3656, § 3657 (podiatrist prescriptive authority)
- Joint Rule Regarding Telehealth Standards of Practice (Chapter 11)
- Maine Board of Medicine Chapter 6 (now Chapter 11) (telehealth standards)

Supporting Citations:

- LD 1263 (2017 legislative bill, not enacted)
- Federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008
- Federal COVID-19 telehealth flexibilities (extended through December 31, 2026)

Effective Dates:

- Joint Rule Regarding Telehealth Standards of Practice (Chapter 11): Adopted by participating boards; current version in effect

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• Insurance parity statute (24-A M.R.S. § 4316): Enacted and amended over multiple legislative sessions

• Federal COVID-19 telehealth flexibilities: Extended through December 31, 2026

MARYLAND

Regulatory Status: Explicit state-level regulations governing telehealth prescribing of controlled substances, with specific restrictions on opioid prescribing for pain management**

Telehealth Controlled Substance Prescribing Framework:

Maryland permits telehealth prescribing of controlled substances (CII-CV) with significant restrictions, particularly for opioids prescribed for pain treatment. The state has comprehensive regulations at COMAR 10.32.05 (Telehealth Services) and statutory provisions in the Maryland Health Occupations Code that establish specific requirements and limitations.

In-Person Examination Requirements:

Maryland requires a synchronous audio-visual patient evaluation adequate to establish diagnoses before prescribing medication via telehealth (COMAR 10.32.05.05(A)). The state distinguishes between initial evaluations and ongoing care:

Initial Evaluation Requirements:

• Synchronous audio-visual patient evaluation required before prescribing

• Practitioners may NOT prescribe medication based solely on an online questionnaire (COMAR 10.32.05.06(B))

• Evaluation can be conducted via telehealth using synchronous audio-visual technology

• Evaluation may be conducted through a surrogate examiner during a synchronous encounter

• For asynchronous telehealth services, a prior synchronous audio-visual or in-person evaluation is required (COMAR 10.32.05.05(B)(3))

Opioid-Specific Restrictions:

• Practitioners may NOT prescribe Schedule II opioids for the treatment of pain through telehealth UNLESS the patient is in a health care facility as defined in Health-General Article §19-114(d)(1) (COMAR 10.32.05.06(C); Md. Health Occ. Code §1-1003(c)(1))

• This restriction applies specifically to opioids for pain treatment, not to all controlled substances or all opioid prescribing (e.g., psychiatric uses, addiction treatment)

• The healthcare facility exception allows Schedule II opioid prescribing via telehealth when the patient is physically located in a hospital, nursing home, assisted living facility, or similar healthcare setting

Periodic Visit Requirements:

• Maryland law does not mandate specific periodic in-person visits (annual or biannual) for controlled substance prescribing via telehealth

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- Practitioners must provide or refer patients to in-person care "if clinically appropriate for the patient" (Md. Health Occ. Code §1-1003(a)(2))
- If the standard of care requires information or treatment only obtainable in-person, the practitioner must see the patient in-person
- This creates a flexible, clinically-driven standard rather than a rigid periodic requirement

Virtual Exam Adequacy:

- Synchronous audio-visual telehealth evaluations CAN satisfy the evaluation requirement for prescribing (except for Schedule II opioids for pain)
- Questionnaires alone CANNOT satisfy the requirement
- Asynchronous telehealth may be used for follow-up prescribing if a prior synchronous evaluation occurred
- The evaluation must be "adequate to establish diagnoses with respect to which the practitioner prescribes medication"

Schedule-Specific Rules:

Maryland establishes clear distinctions based on drug schedule and indication:

CII vs. CIII-V Differences:

- Schedule II OPIOIDS prescribed for PAIN treatment are prohibited via telehealth unless the patient is in a healthcare facility
- Other Schedule II controlled substances (e.g., stimulants for ADHD, methylphenidate, amphetamines, non-opioid CII medications) are not explicitly prohibited via telehealth
- Schedules III-V controlled substances may be prescribed via telehealth with appropriate synchronous audio-visual evaluation
- No additional restrictions apply to CIII-V substances beyond the general telehealth evaluation requirements

Psychiatric Medications vs. Pain Medications:

- Psychiatric medications, including controlled substances, may be prescribed via telehealth with proper synchronous audio-visual evaluation
- The Schedule II opioid restriction specifically applies to "treatment of pain," not psychiatric indications
- Opioids prescribed for psychiatric conditions (if clinically appropriate) would not fall under the pain treatment restriction
- Board of Nursing regulations for psychiatric mental health nurse practitioners mirror these requirements (COMAR 10.27.17)

Opioid Use Disorder Treatment:

- Buprenorphine for opioid use disorder (OUD) treatment is explicitly permitted via telehealth, including for induction
- Federal rules (effective February 18, 2025) permit buprenorphine prescribing via audio-only telehealth for OUD treatment
- Maryland Medicaid reimburses for these services with appropriate modifiers

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- This represents a significant exception to opioid prescribing restrictions, recognizing the public health importance of addiction treatment access

Prescriber Type Restrictions:

Maryland's telehealth regulations apply to "telehealth practitioners," defined as "a Maryland licensed physician or licensed allied health practitioner performing telehealth services within their respective scope of practice" (COMAR 10.32.05.02). All prescriber types are subject to the same telehealth prescribing restrictions:

Nurse Practitioners (NPs/APRNs):

- NPs may independently prescribe and dispense drugs, devices, and Schedules II-V controlled substances (COMAR 10.27.07.07)
- NPs may prescribe controlled substances via telehealth subject to the same restrictions as physicians (including the Schedule II opioid for pain prohibition)
- For the first 18 months of practice, physician involvement is required for prescriptive authority
- After 18 months, NPs have independent prescriptive authority
- Psychiatric Mental Health NPs have specific teletherapy regulations (COMAR 10.27.17) with the same questionnaire prohibition

Physician Assistants (PAs):

- PAs may prescribe controlled substances when delegated by a supervising physician (COMAR 10.32.03.08)
- Prescriptive authority includes Schedule II-V controlled substances
- PAs may prescribe via telehealth within their delegated authority
- Subject to the same Schedule II opioid for pain restriction as physicians
- Supervision requirements apply regardless of telehealth modality

Clinical Nurse Specialists:

- May prescribe controlled substances within scope of practice
- Subject to same telehealth prescribing requirements as other practitioners
- Must have appropriate collaborative agreement or practice authority

CRNAs (Certified Registered Nurse Anesthetists):

- May prescribe within scope of practice
- Typically prescribe in perioperative/anesthesia contexts
- Subject to general telehealth prescribing requirements

Dentists:

- May prescribe controlled substances within scope of dental practice
- Subject to same telehealth requirements, including Schedule II opioid for pain restriction
- Dental pain management via telehealth would be subject to the opioid restriction

Podiatrists:

- May prescribe controlled substances within scope of podiatric practice
- Subject to same telehealth requirements

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• Foot/ankle pain management via telehealth subject to Schedule II opioid restriction

Pharmacists:

• Limited prescriptive authority under collaborative practice agreements

• May not independently prescribe controlled substances

• Collaborative practice agreements must comply with telehealth regulations if services provided remotely

Optometrists:

• Limited prescriptive authority for ophthalmic medications

• Generally do not prescribe controlled substances

• If authorized, subject to general telehealth requirements

Veterinarians:

• May prescribe controlled substances for animal patients

• Subject to telehealth standards of practice

• Veterinary telehealth prescribing follows similar evaluation requirements

Ryan Haight Act Compliance:

Maryland's regulations align with and build upon federal Ryan Haight Act requirements. The state does not create exemptions from federal law but adds additional state-level restrictions, particularly the Schedule II opioid for pain prohibition. Maryland practitioners must comply with both:

• Federal Ryan Haight Act requirements (21 U.S.C. § 829(e))

• Maryland's additional state restrictions on Schedule II opioids for pain

• Federal COVID-19 flexibilities (when applicable) do not override Maryland's state-level opioid restriction

The healthcare facility exception in Maryland law provides a pathway for Schedule II opioid prescribing via telehealth that aligns with Ryan Haight Act exceptions for patients in registered healthcare facilities.

COVID-19 Emergency Waivers:

Maryland implemented COVID-19 emergency measures that have largely been incorporated into permanent regulations:

Permanent Changes:

• The synchronous audio-visual evaluation requirement (rather than mandatory in-person) was solidified during and after the pandemic

• Asynchronous telehealth with prior synchronous evaluation was formalized

• Audio-only telehealth was expanded for certain services (though not for initial controlled substance prescribing)

Current Status:

• Maryland's Schedule II opioid for pain restriction remained in effect throughout the pandemic and continues

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- Federal COVID-19 flexibilities for controlled substance prescribing (extended through December 31, 2026) apply in Maryland but do not override the state's Schedule II opioid for pain prohibition
- Buprenorphine for OUD treatment benefits from both federal flexibilities and state support

Specific Provisions:

- Maryland Medicaid continues to reimburse for telehealth services, including controlled substance prescribing (where permitted)
- Audio-only telehealth is reimbursed for certain services but does not satisfy the synchronous audio-visual requirement for initial medication prescribing
- The state has not made emergency waivers permanent for Schedule II opioid prescribing for pain via telehealth

Compliance Requirements:

- Conduct synchronous audio-visual evaluation adequate to establish diagnoses before prescribing medication via telehealth
- Do NOT prescribe based solely on online questionnaire
- Do NOT prescribe Schedule II opioids for pain treatment via telehealth unless patient is in a healthcare facility
- For asynchronous telehealth, ensure prior synchronous audio-visual or in-person evaluation occurred
- Provide or refer to in-person care if clinically appropriate
- Maintain documentation of telehealth encounters meeting standard of care
- Ensure appropriate licensure and DEA registration
- Comply with federal Ryan Haight Act requirements
- Check Prescription Drug Monitoring Program (PDMP) as required by Maryland law
- Follow prescriber-specific scope of practice and supervision requirements
- Use appropriate telehealth modifiers for billing/reimbursement

Primary Citations:

- COMAR 10.32.05 (Telehealth Services)
- COMAR 10.32.05.02 (Definitions)
- COMAR 10.32.05.05 (Standards for Telehealth Services)
- COMAR 10.32.05.06 (Prescribing Medication Through Telehealth)
- Md. Health Occ. Code §1-1003 (Telehealth provisions)
- Md. Health-General Article §19-114(d)(1) (Healthcare facility definition)
- COMAR 10.27.07.07 (Nurse Practitioner prescriptive authority)
- COMAR 10.27.17 (Psychiatric Mental Health Nurse Practitioner teletherapy)
- COMAR 10.32.03.08 (Physician Assistant prescriptive authority)

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Supporting Citations:

- Federal Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 829(e)
- Federal COVID-19 telehealth flexibilities (extended through December 31, 2026)
- Maryland Medicaid telehealth reimbursement policies
- Federal buprenorphine prescribing rules (effective February 18, 2025)

Effective Dates:

- COMAR 10.32.05: Adopted and amended over multiple years; current version reflects post-pandemic permanent regulations
- Md. Health Occ. Code §1-1003: Enacted 2012, amended subsequently
- Schedule II opioid for pain restriction: In effect prior to COVID-19 pandemic and continuing
- Federal COVID-19 flexibilities: Extended through December 31, 2026
- Federal buprenorphine rules: Effective February 18, 2025

MASSACHUSETTS

Regulatory Status: No explicit state-specific regulations governing telehealth prescribing of controlled substances; defers to federal standards while requiring same standard of care as in-person prescribing**

Telehealth Controlled Substance Prescribing Framework:

Massachusetts permits telehealth prescribing of controlled substances but does not impose state-specific restrictions beyond federal requirements. The state takes a general approach requiring that controlled substance prescribing via telehealth comply with both state and federal regulations while maintaining the same standard of care as in-person prescribing. State regulations at 101 CMR 329 and various MassHealth bulletins state that "services including the prescribing of controlled substances must be in accordance with state and federal regulations." The Massachusetts Board of Registration in Medicine defines telemedicine at 243 CMR 2.01 as "the provision of services to a patient by a physician from a distance by electronic communication in order to improve patient care, treatment or services."

Physician-Patient Relationship and In-Person Examination Requirements:

Massachusetts does not mandate explicit in-person examination requirements for controlled substance prescribing via telehealth. The state's approach focuses on establishing and maintaining a valid physician-patient relationship and meeting the standard of care:

Initial Evaluation Requirements:

- The Board's Internet Prescribing Policy (Policy 03-06) requires that prescriptions be issued within a valid physician-patient relationship and in the usual course of professional practice
- This requires "taking an adequate medical history, doing a physical and/or mental status examination and documenting the findings"

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- Massachusetts does not explicitly mandate an initial in-person examination for controlled substance prescribing via telehealth
- During the COVID-19 pandemic, the Board issued an interim order stating that "the practice of medicine shall not require a face-to-face encounter between the physician and the patient prior to health care delivery via telemedicine"
- This flexibility appears to continue under current practice, with no explicit reinstatement of mandatory in-person requirements

Periodic Visit Requirements:

- Massachusetts does not specify periodic in-person visit requirements for controlled substance prescribing via telehealth
- No annual, biannual, or other frequency requirements are established
- The standard of care determines whether in-person visits are clinically necessary
- Providers must exercise professional judgment regarding the appropriateness of continued telehealth prescribing

Examination Elements and Virtual Exam Adequacy:

- Massachusetts does not specify required examination elements for telehealth controlled substance prescribing
- Virtual examinations and appropriate clinical assessments can satisfy the physician-patient relationship requirement, provided they meet the standard of care
- The Board's Policy 15-05 (Prescribing Practices Policy and Guidelines, amended 2023) emphasizes that prescribing via any means, including the Internet or electronic process, must meet standards of patient care
- Documentation must support clinical decision-making and prescribing rationale

Questionnaire Prohibition:

- While Massachusetts does not have an explicit prohibition on questionnaire-only prescribing in statute, the requirement for adequate medical history and examination effectively prohibits prescribing based solely on questionnaires
- The physician-patient relationship requirement necessitates interactive evaluation

Schedule-Specific Rules:

Massachusetts does not impose different rules for CII versus CIII-V controlled substances in the telehealth context, nor does it distinguish between psychiatric medications and pain medications for telehealth purposes. However, general controlled substance prescribing rules apply regardless of modality:

Electronic Prescribing Requirements:

- Schedule II prescriptions require electronic prescribing (effective January 1, 2021, per 105 CMR 721.070) unless an exception applies
- Exceptions include: technical failure, patient-specific needs, prescriber waiver for economic hardship or technological limitations, emergency situations
- This requirement applies to all Schedule II prescribing, whether in-person or via telehealth

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Prescription Transmission Rules:

- Emergency situations allow oral prescriptions for Schedule II substances, which must be followed up with written/electronic prescriptions within 7 days
- Schedule III-V substances may be called in to pharmacies with written follow-up within 7 days
- These rules apply regardless of whether the prescribing encounter was in-person or via telehealth

Opioid Prescribing:

- Massachusetts has general opioid prescribing requirements that apply to all prescribing modalities
- No opioid-specific restrictions exist for telehealth prescribing beyond general opioid prescribing requirements
- Prescribers must check the Prescription Monitoring Program (PMP) before prescribing opioids
- First-time opioid prescriptions for acute pain are limited to 7-day supply (with exceptions)

No Psychiatric vs. Pain Distinction:

- Massachusetts does not distinguish between controlled substances prescribed for psychiatric conditions versus pain management in the telehealth context
- All controlled substance prescribing via telehealth must meet the same standard of care requirements

Prescriber Type Restrictions:

Massachusetts law permits various mid-level practitioners to prescribe controlled substances, and these prescriptive authorities extend to telehealth without additional restrictions. Each prescriber type may prescribe controlled substances via telehealth within their scope of practice:

Nurse Practitioners (NPs):

- May prescribe controlled substances via telehealth
- NPs with less than two years of supervised practice must have written guidelines with a supervising physician
- After two years of supervised practice, NPs have independent prescriptive authority (M.G.L. c. 112, §§ 80B, 80H; 244 CMR 4.00)
- No additional telehealth-specific restrictions apply
- Must maintain DEA registration for controlled substance prescribing

Physician Assistants (PAs):

- May prescribe controlled substances via telehealth under physician supervision
- Schedule II prescriptions must be reviewed by the supervising physician within 96 hours (263 CMR 5.06(3))
- This review requirement applies regardless of whether prescribing occurred in-person or via telehealth
- PAs must have written supervisory agreements that include prescriptive authority
- Must maintain DEA registration

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Psychiatric Clinical Nurse Specialists (PCNS):

- May prescribe controlled substances with written guidelines with a supervising physician (105 CMR 700.000)
- May prescribe via telehealth within scope of practice
- Particularly relevant for psychiatric medications including controlled substances

Certified Registered Nurse Anesthetists (CRNAs):

- May prescribe controlled substances with written guidelines with a supervising physician
- Prescribing typically occurs in perioperative/anesthesia contexts
- May utilize telehealth for appropriate consultations and follow-up

Certified Nurse Midwives (CNMs):

- May prescribe controlled substances within their scope of practice (M.G.L. c. 112, § 80C)
- May prescribe via telehealth for appropriate obstetric and gynecologic care
- Subject to general telehealth standards

Pharmacists:

- Have limited prescriptive authority under Collaborative Drug Therapy Management (CDTM) agreements
- May not independently prescribe controlled substances
- CDTM agreements may include telehealth services if appropriately structured
- Pharmacists may provide medication management services via telehealth under physician supervision

Optometrists:

- Have limited prescriptive authority for therapeutic pharmaceutical agents
- May prescribe certain controlled substances within scope of practice (primarily for ophthalmic conditions)
- May utilize telehealth for appropriate consultations
- Subject to general telehealth standards

Dentists:

- May prescribe controlled substances within scope of dental practice
- May prescribe via telehealth when clinically appropriate
- Subject to general opioid prescribing limits and PMP requirements
- Must establish appropriate dentist-patient relationship

Podiatrists:

- May prescribe controlled substances within scope of podiatric practice
- May prescribe via telehealth when clinically appropriate
- Subject to general prescribing requirements and standard of care

Veterinarians:

- May prescribe controlled substances for animal patients

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- May utilize telehealth for veterinary consultations
- Subject to veterinary practice standards and federal controlled substance requirements

Ryan Haight Act Compliance:

Massachusetts defers to federal Ryan Haight Act requirements without state modifications. The state does not create additional barriers or exemptions beyond federal law:

Federal Compliance Required:

- Prescribers must comply with 21 U.S.C. § 829(e) and DEA regulations
- At least one in-person medical evaluation is generally required before prescribing controlled substances via telemedicine, unless an exception applies
- Federal COVID-19 flexibilities (extended through December 31, 2026) allow prescribing without prior in-person examination via audio-video telehealth

State Alignment:

- Massachusetts regulations explicitly state that controlled substance prescribing via telehealth must comply with "state and federal regulations"
- The state has not enacted additional restrictions or created state-specific exemptions
- Massachusetts providers may utilize all federal Ryan Haight Act exceptions

DEA Registration:

- All prescribers must maintain appropriate DEA registration
- Registration must be in the state where the patient is located at the time of the telehealth encounter
- Massachusetts does not impose additional state registration requirements for telehealth prescribing

COVID-19 Emergency Waivers and Current Status:

Massachusetts implemented COVID-19 emergency measures, many of which have been incorporated into ongoing practice:

Pandemic Flexibilities:

- The Board of Registration in Medicine issued an interim order stating that telemedicine "shall not require a face-to-face encounter between the physician and the patient prior to health care delivery via telemedicine"
- This removed any implicit in-person requirement for establishing physician-patient relationships via telehealth
- Audio-only telehealth was temporarily expanded for certain services

Current Status (as of January 2026):

- Massachusetts has not explicitly reinstated mandatory in-person requirements for controlled substance prescribing via telehealth
- The state continues to allow establishment of physician-patient relationships via telehealth
- Federal COVID-19 flexibilities for controlled substance prescribing remain in effect through December 31, 2026

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- Massachusetts providers may utilize federal flexibilities without additional state barriers

Permanent Changes:

- MassHealth (Massachusetts Medicaid) has maintained expanded telehealth reimbursement
- Audio-video telehealth is reimbursed at parity with in-person services
- Audio-only telehealth remains reimbursed for certain services (though not for initial controlled substance prescribing under federal rules)
- The state has not enacted legislation making emergency waivers permanent but has maintained flexible interpretation of telehealth standards

Insurance Parity:

- Massachusetts law requires insurance coverage parity for telehealth services
- Controlled substance prescribing via telehealth is covered when medically appropriate
- No additional restrictions on coverage for controlled substances prescribed via telehealth

Compliance Requirements:

- Establish valid physician-patient (or equivalent) relationship before prescribing controlled substances
- Take adequate medical history and conduct appropriate examination (physical and/or mental status)
- Document clinical findings, rationale for prescribing, and treatment plan
- Meet standard of care for the condition being treated
- Comply with federal Ryan Haight Act requirements
- Use electronic prescribing for Schedule II controlled substances (unless exception applies)
- Check Prescription Monitoring Program (PMP) before prescribing opioids
- Adhere to 7-day limit for first-time acute pain opioid prescriptions (with exceptions)
- For PAs: Ensure supervising physician reviews Schedule II prescriptions within 96 hours
- For NPs with less than 2 years experience: Maintain written guidelines with supervising physician
- Maintain appropriate state licensure and DEA registration
- Follow prescriber-specific scope of practice requirements
- Document telehealth encounters appropriately for billing and clinical purposes

Primary Citations:

- 243 CMR 2.01 (Definition of telemedicine)
- 101 CMR 329 (Telehealth services regulations)
- 105 CMR 721.070 (Electronic prescribing requirements for Schedule II)
- 105 CMR 700.000 (Controlled substance prescribing regulations)
- M.G.L. c. 112, §§ 80B, 80H (Nurse Practitioner prescriptive authority)
- M.G.L. c. 112, § 80C (Certified Nurse Midwife prescriptive authority)
- 244 CMR 4.00 (Nurse Practitioner regulations)

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• 263 CMR 5.06(3) (Physician Assistant prescriptive authority and supervision)

• Board of Registration in Medicine Policy 03-06 (Internet Prescribing Policy)

• Board of Registration in Medicine Policy 15-05 (Prescribing Practices Policy and Guidelines, amended 2023)

Supporting Citations:

• Federal Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 829(e)

• Federal COVID-19 telehealth flexibilities (extended through December 31, 2026)

• MassHealth telehealth reimbursement policies and bulletins

• Board of Registration in Medicine interim orders during COVID-19 pandemic

• Massachusetts Prescription Monitoring Program requirements

Effective Dates:

• Electronic prescribing requirement for Schedule II: Effective January 1, 2021

• Board Policy 15-05 (Prescribing Practices): Amended 2023

• COVID-19 interim orders: Issued during 2020 public health emergency; flexibility continues

• Federal COVID-19 telehealth flexibilities: Extended through December 31, 2026

• Telehealth insurance parity: Ongoing under Massachusetts law

• Current regulations reflect post-pandemic permanent telehealth framework with continued federal flexibilities

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Michigan, Minnesota, Mississippi

MICHIGAN

Regulatory Status: Explicit regulations exist**

Telehealth Controlled Substance Prescribing Authorization:

Michigan permits controlled substance prescribing via telehealth, subject to compliance with all applicable controlled substance prescribing requirements. The state initially prohibited controlled substance prescribing via telehealth when it enacted its telehealth law in 2016, but subsequently amended the statute effective March 31, 2017, to permit such prescribing. MCL § 333.16285(1)(b) allows health professionals providing telehealth services to prescribe controlled substances if "the health professional meets the requirements of this act applicable to that health professional for prescribing a controlled substance."

In-Person Examination Requirements:

Michigan does NOT require an initial in-person examination for telehealth prescribing of controlled substances. The statute explicitly permits establishment of the required "bona fide prescriber-patient relationship" through telehealth. MCL § 333.7104(1) defines "bona fide prescriber-patient

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relationship" to include "a relevant medical evaluation of the patient conducted in person or through telehealth as that term is defined in section 16283."

The bona fide prescriber-patient relationship requires:

- Review of the patient's relevant medical or clinical records
- Completion of an assessment of the patient's medical history and current medical condition
- Conduct of a relevant medical evaluation (which may be via telehealth)
- Creation and maintenance of records in accordance with medically accepted standards
- Provision of follow-up care or referral of the patient for follow-up care

No periodic in-person visits are mandated by statute. Online questionnaires alone are insufficient to establish a bona fide prescriber-patient relationship. The Michigan Board of Pharmacy, in conjunction with the National Association of Boards of Pharmacy and Federation of State Medical Boards, considers prescriptions issued pursuant only to an internet questionnaire to be invalid.

Schedule-Specific Rules and Restrictions:

Michigan law applies uniformly to all Schedule II-V controlled substances with the following distinctions:

Opioids for Acute Pain: Prescribers may not prescribe more than a 7-day supply of an opioid within a 7-day period when treating acute pain (effective July 1, 2018). MCL § 333.7303a.

Schedule II Quantity Limits for Mid-Level Prescribers: Nurse practitioners and nurse midwives delegated prescribing authority may not prescribe Schedule II controlled substances in quantities greater than a 30-day supply.

Michigan Automated Prescription System (MAPS) Requirement: Before prescribing or dispensing a controlled substance in a quantity exceeding a 3-day supply, prescribers must obtain and review a MAPS report (effective June 1, 2018). This requirement applies to all controlled substance prescriptions, whether issued via telehealth or in-person.

Opioid Consent Requirement: Prescribers must provide patients with statutorily-required information on opioids and obtain a signed "Start Talking" consent form before issuing new opioid prescriptions.

No explicit distinctions are made between psychiatric medications versus pain medications beyond the acute pain opioid limitation noted above.

Prescriber Type Restrictions:

Michigan law permits various prescriber types to prescribe controlled substances via telehealth, subject to scope of practice and delegation requirements:

Physicians (MD/DO): May prescribe all Schedule II-V controlled substances via telehealth without restrictions beyond the bona fide prescriber-patient relationship requirement.

Nurse Practitioners/APRNs: May prescribe Schedule II-V controlled substances via telehealth as a delegated act of a physician, pursuant to written authorization under MCL § 333.17211a. Both the APRN's and supervising physician's names and DEA numbers must be indicated on prescriptions. Schedule II prescriptions are limited to 30-day supplies.

Physician Assistants: May prescribe controlled substances under physician delegation with written authorization, subject to the same requirements as nurse practitioners.

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Nurse Midwives: May prescribe Schedule II-V controlled substances under physician delegation, with Schedule II prescriptions limited to 30-day supplies.

Certified Registered Nurse Anesthetists (CRNAs): Explicitly excluded from controlled substance delegation authority under Michigan administrative rules.

Dentists, Podiatrists, and Veterinarians: Are defined as "prescribers" under Michigan law and may prescribe controlled substances within their scope of practice via telehealth, subject to the bona fide prescriber-patient relationship requirement.

Optometrists (Certified): May prescribe controlled substances within their scope of practice via telehealth if certified to do so.

Pharmacists: Not authorized to prescribe controlled substances in Michigan.

All prescribers must comply with the bona fide prescriber-patient relationship requirement and other controlled substance prescribing requirements regardless of whether prescribing via telehealth or in-person.

Ryan Haight Act Compliance:

Michigan's regulations are consistent with the Ryan Haight Act. The state's requirement for a bona fide prescriber-patient relationship aligns with federal requirements, and Michigan's explicit authorization of telehealth for establishing this relationship provides clarity for practitioners. Michigan does not impose additional state-specific modifications beyond the Ryan Haight Act requirements.

COVID-19 Emergency Waivers:

Michigan's permanent statutory framework, enacted in 2017, already permitted telehealth prescribing of controlled substances prior to the COVID-19 pandemic. No temporary emergency waivers were necessary, and no COVID-specific provisions required conversion to permanent status. The state's telehealth controlled substance prescribing framework remains as established by the 2017 amendments.

Compliance Requirements:

- Establish bona fide prescriber-patient relationship (may be via telehealth)
- Review patient's relevant medical/clinical records
- Complete assessment of patient's medical history and current condition
- Conduct relevant medical evaluation (in-person or via telehealth)
- Create and maintain records per medically accepted standards
- Provide or arrange follow-up care
- Check MAPS before prescribing >3-day supply
- Limit acute pain opioid prescriptions to 7-day supply
- Obtain "Start Talking" consent for opioid prescriptions
- Mid-level prescribers: obtain physician delegation, limit Schedule II to 30-day supply
- Do not rely solely on online questionnaires

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Primary Citations:

- MCL § 333.16285(1)(b) - Telehealth controlled substance prescribing authorization
- MCL § 333.7104(1) - Bona fide prescriber-patient relationship definition
- MCL § 333.7303a - Opioid acute pain prescribing limits
- MCL § 333.17211a - APRN controlled substance prescribing delegation

Supporting Citations:

- Michigan Board of Pharmacy guidance on internet questionnaire prescriptions
- National Association of Boards of Pharmacy standards
- Federation of State Medical Boards guidelines
- Michigan Automated Prescription System (MAPS) regulations

Effective Dates:

- March 31, 2017: Amendment permitting telehealth controlled substance prescribing
- July 1, 2018: Opioid acute pain prescribing limits
- June 1, 2018: MAPS checking requirement for >3-day supplies

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MINNESOTA

Regulatory Status: Explicit regulations exist**

Telehealth Controlled Substance Prescribing Authorization:

Minnesota permits controlled substance prescribing via telehealth with specific examination requirements. The state does not have separate telehealth-only controlled substance regulations; rather, Minnesota Statute § 151.37, subd. 2(d) and (e) establishes requirements for prescribing controlled substances that apply to both in-person and telehealth encounters. The statute explicitly recognizes telehealth as a valid modality for meeting examination requirements, particularly for substance use disorder treatment with medications for opioid use disorder.

In-Person Examination Requirements:

Minnesota Statute § 151.37, subd. 2(d) requires that prescriptions for controlled substances (Schedules II-V) must be based on "a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment."

The examination requirement is satisfied if any of the following conditions are met:

1. The prescribing practitioner examines the patient at the time the prescription is issued

2. The prescribing practitioner has performed a prior examination of the patient

3. Another prescribing practitioner within the same group practice or clinic has examined the patient

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4. A consulting practitioner to whom the prescribing practitioner referred the patient has examined the patient

5. The referring practitioner has performed an examination in the case of a consultant practitioner issuing a prescription when providing services by means of telehealth

For substance use disorder treatment with medications for opioid use disorder, Minn. Stat. § 151.37, subd. 2(e)(2) explicitly allows the examination requirement to be satisfied via telehealth examination.

No specific frequency requirements (annual, biannual, or otherwise) are mandated for periodic in-person visits. The statute does not specify particular examination elements beyond requiring an examination "adequate to establish a diagnosis and identify underlying conditions and contraindications."

Questionnaires alone are insufficient. Minnesota law requires an actual examination, not merely an online questionnaire. Virtual exams via telehealth may satisfy the requirement for substance use disorder treatment, and the statute's language suggests telehealth examinations may be acceptable more broadly, though this is not explicitly stated for all controlled substance categories.

Schedule-Specific Rules and Restrictions:

Minnesota's examination requirement applies uniformly to:

- Controlled substance drugs listed in Minn. Stat. § 152.02, subdivisions 3-5 (Schedules II-IV)
- Drugs defined by the Board of Pharmacy as controlled substances under § 152.02, subdivisions 7, 8, and 12
- Muscle relaxants
- Centrally acting analgesics with opioid activity
- Stimulants
- Depressants

Opioid Acute Pain Limits: Minn. Stat. § 152.11, subd. 4 limits opioid prescriptions for acute pain to 7 days for adults and 5 days for minors, regardless of whether prescribed via telehealth or in-person.

Substance Use Disorder Treatment: Explicit telehealth authorization exists for prescribing medications for opioid use disorder in substance use disorder treatment contexts.

No explicit distinctions are made between Schedule II versus Schedule III-V controlled substances, psychiatric medications versus pain medications, or other opioid-specific restrictions beyond the general examination requirement and acute pain limits noted above.

Prescriber Type Restrictions:

Minnesota Statute § 152.12 authorizes the following practitioners to prescribe controlled substances, with authority extending to telehealth prescribing subject to the examination requirements in § 151.37:

Physicians (MD/DO): May prescribe all Schedule II-V controlled substances via telehealth.

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Advanced Practice Registered Nurses (APRNs): May prescribe Schedule II-V controlled substances via telehealth. The definition of "practitioner" in Minn. Stat. § 151.01, subd. 23 includes advanced practice registered nurses.

Physician Assistants (PAs): May prescribe Schedule II-V controlled substances via telehealth.

Dentists (DDS/DMD): Licensed doctors of dental surgery or dental medicine may prescribe controlled substances via telehealth within their scope of practice.

Podiatrists (DPM): Licensed doctors of podiatry may prescribe controlled substances via telehealth within their scope of practice.

Optometrists: LIMITED to prescribing Schedule IV and V controlled substances only. May not prescribe Schedule II or III controlled substances.

Veterinarians: Licensed doctors of veterinary medicine may prescribe controlled substances for animal use only.

Certified Nurse Midwives: Included in the definition of "practitioner" and may prescribe controlled substances within their scope of practice.

Certified Registered Nurse Anesthetists (CRNAs): Not explicitly addressed in the controlled substance prescribing statutes; authority would depend on scope of practice regulations.

Pharmacists: Have limited prescribing authority for specific medications (hormonal contraceptives, nicotine replacement therapy, opiate antagonists) but do not have general controlled substance prescribing authority.

The statute does not distinguish between telehealth and in-person prescribing authority. If a practitioner is authorized to prescribe controlled substances under § 152.12, they may do so via telehealth subject to the examination requirements in § 151.37.

Ryan Haight Act Compliance:

Minnesota's regulations are consistent with the Ryan Haight Act. The state's examination requirement aligns with federal requirements for a valid prescription, and Minnesota's explicit recognition of telehealth for substance use disorder treatment with medications for opioid use disorder is consistent with federal DEA exceptions. Minnesota does not impose additional state-specific modifications that conflict with federal Ryan Haight Act requirements.

COVID-19 Emergency Waivers:

Minnesota's statutory framework already permitted telehealth prescribing of controlled substances prior to the COVID-19 pandemic, subject to the examination requirements. The state did not need to enact temporary emergency waivers specific to controlled substance prescribing via telehealth. Any COVID-related telehealth expansions in Minnesota primarily addressed payment parity and technology requirements rather than controlled substance prescribing authorization, which was already established in statute.

Compliance Requirements:

- Conduct documented patient evaluation including examination adequate to establish diagnosis
- Identify underlying conditions and contraindications to treatment

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- Ensure examination is performed by prescribing practitioner, or by another practitioner in same group/clinic, or by consulting/referring practitioner
- For substance use disorder treatment with medications for opioid use disorder, telehealth examination is explicitly permitted
- Limit opioid prescriptions for acute pain to 7 days (adults) or 5 days (minors)
- Maintain documentation of examination and evaluation
- Optometrists limited to Schedule IV and V only
- Do not prescribe based solely on online questionnaire

Primary Citations:

- Minn. Stat. § 151.37, subd. 2(d) - Controlled substance prescribing examination requirement
- Minn. Stat. § 151.37, subd. 2(e)(2) - Telehealth examination for substance use disorder treatment
- Minn. Stat. § 152.12 - Authorized controlled substance prescribers
- Minn. Stat. § 152.11, subd. 4 - Opioid acute pain prescribing limits
- Minn. Stat. § 151.01, subd. 23 - Definition of "practitioner"
- Minn. Stat. § 152.02 - Controlled substance schedules

Supporting Citations:

- Minnesota Board of Pharmacy regulations
- Minnesota Board of Medical Practice guidance
- Minnesota Department of Health telehealth resources

Effective Dates:

The current statutory framework has been in effect with various amendments over time. The explicit recognition of telehealth for substance use disorder treatment was clarified in recent legislative sessions, though the exact effective date of subd. 2(e)(2) would require review of specific session law amendments.

MISSISSIPPI

Regulatory Status: Explicit regulations exist with significant restrictions**

Telehealth Controlled Substance Prescribing Authorization:

Mississippi permits controlled substance prescribing via telehealth with substantial limitations. Mississippi Code § 41-29-137(f) requires at least one in-person medical evaluation for valid controlled substance prescriptions, with specific exceptions for: (a) practitioners engaged in the practice of telemedicine as authorized under state or federal law; or (b) covering practitioners who conduct evaluations at the request of a practitioner who has conducted an in-person evaluation within the previous 24 months.

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Critically, Mississippi State Board of Medical Licensure regulations (30 Miss. Admin. Code Part 2635, Rule 5.16) explicitly prohibit telehealth services from being used for the management of chronic pain with controlled substance prescription drugs. This prohibition represents a significant restriction on telehealth controlled substance prescribing in Mississippi.

In-Person Examination Requirements:

Mississippi Code § 41-29-137(f)(1)(A) requires at least one in-person medical evaluation of the patient for a valid controlled substance prescription, except as otherwise authorized. The statute defines "in-person medical evaluation" as a medical evaluation conducted with the patient in the physical presence of the practitioner.

Initial In-Person Requirement: At least one in-person medical evaluation is required before prescribing controlled substances via telehealth, unless the practitioner qualifies for an exception (telemedicine as authorized under state or federal law, or covering practitioner arrangement).

Covering Practitioner Exception: A covering practitioner may conduct subsequent evaluations (including via telemedicine) if the original practitioner conducted an in-person evaluation or telemedicine evaluation within the previous 24 months. This creates a pathway for ongoing telehealth prescribing after an initial qualifying evaluation.

Examination Standards: For telemedicine generally (non-controlled substances), Part 2635, Rule 5.5 allows examinations via telehealth if the technology is sufficient to provide adequate information as if the exam had been performed in person. However, a simple questionnaire without an appropriate examination violates Mississippi policy.

Periodic Visit Requirements: The regulations do not specify mandatory periodic visit frequency requirements beyond the initial in-person evaluation. However, the covering practitioner provision references evaluations within the "previous 24 months," suggesting that evaluations should occur at least biennially to maintain prescribing authority.

Questionnaires and Virtual Exams: Mississippi Code § 41-29-137(f)(3) explicitly prohibits prescriptions based solely on an online medical questionnaire. Virtual exams may satisfy requirements if conducted with appropriate technology and clinical standards, but cannot be based solely on questionnaires.

Schedule-Specific Rules and Restrictions:

Chronic Pain Prohibition: The prohibition on telehealth for chronic pain management with controlled substances (30 Miss. Admin. Code Part 2635, Rule 5.16) applies to all schedules of controlled substances. This represents the most significant schedule-related restriction in Mississippi.

Optometrist Limitations: Mississippi Code § 41-29-137(d) specifically limits optometrists to prescribing only Schedule IV or V oral analgesic controlled substances for eye disease treatment.

Pain vs. Psychiatric Medications: The regulations distinguish between psychiatric medications (mental health services) and pain medications, with explicit prohibition of telehealth for chronic pain with controlled substances. Mental health services via telehealth are permitted, allowing for psychiatric medication management via telehealth, subject to the in-person evaluation requirement.

Schedule II vs. III-V: No specific distinctions are made between Schedule II versus Schedule III-V for purposes other than the chronic pain prohibition and optometrist limitations. All schedules are subject to the in-person evaluation requirement.

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Prescriber Type Restrictions:

Mississippi regulations specify different authorities for various prescriber types:

Physicians (MD/DO): May prescribe controlled substances via telehealth subject to the in-person evaluation requirement and chronic pain prohibition (Part 2635, Chapter 5; Part 2640).

Physician Assistants (PAs): May prescribe controlled substances with appropriate DEA registration and supervision, subject to the same state law requirements including the in-person evaluation mandate (30 Miss. Admin. Code Part 2615, Rule 1.5).

Advanced Practice Registered Nurses (APRNs): Including nurse practitioners (NPs), certified nurse practitioners (CNPs), certified nurse midwives (CNMs), certified registered nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs), may prescribe controlled substances via telehealth subject to DEA registration, collaborative physician relationship, and compliance with Miss. Code Ann. § 41-29-137 requirements (30 Miss. Admin. Code Part 2840, Rule 1.5).

Optometrists: Limited to prescribing Schedule IV or V oral analgesic controlled substances for eye disease by written prescription only (Miss. Code Ann. § 41-29-137(d)). This represents a significant restriction compared to other states.

Dentists: May prescribe controlled substances only for dental-related conditions and must register with the Mississippi Prescription Monitoring Program. Telehealth prescribing authority subject to in-person evaluation requirement.

Podiatrists: Included in the definition of "physician" under Part 2640 and may prescribe controlled substances within their scope of practice, subject to in-person evaluation requirement.

Pharmacists: Not authorized to prescribe controlled substances independently in Mississippi.

Veterinarians: Exempt from certain Prescription Monitoring Program reporting requirements for controlled substances dispensed to animals, but subject to controlled substance prescribing requirements for animal patients.

Ryan Haight Act Compliance:

Mississippi's statute explicitly incorporates Ryan Haight Act compliance. Miss. Code Ann. § 41-29-137(f)(4) provides that nothing in the in-person evaluation requirement applies to "a prescription issued by a practitioner engaged in the practice of telemedicine as authorized under state or federal law." This creates an exception that aligns with federal Ryan Haight Act exceptions.

The statute also prohibits prescriptions based solely on online medical questionnaires (Miss. Code Ann. § 41-29-137(f)(3)), which is consistent with Ryan Haight Act requirements.

Mississippi's regulations do not impose additional modifications that conflict with the Ryan Haight Act, though the state's chronic pain prohibition and in-person evaluation requirement represent more restrictive state standards that practitioners must follow in addition to federal requirements.

COVID-19 Emergency Waivers:

Mississippi enacted emergency orders during the COVID-19 pandemic that temporarily modified certain telehealth requirements. However, the chronic pain prohibition (Rule 5.16) and the in-person evaluation requirement for controlled substances (Miss. Code Ann. § 41-29-137(f)) remained in effect throughout the pandemic.

As of the current regulatory framework, Mississippi has not made permanent any COVID-specific waivers related to controlled substance prescribing via telehealth. The pre-pandemic statutory and

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regulatory framework remains in effect, including the in-person evaluation requirement and chronic pain prohibition.

Practitioners should note that federal COVID-related DEA flexibilities (such as the public health emergency exception to Ryan Haight Act in-person requirements) operated independently of Mississippi state law, and practitioners were required to comply with both federal flexibilities and Mississippi's more restrictive state requirements.

Compliance Requirements:

- Conduct at least one in-person medical evaluation before prescribing controlled substances (unless qualifying exception applies)
- Do NOT use telehealth for chronic pain management with controlled substances
- Do NOT prescribe based solely on online questionnaire
- Covering practitioners: ensure original practitioner conducted evaluation within previous 24 months
- Use technology sufficient to provide adequate information equivalent to in-person exam
- Register with Mississippi Prescription Monitoring Program
- Maintain collaborative physician relationship (APRNs)
- Obtain DEA registration appropriate to prescriber type
- Optometrists: limit to Schedule IV-V oral analgesics for eye disease only
- Dentists: prescribe only for dental-related conditions
- Document all evaluations and maintain medical records per state standards

Primary Citations:

- Miss. Code Ann. § 41-29-137(f) - In-person medical evaluation requirement for controlled substances
- Miss. Code Ann. § 41-29-137(f)(3) - Prohibition on online questionnaire-only prescriptions
- Miss. Code Ann. § 41-29-137(f)(4) - Telemedicine exception consistent with state/federal law
- Miss. Code Ann. § 41-29-137(d) - Optometrist prescribing limitations
- 30 Miss. Admin. Code Part 2635, Rule 5.16 - Prohibition on telehealth for chronic pain with controlled substances
- 30 Miss. Admin. Code Part 2635, Rule 5.5 - Telemedicine examination standards
- 30 Miss. Admin. Code Part 2615, Rule 1.5 - Physician assistant controlled substance prescribing
- 30 Miss. Admin. Code Part 2840, Rule 1.5 - APRN controlled substance prescribing
- 30 Miss. Admin. Code Part 2640 - Physician telemedicine regulations

Supporting Citations:

- Mississippi State Board of Medical Licensure guidance
- Mississippi Prescription Monitoring Program regulations
- Mississippi Board of Pharmacy guidance

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- Mississippi State Board of Nursing regulations

Effective Dates:

The in-person evaluation requirement in Miss. Code Ann. § 41-29-137(f) has been in effect since its enactment. The chronic pain prohibition in Rule 5.16 was adopted by the Mississippi State Board of Medical Licensure and remains in effect as part of the current regulatory framework. Practitioners should verify the most current effective dates with the respective licensing boards, as regulations may be amended through the administrative rulemaking process.

Missouri, Montana, Nebraska

MISSOURI

Regulatory Status: Explicit state regulations exist governing telehealth prescribing of controlled substances, though Missouri does not impose additional restrictions beyond federal law specifically for the telehealth modality.**

Telehealth CS Prescribing Authority:

Missouri permits controlled substances to be prescribed via telehealth, subject to establishing a valid physician-patient relationship and compliance with federal Ryan Haight Act requirements. The state's regulatory framework focuses on the establishment and maintenance of appropriate provider-patient relationships rather than imposing categorical prohibitions on telehealth prescribing of specific controlled substance schedules.

In-Person Examination Requirements:

Missouri law does NOT require an in-person examination for telehealth prescribing at the state level. Under Mo. Rev. Stat. § 191.1146, a physician-patient relationship may be established through three pathways:

1. An in-person encounter

2. Consultation with another physician who has an established relationship with the patient

3. A telemedicine encounter, if the standard of care does not require an in-person encounter and is conducted in accordance with evidence-based standards of practice

For telemedicine establishment of the relationship, the statute requires:

- Technology sufficient to establish an informed diagnosis as though performed in person
- Interview of the patient
- Collection and review of relevant medical history
- Performance of an examination sufficient for diagnosis and treatment

Critical Limitation: Questionnaires (internet or telephone-based) do NOT constitute an acceptable medical interview and examination under Mo. Rev. Stat. § 191.1146(2).**

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Missouri law explicitly prohibits prescribing based solely on telephone evaluation UNLESS a previously established and ongoing physician-patient relationship exists (Mo. Rev. Stat. § 334.108(3)). Audio-video telemedicine is permitted for initial encounters.

No specific periodic visit requirements (annual or biannual) are mandated by Missouri state law. However, federal Ryan Haight Act requirements apply, currently subject to federal COVID-19 flexibilities extended through December 31, 2026.

Schedule-Specific Rules:

Missouri does not distinguish between Schedule II-V controlled substances for telehealth prescribing purposes at the state level. However, significant schedule-based restrictions exist for mid-level prescribers:

Advanced Practice Registered Nurses (APRNs):

- May prescribe Schedules III, IV, and V controlled substances when delegated authority in a collaborative practice arrangement
- For Schedule II: LIMITED to hydrocodone-containing medications and Schedule II controlled substances for hospice patients only
- Schedule II-hydrocodone and Schedule III narcotic controlled substance prescriptions are limited to a 120-hour (5-day) supply without refill

Physician Assistants (PAs):

- May prescribe Schedules III, IV, and V controlled substances when delegated in a collaborative practice arrangement
- For Schedule II: LIMITED to hydrocodone-containing medications only (does not include hospice exception available to APRNs)
- Same 120-hour supply limit applies

Physicians, Podiatrists, and Dentists:

- Full prescriptive authority for all schedules within their scope of practice

Optometrists:

- Those certified to administer pharmaceutical agents may prescribe Schedule III-V controlled substances and Schedule II hydrocodone or hydrocodone combination medications

Missouri does not impose specific distinctions between psychiatric medications versus pain medications for telehealth purposes, though standard of care requirements apply to all prescribing.

Prescriber Type Restrictions:

Physicians (MD/DO):

May prescribe all controlled substances via telehealth with valid physician-patient relationship.

APRNs (excluding CRNAs):

May prescribe via telehealth when authority is delegated in collaborative practice arrangement. Must have:

- Certificate of controlled substance prescriptive authority from Board of Nursing
- 1,000 hours of advanced practice experience

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• Collaborative practice arrangement with physician

Collaboration may occur via telehealth per 20 CSR 2200-4.200(4)(F). Limited to Schedules III-V and hydrocodone/hospice Schedule II as noted above.

CRNAs (Certified Registered Nurse Anesthetists):

Explicitly EXCLUDED from controlled substance prescriptive authority under Mo. Rev. Stat. § 195.070.

Physician Assistants:

May prescribe via telehealth when authority is delegated in collaborative practice arrangement. Limited to Schedules III-V and hydrocodone Schedule II as noted above.

Pharmacists:

Missouri pharmacists do not have independent prescriptive authority for controlled substances.

Optometrists:

Those certified to administer pharmaceutical agents may prescribe limited controlled substances via telehealth within scope of practice (Schedule III-V and Schedule II hydrocodone).

Dentists:

Full prescriptive authority for controlled substances via telehealth within scope of practice.

Podiatrists:

Full prescriptive authority for controlled substances via telehealth within scope of practice.

Veterinarians:

May prescribe controlled substances for animal patients within scope of practice; no specific telehealth restrictions identified beyond general requirements.

Ryan Haight Act Compliance:

Missouri defers to federal Ryan Haight Act requirements. State law does not create modifications or exceptions to federal standards. Practitioners must comply with federal law, including:

• Current federal COVID-19 telemedicine flexibilities (extended through December 31, 2026)

• Upon expiration of federal flexibilities, the Ryan Haight Act's requirement of at least one in-person medical evaluation before prescribing controlled substances via telemedicine, unless an exception applies

• DEA registration requirements

COVID-19 Emergency Waivers:

Missouri has not enacted state-level COVID-19 waivers specific to controlled substance prescribing via telehealth. The state relies on federal flexibilities, which remain in effect through December 31, 2026 under DEA's temporary extensions.

Compliance Requirements:

• Establish valid physician-patient relationship through in-person encounter, consultation with another provider, or telemedicine encounter meeting statutory standards

• Use technology sufficient to establish informed diagnosis as though performed in person

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- Conduct interview of patient, collect/review relevant medical history, and perform examination sufficient for diagnosis and treatment
- Do NOT rely solely on questionnaires (internet or telephone) for medical interview and examination
- Do NOT prescribe based solely on telephone evaluation unless previously established and ongoing relationship exists
- Audio-video telemedicine required for initial encounters
- Mid-level prescribers must operate within collaborative practice arrangements with appropriate delegation
- Comply with schedule-specific limitations for APRNs and PAs
- Maintain compliance with federal Ryan Haight Act requirements
- Follow standard of care requirements for all prescribing

Primary Citations:

- Mo. Rev. Stat. § 191.1146 (Telemedicine; physician-patient relationship establishment)
- Mo. Rev. Stat. § 334.108(3) (Prohibition on telephone-only prescribing)
- Mo. Rev. Stat. § 195.070 (Controlled substance prescriptive authority by practitioner type)
- Mo. Rev. Stat. § 335.019 (APRN controlled substance prescriptive authority requirements)
- Mo. Rev. Stat. § 334.747(1) (PA controlled substance prescriptive authority)
- Mo. Rev. Stat. § 336.220 (Optometrist prescriptive authority)
- 20 CSR 2200-4.200(9) (APRN controlled substance prescribing limitations)
- 20 CSR 2200-4.200(4)(F) (Telehealth collaboration provisions)
- 20 Mo. Code of State Regs. 2210-2.080(6) (Optometrist controlled substance prescribing)

Supporting Citations:

- Federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008
- DEA COVID-19 telemedicine flexibilities (extended through December 31, 2026)

Effective Dates:

Mo. Rev. Stat. § 191.1146 establishes the current framework for telemedicine physician-patient relationships. The collaborative practice arrangement requirements for APRNs and PAs reflect ongoing statutory and regulatory provisions. Federal COVID-19 flexibilities were most recently extended through December 31, 2026.

MONTANA

Regulatory Status: Explicit state regulations exist governing telehealth prescribing of controlled substances through ARM 24.156.813 (Practice Requirements for Physicians and Physician Assistants Using Telemedicine), which was significantly amended effective February 10, 2024.**

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Telehealth CS Prescribing Authority:

Montana explicitly permits telehealth prescribing of controlled substances, including Schedule II drugs. The 2024 amendments to ARM 24.156.813 modernized Montana's approach by removing previous restrictions and aligning state regulations with evolving telemedicine standards.

In-Person Examination Requirements:

Montana's regulations are notably flexible regarding in-person examinations. ARM 24.156.813(3) provides that a provider-patient relationship may be established for purposes of telemedicine through three pathways:

1. By an in-person medical interview and physical examination when the standard of care requires an in-person encounter
2. By consultation with another licensee or health care provider who has a documented relationship with the patient and who agrees to participate in, or supervise, the patient's care
3. Through telemedicine if the standard of care does not require an in-person encounter

Significant 2024 Change:** Montana REMOVED the requirement for an in-person examination before prescribing Schedule II controlled substances in the February 10, 2024 amendment to ARM 24.156.813. This represents a substantial liberalization of Montana's telehealth controlled substance prescribing framework.

The regulation requires adherence to "the same standards of care required for in-person medical care settings" but does not mandate specific exam elements or periodic visit schedules. Virtual exams can satisfy requirements if the standard of care does not require an in-person encounter.

No periodic visit requirements (annual or biannual) are specified in Montana regulations.

Schedule-Specific Rules:

Schedule II Drugs:

ARM 24.156.813(4) explicitly states: "The licensee using telemedicine in patient care may prescribe Schedule II drugs in compliance with Drug Enforcement Agency requirements and 37-20-404, MCA."

Schedules III-V:

Permitted via telehealth with same requirements as Schedule II.

Physician Assistant Limitations:

Montana limits PA prescription of Schedule II drugs to a 30-day supply. This limitation applies to all PA prescribing, not specifically to telehealth.

General Opioid Restrictions:

Mont. Code Ann. § 37-2-108 imposes a 7-day supply limit for opioid-naive patients. This applies to all prescribing modalities, not specifically to telehealth.

Montana regulations do not create specific distinctions between psychiatric medications versus pain medications for telehealth purposes. The standard of care framework applies uniformly across medication types.

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Prescriber Type Restrictions:

Physicians (MD/DO):

Full authority to prescribe controlled substances via telehealth per ARM 24.156.813.

Physician Assistants:

Explicitly included in ARM 24.156.813 (amended 2024). Can prescribe Schedule II drugs via telehealth with 30-day supply limitation. Must maintain DEA registration per Mont. Code Ann. § 37-20-404(d).

Nurse Practitioners/APRNs:

Montana is a full practice authority state for NPs. While not explicitly mentioned in ARM 24.156.813, NPs can prescribe controlled substances within their scope of practice. Montana allows NPs to prescribe Schedule II-V controlled substances with DEA registration. No state-specific telehealth restrictions identified beyond general practice requirements.

CRNAs (Certified Registered Nurse Anesthetists):

Can prescribe within scope of practice; no specific telehealth controlled substance prescribing restrictions identified.

Clinical Nurse Specialists:

Can prescribe within scope of practice; no specific telehealth controlled substance prescribing restrictions identified.

Pharmacists:

Mont. Code Ann. § 37-7-101 (as amended by SB 112, 2023) explicitly prohibits pharmacists from prescribing controlled substances, whether via telehealth or otherwise.

Optometrists:

Can prescribe controlled substances within their scope of practice. Mont. Code Ann. § 37-2-104 governs dispensing by medical practitioners. No specific telehealth restrictions identified beyond general requirements.

Dentists:

Can prescribe controlled substances within their scope of practice via telehealth. No specific restrictions identified beyond general requirements and the 7-day opioid-naive patient limitation.

Podiatrists:

Can prescribe controlled substances within their scope of practice via telehealth. No specific restrictions identified beyond general requirements.

Veterinarians:

Can prescribe controlled substances for animal patients within scope of practice; no specific telehealth restrictions identified.

Ryan Haight Act Compliance:

Montana regulations reference and require compliance with DEA requirements. ARM 24.156.813(4) specifically requires Schedule II prescribing "in compliance with Drug Enforcement Agency requirements." Montana does not have state modifications that supersede the Ryan Haight Act; practitioners must comply with federal law.

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Currently, federal COVID-19 telemedicine flexibilities allow prescribing of Schedule II-V controlled substances via telemedicine without a prior in-person medical evaluation, extended through December 31, 2026 under DEA's temporary extensions.

Montana's removal of the state-level in-person examination requirement for Schedule II prescribing (effective February 10, 2024) positions the state to continue permitting telehealth controlled substance prescribing even after federal flexibilities expire, subject to compliance with whatever federal framework is ultimately adopted.

COVID-19 Emergency Waivers:

Montana has not enacted separate state-level COVID-19 waivers. Instead, the state took a more permanent approach by amending ARM 24.156.813 effective February 10, 2024 to remove the in-person examination requirement for Schedule II prescribing. This regulatory change effectively makes permanent the flexibility that was temporarily available during the COVID-19 public health emergency, though practitioners must still comply with federal requirements.

Compliance Requirements:

- Establish provider-patient relationship through one of three pathways: in-person encounter (when standard of care requires), consultation with another provider with documented patient relationship, or telemedicine encounter (when standard of care permits)
- Adhere to same standards of care required for in-person medical care settings
- For Schedule II prescribing, comply with DEA requirements and Mont. Code Ann. § 37-20-404
- Physician assistants limited to 30-day supply for Schedule II prescriptions
- Comply with 7-day supply limit for opioid-naive patients (applies to all prescribing)
- Maintain appropriate DEA registration
- Document telemedicine encounters appropriately
- Ensure technology is adequate for standard of care

Primary Citations:

- ARM 24.156.813 (Practice Requirements for Physicians and Physician Assistants Using Telemedicine) (amended effective February 10, 2024)
- Mont. Code Ann. § 37-20-404 (Controlled substance prescribing requirements)
- Mont. Code Ann. § 37-2-108 (Opioid prescribing limitations for opioid-naive patients)
- Mont. Code Ann. § 37-7-101 (Pharmacist scope of practice) (amended by SB 112, 2023)
- Mont. Code Ann. § 37-2-104 (Dispensing by medical practitioners)

Supporting Citations:

- Federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008
- DEA COVID-19 telemedicine flexibilities (extended through December 31, 2026)
- NCBI StatPearls 2023 (PA prescribing limitations)

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Effective Dates:

ARM 24.156.813 was significantly amended effective February 10, 2024, removing the in-person examination requirement for Schedule II controlled substance prescribing via telemedicine. This represents the most current regulatory framework. Mont. Code Ann. § 37-7-101 was amended by SB 112 in 2023 to clarify pharmacist prescribing prohibitions.

NEBRASKA

Regulatory Status: Nebraska does not have explicit state-specific regulations governing telehealth prescribing of controlled substances beyond general telehealth prescribing authority. The state's approach relies primarily on federal law compliance and general telehealth statutes.**

Telehealth CS Prescribing Authority:

Nebraska's primary telehealth prescribing statute, Neb. Rev. Stat. § 38-1,143(2), provides broad authority: "Any credential holder under the Uniform Credentialing Act who is providing a telehealth service to a patient may prescribe the patient a drug if the credential holder is authorized to prescribe under state and federal law."

This language explicitly defers to federal law for controlled substance prescribing requirements, including the Ryan Haight Act. The statute's permissive framework allows controlled substance prescribing via telehealth by any practitioner authorized to prescribe under both state and federal law.

In-Person Examination Requirements:

Nebraska statutes do not impose state-specific in-person examination requirements for controlled substance prescribing via telehealth. The state explicitly allows provider-patient relationships to be established through telehealth under Neb. Rev. Stat. § 38-1,143(1), and does not mandate initial in-person visits at the state level.

According to authoritative sources (AAFP Legal Requirements for Telehealth, May 2023), Nebraska requires the following for controlled substance prescribing via telehealth:

1. Valid license or certificate in Nebraska
2. Establishment of clinician-patient relationship
3. Evaluation and risk assessment
4. Diagnosis and treatment plan
5. Documentation in medical record
6. Informed consent if prescribing a controlled substance

These requirements can be satisfied through telehealth encounters; Nebraska does not mandate in-person visits for initial or periodic examinations at the state level. The state defers to federal Ryan Haight Act requirements, which currently allow telehealth-only encounters under COVID-19 flexibilities extended through December 31, 2026.

No periodic visit requirements (annual or biannual) are specified in Nebraska law.

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Schedule-Specific Rules:

Nebraska law does not differentiate between Schedule II and Schedule III-V controlled substances for telehealth prescribing purposes. The state's Uniform Controlled Substances Act and Pharmacy Practice Act contain general controlled substance prescribing requirements but do not create telehealth-specific schedule distinctions.

Electronic Prescribing Requirements:

LB583 mandates electronic prescribing of controlled substances (EPCS):

- Effective January 1, 2022 for most practitioners
- Effective January 1, 2024 for dentists

This requirement applies to all controlled substance prescribing, whether via telehealth or in-person, and does not create differential treatment based on prescribing modality.

No Medication-Type Distinctions:

Nebraska has not identified state-level restrictions distinguishing psychiatric medications from pain medications or imposing opioid-specific telehealth limitations beyond federal requirements. Standard of care principles apply uniformly.

Prescriber Type Restrictions:

Nebraska's statute applies to "any credential holder under the Uniform Credentialing Act" who is "authorized to prescribe under state and federal law." This broad language encompasses multiple practitioner types, with no mid-level prescriber restrictions specific to telehealth. If a practitioner can prescribe controlled substances in-person under Nebraska law, they may do so via telehealth subject to federal requirements.

Physicians and Osteopathic Physicians:

Full prescribing authority via telehealth for all controlled substance schedules.

Physician Assistants (PAs):

May prescribe drugs and devices within scope of practice under Neb. Rev. Stat. § 38-2055, including via telehealth. No telehealth-specific restrictions on controlled substance prescribing.

Nurse Practitioners (NPs/APRNs):

Have prescribing authority within scope of practice, including controlled substances via telehealth. No telehealth-specific restrictions identified.

Certified Nurse Midwives (CNMs):

Authorized to prescribe within scope of practice, including via telehealth.

Certified Registered Nurse Anesthetists (CRNAs):

May administer controlled substances within scope of practice. Prescribing authority subject to scope limitations.

Clinical Nurse Specialists:

May prescribe within scope of practice, including via telehealth.

Dentists:

Full prescribing authority via telehealth for controlled substances within scope of practice. Subject to EPCS requirements as of January 1, 2024.

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Optometrists:

May prescribe controlled substances within their respective scope of practice via telehealth.

Podiatrists:

May prescribe controlled substances within their respective scope of practice via telehealth.

Pharmacists:

Nebraska pharmacists may not independently prescribe controlled substances but may dispense pursuant to valid prescriptions, including those issued via telehealth.

Veterinarians:

Explicitly EXCLUDED from Neb. Rev. Stat. § 38-1,143(4) telehealth prescribing provisions. This represents a notable exception to Nebraska's otherwise permissive telehealth prescribing framework.

Ryan Haight Act Compliance:

Nebraska explicitly defers to federal law. Neb. Rev. Stat. § 38-1,143(2) conditions telehealth prescribing on authorization "under state and federal law." This incorporates the Ryan Haight Act's requirements by reference. Nebraska has not enacted state-level modifications to Ryan Haight standards.

Practitioners must comply with:

1. Current federal COVID-19 telemedicine flexibilities (extended through December 31, 2026 per DEA's Fourth Temporary Extension), which allow prescribing of Schedule II-V controlled substances via telemedicine without a prior in-person medical evaluation

2. Upon expiration of federal flexibilities, the Ryan Haight Act's general requirement of at least one in-person medical evaluation before prescribing controlled substances via telemedicine, unless an exception applies

3. DEA registration requirements in each state where the practitioner is prescribing

Nebraska's statutory framework will automatically incorporate whatever federal standards are in effect, as the state statute explicitly requires compliance with federal law.

COVID-19 Emergency Waivers:

Nebraska has not enacted separate state-level COVID-19 waivers for controlled substance prescribing via telehealth. The state relies entirely on federal flexibilities, which remain in effect through December 31, 2026. Nebraska's statutory framework (Neb. Rev. Stat. § 38-1,143(2)) automatically incorporates federal requirements by reference, so practitioners benefit from federal flexibilities without need for separate state action.

When federal flexibilities expire, Nebraska practitioners will need to comply with whatever federal framework is ultimately adopted, as Nebraska law defers to federal requirements.

Compliance Requirements:

- Maintain valid Nebraska license or certificate under the Uniform Credentialing Act
- Establish clinician-patient relationship (may be accomplished via telehealth)
- Conduct evaluation and risk assessment appropriate to the clinical situation
- Develop diagnosis and treatment plan

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- Maintain documentation in medical record
- Obtain informed consent if prescribing a controlled substance
- Comply with electronic prescribing requirements (effective January 1, 2022 for most practitioners; January 1, 2024 for dentists)
- Maintain compliance with federal Ryan Haight Act requirements
- Ensure authorization to prescribe under both state and federal law
- Maintain appropriate DEA registration
- Veterinarians may not prescribe via telehealth under Nebraska law

Primary Citations:

- Neb. Rev. Stat. § 38-1,143 (Telehealth services; prescribing authority; establishment of provider-patient relationship)
- Neb. Rev. Stat. § 38-2055 (Physician assistant scope of practice)
- LB583 (Electronic prescribing of controlled substances mandate)
- Nebraska Uniform Controlled Substances Act
- Nebraska Pharmacy Practice Act

Supporting Citations:

- AAFP Legal Requirements for Telehealth (May 2023)
- Federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008
- DEA COVID-19 telemedicine flexibilities (extended through December 31, 2026)

Effective Dates:

Neb. Rev. Stat. § 38-1,143 establishes the current telehealth prescribing framework. Electronic prescribing requirements under LB583 became effective January 1, 2022 for most practitioners and January 1, 2024 for dentists. Federal COVID-19 flexibilities remain in effect through December 31, 2026.

NEVADA

Regulatory Status: Explicit regulations exist**

Telehealth Controlled Substance Prescribing Authorization:

Nevada explicitly permits telehealth prescribing of controlled substances across all schedules (CII-CV). The state's pharmacy law establishes that a bona fide practitioner-patient relationship exists when the patient has been examined "in person, electronically, telephonically or by fiber optics, including, without limitation, through telehealth" within the 6 months immediately preceding the prescription date. This language provides clear statutory authorization for remote prescribing of controlled substances without requiring an initial in-person encounter.

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In-Person Examination Requirements:

Nevada does not require an initial in-person examination to establish the practitioner-patient relationship necessary for controlled substance prescribing. A telehealth examination is explicitly sufficient to establish this relationship. However, the state mandates periodic examinations on a semi-annual basis—practitioners must examine patients (either in-person or via telehealth) within 6 months immediately preceding any controlled substance prescription issuance.

For pain management prescriptions specifically (Schedules II-IV controlled substances prescribed for pain treatment), Nevada imposes additional examination requirements:

- Relevant medical history must be obtained
- Physical examination directed to the source of pain within the practitioner's scope of practice must be conducted
- For prescriptions of 30 days or longer, practitioners must make a good faith effort to obtain and review prior medical records
- Assessment of mental health and risk of abuse/dependency using validated methods is required

Virtual examinations and telehealth encounters explicitly satisfy these requirements. The statute does not distinguish between in-person and telehealth examinations for purposes of establishing or maintaining the bona fide relationship. Online questionnaires alone, however, would not constitute a proper "examination" under the standard of care requirements.

For ongoing pain management, additional periodic requirements apply:

- Practitioners cannot issue more than one additional prescription increasing the dose unless they meet with the patient (in-person OR via telehealth) to reevaluate the treatment plan
- After 90 consecutive days of controlled substance use for pain, practitioners must meet with the patient (in-person OR via telehealth) to review the treatment plan and determine continued medical appropriateness

Schedule-Specific Rules:

The 6-month examination requirement applies uniformly to all controlled substance schedules (CII-CV). However, Nevada creates differential requirements for out-of-state prescribers: pharmacists must establish and document the bona fide relationship for Schedule II prescriptions, while for Schedules III-IV, they must establish the relationship but are not required to document it for subsequent prescriptions.

Pain management prescriptions receive heightened scrutiny regardless of schedule:

- For acute pain, controlled substance prescriptions are limited to 14 days
- Opioid prescriptions for opioid-naïve patients are limited to 90 morphine milligram equivalents (MME) unless medically necessary with documentation
- Special informed consent requirements apply to opioid prescriptions, including information about naloxone availability, risks to women aged 15-45 years, and risks for minors

Nevada does not create separate regulatory pathways for psychiatric medications versus pain medications, though pain medications carry the additional requirements described above. The state's opioid-specific restrictions focus on dosage limitations, informed consent, and treatment plan documentation rather than prohibiting telehealth prescribing.

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Prescriber Type Authorization:

Nevada authorizes a broad range of prescriber types to prescribe controlled substances via telehealth, subject to their scope of practice and licensing requirements:

Physicians (MD/DO): Fully authorized to prescribe all controlled substance schedules via telehealth with appropriate Nevada medical license and DEA/state controlled substance registration.

Physician Assistants: May prescribe controlled substances via telehealth if authorized by a Nevada Board of Pharmacy registration certificate. PAs must obtain separate registration from the Board of Pharmacy and pass a pharmacy law examination. They are subject to the same 6-month examination requirements as physicians.

Advanced Practice Registered Nurses (APRNs): Explicitly authorized to prescribe controlled substances via telehealth. Nevada statute specifically states that APRNs "may perform the acts described...by using equipment that transfers information...including, without limitation, through telehealth." For Schedule II substances, APRNs must have either: (a) 2 years or 2,000 hours of clinical experience, OR (b) a protocol approved by a collaborating physician.

Certified Registered Nurse Anesthetists (CRNAs): Authorized to order, prescribe, possess, or administer controlled substances and are recognized as practitioners under Nevada pharmacy law.

Clinical Nurse Specialists: Included within the APRN category and subject to the same requirements.

Dentists: Authorized as "practitioners" under Nevada pharmacy law and may prescribe controlled substances via telehealth subject to the same 6-month examination requirement and within their scope of practice.

Optometrists: Authorized to prescribe controlled substances via telehealth when certified by the Nevada State Board of Optometry to prescribe pharmaceutical agents, within the scope of their certification.

Podiatrists: Authorized as "practitioners" under Nevada pharmacy law and may prescribe controlled substances via telehealth within their scope of practice. Notably, veterinarians are exempt from certain pain management requirements.

Veterinarians: Authorized as "practitioners" and may prescribe controlled substances via telehealth for animal patients. They are exempt from certain pain management documentation requirements that apply to human medicine.

Pharmacists: Have limited authority for medication-assisted treatment of opioid use disorder under specific protocol but do not have general controlled substance prescribing authority.

Ryan Haight Act Compliance:

Nevada law operates in conjunction with federal requirements. Practitioners must maintain both state licensure and appropriate DEA registration. The state's telehealth provisions do not create exemptions from federal Ryan Haight Act requirements; rather, they establish state-level standards that practitioners must meet in addition to federal requirements. Nevada has not enacted specific state modifications to the Ryan Haight Act's in-person examination requirement, instead creating its own parallel framework through the 6-month examination requirement.

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COVID-19 Emergency Waivers:

Nevada's telehealth controlled substance prescribing framework was established through permanent statutory changes rather than emergency waivers. The state's current regulations reflect permanent law rather than temporary COVID-19 measures. The explicit inclusion of telehealth in the definition of acceptable examination modalities represents a permanent feature of Nevada law, not a temporary emergency provision.

Compliance Requirements:

- Establish and maintain bona fide practitioner-patient relationship through examination within 6 months preceding prescription
- For pain management CS (CII-IV): obtain medical history, conduct physical examination, review prior records for prescriptions ≥30 days, assess mental health and abuse risk
- Meet with patients (in-person or telehealth) before increasing pain medication doses beyond one additional prescription
- Conduct 90-day review for patients on continuous pain management
- Maintain Nevada professional license and DEA registration
- For acute pain: limit CS to 14 days; limit opioids to 90 MME for opioid-naïve patients unless documented medical necessity
- Provide informed consent for opioid prescriptions including naloxone information and risk disclosures
- Document all examinations and treatment decisions in medical records
- For out-of-state prescribers: ensure pharmacists can verify bona fide relationship (with documentation for CII)

Primary Citations:

- NRS 639.235 (Bona fide practitioner-patient relationship; examination requirements)
- NRS 639.23912 (Pain management evaluation requirements)
- NRS 639.23911 (Dose increase restrictions for pain management)
- NRS 639.23913 (90-day review requirement for pain management)
- NRS 632.237 (APRN prescriptive authority and telehealth authorization)
- NRS 632.2397 (CRNA controlled substance authority)
- NRS 639.0125 (Definitions of "practitioner")
- NRS 639.1373 (Physician assistant prescribing authority)
- NRS 636.288 (Optometrist pharmaceutical agent certification)
- NRS 639.28079 (Pharmacist medication-assisted treatment authority)

Supporting Citations:

- Nevada Board of Pharmacy regulations implementing NRS Chapter 639
- Nevada State Board of Nursing regulations for APRN practice

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- Nevada Medical Board guidance on telemedicine standards of care

Effective Dates:

The current telehealth prescribing framework reflects amendments to Nevada pharmacy law that have been in effect since 2015, with subsequent amendments to pain management requirements enacted in 2017 and opioid prescribing limitations added in 2017-2019. The explicit inclusion of telehealth in the bona fide relationship definition has been part of Nevada law since the 2015 legislative session. Pain management requirements under NRS 639.23911-639.23913 became effective July 1, 2017.

NEW HAMPSHIRE

Regulatory Status:** Explicit regulations exist with recent comprehensive reform

Telehealth Controlled Substance Prescribing Authorization:

New Hampshire permits telehealth prescribing of controlled substances in Schedules II-IV (both opioid and non-opioid). The state underwent significant legislative evolution culminating in Senate Bill 252, which became effective August 23, 2025, substantially liberalizing the state's telehealth controlled substance prescribing framework. This recent legislation represents a major policy shift from New Hampshire's previous more restrictive approach.

In-Person Examination Requirements:

Under the current law effective August 23, 2025, New Hampshire does NOT require an initial in-person examination before prescribing controlled substances via telehealth. This represents a significant change from prior law, which required establishment of a physician-patient or APRN-patient relationship before telehealth prescribing could commence.

For ongoing treatment, the law requires a subsequent "evaluation" (not necessarily in-person) conducted by a practitioner licensed to prescribe the drug at intervals appropriate for the patient, medical condition, and drug, but NOT LESS THAN ANNUALLY. The critical change in the 2025 legislation was the shift from requiring "in-person exams" to requiring "evaluations," providing substantially greater flexibility. These evaluations can be conducted via telehealth modalities including video, audio, or other interactive technologies.

The law mandates that practitioners use the same standard of care for telehealth encounters as would apply to in-person encounters. For specific contexts, such as physicians prescribing spectacle or contact lenses via telemedicine, additional requirements apply: practitioners must obtain updated medical history, make an appropriate diagnosis, conform to the standard of care, and cannot determine a prescription solely by online questionnaire.

Online questionnaires alone explicitly do NOT satisfy New Hampshire's requirements and cannot form the basis of a valid practitioner-patient relationship. The statute specifically prohibits prescribing controlled substances based solely on questionnaire responses without proper clinical evaluation.

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Schedule-Specific Rules:

New Hampshire's telehealth prescribing authorization covers Schedules II-IV uniformly, with both opioid and non-opioid controlled substances treated the same under the telehealth framework. Schedule V controlled substances are not explicitly addressed in the telehealth statutes, suggesting they fall under general prescribing authority without special telehealth restrictions.

The law does not create distinctions between Schedule II and Schedules III-V for telehealth purposes—all are subject to the same annual evaluation requirement and standard of care provisions. Similarly, New Hampshire does not differentiate between psychiatric medications and pain medications in its telehealth controlled substance prescribing regulations.

For opioid prescribing specifically, all Schedule II-IV opioids may be prescribed via telehealth with annual evaluation requirements. However, methadone hydrochloride for substance use disorder treatment has specific restrictions and must be provided in accordance with federal regulations governing opioid treatment programs.

New Hampshire has established special provisions for substance use disorder (SUD) treatment in designated locations including state hospitals, correctional facilities, community mental health centers, SAMHSA-certified opioid treatment programs, VA facilities, and "doorway" programs. These settings may have different requirements for telehealth prescribing of medications for addiction treatment.

Prescriber Type Authorization:

Senate Bill 252 explicitly authorized multiple prescriber types to prescribe controlled substances via telehealth:

Physicians (MD/DO): Fully authorized to prescribe Schedules II-IV controlled substances via telehealth under RSA 329:1-d, III.

Physician Assistants: Explicitly authorized under SB 252 to prescribe controlled substances via telehealth pursuant to RSA 328-D:3-b, XIII. PAs are subject to the same annual evaluation requirements and standard of care provisions as physicians.

Advanced Practice Registered Nurses (APRNs/Nurse Practitioners): Explicitly authorized under SB 252 to prescribe controlled substances via telehealth pursuant to RSA 326-B:11, III-a. APRNs are subject to the same requirements as physicians and PAs.

Clinical Nurse Specialists: Included under the APRN category if appropriately licensed in New Hampshire.

The statute specifically limits controlled substance telehealth prescribing to "prescribers as defined in RSA 329:1-d, I and RSA 326-B:2, XII(a)"—which refers to physicians, physician assistants, and APRNs. Other prescriber types are not explicitly authorized:

Certified Registered Nurse Anesthetists (CRNAs): Not specifically addressed in the telehealth controlled substance prescribing statutes. While CRNAs are APRNs in New Hampshire, their prescriptive authority for controlled substances via telehealth is not explicitly stated in the telehealth framework.

Pharmacists: Not authorized to prescribe controlled substances. Pharmacists may provide medication reviews and consultations via telehealth but do not have prescribing authority.

Optometrists: Can prescribe Schedule III-V controlled substances generally under RSA 327:1-III, but no specific telehealth controlled substance prescribing authorization was found in the statutes.

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Dentists: No specific telehealth controlled substance prescribing authorization found in the statutes reviewed.

Podiatrists: No specific telehealth controlled substance prescribing authorization found in the statutes reviewed.

Veterinarians: No specific telehealth controlled substance prescribing authorization found in the statutes reviewed.

The absence of explicit authorization for these prescriber types does not necessarily prohibit their telehealth prescribing within scope of practice, but the statute's specific limitation to physicians, PAs, and APRNs suggests legislative intent to restrict the telehealth controlled substance framework to these provider types.

Ryan Haight Act Compliance:

New Hampshire law explicitly requires compliance with "all federal and state laws and regulations" in multiple statutory provisions (RSA 329:1-d, III; RSA 328-D:3-b, XIII; RSA 326-B:11, III-a). This language incorporates the Ryan Haight Act's requirements by reference.

New Hampshire has established rulemaking authority for registering practitioners with DEA special registration under the Ryan Haight Act's provisions (21 U.S.C. § 831(h)), as referenced in RSA 329:9, XXI and RSA 326-B:9, XIII. This suggests the state anticipated and prepared for practitioners to obtain the special DEA registration for telemedicine prescribing of controlled substances.

The state's removal of the initial in-person examination requirement in 2025 does not create a conflict with federal law because practitioners must still comply with federal requirements. During the current period of federal COVID-19 telehealth flexibilities (extended through December 31, 2026), practitioners can prescribe controlled substances via telehealth without an in-person examination under federal law. After federal flexibilities expire, New Hampshire practitioners would need to either: (1) conduct an in-person examination, (2) qualify for a Ryan Haight Act exception, or (3) obtain DEA special registration for telemedicine prescribing.

COVID-19 Emergency Waivers:

New Hampshire's Senate Bill 252, effective August 23, 2025, represents a permanent change to state law rather than a temporary COVID-19 waiver. The legislation removed previous restrictions and created a permanent framework for telehealth controlled substance prescribing. The timing of this legislation—enacted in 2025 after the acute phase of the COVID-19 pandemic—suggests legislative intent to make telehealth prescribing a permanent feature of New Hampshire healthcare rather than a temporary emergency measure.

However, the practical implementation of New Hampshire's liberalized framework depends on federal COVID-19 telehealth flexibilities, which the DEA has extended through December 31, 2026. After this date, unless federal law changes, the interaction between New Hampshire's permissive state law and federal Ryan Haight Act requirements will need to be reconciled through DEA special registration or other mechanisms.

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Compliance Requirements:

- Establish valid practitioner-patient relationship via telehealth (no initial in-person requirement)
- Conduct evaluations at intervals appropriate for patient, condition, and drug, but at minimum annually
- Apply same standard of care as in-person encounters
- Cannot prescribe based solely on online questionnaire responses
- Maintain appropriate New Hampshire professional license
- Maintain DEA registration and comply with all federal controlled substance laws
- For substance use disorder treatment: comply with additional federal and state requirements for opioid treatment programs
- Document all telehealth encounters and clinical decision-making
- Use interactive communication technologies (not asynchronous-only)
- Ensure compliance with HIPAA and state privacy laws
- Maintain professional liability insurance

Primary Citations:

- RSA 329:1-d (Physician telemedicine and telehealth practice)
- RSA 328-D:3-b, XIII (Physician assistant telehealth authority)
- RSA 326-B:11, III-a (APRN telehealth authority)
- RSA 318-B:2, XII-d and XII-e (Controlled substance prescribing; prohibition on questionnaire-only prescribing)
- Senate Bill 252 (2025) (Comprehensive telehealth controlled substance reform)
- RSA 329:9, XXI (Rulemaking authority for DEA special registration)
- RSA 326-B:9, XIII (APRN board rulemaking for DEA registration)
- 21 U.S.C. § 831(h) (Ryan Haight Act special registration provisions)

Supporting Citations:

- New Hampshire Board of Medicine guidance on telemedicine standards
- New Hampshire Board of Nursing APRN practice guidelines
- DEA COVID-19 telehealth flexibility extensions
- Federal SAMHSA regulations for opioid treatment programs

Effective Dates:

Senate Bill 252 became effective August 23, 2025. This legislation substantially amended prior law that had been in effect since 2020. The 2020 law (which required initial in-person examinations) was itself an evolution from earlier, more restrictive provisions. The current framework represents the most permissive iteration of New Hampshire's telehealth controlled substance prescribing regulations to date.

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Prior to August 23, 2025, New Hampshire required establishment of a physician-patient or APRN-patient relationship before telehealth prescribing of controlled substances, and required in-person examinations rather than the current "evaluation" standard. The 2025 amendments removed these restrictions while maintaining the annual evaluation requirement and standard of care provisions.

NEW JERSEY

Regulatory Status:** Explicit regulations exist with comprehensive schedule-specific requirements

Telehealth Controlled Substance Prescribing Authorization:

New Jersey permits telehealth prescribing of controlled substances across Schedules II-V, but with significantly different requirements based on schedule classification. The state has codified its telehealth controlled substance framework in both statute (N.J.S.A. Title 45) and detailed administrative regulations applicable to specific prescriber types. New Jersey's approach is notably more restrictive for Schedule II substances than for Schedules III-V, creating a two-tiered regulatory framework.

In-Person Examination Requirements:

New Jersey imposes schedule-specific in-person examination requirements:

Schedule II Controlled Dangerous Substances:

For Schedule II CDS, New Jersey requires BOTH an initial in-person examination AND periodic in-person visits every THREE MONTHS for the duration of Schedule II treatment. This represents one of the most restrictive telehealth controlled substance frameworks in the United States. The quarterly in-person requirement applies regardless of the patient's condition, stability, or duration of treatment.

Practitioners cannot prescribe Schedule II controlled substances via telehealth without first conducting an in-person examination to establish the provider-patient relationship. Subsequently, patients must be seen in-person at least once every three months (quarterly) for as long as Schedule II prescribing continues. These in-person visits cannot be satisfied by telehealth encounters—they must be face-to-face examinations.

The examination must meet the same standard of care applicable to in-person settings. Practitioners cannot prescribe Schedule II controlled substances based solely on online questionnaire responses, even if a proper provider-patient relationship has been established through other means.

Important Exception for Pediatric Stimulants:

New Jersey creates a significant exception to the Schedule II in-person requirement for stimulant medications prescribed to minors. The in-person examination requirement does NOT apply when prescribing Schedule II stimulants to patients under age 18, provided that:

- The provider uses interactive, real-time, two-way audio AND video technologies
- Written consent is obtained from the parent or legal guardian explicitly waiving the in-person examination requirements

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This exception recognizes the particular challenges families face in accessing pediatric ADHD treatment and the relative safety profile of stimulant medications in this population when properly monitored.

Schedule III-V Controlled Dangerous Substances:

For Schedules III-V, New Jersey does NOT impose state-specific in-person examination requirements. Practitioners may establish the provider-patient relationship via telehealth and continue prescribing these substances through telehealth encounters without mandatory in-person visits. However, practitioners must still:

- Establish a proper provider-patient relationship via telehealth
- Meet the standard of care applicable to in-person settings
- Not prescribe based solely on online questionnaire responses
- Comply with federal Ryan Haight Act requirements (which generally require an in-person examination for initial controlled substance prescribing, subject to current COVID-19 flexibilities)

Schedule-Specific Rules:

New Jersey's regulatory framework creates clear distinctions between Schedule II and Schedules III-V:

Schedule II:

- Initial in-person examination required
- Quarterly (every 3 months) in-person visits mandatory
- Exception for pediatric stimulants with parental consent and audio-video technology
- Applies to all Schedule II substances regardless of indication

Schedules III-V:

- No state-mandated in-person examination requirement
- Subject to federal Ryan Haight Act requirements
- Must establish proper telehealth provider-patient relationship
- Standard of care requirements apply

New Jersey does not create explicit distinctions between psychiatric medications and pain medications in its telehealth regulations. The Schedule II rules apply uniformly regardless of whether the medication is prescribed for ADHD, pain management, or other indications. A Schedule II stimulant for ADHD is subject to the same quarterly in-person requirement as a Schedule II opioid for pain (except for the pediatric stimulant exception noted above).

Opioid-Specific Restrictions:

New Jersey has comprehensive opioid prescribing regulations that apply to both telehealth and in-person prescribing:

- Discussion of risks and benefits required before initiating opioid therapy
- Pain management agreements required for chronic pain treatment
- Five-day supply limit for initial acute pain prescriptions (with exceptions for certain conditions)

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- Mandatory prescription monitoring program (PMP) checks before prescribing
- Continuing education requirements for prescribers

These opioid-specific requirements apply regardless of whether prescribing occurs via telehealth or in-person. They are additive to the Schedule II in-person examination requirements—practitioners must satisfy both the quarterly in-person visit requirement AND the opioid-specific prescribing rules.

Prescriber Type Authorization:

New Jersey defines "health care provider" broadly under Title 45 and permits telehealth by any validly licensed provider within their scope of practice. For controlled substance prescribing via telehealth, the following framework applies:

Fully Authorized (within scope of practice):

Physicians (MD/DO): May prescribe all controlled substance schedules via telehealth, subject to Schedule II in-person requirements.

Physician Assistants: Explicitly authorized to prescribe controlled substances via telehealth subject to the same Schedule II requirements as physicians. N.J.A.C. 13:35-2C.6 applies the telehealth framework to PA practice. PAs must practice under appropriate supervision agreements and within their scope of practice as defined by the State Board of Medical Examiners.

Advanced Practice Nurses/Nurse Practitioners (APRNs/NPs): Explicitly authorized to prescribe controlled substances via telehealth subject to the same Schedule II requirements. N.J.A.C. 13:37-8A.6 applies the telehealth framework to APRN practice. APRNs must practice within their scope of practice and any applicable collaborative agreements.

Certified Nurse Midwives: Authorized within their scope of practice, which typically includes Schedule III-V substances but limited Schedule II authority.

Optometrists: May prescribe Schedule III-V controlled substances and Schedule II hydrocodone/hydrocodone combinations within their scope of practice via telehealth. Optometrists' prescribing authority is limited to medications related to eye care.

Dentists: Authorized to prescribe controlled substances via telehealth within their scope of practice. N.J.A.C. 13:30-9.4 applies telehealth rules to dental practice. Dentists prescribing Schedule II substances via telehealth would be subject to the quarterly in-person examination requirement.

Podiatrists: Authorized to prescribe controlled substances via telehealth within their scope of practice, which is limited to conditions of the foot and ankle.

Scope Limitations and Unclear Authorization:

CRNAs (Certified Registered Nurse Anesthetists): No explicit mention of independent controlled substance prescribing authority via telehealth in the regulations reviewed. CRNAs typically work under anesthesiologist supervision and their telehealth prescribing authority is not clearly addressed.

Clinical Nurse Specialists: Subject to Board of Nursing regulations. Authority depends on specific certification and scope of practice.

Pharmacists: Do not have independent prescribing authority for controlled substances in New Jersey. Pharmacists may provide medication therapy management and consultations via telehealth but cannot prescribe.

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Veterinarians: Subject to separate regulations under N.J.A.C. 13:44-4A. Veterinary telehealth prescribing authority exists but specific controlled substance provisions are governed by veterinary-specific regulations.

All prescribers utilizing telehealth for controlled substance prescribing must:

- Maintain valid New Jersey professional licensure
- Remain subject to their respective licensing board regulations
- Maintain appropriate professional liability insurance
- Remain subject to New Jersey jurisdiction for disciplinary purposes
- Comply with supervision or collaboration requirements applicable to their license type
- Maintain DEA registration

Ryan Haight Act Compliance:

New Jersey law explicitly requires compliance with federal law, including the Ryan Haight Act. N.J.S.A. 45:1-62 states that telehealth services must comply with both federal and state law. This means New Jersey practitioners must satisfy BOTH the state's requirements (including Schedule II quarterly in-person visits) AND federal Ryan Haight Act requirements.

For Schedule II substances, New Jersey's requirements are more stringent than federal requirements, so compliance with New Jersey law ensures federal compliance. For Schedules III-V, practitioners must still comply with federal Ryan Haight Act requirements even though New Jersey does not impose state-level in-person examination mandates.

The federal DEA has extended COVID-19 telehealth flexibilities through December 31, 2026 (Fourth Temporary Extension), which allows practitioners to prescribe controlled substances via telehealth without an in-person examination during this period. However, New Jersey's state law Schedule II requirements remain in effect regardless of federal flexibilities—the federal flexibility does not override New Jersey's more restrictive state requirements.

COVID-19 Emergency Waivers:

New Jersey's telehealth controlled substance prescribing framework was established through permanent statutory and regulatory changes, not temporary COVID-19 waivers. The state enacted comprehensive telehealth legislation (N.J.S.A. 45:1-61 et seq.) that created permanent standards for telehealth practice.

However, the practical impact of New Jersey's regulations has been influenced by federal COVID-19 flexibilities. During the federal public health emergency and subsequent DEA extensions, the federal requirement for an in-person examination before prescribing controlled substances was waived. This federal flexibility does not affect New Jersey's state-level Schedule II quarterly in-person requirement, which remains in effect.

New Jersey has not enacted legislation to make COVID-19 emergency waivers permanent because the state's telehealth framework was already established as permanent law. The state did issue emergency guidance during the pandemic, but the underlying statutory framework remained constant.

After federal COVID-19 flexibilities expire on December 31, 2026, New Jersey practitioners prescribing Schedules III-V controlled substances via telehealth will need to either: (1) conduct an in-person examination to comply with the Ryan Haight Act, (2) qualify for a Ryan Haight Act

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exception, or (3) obtain DEA special registration for telemedicine prescribing. Schedule II prescribing will continue to require quarterly in-person visits under state law regardless of federal requirements.

Compliance Requirements:

- For Schedule II CDS: Conduct initial in-person examination before any telehealth prescribing
- For Schedule II CDS: Conduct in-person examinations every 3 months (quarterly) for duration of treatment
- Exception: Pediatric stimulants (under age 18) may be prescribed via audio-video telehealth with parental written consent waiving in-person requirements
- For Schedules III-V: Establish proper provider-patient relationship via telehealth (no state-mandated in-person requirement, but federal Ryan Haight Act applies)
- Apply same standard of care as in-person encounters
- Cannot prescribe based solely on online questionnaire responses
- For opioids: Discuss risks/benefits, use pain management agreements for chronic pain, limit initial acute pain prescriptions to 5 days, check prescription monitoring program
- Maintain valid New Jersey professional license appropriate to prescriber type
- Maintain DEA registration and comply with all federal controlled substance requirements
- Maintain professional liability insurance
- Remain subject to New Jersey licensing board jurisdiction
- Document all telehealth encounters thoroughly
- Use secure, HIPAA-compliant technology platforms
- Verify patient identity and location
- Ensure appropriate supervision/collaboration if required by license type

Primary Citations:

- N.J.S.A. 45:1-61 et seq. (Telehealth Act)
- N.J.S.A. 45:1-62 (Telehealth standards and federal law compliance)
- N.J.A.C. 13:35-2C.6 (Physician assistant telehealth regulations)
- N.J.A.C. 13:37-8A.6 (APRN telehealth regulations)
- N.J.A.C. 13:30-9.4 (Dental telehealth regulations)
- N.J.A.C. 13:35-7.6 (Opioid prescribing regulations)
- N.J.A.C. 13:44-4A (Veterinary telehealth regulations)
- N.J.S.A. Title 24 (Controlled Dangerous Substances Act)
- N.J.S.A. Title 45 (Professional licensing statutes)

Supporting Citations:

- New Jersey Board of Medical Examiners guidance on telemedicine
- New Jersey Board of Nursing APRN practice guidelines

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- New Jersey State Board of Dentistry telehealth guidance
- DEA COVID-19 telehealth flexibility extensions (through December 31, 2026)
- Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 831

Effective Dates:

New Jersey's comprehensive Telehealth Act (N.J.S.A. 45:1-61 et seq.) was enacted in 2017 and has been amended several times, most recently in 2020 and 2021 to address COVID-19 pandemic issues and expand telehealth access. The Schedule II quarterly in-person examination requirement has been in effect since the original telehealth regulations were promulgated.

The pediatric stimulant exception was added through regulatory amendments to address access barriers for families seeking ADHD treatment for children. The specific effective date of this exception varies by prescriber type based on when each licensing board adopted the relevant regulations, but all boards had implemented this exception by 2019.

Opioid prescribing regulations under N.J.A.C. 13:35-7.6 became effective in 2017 following the state's response to the opioid epidemic, with subsequent amendments in 2018 and 2019. These regulations apply to both telehealth and in-person prescribing.

NEW MEXICO

Regulatory Status: No explicit state-specific regulations for telehealth prescribing of controlled substances; general telehealth framework combined with federal Ryan Haight Act requirements**

Telehealth CS Prescribing - General Framework:

New Mexico permits telehealth prescribing of controlled substances through its general telehealth framework without creating separate controlled substance-specific restrictions. The state's approach relies on the New Mexico Telehealth Act (NMSA 1978, §§ 24-25-1 to 24-25-5) and Medical Board regulations at 16.10.8.8 NMAC, which establish that prescribing without an established physician-patient relationship constitutes unprofessional conduct, subject to enumerated exceptions.

The critical exception for telehealth prescribing is found in 16.10.8.8(6) NMAC, which permits establishment of a physician-patient relationship through "face-to-face telehealth encounters using standard videoconferencing technology" when: (a) medical history and informed consent are obtained; (b) a medical record is generated; and (c) a physical examination is either recorded as appropriate or waived when not normally required for the specific services being provided. This regulation applies to "physicians and physician assistants" and does not differentiate between controlled and non-controlled substances.

The Board of Pharmacy requires that prescriptions issued via telehealth meet the same standards as in-person prescriptions, and practitioners must conduct thorough evaluations before prescribing medications. However, New Mexico has not enacted state-specific modifications to federal Ryan Haight Act requirements for controlled substances.

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In-Person Examination Requirements:

New Mexico's regulations permit telehealth encounters to satisfy physician-patient relationship requirements without mandating in-person visits, provided the encounter meets the criteria in 16.10.8.8(6) NMAC. The regulation explicitly allows physical examination requirements to be "waived when not normally part of a typical face-to-face encounter for the specific services being provided."

For controlled substances specifically, absent current federal flexibilities, the Ryan Haight Act would require at least one in-person medical evaluation before prescribing via telemedicine. The federal Act does not mandate periodic in-person visits after the initial evaluation, and New Mexico has not imposed additional state-level periodic visit requirements.

The state does not specify particular examination elements, frequency requirements (annual/biannual), or detailed protocols for virtual examinations. The regulation requires that medical history and informed consent be obtained, a medical record generated, and physical examination conducted or appropriately waived based on the nature of services provided.

Schedule-Specific Rules:

New Mexico statutes and regulations do not distinguish between different schedules of controlled substances (CII vs. CIII-V) for telehealth prescribing purposes. The state has not created separate rules for psychiatric medications versus pain medications or opioid-specific restrictions in the telehealth context.

The state does maintain general pain management regulations at 16.10.14 NMAC for Medical Board licensees that apply to controlled substance prescribing regardless of modality (telehealth or in-person). These regulations require practitioners to check the Prescription Monitoring Program (PMP) for initial controlled substance prescriptions (Schedules II-V) when the day supply exceeds four days, or if there is a gap in prescribing for 30 days or more. This PMP check requirement applies equally to telehealth and in-person prescribing.

Prescriber Type Restrictions:

New Mexico's definition of "practitioner" for controlled substances purposes is broad and includes physicians, dentists, podiatrists, veterinarians, scientific investigators, pharmacies, hospitals, and other persons licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in New Mexico (NMSA 1978, § 30-31-2).

The 16.10.8.8 NMAC regulation specifically applies to "physicians and physician assistants," explicitly authorizing PAs to establish physician-patient relationships via telehealth for prescribing purposes under the same conditions as physicians.

Nurse Practitioners and APRNs:** New Mexico grants nurse practitioners independent practice authority. NPs with prescriptive authority may prescribe controlled substances within their scope of practice. The state's telehealth framework does not create separate restrictions for NPs beyond those applicable to physicians, though NPs must comply with their own board's regulations regarding prescribing practices.

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Pharmacists:** New Mexico has expanded pharmacist prescriptive authority in recent years, but pharmacist prescribing of controlled substances via telehealth would be subject to both pharmacy board regulations and federal DEA requirements.

Dentists, Podiatrists, Veterinarians:** These practitioners are included in the state's definition of "practitioner" and may prescribe controlled substances within their scope of practice. The general telehealth framework would apply, subject to their respective board regulations and federal requirements.

Ryan Haight Act Compliance and Federal Flexibilities:

New Mexico has not enacted state-specific modifications to the federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008. Therefore, prescribers in New Mexico must comply with federal requirements, which generally mandate an in-person medical evaluation before prescribing controlled substances via telemedicine, subject to narrow statutory exceptions enumerated in 21 U.S.C. § 829(e).

As of January 2026, the DEA has extended COVID-19 public health emergency flexibilities through December 31, 2026, allowing DEA-registered practitioners to prescribe Schedule II-V controlled substances via telemedicine without a prior in-person evaluation. These are temporary federal flexibilities, not permanent New Mexico state law.

COVID Emergency Waivers:

New Mexico has not enacted permanent state-level waivers or modifications based on COVID-19 emergency flexibilities. The state's telehealth framework existed prior to the pandemic and remains in effect. Practitioners currently benefit from federal DEA flexibilities extended through December 31, 2026, but these are subject to change or expiration based on federal action.

Compliance Requirements:

- Establish physician-patient relationship via face-to-face telehealth encounter using standard videoconferencing technology
- Obtain medical history and informed consent
- Generate and maintain medical record
- Conduct physical examination as appropriate or document waiver when not normally required
- Check Prescription Monitoring Program for controlled substance prescriptions exceeding 4-day supply or with 30+ day gap
- Comply with federal Ryan Haight Act requirements (currently subject to temporary DEA flexibilities through December 31, 2026)
- Meet same standards for telehealth prescriptions as in-person prescriptions
- Maintain DEA registration and state licensure

Primary Citations:

- New Mexico Telehealth Act, NMSA 1978, §§ 24-25-1 to 24-25-5

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- 16.10.8.8 NMAC (New Mexico Medical Board - Physician-Patient Relationship and Prescribing)
- 16.10.14 NMAC (New Mexico Medical Board - Pain Management)
- NMSA 1978, § 30-31-2 (Controlled Substances Act definitions)
- 21 U.S.C. § 829(e) (Ryan Haight Act)

Supporting Citations:

- New Mexico Board of Pharmacy regulations regarding prescription standards
- New Mexico Board of Nursing regulations regarding NP prescriptive authority
- DEA COVID-19 flexibility extensions (effective through December 31, 2026)

Effective Dates:

The New Mexico Telehealth Act was enacted in 2017. The Medical Board regulations at 16.10.8.8 NMAC were adopted to implement telehealth prescribing standards and remain in effect. Pain management regulations at 16.10.14 NMAC include PMP check requirements that have been in effect since their adoption. Federal DEA flexibilities for telehealth controlled substance prescribing were extended most recently in 2024 and remain effective through December 31, 2026.

NEW YORK

Regulatory Status: Explicit regulations exist governing telehealth prescribing of controlled substances**

Telehealth CS Prescribing - Comprehensive Regulatory Framework:

New York has established explicit regulations governing telehealth prescribing of controlled substances through amendments to 10 NYCRR §§ 80.62, 80.63, and 80.84, which became effective May 21, 2025. These regulations create a comprehensive framework that establishes a general requirement for in-person medical evaluations prior to prescribing controlled substances, with specific enumerated exceptions including telehealth prescribing when compliant with federal DEA regulations.

Under 10 NYCRR § 80.63(e)(4), telehealth controlled substance prescribing is explicitly permitted "through telemedicine or telehealth – as such terms are defined by article 29-G of the Public Health Law, consistent with all applicable state laws and regulations and the laws, rules and regulations of the Drug Enforcement Administration, United States Department of Justice, or any successor agency." The regulation specifically includes "any controlled substance as approved by the Food and Drug Administration (FDA), or its successor agency, and the New York State Department of Health for the treatment of opioid use disorder."

Critically, New York's regulation incorporates federal compliance as a condition precedent, meaning practitioners must comply with both state and federal DEA rules. As of January 2026, federal DEA temporary waivers remain in effect through December 31, 2026, permitting Schedule II-V controlled substance prescribing via telehealth without prior in-person evaluation.

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In-Person Examination Requirements:

General Rule:** 10 NYCRR § 80.63(d) establishes that "no controlled substance shall be prescribed prior to an in-person medical evaluation of the patient by the prescribing practitioner for the medical condition for which the controlled substance is being considered." The practitioner determines the parameters and frequency of medical evaluations using generally accepted medical standards.

Exceptions to In-Person Requirement (10 NYCRR § 80.63(e)):

(1) Consulting/Referring Practitioner Exception:** A practitioner may prescribe after reviewing the patient's record if it contains results of an in-person medical evaluation performed by a consulting or referring practitioner within the previous 12 months specific to the medical condition for which the prescription is being considered. This creates a pathway for specialists to prescribe based on another practitioner's recent in-person evaluation.

(2) Covering Practitioner Exception:** In the temporary absence of the initial prescriber for continuing therapy, a covering practitioner may prescribe provided the covering practitioner either: (i) is part of the same practice and has direct access to the patient's medical records warranting continued prescribing, or (ii) has direct and adequate consultation with the initial prescriber who assures the necessity of continued prescribing. This exception facilitates continuity of care during practitioner absences.

(3) Emergency Situations:** For emergency situations involving a new medical condition warranting controlled substance prescription where no alternative treatment is available and the prescribing practitioner has an established practitioner-patient relationship with the patient. The prescription cannot exceed a 5-day supply, creating a limited emergency exception with strict quantity controls.

(4) Telehealth Exception:** Through telemedicine or telehealth consistent with all applicable state laws and regulations and DEA rules. This exception effectively permits telehealth-only controlled substance prescribing when federal requirements are met.

Frequency Requirements:** No specific periodic visit requirements (annual/biannual) are mandated by state regulation. The practitioner determines frequency using generally accepted medical standards, providing clinical flexibility while maintaining professional accountability.

Examination Elements:** The regulation does not specify particular examination elements required. However, 10 NYCRR § 80.62 requires that the patient record contain: patient identification data; chief complaint; present illness; past medical history; medical evaluation pursuant to § 80.63; diagnosis; and other data supporting diagnosis. This creates a comprehensive documentation requirement without prescribing specific examination techniques.

Virtual Exams/Questionnaires:** The regulation explicitly permits telehealth evaluations when compliant with federal law. New York Public Health Law § 2999-cc defines "telemedicine" as synchronous, two-way electronic audio-visual communications, while "telehealth" more broadly encompasses telemedicine, store and forward technology, remote patient monitoring, and audio-only telephone communication. The regulation was amended to include "telehealth" specifically to permit audio-only encounters for buprenorphine prescribing consistent with federal rules,

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demonstrating New York's intent to align with federal flexibilities for medication-assisted treatment.

Schedule-Specific Rules:

No Schedule-Specific Distinctions in State Law:** New York's regulation does not differentiate between Schedule II and Schedule III-V controlled substances for telehealth prescribing purposes. The same requirements and exceptions apply across all controlled substance schedules.

No Psychiatric vs. Pain Medication Distinctions:** The regulation does not create separate pathways or restrictions based on the therapeutic purpose of the controlled substance prescription. Whether prescribing for psychiatric conditions, pain management, or other indications, the same regulatory framework applies.

Opioid Use Disorder Treatment:** The regulation explicitly addresses controlled substances "approved by the Food and Drug Administration (FDA), or its successor agency, and the New York State Department of Health for the treatment of opioid use disorder," specifically authorizing telehealth prescribing for medications like buprenorphine. This reflects New York's policy priority of expanding access to medication-assisted treatment.

Federal Schedule Restrictions Apply:** While New York does not impose additional schedule-specific restrictions, practitioners must comply with federal DEA scheduling requirements, which impose different controls on Schedule II substances (no refills, written or electronic prescription required) versus Schedule III-V substances (limited refills permitted).

Prescriber Type Restrictions:

New York's controlled substance prescribing regulations apply to "practitioners" as defined by state law. The regulations at 10 NYCRR § 80.63 apply broadly to practitioners authorized to prescribe controlled substances under New York law.

Physicians (MD/DO):** May prescribe controlled substances via telehealth subject to the requirements and exceptions outlined in 10 NYCRR § 80.63. Physicians must maintain appropriate licensure and DEA registration.

Physician Assistants (PAs):** New York Education Law § 6542 authorizes PAs to prescribe controlled substances under physician supervision. PAs may utilize telehealth for controlled substance prescribing subject to the same regulatory framework as physicians, provided they maintain appropriate collaborative agreements and comply with supervision requirements.

Nurse Practitioners (NPs/APRNs):** New York Education Law § 6902 authorizes NPs to prescribe controlled substances under collaborative agreements with physicians. NPs may prescribe controlled substances via telehealth under the same conditions as physicians, subject to maintaining appropriate collaborative practice agreements.

Clinical Nurse Specialists (CNSs):** CNSs with prescriptive authority may prescribe controlled substances within their scope of practice via telehealth, subject to collaborative practice requirements and the general regulatory framework.

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Certified Registered Nurse Anesthetists (CRNAs):** CRNAs may prescribe controlled substances within their limited scope of practice related to anesthesia services, subject to collaborative practice requirements.

Pharmacists:** New York has expanded pharmacist prescriptive authority for certain medications, but pharmacist prescribing of controlled substances remains limited and subject to specific protocols. Telehealth prescribing by pharmacists would be subject to pharmacy practice act limitations.

Dentists, Podiatrists, Optometrists, Veterinarians:** These practitioners may prescribe controlled substances within their respective scopes of practice. The general telehealth framework at 10 NYCRR § 80.63 would apply to their controlled substance prescribing via telehealth, subject to their respective practice act limitations and DEA registration requirements.

Ryan Haight Act Compliance and State Modifications:

New York's regulation at 10 NYCRR § 80.63(e)(4) explicitly requires compliance with "the laws, rules and regulations of the Drug Enforcement Administration, United States Department of Justice, or any successor agency." This creates a direct incorporation of federal Ryan Haight Act requirements into New York state law.

The Ryan Haight Act (21 U.S.C. § 829(e)) generally prohibits prescribing controlled substances via telemedicine without at least one in-person medical evaluation, subject to seven narrow statutory exceptions. New York has not created state-specific modifications that would exempt practitioners from federal requirements; rather, the state regulation requires federal compliance as a condition of utilizing the telehealth exception.

The practical effect is that New York practitioners prescribing controlled substances via telehealth must comply with both: (1) New York's state regulatory framework at 10 NYCRR § 80.63, and (2) federal DEA requirements under the Ryan Haight Act. Currently, federal DEA temporary flexibilities permit telehealth prescribing without prior in-person evaluation through December 31, 2026, which effectively allows New York practitioners to utilize the telehealth exception during this period.

COVID Emergency Waivers and Permanent Changes:

New York's comprehensive regulations at 10 NYCRR §§ 80.62, 80.63, and 80.84 became effective May 21, 2025, representing a permanent regulatory framework rather than temporary emergency waivers. These regulations were adopted after the COVID-19 public health emergency and incorporate lessons learned during the pandemic.

The regulations do not represent temporary COVID waivers but rather permanent state law that will remain in effect regardless of federal emergency declarations. However, the practical ability to utilize the telehealth exception in § 80.63(e)(4) depends on federal DEA rules, which currently include temporary flexibilities extended through December 31, 2026.

New York's decision to include both "telemedicine" and "telehealth" in the regulation, with telehealth encompassing audio-only communication, reflects a permanent policy choice to align with federal flexibilities for buprenorphine prescribing and potentially other controlled substances as federal rules evolve.

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Compliance Requirements:

- Maintain valid New York professional license and DEA registration
- Comply with federal DEA regulations including Ryan Haight Act requirements
- Establish practitioner-patient relationship through appropriate means
- Conduct or document exception to in-person medical evaluation requirement
- For consulting/referring practitioner exception: verify in-person evaluation within previous 12 months
- For emergency prescriptions: limit to 5-day supply with established relationship
- Maintain comprehensive patient records including: identification data, chief complaint, present illness, past medical history, medical evaluation, diagnosis, and supporting data
- Use telemedicine (audio-visual) or telehealth (including audio-only when appropriate) technology
- For opioid use disorder treatment: ensure medications are FDA and NYS DOH approved
- Document clinical decision-making and rationale for prescribing
- Comply with prescription monitoring program requirements
- For mid-level prescribers: maintain appropriate collaborative practice agreements or supervision arrangements

Primary Citations:

- 10 NYCRR § 80.62 (Patient Records)
- 10 NYCRR § 80.63 (Prescribing of Controlled Substances)
- 10 NYCRR § 80.84 (Prescribing of Controlled Substances for Treatment of Opioid Use Disorder)
- New York Public Health Law § 2999-cc (Telemedicine and Telehealth definitions)
- New York Public Health Law Article 29-G (Telemedicine)
- New York Education Law § 6542 (Physician Assistant practice)
- New York Education Law § 6902 (Nurse Practitioner practice)
- 21 U.S.C. § 829(e) (Ryan Haight Act)

Supporting Citations:

- New York State Department of Health guidance on telemedicine
- New York State Education Department Office of Professions regulations
- DEA COVID-19 flexibility extensions (effective through December 31, 2026)
- New York State Board of Pharmacy regulations

Effective Dates:

The comprehensive controlled substance prescribing regulations at 10 NYCRR §§ 80.62, 80.63, and 80.84 became effective May 21, 2025. These regulations represent the current permanent framework for telehealth controlled substance prescribing in New York. Federal DEA temporary

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flexibilities permitting telehealth prescribing without prior in-person evaluation are currently extended through December 31, 2026.

NORTH CAROLINA

Regulatory Status:** Explicit regulations exist through North Carolina Medical Board Position Statement, statutes, and the STOP Act

Telehealth CS Prescribing - Framework and Limitations:

North Carolina has established explicit regulations governing telehealth prescribing of controlled substances through North Carolina Medical Board Position Statement 5.1.4 (Telemedicine), related statutes including the STOP Act of 2017 (S.L. 2017-74), and specific provisions in N.C. Gen. Stat. §§ 90-18.1 and 90-18.2 governing physician assistant and nurse practitioner prescribing.

The NC Medical Board permits controlled substance prescribing via telehealth if practitioners comply with all relevant federal and state laws and meet the applicable standard of care. However, the Board has established a critical limitation: "It is not consistent with the current standard of care to prescribe controlled substances for the treatment of pain in which the only patient encounter is by means of telemedicine and there are no other licensed healthcare providers involved in the initial and ongoing evaluations of the patient."

This creates a bifurcated approach where controlled substances may be prescribed via telehealth for conditions other than pain management (such as psychiatric conditions, opioid use disorder treatment, or other medical conditions), but pain management with controlled substances via telehealth-only encounters is prohibited unless other licensed healthcare providers are involved in patient evaluation.

The Board's position statement emphasizes that telemedicine is "the practice of medicine using electronic communications, information technology or other means between a licensee in one location and a patient in another location with or without an intervening healthcare provider." This definition encompasses various modalities but requires that the technology employed be "sufficient to accurately diagnose and treat the patient in conformity with the applicable standard of care."

In-Person Examination Requirements:

General Rule:** North Carolina does not mandate an in-person examination for telehealth prescribing if the technology employed is sufficient to accurately diagnose and treat the patient in conformity with the applicable standard of care. Position Statement 5.1.4 states: "There is no requirement that a physician conduct an in-person physical examination of a patient before a physician-patient relationship may be established."

Pain Management Exception:** The critical exception is for pain management with controlled substances. The Board's position that it is "not consistent with the current standard of care to prescribe controlled substances for the treatment of pain in which the only patient encounter is by means of telemedicine and there are no other licensed healthcare providers involved" effectively requires either: (1) in-person evaluation by the prescribing practitioner, or (2) involvement of other licensed healthcare providers in initial and ongoing evaluations.

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Frequency Requirements:** North Carolina does not specify mandatory periodic visit requirements (annual/biannual) in statute or regulation. The practitioner must meet the applicable standard of care, which may require periodic in-person evaluations depending on the clinical circumstances, medication prescribed, and patient condition.

Evaluation Elements:** Position Statement 5.1.4 requires that evaluation include "patient history, mental status evaluation, physical examination, and appropriate diagnostic and laboratory testing using accepted medical practices." The physical examination component may be conducted via telemedicine technology if the technology is sufficient to meet the standard of care, except for pain management with controlled substances as noted above.

Virtual Exams/Questionnaires:** Virtual examinations can satisfy requirements if the technology employed is "sufficient to accurately diagnose and treat the patient in conformity with the applicable standard of care." The Board recognizes that telemedicine may involve "an intervening healthcare provider" at the patient's location who can assist with physical examination components. Questionnaires alone would not satisfy the requirement for patient history, mental status evaluation, and physical examination.

Schedule-Specific Rules:

No CII vs. CIII-V Distinction: North Carolina does not distinguish between Schedule II and Schedule III-V controlled substances for general telehealth prescribing purposes. The same standard of care requirements apply across all controlled substance schedules.**

Psychiatric vs. Pain Medications - Significant Distinction: North Carolina creates a significant distinction between pain management and other therapeutic uses of controlled substances. While controlled substances for psychiatric conditions, opioid use disorder treatment, and other medical conditions may be prescribed via telehealth with appropriate evaluation, pain management with controlled substances via telehealth-only encounters is prohibited unless other licensed healthcare providers are involved in patient evaluation.**

STOP Act Limitations: The Strengthen Opioid Misuse Prevention (STOP) Act of 2017 (S.L. 2017-74) imposes specific limitations on opioid prescribing:**

• **Acute Pain - Initial Prescription:** Limited to 5-day supply (N.C. Gen. Stat. § 90-106(a3))

• **Acute Pain - Post-Operative:** Limited to 7-day supply for post-operative acute pain

• **Exceptions:** These limitations do not apply to: (1) treatment of chronic pain; (2) pain associated with cancer; (3) palliative care; (4) medication-assisted treatment for substance use disorders; (5) patients in hospice care; (6) residents of long-term care facilities; (7) when prescriber documents medical necessity for exceeding limits

Opioid-Specific Requirements: The STOP Act requires:**

• **Electronic Prescribing:** Mandatory electronic prescribing of "targeted controlled substances" (Schedule II-III opioids and narcotics) effective January 1, 2020, with limited exceptions for technological failures, patient-specific circumstances, or prescriber waivers

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- **CSRS Checks:** Mandatory Controlled Substances Reporting System (CSRS) checks before prescribing targeted controlled substances, with specific timing requirements
- **Patient Review:** Review of patient's controlled substance prescription history before prescribing

These requirements apply regardless of whether prescribing occurs via telehealth or in-person.

Prescriber Type Restrictions:

Physicians (MD/DO):** May prescribe controlled substances via telehealth subject to standard of care requirements and pain management restrictions outlined in Position Statement 5.1.4. Physicians must maintain appropriate North Carolina licensure and DEA registration.

Physician Assistants (PAs):** May prescribe controlled substances via telehealth under physician supervision. N.C. Gen. Stat. § 90-18.1(b1) imposes specific consultation requirements for PAs prescribing targeted controlled substances:

When a PA treats a patient at a facility that primarily engages in the treatment of pain by prescribing narcotic medications AND the therapeutic use of the targeted controlled substance is expected to exceed 30 days, the PA must:

- **Initial Consultation:** Personally consult with the supervising physician before prescribing the targeted controlled substance
- **Ongoing Consultation:** Personally consult with the supervising physician at least once every 90 days while continuing to prescribe

Definition of Consultation:** Per 21 NCAC 32M .0111A, "consult" means "meaningful communication, occurring either in person or electronically, between the [PA] and a supervising physician that is documented in the patient medical record." This allows electronic consultation rather than requiring in-person meetings between PA and supervising physician.

Nurse Practitioners (NPs/APRNs):** May prescribe controlled substances via telehealth under the same conditions as PAs. N.C. Gen. Stat. § 90-18.2(b)(5) imposes identical consultation requirements for NPs prescribing targeted controlled substances at pain management facilities. NPs require collaborative practice agreements with supervising physicians.

The consultation requirements for both PAs and NPs apply specifically to facilities "that primarily engage in the treatment of pain by prescribing narcotic medications" and when therapeutic use is expected to exceed 30 days. For other practice settings or shorter-term prescribing, these specific consultation requirements do not apply, though general supervision and collaboration requirements remain.

Other Advanced Practice Registered Nurses:** The North Carolina Board of Nursing Position Statement confirms that APRNs (including CRNAs, CNMs, CNSs) may practice via telehealth within their scope of practice and must have prescriptive authority in the state where the client is located. CRNAs, CNMs, and CNSs with prescriptive authority may prescribe controlled substances via telehealth within their respective scopes of practice, subject to collaborative practice requirements and standard of care obligations.

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Pharmacists:** North Carolina has expanded pharmacist prescriptive authority through collaborative practice agreements, but pharmacist prescribing of controlled substances remains limited and subject to specific protocols. Telehealth prescribing by pharmacists would be subject to pharmacy practice act limitations and collaborative agreement terms.

Dentists:** May prescribe controlled substances within their scope of practice (dental conditions). The general telehealth framework and STOP Act limitations would apply to dental prescribing of controlled substances via telehealth. Dentists must comply with standard of care requirements and may face practical limitations in conducting adequate examinations via telehealth for dental conditions.

Podiatrists:** May prescribe controlled substances within their scope of practice (foot and ankle conditions). The general telehealth framework would apply, subject to standard of care requirements and STOP Act limitations.

Optometrists:** North Carolina optometrists have limited prescriptive authority that generally does not extend to controlled substances, with narrow exceptions for specific therapeutic uses. Telehealth prescribing would be subject to optometry practice act limitations.

Veterinarians:** May prescribe controlled substances for animal patients within their scope of practice. The North Carolina Veterinary Medical Board governs veterinary telemedicine and controlled substance prescribing. Veterinarians must establish a veterinarian-client-patient relationship, which may be accomplished through telemedicine in appropriate circumstances.

Ryan Haight Act Compliance and State Modifications:

North Carolina defers to federal DEA requirements regarding the Ryan Haight Act. The NC Medical Board Position Statement 5.1.4 requires compliance with "all relevant federal and state laws," which includes the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (21 U.S.C. § 829(e)).

North Carolina has not enacted state-specific modifications that would create additional exceptions to or restrictions beyond the federal Ryan Haight Act. The state's approach is to layer its own standard of care requirements (particularly the pain management restriction) on top of federal requirements rather than modifying federal law.

The practical effect is that North Carolina practitioners must comply with both: (1) federal Ryan Haight Act requirements (currently subject to temporary DEA flexibilities through December 31, 2026), and (2) North Carolina's standard of care requirements including the prohibition on pain management with controlled substances via telehealth-only encounters.

COVID Emergency Waivers and Permanent Changes:

North Carolina has not enacted permanent statutory changes based on COVID-19 emergency waivers. The state's telehealth framework existed prior to the pandemic, and the Medical Board's Position Statement 5.1.4 represents ongoing policy rather than temporary emergency measures.

However, North Carolina practitioners currently benefit from federal DEA temporary flexibilities extended through December 31, 2026, which permit telehealth prescribing of Schedule II-V controlled substances without prior in-person evaluation. These federal flexibilities override the federal Ryan Haight Act's in-person requirement but do not override North Carolina's state-level

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standard of care requirement prohibiting pain management with controlled substances via telehealth-only encounters.

The North Carolina General Assembly has considered legislation to expand and clarify telehealth authority, but as of January 2026, the fundamental framework remains based on the Medical Board's position statement and existing statutes including the STOP Act.

Compliance Requirements:

- Maintain valid North Carolina professional license and DEA registration
- Comply with federal DEA regulations including Ryan Haight Act requirements
- Establish practitioner-patient relationship through appropriate means
- Use technology sufficient to accurately diagnose and treat patient in conformity with applicable standard of care
- Conduct evaluation including patient history, mental status evaluation, physical examination, and appropriate diagnostic and laboratory testing
- **For pain management with controlled substances:** Ensure either in-person evaluation or involvement of other licensed healthcare providers in initial and ongoing evaluations
- **For acute pain prescriptions:** Limit initial prescriptions to 5-day supply (7 days post-operative) unless exception applies
- **For targeted controlled substances (Schedule II-III opioids):** Use electronic prescribing (with limited exceptions)
- Check CSRS (Controlled Substances Reporting System) before prescribing targeted controlled substances
- Review patient's controlled substance prescription history
- **For PAs and NPs at pain management facilities:** Consult with supervising physician before initial prescription and every 90 days for ongoing prescriptions when therapeutic use expected to exceed 30 days
- Document consultation in patient medical record
- Maintain comprehensive medical records
- Comply with collaborative practice agreement requirements (for NPs, PAs, and other mid-level prescribers)
- Meet same standards for telehealth prescriptions as in-person prescriptions

Primary Citations:

- North Carolina Medical Board Position Statement 5.1.4 (Telemedicine)
- N.C. Gen. Stat. § 90-106(a3) (STOP Act - prescription limitations)
- N.C. Gen. Stat. § 90-18.1(b1) (Physician Assistant prescribing and consultation requirements)
- N.C. Gen. Stat. § 90-18.2(b)(5) (Nurse Practitioner prescribing and consultation requirements)
- 21 NCAC 32M .0111A (Definition of consultation for PAs and NPs)
- S.L. 2017-74 (Strengthen Opioid Misuse Prevention Act - STOP Act)
- 21 U.S.C. § 829(e) (Ryan Haight Act)

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Supporting Citations:

- North Carolina Board of Nursing Position Statement on Telehealth
- North Carolina Controlled Substances Reporting System (CSRS) regulations
- North Carolina Board of Pharmacy regulations
- North Carolina Veterinary Medical Board telemedicine policies
- DEA COVID-19 flexibility extensions (effective through December 31, 2026)

Effective Dates:

The STOP Act (S.L. 2017-74) was enacted in 2017, with electronic prescribing requirements effective January 1, 2020. The North Carolina Medical Board Position Statement 5.1

STATE-BY-STATE TELEHEALTH CONTROLLED SUBSTANCE PRESCRIBING ANALYSIS

North Dakota, Ohio, Oklahoma

NORTH DAKOTA

Regulatory Status: Explicit regulations exist**

Telehealth Controlled Substance Prescribing Authorization:

North Dakota permits telehealth prescribing of controlled substances CII-CV with significant restrictions, particularly regarding opioids. The state has established comprehensive standards through N.D. Admin. Code § 50-02-15, which governs telemedicine practice for physicians and physician assistants. Controlled substances may be prescribed via telehealth provided the prescriber complies with all state and federal laws regarding controlled substance prescribing and participates in the North Dakota Prescription Drug Monitoring Program (PDMP).

Critical Opioid Prohibition: Opioids may ONLY be prescribed through telemedicine in two circumstances: (1) when prescribed as FDA-approved medication-assisted treatment (MAT) for opioid use disorder, or (2) to a patient in a hospital or other healthcare facility. Opioids may NOT be prescribed through telemedicine for pain management or any other purpose outside these exceptions.**

In-Person Examination Requirements:

North Dakota does NOT require an initial in-person examination for telehealth prescribing of controlled substances. The examination or evaluation may be performed entirely through telemedicine if it is "equivalent to an in-person examination." The state provides specific guidance on what constitutes an acceptable telemedicine examination:

Acceptable Examination Methods:

- Video examination utilizing appropriate diagnostic testing and peripherals

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- Examination conducted with an appropriately licensed intervening healthcare provider who provides necessary physical findings to the remote prescriber

Inadequate Examination Methods:

- Static online questionnaire alone
- Audio-only conversation (telephone consultation without video)

These methods do NOT meet the standard of care for establishing a valid patient-licensee relationship for controlled substance prescribing.

Periodic Visit Requirements: North Dakota regulations do not specify ongoing periodic in-person visit requirements (annual, biannual, or otherwise) for continued controlled substance prescribing via telehealth for non-opioid controlled substances. Once a valid patient-licensee relationship is established through an acceptable telemedicine examination meeting the standard of care, subsequent follow-up care and prescription renewals may be provided via telehealth.

Schedule-Specific and Medication-Type Rules:

Non-Opioid Controlled Substances (CII-CV): May be prescribed via telehealth after proper telemedicine examination equivalent to in-person standard of care, subject to compliance with all state and federal laws. No distinction is made between Schedule II versus Schedule III-V for non-opioid controlled substances.

Opioid Restrictions: The prohibition on opioid prescribing via telemedicine is substance-based rather than schedule-based. All opioids (regardless of schedule) are prohibited except for:

- FDA-approved MAT for opioid use disorder (e.g., buprenorphine, methadone in qualified settings)
- Patients physically located in hospitals or healthcare facilities at time of telemedicine encounter

Psychiatric Medications: No specific restrictions beyond general controlled substance requirements. Non-opioid controlled substances used in psychiatric treatment (e.g., benzodiazepines, stimulants) may be prescribed via telehealth following appropriate examination.

Pain Medications: Opioids for pain management are explicitly prohibited via telehealth. Non-opioid controlled substances for pain (e.g., tramadol, certain muscle relaxants) are permitted via telehealth.

Prescriber Type Restrictions:

Physicians and Physician Assistants: Explicitly authorized under N.D. Admin. Code § 50-02-15. "Licensee" is defined as "a physician or physician assistant licensed to practice in North Dakota." Physician assistants may prescribe Schedule II-V controlled substances within their scope of practice and must maintain separate DEA registration. PAs must comply with all requirements applicable to physicians regarding telemedicine examinations and the opioid prohibition.

Nurse Practitioners/APRNs: North Dakota grants APRNs full independent practice authority without collaborative practice agreements or physician supervision requirements. APRNs with prescriptive authority may prescribe controlled substances as defined by N.D. Cent. Code § 43-15-01 pursuant to applicable state and federal laws. They must obtain separate DEA registration for controlled substances and participate in the PDMP.

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While the telemedicine statute (§ 50-02-15) specifically references physicians and physician assistants, APRNs practicing independently are subject to general telehealth standards of care and professional practice requirements. The opioid prohibition would apply to APRNs through federal law compliance requirements and standard of care obligations, though the administrative code does not explicitly reference APRNs in the telemedicine prescribing section.

CRNAs and Clinical Nurse Specialists: Licensed as APRNs in North Dakota with prescriptive authority for controlled substances, subject to the same requirements as nurse practitioners. Must maintain DEA registration and PDMP participation.

Pharmacists: North Dakota granted pharmacists limited prescriptive authority effective January 1, 2022, for immunizations and tobacco cessation products per statewide protocols. Pharmacists do NOT have general controlled substance prescribing authority via telehealth.

Optometrists: No specific telehealth controlled substance prescribing regulations found. Optometrists with controlled substance prescribing authority under their practice act would be subject to general telehealth requirements and standard of care obligations.

Dentists: No specific telehealth controlled substance prescribing regulations found. Dentists would be subject to their respective practice act requirements and general telehealth standards.

Podiatrists: No specific telehealth controlled substance prescribing regulations found. Subject to practice act requirements and general telehealth standards.

Veterinarians: May prescribe controlled substances within scope of veterinary practice. However, North Dakota law specifies that a veterinarian-client-patient relationship may NOT be established solely through telemedicine and requires a timely in-person examination of the animal. This effectively prohibits initial controlled substance prescribing via telehealth in veterinary practice.

Ryan Haight Act Compliance and State Modifications:

North Dakota explicitly requires compliance with federal law. N.D. Admin. Code § 50-02-15-02 states: "Licensees who prescribe controlled substances, as defined by North Dakota law, in circumstances allowed under this rule, must comply with all state and federal laws regarding the prescribing of controlled substances, and must participate in the North Dakota prescription drug monitoring program."

The state references Ryan Haight Act definitions and requirements. North Dakota's allowance of initial telemedicine examinations without in-person visits for non-opioid controlled substances operates within the framework of federal DEA flexibilities, particularly those extended during and after the COVID-19 public health emergency.

North Dakota has NOT enacted state-level modifications that would exempt prescribers from Ryan Haight Act requirements. Instead, the state has aligned its regulations to operate within federal parameters while adding state-specific restrictions (the opioid prohibition for pain management).

COVID-19 Emergency Waivers:

North Dakota's current telemedicine regulations (N.D. Admin. Code § 50-02-15) were adopted to provide permanent regulatory framework following COVID-19 emergency flexibilities. The regulations do not appear to be temporary emergency measures but rather permanent rules that incorporate lessons learned during the pandemic.

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The state's allowance of video-based examinations without initial in-person visits for non-opioid controlled substances aligns with federal DEA enforcement discretion policies that have been extended beyond the original public health emergency declaration. However, North Dakota has maintained stricter state-level restrictions on opioid prescribing via telemedicine than federal requirements.

Compliance Requirements:

- Establish valid patient-licensee relationship through telemedicine examination equivalent to in-person standard of care
- Use video-based examination with appropriate diagnostic testing/peripherals OR involve appropriately licensed intervening healthcare provider
- Do NOT rely solely on questionnaires or audio-only consultations
- Comply with all state and federal controlled substance laws
- Register with and participate in North Dakota PDMP
- Maintain DEA registration appropriate to prescribing authority
- Do NOT prescribe opioids via telemedicine except for FDA-approved MAT for opioid use disorder or to patients in healthcare facilities
- Document telemedicine encounters appropriately
- Maintain same standard of care as in-person visits

Primary Citations:

- N.D. Admin. Code § 50-02-15 (Telemedicine)
- N.D. Admin. Code § 50-02-15-02 (Controlled substance prescribing requirements)
- N.D. Cent. Code § 43-15-01 (APRN prescriptive authority definitions)
- N.D. Cent. Code § 43-17-02.1 (Physician assistant prescriptive authority)

Supporting Citations:

- North Dakota Board of Nursing regulations regarding APRN independent practice
- North Dakota Board of Pharmacy regulations regarding pharmacist prescriptive authority
- Federal Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 829(e)
- DEA regulations, 21 C.F.R. § 1306.21

Effective Dates:

N.D. Admin. Code § 50-02-15 governing telemedicine practice was adopted and became effective following standard administrative rulemaking procedures. The opioid prohibition for telemedicine prescribing has been in effect as part of the state's response to the opioid epidemic and remains current law. Specific effective dates for the most recent amendments were not provided in the research materials but the regulations represent current, active law as of 2024-2025.

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OHIO

Regulatory Status: Explicit regulations exist**

Telehealth Controlled Substance Prescribing Authorization:

Ohio has comprehensive and explicit regulations governing telehealth prescribing of controlled substances, codified in Ohio Revised Code § 4743.09 and Ohio Administrative Code Rules 4731-11-09 and 4731-37-01. These regulations became effective February 28, 2023, replacing earlier emergency rules and providing permanent regulatory framework. Controlled substances CII-CV may be prescribed via telehealth with significant restrictions and requirements that vary by schedule and patient status.

In-Person Examination Requirements:

Ohio imposes schedule-specific in-person examination requirements with enumerated exceptions:

Schedule II Controlled Substances - Initial In-Person Visit Required:

Physicians and physician assistants MUST conduct a physical examination of a NEW PATIENT as part of an initial in-person visit BEFORE prescribing Schedule II controlled substances via telehealth (OAC 4731-11-09(D)). This is a mandatory requirement with only the following exceptions:

1. **Hospice or Palliative Care Patients:** Schedule II substances may be prescribed via telehealth to patients receiving hospice or palliative care services without initial in-person visit.

2. **Substance Use Disorder Treatment:** Schedule II substances may be prescribed via telehealth when prescribed as FDA-approved medication-assisted treatment (MAT) or for treatment of opioid use disorder, without initial in-person examination.

3. **Mental Health Conditions:** Schedule II controlled substances may be prescribed via telehealth to NEW patients when prescribed to treat a mental health condition as defined by DSM-5-TR criteria, without initial in-person visit (OAC 4731-11-09(E)(3)).

4. **Emergency Situations:** Schedule II substances may be prescribed via telehealth in emergency situations, limited to a 3-day supply or the duration of the emergency (whichever is less). The prescriber may NOT re-prescribe Schedule II substances via telehealth without conducting an in-person examination (OAC 4731-11-09(E)(4)).

5. **Federal Law Exemptions:** When federal law provides specific exemptions (must comply with Ryan Haight Act exception criteria).

Schedule III-V Controlled Substances:

Ohio regulations do NOT explicitly require an initial in-person visit for Schedule III-V controlled substances for new patients. However, prescribing must comply with federal law and meet the standard of care equivalent to in-person visits. The prescriber must establish a valid physician-patient relationship through appropriate telemedicine examination.

Periodic Visit Requirements:

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Ohio regulations do NOT specify ongoing periodic in-person visit requirements (annual, biannual, or other frequency) for continued controlled substance prescribing via telehealth. Once the initial requirements are met (in-person visit for Schedule II where required, or appropriate telemedicine examination for Schedule III-V), ongoing care may be provided via telehealth as clinically appropriate, maintaining standard of care.

Virtual Examination Requirements:

When prescribing controlled substances via telehealth, Ohio requires compliance with federal Ryan Haight Act standards:

- Audio-video, two-way, real-time interactive communication is required
- Telephones, facsimile machines, and email do NOT meet the definition of an interactive telecommunications system
- Asynchronous store-and-forward technologies may be used for photographs specific to the patient's medical condition when adequate for diagnosis confirmation
- The telemedicine examination must meet the same standard of care as an in-person examination

Schedule-Specific and Medication-Type Rules:

Schedule II vs. Schedule III-V Distinction:

Schedule II controlled substances have explicit initial in-person examination requirements for new patients with enumerated exceptions. Schedule III-V substances are subject to general telehealth standards and federal law compliance but lack the specific initial in-person visit mandate, providing greater flexibility for telemedicine prescribing.

Psychiatric Medications vs. Pain Medications:

Ohio provides a significant exception for mental health treatment. Controlled substances (INCLUDING Schedule II) may be prescribed via telehealth to NEW patients when treating a mental health condition as defined by DSM-5-TR criteria (OAC 4731-11-09(E)(3)). This exception applies regardless of whether the controlled substance is a stimulant (e.g., for ADHD), benzodiazepine (for anxiety disorders), or other controlled substance used in psychiatric treatment.

No separate distinction is made for pain medications versus other therapeutic uses beyond the emergency situation exception (which would include acute pain management with 3-day limit).

Opioid-Specific Provisions:

MAT/opioid use disorder treatment receives explicit exception allowing Schedule II prescribing via telehealth without initial in-person visit when using FDA-approved medications for MAT or opioid use disorder treatment (OAC 4731-11-09(E)(2)). This includes buprenorphine products and other approved MAT medications.

Prescriber Type Restrictions:

Physicians (MD/DO):

Fully authorized under OAC 4731-11-09 to prescribe controlled substances via telehealth subject to the requirements outlined above. Must hold active, unrestricted Ohio medical license and valid DEA registration.

Physician Assistants (PAs):

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Explicitly authorized under OAC 4731-11-09 to prescribe controlled substances via telehealth subject to the same requirements as physicians. PAs must:

- • Hold valid prescriber number issued by the State Medical Board of Ohio
- • Have been granted physician-delegated prescriptive authority through their supervising physician agreement
- • Comply with all Schedule II in-person examination requirements and exceptions
- • Maintain appropriate DEA registration

Advanced Practice Registered Nurses (APRNs - NPs, CNSs, CNMs):

APRNs are NOT directly governed by the State Medical Board rules (OAC 4731-11-09) but are indirectly affected through their collaborative relationships. Ohio APRNs practice under "standard care arrangements" with collaborating physicians rather than full independent practice.

Key APRN Restrictions:

- • APRNs with standard care arrangements are limited by their collaborating physician's restrictions
- • If the collaborating physician cannot prescribe certain controlled substances via telehealth under specific circumstances, the APRN is similarly limited
- • APRNs have separate statutory restrictions under Ohio Revised Code § 4723.481 for Schedule II controlled substances
- • APRNs may only prescribe Schedule II substances in limited settings: hospitals, institutional facilities, and certain practice settings
- • APRNs generally CANNOT prescribe Schedule II controlled substances from convenience care clinics
- • APRNs must prescribe within the scope of their collaborating physician's authority and their standard care arrangement

Certified Registered Nurse Anesthetists (CRNAs):

CRNAs are not specifically addressed in the controlled substance telehealth prescribing regulations. CRNAs in Ohio typically administer rather than prescribe controlled substances in perioperative settings. General prescribing via telehealth would be subject to their scope of practice limitations and standard care arrangement requirements.

Pharmacists:

Ohio pharmacists do NOT have authority to prescribe controlled substances via telehealth. Pharmacists may provide certain clinical services and participate in collaborative practice agreements, but controlled substance prescribing authority is not included.

Optometrists:

Ohio optometrists have limited controlled substance prescribing authority (primarily Schedule III-V and limited Schedule II). No specific telehealth controlled substance prescribing regulations were identified for optometrists. They would be subject to their practice act requirements and general telehealth standards if prescribing controlled substances remotely.

Dentists:

Dentists may prescribe controlled substances within their scope of practice. While not explicitly addressed in OAC 4731-11-09 (which governs physicians and PAs), dentists prescribing controlled substances via telehealth would be subject to their board's regulations and general standard of

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care requirements. The State Dental Board may have separate telehealth prescribing requirements.

Podiatrists:

Podiatrists may prescribe controlled substances within their scope of practice. Similar to dentists, specific telehealth controlled substance prescribing regulations for podiatrists were not identified in the medical board rules. They would be subject to their board's regulations.

Veterinarians:

Veterinarians prescribe controlled substances for animal patients only. Veterinary telemedicine prescribing would be governed by the State Veterinary Medical Board regulations, not the medical board rules analyzed here.

Ryan Haight Act Compliance and State Modifications:

Ohio explicitly requires compliance with federal law throughout its telehealth controlled substance prescribing regulations. OAC 4731-11-09 references Ryan Haight Act requirements and incorporates federal standards by reference.

Ohio has NOT created state-level exemptions from Ryan Haight Act requirements. Instead, Ohio has added STATE-LEVEL restrictions that are MORE stringent than federal requirements in certain circumstances:

- The mandatory in-person examination for Schedule II controlled substances for new patients (with enumerated exceptions) goes beyond baseline Ryan Haight requirements
- Ohio's regulations operate within the framework of federal DEA enforcement discretion policies while adding state-specific protections

Ohio's approach recognizes that federal DEA flexibilities (particularly those extended during and after COVID-19) allow telemedicine prescribing of controlled substances without in-person visits in certain circumstances, and the state has created a regulatory framework that permits this while adding safeguards for Schedule II substances.

COVID-19 Emergency Waivers:

Ohio's current regulations (OAC 4731-11-09, effective February 28, 2023) represent PERMANENT rules, not temporary emergency waivers. These regulations were adopted following the COVID-19 public health emergency to provide ongoing regulatory clarity.

The regulations incorporate lessons learned during the pandemic while establishing permanent standards. Ohio had earlier emergency rules during COVID-19 that were more permissive; the February 2023 rules represent a calibrated permanent approach that maintains some flexibility (particularly for Schedule III-V substances and mental health treatment) while imposing stricter requirements for Schedule II substances.

No COVID-19 emergency waivers remain in effect as separate temporary measures. The current permanent regulations represent Ohio's post-pandemic regulatory framework.

Compliance Requirements:

- Establish valid physician-patient relationship through appropriate telemedicine examination meeting standard of care
- Use audio-video, two-way, real-time interactive communication (not telephone-only or email)

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- For Schedule II controlled substances to NEW patients: conduct in-person physical examination UNLESS patient qualifies for enumerated exceptions (hospice/palliative care, MAT/opioid use disorder, mental health condition treatment, emergency situation with 3-day limit, or federal law exemption)
- For Schedule III-V controlled substances: may prescribe via telehealth after appropriate examination without mandatory in-person visit
- Comply with all state and federal controlled substance laws
- Maintain appropriate DEA registration
- Document telemedicine encounters appropriately
- Physician assistants must have valid prescriber number and physician-delegated authority
- APRNs must operate within standard care arrangement limitations and collaborating physician authority
- Emergency Schedule II prescribing limited to 3-day supply; no re-prescribing without in-person exam
- Maintain same standard of care as in-person visits

Primary Citations:

- Ohio Revised Code § 4743.09 (Telehealth services)
- Ohio Administrative Code Rule 4731-11-09 (Prescribing controlled substances via telemedicine - physicians and physician assistants)
- Ohio Administrative Code Rule 4731-37-01 (Telemedicine general standards)
- Ohio Revised Code § 4723.481 (APRN Schedule II prescribing restrictions)

Supporting Citations:

- DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision) - referenced for mental health condition definitions
- Federal Ryan Haight Online Pharmacy Consumer Protection Act, 21 U.S.C. § 829(e)
- DEA regulations, 21 C.F.R. § 1306.21
- Ohio State Medical Board guidance documents on telemedicine prescribing

Effective Dates:

Ohio Administrative Code Rules 4731-11-09 and 4731-37-01 became effective **February 28, 2023**. These rules replaced earlier emergency rules that were in effect during the COVID-19 public health emergency and represent permanent regulatory framework. The rules have remained in effect without subsequent amendment as of 2024-2025.

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OKLAHOMA

Regulatory Status:** Explicit regulations exist

Telehealth Controlled Substance Prescribing Authorization:

Oklahoma has explicit state-level regulations that significantly RESTRICT telehealth prescribing of certain controlled substances, particularly opioids and benzodiazepines. These restrictions operate independently of and in addition to federal Ryan Haight Act requirements. The primary restriction is codified in Oklahoma Statutes Title 59, § 478.1(C), which was enacted in 2017 (effective November 1, 2017) and subsequently amended in 2021 and 2023.

Primary Statutory Prohibition - 59 O.S. § 478.1(C):

Telemedicine encounters in Oklahoma SHALL NOT be used to establish a valid physician-patient relationship for the purpose of prescribing:

- Opiates
- Synthetic opiates
- Semisynthetic opiates
- Benzodiazepines
- Carisoprodol (muscle relaxant)

Exceptions to the Prohibition:

Telemedicine encounters MAY be used to prescribe the above substances ONLY when prescribing:

1. **Opioid Antagonists or Partial Agonists:** Pursuant to 63 O.S. §§ 1-2506.1 and 1-2506.2 (e.g., naloxone for overdose reversal, buprenorphine when used as antagonist/partial agonist)

2. **FDA-Approved MAT:** Schedule III, IV, or V controlled dangerous substances approved by the FDA for medication-assisted treatment (MAT) or detoxification treatment for substance use disorder (added by amendment in 2021 and 2023)

This prohibition is substance-based rather than schedule-based, meaning it applies to opioids and benzodiazepines regardless of their DEA schedule classification.

In-Person Examination Requirements:

Oklahoma law does NOT explicitly require periodic in-person visits (annual, biannual, or other frequency) for telehealth prescribing of non-restricted controlled substances. However:

Effective In-Person Requirement for Restricted Substances:

The prohibition on establishing physician-patient relationships via telehealth for opioids and benzodiazepines effectively requires an in-person visit BEFORE prescribing these substances (except for MAT exceptions). The statute prohibits using telemedicine to "establish" the relationship for prescribing purposes, which means:

- Initial prescription of opioids/benzodiazepines requires in-person visit

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• The law does not explicitly address whether ongoing prescriptions for established patients may be managed via telehealth

Oklahoma Board of Osteopathic Examiners Position:

Oklahoma Administrative Code 510:5-7-7 (Board of Osteopathic Examiners) states it is unprofessional conduct to "renew a prescription for controlled drugs over telemedicine" without an initial in-person prescription. This suggests that even renewals of controlled substance prescriptions via telemedicine are problematic without an initial in-person prescription.

Standard of Care Requirements:

59 O.S. § 652 requires that telemedicine services meet the same standard of care as in-person services. This standard of care requirement applies to all prescribing, including controlled substances.

Non-Restricted Controlled Substances:

For controlled substances NOT subject to the § 478.1(C) prohibition (e.g., stimulants for ADHD, non-benzodiazepine Schedule IV substances), Oklahoma law does not mandate specific in-person visit requirements, though standard of care and professional judgment apply.

Schedule-Specific and Medication-Type Rules:

Oklahoma's restrictions are substance-based rather than purely schedule-based, creating a complex regulatory landscape:

Schedule II Controlled Substances:

• **Opioids (Schedule II):** Prohibited via telehealth for initial physician-patient relationship establishment, EXCEPT for FDA-approved MAT for substance use disorder

• **Non-Opioid Schedule II (e.g., methylphenidate, amphetamines for ADHD, cocaine for medical use):** Not explicitly prohibited by § 478.1(C); appear permissible via telehealth subject to standard of care requirements, though not explicitly addressed in statute

Schedule III Controlled Substances:

• **Opioids (Schedule III - e.g., hydrocodone combinations, codeine combinations):** Prohibited via telehealth for initial relationship establishment, EXCEPT for FDA-approved MAT

• **Non-Opioid Schedule III:** Permitted via telehealth subject to standard of care

Schedule IV Controlled Substances:

• **Benzodiazepines:** Explicitly prohibited via telehealth for initial relationship establishment, no exceptions

• **Carisoprodol:** Explicitly prohibited via telehealth for initial relationship establishment

• **Other Schedule IV (e.g., tramadol, zolpidem, modafinil):** Permitted via telehealth subject to standard of care

Schedule V Controlled Substances:

• **Opioid-containing Schedule V:** Prohibited via telehealth for initial relationship establishment, EXCEPT for FDA-approved MAT

• **Non-Opioid Schedule V:** Permitted via telehealth subject to standard of care

MAT Exception Details:

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The 2021 and 2023 amendments added an important exception for "Schedule III, IV, or V controlled dangerous substances approved by the FDA for medication-assisted treatment or detoxification treatment for substance use disorder." This exception allows telemedicine prescribing of:

- Buprenorphine products (Schedule III) for opioid use disorder
- Buprenorphine/naloxone combinations for MAT
- Other FDA-approved MAT medications in Schedules III-V

Notably, this exception does NOT extend to Schedule II substances used for MAT (e.g., methadone), which would still be prohibited via telemedicine under Oklahoma law.

Prescriber Type Restrictions:

Oklahoma has significant variations in controlled substance prescribing authority among different prescriber types, which directly impact telehealth prescribing capabilities:

Physicians (MD/DO):

Fully authorized to prescribe Schedule II-V controlled substances within scope of practice. Subject to § 478.1(C) prohibition on using telemedicine to establish physician-patient relationships for opioids, benzodiazepines, and carisoprodol (with MAT exception).

Physician Assistants (PAs):

Oklahoma significantly expanded PA authority in 2025 through HB 2584, creating a two-tier system:

Supervised PAs (with Practice Agreement):

- May prescribe Schedule II-V controlled substances
- Schedule II prescribing requires updated practice agreement (effective August 29, 2025)
- Subject to same § 478.1(C) telehealth restrictions as physicians
- Must maintain DEA registration

Independent PAs (6,240+ clinical hours):

- May prescribe Schedule III-V controlled substances only
- CANNOT prescribe Schedule II controlled substances under any circumstances
- Subject to § 478.1(C) telehealth restrictions for Schedule III-V opioids and benzodiazepines
- Must maintain DEA registration

Advanced Practice Registered Nurses (APRNs - NPs, CNSs, CNMs):

Oklahoma APRNs have SIGNIFICANT limitations on controlled substance prescribing authority:

Schedule II Prohibition:

- APRNs may NOT prescribe Schedule I or II controlled substances under ANY circumstances (63 O.S. § 2-312(C))
- This is an absolute prohibition - no exceptions for any setting or circumstance
- Applies to all opioids in Schedule II, stimulants, and other Schedule II substances

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Schedule III-V Authority:

- APRNs may prescribe ONLY Schedule III-V controlled substances
- Must practice under physician supervision (Oklahoma is not a full practice authority state for prescribing)
- Limited to 30-day supply for Schedule III-V controlled substances
- Subject to § 478.1(C) telehealth restrictions for Schedule III-V opioids and benzodiazepines
- MAT exception would apply to Schedule III-V substances approved for MAT

Certified Registered Nurse Anesthetists (CRNAs):

CRNAs in Oklahoma have very limited controlled substance authority:

- May order, select, obtain, and administer Schedule II-V controlled substances ONLY in perioperative/periobstetrical settings (63 O.S. § 2-312(D))
- Authorized settings: preanesthetic preparation, anesthesia induction/maintenance/emergence, or post-anesthesia care
- NOT authorized for general prescribing or telehealth prescribing outside these specific settings
- This is an administration authority, not general prescribing authority

Dentists:

- Authorized to prescribe controlled substances within scope of dental practice
- Subject to § 478.1(C) telehealth restrictions for opioids, benzodiazepines, and carisoprodol
- Must maintain DEA registration
- Dental Board may have additional regulations

Podiatrists:

- Authorized to prescribe controlled substances within scope of podiatric practice
- Subject to § 478.1(C) telehealth restrictions for opioids, benzodiazepines, and carisoprodol
- Must maintain DEA registration
- Podiatric Medical Board may have additional regulations

Optometrists:

Oklahoma optometrists have limited controlled substance prescribing authority:

- May prescribe Schedule III-V controlled substances within scope of practice
- May prescribe Schedule II controlled substances containing hydrocodone combinations for a FIVE-DAY SUPPLY ONLY
- Subject to § 478.1(C) telehealth restrictions for opioids (including the limited Schedule II hydrocodone authority)
- Must maintain DEA registration

Pharmacists:

- NOT authorized to prescribe controlled substances in Oklahoma
- Pharmacists may dispense controlled substances pursuant to valid prescriptions but do not have independent prescribing authority

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Veterinarians:

• May prescribe controlled substances for animal use only, not for human use (63 O.S. § 2-312(B))

• Veterinary telemedicine prescribing would be subject to separate veterinary practice act requirements

• The § 478.1(C) prohibition applies to human patient care and would not directly govern veterinary practice

Ryan Haight Act Compliance and State Modifications:

Oklahoma's approach to the Ryan Haight Act is unique in that the state has imposed STRICTER requirements than federal law rather than seeking exemptions or modifications:

State Restrictions Beyond Federal Requirements:

The Ryan Haight Act (21 U.S.C. § 829(e)) generally requires at least one in-person medical evaluation before prescribing controlled substances via the internet, with specific exceptions. Oklahoma's § 478.1(C) goes further by:

1. Prohibiting telemedicine prescribing of opioids and benzodiazepines for initial relationship establishment (with limited MAT exception)

2. Applying this prohibition regardless of whether the prescriber could meet a Ryan Haight Act exception

3. Creating a substance-based prohibition rather than a schedule-based approach

Federal DEA Flexibilities:

During and after the COVID-19 public health emergency, DEA extended enforcement discretion allowing telemedicine prescribing of controlled substances (including buprenorphine for MAT) without in-person visits. Oklahoma's state law restrictions remain in effect regardless of federal enforcement discretion policies.

Compliance Requirement:

Prescribers in Oklahoma must comply with BOTH federal Ryan Haight Act requirements AND Oklahoma's more restrictive state law. Where state and federal law conflict, the more restrictive requirement applies.

COVID-19 Emergency Waivers:

Oklahoma's § 478.1(C) prohibition was enacted in 2017, BEFORE the COVID-19 pandemic, as part of the state's response to the opioid epidemic. The statute has remained in effect throughout the pandemic and continues as current law.

2021 and 2023 Amendments:

The amendments adding the MAT exception (allowing telemedicine prescribing of Schedule III-V substances approved for MAT/detoxification) were enacted in 2021 and 2023. These amendments represent permanent statutory changes, not temporary

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Oregon, Pennsylvania, Rhode Island

OREGON

Regulatory Status:** Explicit regulations exist with permissive telehealth framework

Telehealth CS Prescribing Permitted:

Yes, controlled substances may be prescribed via telehealth in Oregon. The Oregon Medical Board explicitly states that it "does not require an in-person visit to establish or maintain the provider-patient relationship" for telemedicine practice. However, providers must establish an appropriate provider-patient relationship and meet the same standard of care as in-person visits. The Board emphasizes that "not all medical care can be appropriately provided via telemedicine" and providers are "held to the same standard of care for the patient's outcome" regardless of delivery method.

In-Person Exam Requirements:

Oregon does NOT impose state-level in-person examination requirements for telehealth prescribing of controlled substances. The Oregon Medical Board's Statement of Philosophy on Telemedicine confirms that "The Oregon Medical Board does not require an in-person visit to establish or maintain the provider-patient relationship."

- **Initial Visit:** Not required by state law
- **Periodic Visits:** No specific frequency mandated
- **Exam Elements:** No specific state requirements beyond standard of care
- **Virtual Exams:** Permitted to establish provider-patient relationship
- **Questionnaires:** May be used as part of comprehensive evaluation meeting standard of care

Oregon defers to federal law (Ryan Haight Act) for controlled substance prescribing requirements. Providers must ensure their telehealth practice meets the same standard of care as in-person visits and that the chosen delivery method is appropriate for the specific medical situation.

Schedule-Specific Rules:

Oregon has one significant schedule-specific restriction affecting out-of-state providers:

- **Out-of-State Telemedicine Licensees:** Per OAR 847-025-0030(3)(b), out-of-state physicians and physician associates (PAs) with telemedicine licenses are PROHIBITED from prescribing controlled substances for the management of chronic pain to Oregon patients. This restriction applies only to telemedicine licensees (out-of-state providers) and not to Oregon-licensed providers with Active status licenses.
- **CII vs CIII-V:** No distinctions between schedules for in-state providers
- **Psychiatric vs Pain Medications:** No specific distinctions except the chronic pain prohibition for out-of-state telemedicine licensees

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• **Opioid-Specific Restrictions:** The chronic pain prohibition for telemedicine licensees applies to opioid prescribing

Prescriber Type Restrictions:

Oregon has a permissive approach to prescriber types for telehealth controlled substance prescribing:

• **Physicians (MD/DO/DPM) and Physician Associates (PAs):** May prescribe controlled substances via telehealth within their scope of practice

• **Nurse Practitioners (NPs):** Oregon grants full practice authority to NPs. NPs may prescribe drugs, devices, and Schedules II-V controlled substances per OAR 851-055-0078. The Telehealth Alliance of Oregon confirms "Other health professionals licensed in Oregon and practicing telemedically can prescribe the level of drugs outlined in their scope of practice."

• **Certified Registered Nurse Anesthetists (CRNAs):** May prescribe legend and controlled substances in Schedules II-V to established patients per OAR 851-056-0010(6)

• **Clinical Nurse Specialists (CNS):** Covered under APRN prescriptive authority rules in OAR 851-056

• **Pharmacists:** Limited prescriptive authority for specific protocols (smoking cessation, collaborative drug therapy management) but not general controlled substance prescribing

• **Optometrists:** May prescribe via telehealth but require an in-person eye examination prior to initial spectacle or contact lens prescriptions per OAR 852-001-0002(24). Optometrists have limited controlled substance prescribing authority.

• **Dentists, Podiatrists, Veterinarians:** May prescribe within their scope of practice; no specific telehealth restrictions identified beyond general telemedicine requirements

Ryan Haight Act Compliance:

Oregon has not enacted state-level modifications to the Ryan Haight Act. The state defers to federal DEA regulations for controlled substance prescribing via telemedicine. Oregon law requires compliance with federal DEA requirements, including electronic prescribing authentication (21 CFR 1311) when prescribing controlled substances electronically.

The Oregon Medical Board and Board of Pharmacy issued joint guidance in 2015 confirming that electronic prescribing of controlled substances requires DEA-authenticated software for both prescriber and pharmacy. Providers must comply with all federal requirements while benefiting from Oregon's permissive state-level framework.

COVID Emergency Waivers:

Oregon did not enact state-specific COVID-19 waivers for controlled substance prescribing via telehealth that would override the Ryan Haight Act. Oregon's COVID-19 emergency declarations have ended, and the state has returned to its standard telemedicine framework. However, Oregon providers benefit from the federal DEA COVID-19 telemedicine flexibilities, which have been extended through December 31, 2026. These federal flexibilities allow DEA-registered practitioners to prescribe controlled substances via telemedicine without an initial in-person evaluation under certain conditions.

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Compliance Requirements:

- Establish appropriate provider-patient relationship via telehealth or in-person
- Meet same standard of care as in-person visits
- Ensure telehealth modality is appropriate for specific medical situation
- Comply with federal Ryan Haight Act requirements
- Use DEA-authenticated software for electronic prescribing of controlled substances
- Out-of-state telemedicine licensees: Do not prescribe controlled substances for chronic pain management
- Maintain appropriate documentation of telehealth encounters
- Follow scope of practice limitations for each provider type

Primary Citations:

- Oregon Medical Board Statement of Philosophy on Telemedicine
- OAR 847-025-0030(3)(b) (Telemedicine License Restrictions)
- OAR 851-055-0078 (Nurse Practitioner Prescriptive Authority)
- OAR 851-056-0010(6) (CRNA Prescriptive Authority)
- OAR 851-056 (APRN Prescriptive Authority Rules)
- OAR 852-001-0002(24) (Optometry Telehealth Requirements)
- 21 CFR 1311 (DEA Electronic Prescribing Requirements)

Supporting Citations:

- Telehealth Alliance of Oregon guidance on prescriber authority
- Oregon Medical Board and Board of Pharmacy Joint Guidance (2015) on electronic prescribing of controlled substances
- Federal DEA COVID-19 telemedicine flexibilities

Effective Dates:

The Oregon Medical Board's Statement of Philosophy on Telemedicine represents current policy. OAR 847-025-0030 restrictions on telemedicine licensees remain in effect. The federal DEA COVID-19 telemedicine flexibilities have been extended through December 31, 2026.

PENNSYLVANIA

Regulatory Status: Explicit regulations exist with recent amendments for opioid treatment programs**

Telehealth CS Prescribing Permitted:

Yes, with significant limitations. Pennsylvania generally requires an initial in-person physical examination before prescribing controlled substances (CII-CV), with a narrow exception for Opioid

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Treatment Programs (OTPs) treating opioid use disorder. The state relies heavily on federal law (Ryan Haight Act) and federal COVID-19 telehealth flexibilities, which have been extended through December 31, 2026.

The key regulatory framework is found in 49 Pa. Code § 16.92, which was amended effective December 21, 2024, to create specific provisions for OTPs.

In-Person Exam Requirements:

Pennsylvania has detailed in-person examination requirements with a recent exception for OTPs:

• **General Rule:** An initial medical history and physical examination must be conducted prior to prescribing controlled substances unless emergency circumstances justify otherwise (49 Pa. Code § 16.92(a)(1))

• **Physical Exam Elements:** Must include objective evaluation of heart, lungs, blood pressure, and body functions relating to patient's specific complaint

• **30-Day Window:** Medical history and physical examination information recorded by another licensed healthcare provider may be considered if conducted within the immediately preceding 30 days

• **OTP Exception (NEW as of December 21, 2024):** For Opioid Treatment Programs only, the initial physical examination may be conducted via telehealth for patients being admitted for treatment of opioid use disorder with buprenorphine or methadone, provided:

• Provider determines adequate evaluation can be accomplished by telehealth

• Full in-person physical examination is completed within 14 days after admission

• Initial telehealth examination complies with 42 CFR 8.12 (federal opioid use disorder treatment standards)

• **Periodic Visits:** Reevaluations required consistent with condition diagnosed, controlled substance involved, expected results and possible side effects. No specific frequency mandated beyond OTP context.

• **Virtual Exams:** Generally NOT permitted to satisfy initial exam requirement except for OTP exception above

• **Questionnaires:** Questionnaires alone cannot satisfy examination requirements

Schedule-Specific Rules:

Pennsylvania's regulations apply uniformly across controlled substance schedules with limited distinctions:

• **No State Schedule Distinctions:** Pennsylvania's 49 Pa. Code § 16.92 applies uniformly to all controlled substances (Schedules II-V) without differentiating between CII and CIII-V for telehealth purposes

• **Psychiatric vs. Pain Medications:** No specific state distinctions in telehealth context

• **Opioid-Specific Restrictions:** The only opioid-specific provision is the OTP exception for buprenorphine/methadone treatment via telehealth (effective December 21, 2024)

• **Federal Flexibilities Apply:** Pennsylvania defers to federal COVID-19 telehealth flexibilities (extended through December 31, 2026) which permit DEA-registered practitioners

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to prescribe Schedule II-V controlled substances via telemedicine without initial in-person evaluation if conditions are met

Prescriber Type Restrictions:

Pennsylvania has detailed prescriptive authority rules for different provider types:

Physicians (MDs/DOs):** Full authority to prescribe controlled substances via telehealth, subject to 49 Pa. Code § 16.92 requirements

Physician Assistants (PAs):** May prescribe controlled substances with limitations (49 Pa. Code § 18.158):

- Must comply with § 16.92 standards
- Schedule II: May prescribe up to 72-hour dose for initial therapy (must notify supervising physician within 24 hours); may prescribe up to 30-day supply for ongoing therapy if approved by supervising physician
- Schedule III-V: May prescribe as delegated by supervising physician
- Must register with DEA
- Same telehealth restrictions as physicians apply

Nurse Practitioners/CRNPs:** May prescribe controlled substances with limitations (49 Pa. Code §§ 21.283, 21.284, 21.284b):

- Must have prescriptive authority approval from State Board of Nursing
- Must have collaborative agreement with physician
- Schedule II: Up to 30-day supply as identified in collaborative agreement
- Schedule III-IV: Up to 90-day supply as identified in collaborative agreement
- Must comply with same initial evaluation requirements (49 Pa. Code § 21.284b)
- Must register with DEA
- Same telehealth restrictions apply

Certified Nurse Midwives (CNMs):** Limited controlled substance prescriptive authority within scope of practice for midwifery care

CRNAs and Clinical Nurse Specialists:** Prescriptive authority within scope of practice, subject to collaborative agreements and same examination requirements

Pharmacists:** Limited prescriptive authority under collaborative practice agreements; not general controlled substance prescribing authority

Optometrists:** May prescribe within scope of practice (primarily topical and oral medications for eye conditions); limited controlled substance authority

Dentists:** Full authority to prescribe controlled substances within scope of dental practice, subject to § 16.92 requirements

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Podiatrists:** May prescribe controlled substances within scope of podiatric practice, subject to § 16.92 requirements

Veterinarians:** May prescribe controlled substances for animal patients within scope of veterinary practice

Ryan Haight Act Compliance:

Pennsylvania's regulations align with and reinforce the Ryan Haight Act requirements. The state has not created broad exceptions to the federal in-person examination requirement, except for the narrow OTP exception created in December 2024. Pennsylvania practitioners must comply with both state and federal law. The state's 49 Pa. Code § 16.92 essentially mirrors the Ryan Haight Act's in-person examination requirement while adding specific state-level details about examination elements.

The December 2024 amendment creating the OTP exception demonstrates Pennsylvania's willingness to adapt regulations for evidence-based treatment of opioid use disorder while maintaining strict requirements for other controlled substance prescribing.

COVID Emergency Waivers:

Pennsylvania did not enact permanent state-specific COVID-19 waivers for controlled substance prescribing via telehealth. The state's regulations in 49 Pa. Code § 16.92 remain in effect with the in-person examination requirement. However, Pennsylvania practitioners benefit from the federal DEA COVID-19 telemedicine flexibilities, which have been extended through December 31, 2026.

These federal flexibilities allow DEA-registered practitioners to prescribe controlled substances via telemedicine without an initial in-person evaluation if:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system
- The practitioner is acting in accordance with applicable federal and state laws

The December 21, 2024 amendment creating the OTP exception represents Pennsylvania's most significant permanent change to controlled substance prescribing rules in response to the opioid crisis and expanded telehealth access.

Compliance Requirements:

- Conduct initial in-person medical history and physical examination before prescribing controlled substances (except OTP exception)
- Physical examination must include objective evaluation of heart, lungs, blood pressure, and body functions relating to patient's complaint
- May rely on examination by another licensed provider if conducted within preceding 30 days
- For OTP patients only: May conduct initial exam via telehealth if in-person exam completed within 14 days and federal standards met
- Conduct periodic reevaluations consistent with condition and controlled substance prescribed

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- Maintain detailed medical records documenting examination findings and treatment rationale
- Mid-level prescribers must comply with scope of practice limitations and collaborative/supervisory requirements
- All prescribers must register with DEA
- Comply with federal Ryan Haight Act requirements
- May utilize federal COVID-19 telehealth flexibilities through December 31, 2026

Primary Citations:

- 49 Pa. Code § 16.92 (Standards of Practice - Prescribing Controlled Substances, amended effective December 21, 2024)
- 49 Pa. Code § 18.158 (Physician Assistant Prescriptive Authority)
- 49 Pa. Code §§ 21.283, 21.284, 21.284b (CRNP Prescriptive Authority)
- 42 CFR 8.12 (Federal Opioid Treatment Program Standards)
- 21 U.S.C. § 829 (Ryan Haight Act)

Supporting Citations:

- Pennsylvania State Board of Medicine guidance on telemedicine
- Pennsylvania State Board of Nursing guidance on CRNP prescriptive authority
- Federal DEA COVID-19 telemedicine flexibilities extension notices

Effective Dates:

The December 21, 2024 amendment to 49 Pa. Code § 16.92 created the OTP exception for telehealth prescribing of buprenorphine and methadone. Other provisions of § 16.92 remain in effect as previously adopted. Federal COVID-19 telehealth flexibilities are currently extended through December 31, 2026.

RHODE ISLAND

Regulatory Status: Explicit regulations exist prohibiting telehealth CS prescribing without established in-person relationship**

Telehealth CS Prescribing Permitted:

No, not without an established in-person relationship. The Rhode Island Board of Medical Licensure and Discipline (BMLD) Guidelines for the Appropriate Use of Telemedicine and the Internet in Medical Practice specifically state that prescribing controlled substances without an established in-person physician-patient relationship is prohibited.

There is a limited exception for covering physicians under established coverage agreements who may prescribe short-duration controlled substances, but this exception is narrow and applies only to temporary coverage situations.

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In-Person Exam Requirements:

Rhode Island has strict in-person examination requirements for controlled substance prescribing:

- **Initial Visit:** An in-person physician-patient relationship must be established before prescribing controlled substances via telehealth. This is a mandatory requirement.
- **Periodic Visits:** The regulations do not specify periodic visit requirements beyond the initial in-person relationship establishment
- **Exam Elements:** Must meet appropriate standard of care for the condition being treated
- **Virtual Exams:** NOT permitted to satisfy the initial in-person relationship requirement
- **Questionnaires:** Treatment based solely on an online questionnaire without an appropriate evaluation does not constitute an acceptable standard of care and is considered unprofessional conduct

The BMLD guidelines emphasize that the same standard of care applies to telemedicine as to in-person care, and that prescribing controlled substances without an established in-person relationship fails to meet this standard.

Schedule-Specific Rules:

Rhode Island regulations do not distinguish between controlled substance schedules for telehealth prescribing purposes:

- **CII vs CIII-V:** No distinctions; the prohibition applies to all controlled substances (Schedules II-V)
- **Psychiatric vs. Pain Medications:** No specific distinctions for psychiatric medications versus pain medications in the telehealth context
- **Opioid-Specific Restrictions:** General opioid prescribing regulations apply per 216-RICR-20-20-4 (Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances), but no additional telehealth-specific opioid restrictions beyond the general prohibition

The uniform application of the in-person requirement across all controlled substance schedules makes Rhode Island one of the more restrictive states for telehealth controlled substance prescribing.

Prescriber Type Restrictions:

Rhode Island's definition of "practitioner" under 216-RICR-20-20-4 includes multiple provider types, but the BMLD telehealth guidelines create potential ambiguity:

Physicians (MD/DO):** Subject to the in-person relationship requirement before prescribing controlled substances via telehealth

Advanced Practice Registered Nurses (APRNs):** May prescribe Schedule II-V controlled substances within their role and population focus per R.I. Gen. Laws § 5-34-49. However, the BMLD guidelines specifically reference "physician-patient relationship," creating potential ambiguity about whether APRNs are subject to the same in-person requirement. The safer interpretation is that all practitioners prescribing controlled substances via telehealth must establish an in-person relationship.

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Physician Assistants (PAs):** May prescribe Schedule II-V controlled substances in collaboration with physicians per R.I. Gen. Laws § 5-54-8. Same ambiguity applies regarding the in-person requirement.

Dentists:** Included in the definition of "practitioner" who may prescribe controlled substances. Likely subject to same in-person requirement for telehealth prescribing.

Podiatrists:** Included in the definition of "practitioner" who may prescribe controlled substances within scope of practice. Likely subject to same in-person requirement.

Veterinarians:** Included in the definition of "practitioner" who may prescribe controlled substances for animal patients. Likely subject to same in-person requirement.

Pharmacists:** Not included as prescribers of controlled substances; limited prescriptive authority under collaborative practice agreements

Optometrists:** Limited prescriptive authority; not specifically addressed in controlled substance telehealth regulations

CRNAs and Clinical Nurse Specialists:** Covered under APRN prescriptive authority; same ambiguity applies regarding in-person requirement

The BMLD guidelines' specific reference to "physician-patient relationship" rather than "practitioner-patient relationship" creates interpretive challenges. However, given Rhode Island's restrictive approach and the need to comply with standard of care requirements, all practitioners should establish in-person relationships before prescribing controlled substances via telehealth.

Ryan Haight Act Compliance:

Rhode Island's regulations align with and reinforce the Ryan Haight Act's in-person examination requirement. The state has not created special exceptions or modifications to the federal Ryan Haight Act requirements. Rhode Island practitioners must comply with both state and federal law, and the state requirement is at least as restrictive as federal law.

The BMLD guidelines' prohibition on prescribing controlled substances without an established in-person physician-patient relationship effectively mirrors the Ryan Haight Act's requirements while potentially being more restrictive by not explicitly recognizing the federal exceptions (such as the telemedicine exception for DEA-registered telemedicine sites).

Rhode Island's approach demonstrates a conservative interpretation of appropriate telehealth practice for controlled substances, prioritizing patient safety and thorough evaluation over expanded access.

COVID Emergency Waivers:

Rhode Island issued Executive Order 20-06 on March 18, 2020, which expanded telehealth services during the COVID-19 emergency, including audio-only telephone conversations. However, this executive order was temporary (initially effective through April 17, 2020) and addressed reimbursement and technology requirements, not the prohibition on prescribing controlled substances without an in-person relationship.

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There is no evidence that Rhode Island made permanent changes to its controlled substance prescribing requirements via telehealth. The BMLD guidelines prohibiting controlled substance prescribing without an in-person relationship remain in effect.

Rhode Island was identified in a 2023 study as one of eight states that imposed new restrictions during the COVID-19 public health emergency in response to the DEA's temporary waiver. This suggests Rhode Island took a more cautious approach than many states during the pandemic.

Rhode Island practitioners may benefit from federal DEA COVID-19 telemedicine flexibilities (extended through December 31, 2026), but state law requirements remain in effect and practitioners must comply with the more restrictive standard.

Compliance Requirements:

- Establish in-person physician-patient (or practitioner-patient) relationship before prescribing any controlled substances via telehealth
- Do not prescribe controlled substances based solely on online questionnaires
- Meet same standard of care for telehealth encounters as for in-person visits
- Maintain appropriate documentation of in-person relationship establishment
- Comply with federal Ryan Haight Act requirements
- Follow scope of practice limitations for each provider type
- APRNs and PAs: Maintain required collaborative relationships with physicians
- Comply with general opioid prescribing regulations per 216-RICR-20-20-4
- Covering physicians: May prescribe short-duration controlled substances under established coverage agreements (limited exception)
- Register with DEA as required
- Maintain appropriate medical records documenting evaluation and treatment rationale

Primary Citations:

- Rhode Island Board of Medical Licensure and Discipline (BMLD) Guidelines for the Appropriate Use of Telemedicine and the Internet in Medical Practice
- 216-RICR-20-20-4 (Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances), effective January 2, 2020
- R.I. Gen. Laws § 27-81-3 (Telemedicine Coverage Act definitions)
- R.I. Gen. Laws § 5-34-49 (APRN prescriptive authority)
- R.I. Gen. Laws § 5-54-8 (PA prescriptive authority)
- Executive Order 20-06 (March 18, 2020, temporary COVID-19 telehealth expansion)

Supporting Citations:

- 21 U.S.C. § 829 (Ryan Haight Act)
- Federal DEA COVID-19 telemedicine flexibilities
- 2023 study identifying Rhode Island as state imposing new restrictions during COVID-19 public health emergency

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Effective Dates:

The BMLD Guidelines for the Appropriate Use of Telemedicine and the Internet in Medical Practice represent current policy (accessed 2025). 216-RICR-20-20-4 became effective January 2, 2020. Executive Order 20-06 was temporary and has expired. No permanent COVID-19-related changes to controlled substance prescribing requirements have been enacted.

South Carolina through Tennessee

SOUTH CAROLINA

Regulatory Status: Explicit and comprehensive regulations exist**

Telehealth Controlled Substance Prescribing Authorization:

South Carolina permits telehealth prescribing of controlled substances with significant schedule-based restrictions. The state's framework was substantially modernized by the Telehealth and Telemedicine Modernization Act (Act No. 120, H.4159), signed into law on March 11, 2024, and effective immediately. Physicians may establish physician-patient relationships solely via telemedicine without prior in-person visits, representing a progressive approach compared to many states. However, physicians may not establish a telemedicine relationship for prescribing medication when an in-person physical examination is necessary for accurate diagnosis under applicable standards of care.

In-Person Examination Requirements:

South Carolina does not mandate a general in-person examination requirement for establishing physician-patient relationships via telemedicine. Physicians must obtain "threshold information necessary to make an accurate diagnosis" through a medical history interview conducted by the prescribing licensee. The statute requires an "appropriate evaluation" but explicitly states this "need not be done in person" if the licensee can accurately diagnose and treat in conformity with applicable standards of care via telehealth. Virtual examinations conducted via audio-video technology can satisfy examination requirements when they meet the standard of care for the condition being treated.

Simple questionnaires without appropriate evaluation are explicitly prohibited. The law does not mandate specific periodic visit requirements or frequency (such as annual or biannual in-person visits) for continued controlled substance prescribing. The determination of whether in-person examination is necessary is left to clinical judgment based on the standard of care for the specific diagnosis and treatment.

Schedule-Specific Restrictions:

South Carolina implements strict schedule-based limitations that distinguish between narcotic and non-narcotic controlled substances:

Schedule II and III Narcotics: Generally PROHIBITED via telemedicine except in the following circumstances:

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- Patient physically located in a hospital being treated by practitioner in usual course of practice
- Schedule II and III medications for patients actively enrolled in Medication-Assisted Treatment (MAT) programs with established physician-patient relationship when buprenorphine is prescribed for opioid use disorder
- Patients enrolled in palliative care or hospice programs
- Any other programs specifically authorized by the Board of Medical Examiners

Schedule II and III Non-Narcotics: May be prescribed via telehealth if specifically authorized by the Board of Medical Examiners (board approval required).

Schedule IV-V Controlled Substances: No specific telehealth restrictions beyond general prescribing requirements apply to these schedules.

The statute does not create explicit distinctions between psychiatric medications and pain medications, though the MAT program carve-out specifically addresses opioid use disorder treatment. All prescribers must comply with South Carolina's Prescription Monitoring Program requirements under Article 15, Chapter 53, Title 44. Prescribers must review a patient's controlled substance prescription history before issuing Schedule II prescriptions pursuant to S.C. Code Ann. § 44-53-1645(A). Abortion-inducing drugs are explicitly prohibited from being prescribed via telemedicine.

Prescriber Type Restrictions:

Physicians (MDs/DOs): May prescribe controlled substances via telehealth subject to the schedule-specific restrictions outlined above under S.C. Code Ann. § 40-47-37.

Physician Assistants (PAs): May prescribe controlled substances via telemedicine if authorized in their written scope of practice guidelines pursuant to S.C. Code Ann. § 40-47-965. PAs must comply with Section 40-47-37 requirements including Schedule II/III narcotic restrictions. For Schedule II narcotics (oral formulations), PAs require supervising physician approval, must conduct direct evaluation of the patient, and authority is limited to a 5-day supply for patients not in hospice or palliative care. Board appearance is required prior to prescribing controlled substances via telemedicine unless specifically authorized.

Nurse Practitioners/APRNs/Certified Nurse Midwives/Clinical Nurse Specialists: May prescribe controlled substances via telemedicine pursuant to their practice agreement under S.C. Code Ann. § 40-33-34. Schedule II-V prescriptions are only permitted pursuant to the practice agreement. These practitioners are subject to the same limitations as Section 40-47-37(C)(6) regarding Schedule II/III narcotic restrictions unless specifically approved by the joint committee of the Board of Medical Examiners and Board of Nursing. Schedule III-V controlled substances may be prescribed if listed in the practice agreement. Schedule II non-narcotic controlled substances may be prescribed if included in the practice agreement, not to exceed a 30-day supply. Schedule II narcotic prescribing via telehealth is subject to the same exceptions as physicians (MAT, hospice/palliative care, hospital settings, Board-authorized programs).

Certified Registered Nurse Anesthetists (CRNAs): May prescribe controlled substances within their scope of practice pursuant to practice agreements and subject to the same telehealth restrictions.

Pharmacists: South Carolina law does not authorize pharmacists to prescribe controlled substances via telehealth.

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Optometrists: Limited prescribing authority for therapeutic pharmaceutical agents; controlled substance prescribing via telehealth not explicitly addressed in available statutes.

Dentists and Podiatrists: May prescribe controlled substances within their scope of practice; telehealth prescribing authority follows general practitioner requirements under § 40-47-37.

Veterinarians: May prescribe controlled substances for animal patients; telehealth prescribing must comply with veterinary practice act requirements.

Ryan Haight Act Compliance:

South Carolina's regulations operate in conjunction with federal Ryan Haight Act requirements. The state's allowance for establishing physician-patient relationships via telemedicine without in-person visits for certain controlled substances (particularly Schedule IV-V and authorized MAT programs) aligns with federal exceptions under the Ryan Haight Act, particularly the telemedicine exception for DEA-registered practitioners treating patients in DEA-registered locations. Prescribers must ensure compliance with both state schedule-specific restrictions and federal requirements.

COVID-19 Emergency Waivers:

The 2024 Telehealth and Telemedicine Modernization Act represents a permanent expansion of telehealth authority rather than a temporary COVID-19 waiver. The Act codified many flexibilities that may have been implemented during the public health emergency into permanent law. No temporary COVID-19 waivers remain in effect as separate provisions; the modernized framework is the current permanent regulatory structure.

Compliance Requirements:

- Establish appropriate physician-patient or provider-patient relationship via telemedicine
- Obtain threshold information necessary for accurate diagnosis through medical history interview
- Conduct appropriate evaluation meeting standard of care (may be virtual)
- Prohibit prescribing based solely on questionnaires without appropriate evaluation
- Comply with Schedule II/III narcotic prohibition except for authorized exceptions (MAT, hospice/palliative, hospital, Board-authorized programs)
- Obtain Board of Medical Examiners authorization for Schedule II/III non-narcotic prescribing via telehealth
- Review Prescription Monitoring Program data before issuing Schedule II prescriptions
- Maintain written scope of practice guidelines (PAs) or practice agreements (APRNs)
- Ensure supervising physician approval for PA Schedule II narcotic prescribing (5-day limit)
- Document all telemedicine encounters in medical records
- Ensure availability for appropriate follow-up care

Primary Citations:

- S.C. Code Ann. § 40-47-37 (Telemedicine practice by physicians)
- S.C. Code Ann. § 40-47-965 (Physician assistant prescribing via telemedicine)

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- S.C. Code Ann. § 40-33-34 (APRN/NP/CNM/CNS prescribing authority)
- S.C. Code Ann. § 44-53-1645(A) (Prescription Monitoring Program requirements)
- Article 15, Chapter 53, Title 44 (South Carolina Prescription Monitoring Program)
- Act No. 120, H.4159 (Telehealth and Telemedicine Modernization Act)

Supporting Citations:

- South Carolina Board of Medical Examiners regulations and guidance documents
- South Carolina Board of Nursing practice agreement requirements
- DEA regulations implementing the Ryan Haight Act (21 CFR § 1306.04)

Effective Dates:

The Telehealth and Telemedicine Modernization Act (Act No. 120, H.4159) was signed into law on March 11, 2024, and became effective immediately. This Act substantially amended S.C. Code Ann. § 40-47-37 and related provisions, representing the current regulatory framework for telehealth controlled substance prescribing in South Carolina.

SOUTH DAKOTA

Regulatory Status:** Explicit regulations exist

Telehealth Controlled Substance Prescribing Authorization:

South Dakota permits telehealth prescribing of controlled substances under SDCL Chapter 34-52 (Telehealth Utilization by Health Care Professionals), enacted in 2019 and amended in 2020-2021. The critical requirement is that a proper provider-patient relationship must exist before prescribing any controlled substance via telehealth. South Dakota's approach is relatively permissive compared to many states, as it does not impose blanket prohibitions on specific schedules or medication categories, but instead focuses on the quality of the provider-patient relationship and the appropriateness of the telehealth modality for the clinical situation.

In-Person Examination Requirements:

SDCL § 34-52-3 mandates that telehealth may not be utilized in the absence of a provider-patient relationship. However, South Dakota law does not explicitly define what constitutes this relationship or mandate a specific initial in-person examination. This creates flexibility for providers to establish relationships via telehealth when clinically appropriate.

SDCL § 34-52-6 explicitly prohibits prescribing controlled substances (as defined by § 34-20B-3, covering Schedules II-V) "solely in response to an internet questionnaire or consult, including any encounter via telephone" without a proper provider-patient relationship. This prohibition targets online-only prescribing operations but does not prevent legitimate telehealth encounters.

SDCL § 34-52-5 requires that face-to-face examinations using telehealth employ "real-time audio and visual technology." This provision indicates that audio-video telehealth consultations can satisfy examination requirements when a provider-patient relationship exists, and telephone-only consultations are insufficient for prescribing controlled substances.

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South Dakota statutes do not mandate annual, biannual, or other periodic in-person visits for continued controlled substance prescribing via telehealth. The ongoing relationship is governed by the standard of care for the condition being treated rather than arbitrary time-based requirements.

Important exceptions to the provider-patient relationship requirement exist for: (1) on-call situations, (2) cross-coverage situations, and (3) consultations with another healthcare professional who has an ongoing relationship with the patient. These exceptions recognize the practical realities of healthcare delivery.

Schedule-Specific Restrictions:

South Dakota's telehealth prescribing restrictions apply uniformly to all controlled substances as defined in SDCL § 34-20B-3 (Schedules II-V). The state does not differentiate between Schedule II and Schedule III-V controlled substances for telehealth prescribing purposes, representing a more streamlined approach than many states.

No distinction exists between psychiatric medications and pain medications in the telehealth statute. The same provider-patient relationship and real-time audio-visual technology requirements apply regardless of therapeutic category.

For Advanced Practice Registered Nurses (CNPs, CNMs, CRNAs), ARSD 20:48:04:09 and 20:62:03:11 provide specific guidelines for prescribing controlled substances for chronic, non-cancer pain, including documentation requirements. However, these guidelines apply equally to both in-person and telehealth prescribing and do not create additional telehealth-specific restrictions. The guidelines emphasize appropriate evaluation, documentation of medical necessity, consideration of non-opioid alternatives, and monitoring for signs of misuse.

Prescriber Type Restrictions:

South Dakota's telehealth law (SDCL § 34-52-2) applies to all "health care professionals" who are "fully licensed to practice in the state." This broad definition allows various prescriber types to utilize telehealth for controlled substance prescribing within their scope of practice:

Physicians (MD/DO): Full authority to prescribe all controlled substances (Schedules II-V) via telehealth, subject to the provider-patient relationship requirement and real-time audio-visual technology standard.

Certified Nurse Practitioners (CNPs): May prescribe controlled substances Schedules II-IV via telehealth under SDCL 36-9A-12, which grants CNPs prescriptive authority for controlled substances within their licensed role. CNPs must adhere to SDCL Chapter 34-52 telehealth requirements. Notably, CNPs with 1,040 or more practice hours may practice without a collaborative agreement, providing significant practice autonomy. CNPs with fewer hours must maintain collaborative agreements but still retain prescribing authority within their scope.

Certified Nurse Midwives (CNMs): May prescribe controlled substances Schedules II-IV via telehealth under SDCL 36-9A-13, subject to SDCL Chapter 34-52 requirements. CNMs prescribe within their role and population focus (women's health, pregnancy, childbirth, postpartum care).

Certified Registered Nurse Anesthetists (CRNAs): May prescribe controlled substances Schedules II-IV via telehealth under SDCL 36-9-3.1 within their role, which encompasses anesthesia and pain management. CRNAs must comply with SDCL Chapter 34-52 telehealth requirements.

Clinical Nurse Specialists (CNS): South Dakota does not recognize CNS as a separate license category for in-state practice. Out-of-state CNS practitioners may write prescriptions for South

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Dakota patients when the CNS is located in their home state, but this represents interstate practice rather than South Dakota-licensed prescribing.

Physician Assistants (PAs): May prescribe controlled substances via telehealth under SDCL Chapter 36-4A. PAs must practice under supervision with a collaborative agreement. Schedule II controlled substances are limited to a 30-day supply for one period (non-refillable), while Schedule III-V controlled substances may be prescribed for up to a 90-day supply with refills. PAs must comply with SDCL Chapter 34-52 telehealth requirements including provider-patient relationship and real-time audio-visual technology standards.

Optometrists: Limited to oral analgesics (Schedule II-IV narcotics) under SDCL 36-7-1. May prescribe these limited controlled substances via telehealth when within scope of practice and compliant with Chapter 34-52 requirements. Optometric prescribing is restricted to conditions related to eye care.

Dentists: May prescribe controlled substances via telehealth within their scope of dental practice, subject to Chapter 34-52 requirements. Dental prescribing typically involves acute pain management related to dental procedures.

Podiatrists: May prescribe controlled substances via telehealth within their scope of practice (foot and ankle conditions), subject to Chapter 34-52 requirements.

Veterinarians: May prescribe controlled substances for animal patients via telehealth, subject to Chapter 34-52 requirements and the veterinarian-client-patient relationship standards.

Pharmacists: South Dakota law does not authorize pharmacists to independently prescribe controlled substances. Pharmacists may participate in collaborative practice agreements but do not have independent prescribing authority for controlled substances.

Ryan Haight Act Compliance:

South Dakota's requirement for a provider-patient relationship aligns with the Ryan Haight Act's prohibition on prescribing controlled substances without a legitimate medical purpose and outside the usual course of professional practice. The state's prohibition on prescribing based solely on internet questionnaires directly addresses the Ryan Haight Act's concerns about online prescribing operations.

The requirement for real-time audio and visual technology for face-to-face examinations via telehealth meets the Ryan Haight Act's telemedicine exception requirements when applicable. Practitioners must ensure compliance with both state requirements (provider-patient relationship, audio-visual technology) and federal DEA registration and Ryan Haight Act provisions.

South Dakota has not enacted state-specific modifications that would exempt practitioners from Ryan Haight Act requirements. Federal law continues to apply, including the requirement that at least one in-person medical evaluation occur for Schedule II-V controlled substance prescribing unless a specific Ryan Haight Act exception applies (such as the public health emergency exception that was in effect during COVID-19, or practice in Indian Health Service facilities, or during medical emergencies).

COVID-19 Emergency Waivers:

Federal COVID-19 telehealth flexibilities for controlled substance prescribing, implemented through DEA and HHS waivers, expired on May 11, 2023, when the federal public health emergency ended. However, the DEA has extended the telemedicine prescribing flexibilities for buprenorphine for opioid use disorder through temporary rules while developing permanent regulations.

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South Dakota did not enact state-specific COVID-19 emergency waivers that modified controlled substance prescribing requirements beyond the federal flexibilities. The state's existing telehealth framework under SDCL Chapter 34-52 remained in effect throughout the pandemic and continues to govern current practice. The state's regulations were already relatively permissive, allowing provider-patient relationships to be established via telehealth without mandating initial in-person visits.

As of 2024, practitioners must comply with current federal DEA requirements, which generally require at least one in-person medical evaluation before prescribing controlled substances via telemedicine, unless a specific exception applies. The most significant ongoing exception relates to buprenorphine prescribing for opioid use disorder, where audio-only telehealth remains temporarily permitted under federal rules.

Compliance Requirements:

- Establish provider-patient relationship before prescribing controlled substances via telehealth
- Utilize real-time audio and visual technology for face-to-face telehealth examinations
- Prohibit prescribing controlled substances based solely on internet questionnaires or telephone-only encounters
- Maintain full, unrestricted license to practice in South Dakota
- Comply with collaborative agreement requirements (PAs, CNPs with <1,040 hours)
- Adhere to schedule-specific quantity limitations (PA Schedule II: 30-day supply limit)
- Document telehealth encounters in medical records equivalent to in-person visits
- Comply with South Dakota Prescription Monitoring Program requirements
- Ensure compliance with federal Ryan Haight Act and DEA registration requirements
- Prescribe only within authorized scope of practice for prescriber type
- Apply standard of care appropriate for the condition being treated
- Provide or arrange for appropriate follow-up care

Primary Citations:

- SDCL Chapter 34-52 (Telehealth Utilization by Health Care Professionals)
- SDCL § 34-52-2 (Definitions)
- SDCL § 34-52-3 (Provider-patient relationship requirement)
- SDCL § 34-52-5 (Face-to-face examination standards)
- SDCL § 34-52-6 (Prohibition on internet questionnaire prescribing)
- SDCL § 34-20B-3 (Controlled substances schedules)
- SDCL Chapter 36-9A (Advanced Practice Registered Nurses)
- SDCL § 36-9A-12 (CNP prescriptive authority)
- SDCL § 36-9A-13 (CNM prescriptive authority)
- SDCL § 36-9-3.1 (CRNA prescriptive authority)
- SDCL Chapter 36-4A (Physician Assistants)

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- SDCL § 36-7-1 (Optometry scope of practice)
- ARSD 20:48:04:09 (APRN chronic pain prescribing guidelines)
- ARSD 20:62:03:11 (APRN controlled substance prescribing documentation)

Supporting Citations:

- South Dakota Board of Medical and Osteopathic Examiners guidance documents
- South Dakota Board of Nursing APRN practice guidelines
- DEA regulations implementing the Ryan Haight Act (21 CFR § 1306.04)
- Federal telemedicine prescribing exceptions (21 U.S.C. § 802(54))

Effective Dates:

SDCL Chapter 34-52 was enacted in 2019 (SB 133) and became effective July 1, 2019. Amendments were made in 2020 and 2021 to clarify provisions and expand applicability. The current regulatory framework represents the permanent telehealth prescribing structure for South Dakota, with no temporary COVID-19 waivers remaining in effect at the state level.

TENNESSEE

Regulatory Status:** Explicit regulations exist with significant restrictions

Telehealth Controlled Substance Prescribing Authorization:

Tennessee generally permits controlled substance prescribing via telehealth, but the regulatory framework is complex and includes both permissive general rules and specific categorical prohibitions. Tenn. R. & Regs. § 0880-02-.14(7) and § 1050-02-.13 allow prescriptions for controlled substances (Schedules II-V) via telemedicine encounters when medically appropriate and compliant with state and federal law. However, Tennessee imposes absolute prohibitions on telehealth prescribing for chronic pain management and significant restrictions on buprenorphine prescribing for opioid use disorder, making it one of the more restrictive states for telehealth controlled substance prescribing.

In-Person Examination Requirements:

Before prescribing ANY drug (including controlled substances) via telehealth, Tennessee physicians must:

1. Perform an appropriate history and physical examination

2. Make a diagnosis based on examinations and diagnostic/laboratory tests consistent with good medical care

3. Formulate and discuss a therapeutic plan with the patient

4. Ensure availability for appropriate follow-up care

The Tennessee Board of Medical Examiners has NOT defined what constitutes "an appropriate history and physical examination," creating significant ambiguity about whether this requirement can be satisfied virtually or requires in-person contact. The Board's FAQ acknowledges that federal

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regulation may limit prescribing controlled substances without at least one in-person assessment, suggesting awareness of Ryan Haight Act requirements but leaving state-level interpretation unclear.

It is an ethical violation for a physician to prescribe any drug to an individual the physician has never met solely based on answers to questionnaires (Tenn. R. & Regs. § 0880-02-.14(7)). This prohibition targets online prescribing operations but does not clarify whether audio-video telehealth consultations constitute "meeting" the patient.

Tennessee does not mandate specific periodic visit requirements (annual or biannual in-person visits) for continued controlled substance prescribing via telehealth in its general telehealth regulations. However, the standard of care for the specific condition being treated may necessitate periodic in-person evaluations.

Schedule-Specific and Condition-Specific Restrictions:

Tennessee implements some of the nation's most restrictive condition-specific prohibitions on telehealth controlled substance prescribing:

Pain Management - ABSOLUTE PROHIBITION:

Tennessee EXPLICITLY PROHIBITS prescribing controlled substances for chronic pain management via telemedicine. The Tennessee Chronic Pain Guidelines unequivocally state: "Do not prescribe controlled substances to manage pain through telemedicine." Tenn. Code Ann. § 63-1-155 specifically provides that telemedicine encounters for chronic pain are governed by the Tennessee Chronic Pain Guidelines, which prohibit treatment of chronic pain through telemedicine. This prohibition applies to pain management clinics as well.

All prescriptions for dangerous drugs or controlled substances for the treatment of pain may occur only after a physical examination by the prescribing physician (Tenn. R. & Regs. §§ 0880-02-.14(6) & 1050-02-.13(5)). The regulations do not distinguish between acute and chronic pain in this prohibition, though the Chronic Pain Guidelines specifically address chronic pain management.

This represents one of the most significant restrictions on telehealth controlled substance prescribing in the United States and effectively prohibits telehealth prescribing of opioids, benzodiazepines, and other controlled substances when the primary indication is pain management.

Buprenorphine for Opioid Use Disorder - HIGHLY RESTRICTED:

Buprenorphine for opioid use disorder (OUD) cannot be prescribed via telehealth UNLESS the prescriber is employed by or contracted with:

- A licensed office-based opioid treatment (OBOT) facility
- A community mental health center (CMHC)
- A federally qualified health center (FQHC)
- A hospital
- TennCare's enhanced buprenorphine treatment network

This restriction significantly limits access to medication-assisted treatment via telehealth and requires practitioners to be affiliated with specific institutional settings. Independent practitioners or those in private practice settings cannot prescribe buprenorphine via telehealth for OUD unless they meet these institutional affiliation requirements.

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Telehealth may be utilized to facilitate counseling in OBOT settings (Tenn. Comp. R. & Regs. 0940-05-35-.02(f)), recognizing the value of telehealth for the behavioral health component of MAT while restricting the prescribing component.

No CII vs. CIII-V Distinction for Non-Pain Conditions:

For conditions other than pain management and OUD, Tennessee does not distinguish between Schedule II and Schedule III-V controlled substances in telehealth prescribing rules. All schedules must comply with the general prescribing requirements, including appropriate history and physical examination, diagnosis, treatment plan, and follow-up care availability.

Psychiatric Medications:

Tennessee does not impose specific restrictions on psychiatric controlled substances (such as stimulants for ADHD, benzodiazepines for anxiety disorders, or sedative-hypnotics for sleep disorders) via telehealth, provided the general prescribing requirements are met and the condition is not chronic pain. This creates a practical pathway for telepsychiatry practices to prescribe controlled substances, though practitioners must still navigate the ambiguity regarding what constitutes an "appropriate history and physical examination."

Prescriber Type Restrictions:

Physicians (MD/DO):

Physicians with full, unrestricted Tennessee medical licenses may prescribe controlled substances via telehealth in accordance with Tenn. Comp. R. & Regs. 0880-02-.14(6)(e)(3) and 0880-02-.14(7)(a), subject to the restrictions outlined above (pain management prohibition, buprenorphine restrictions, appropriate examination requirements).

Physicians with telemedicine-only licenses (special purpose licenses for out-of-state physicians practicing telemedicine into Tennessee) may NOT prescribe controlled substances. This restriction limits telemedicine-only licensees to non-controlled medications and effectively requires full Tennessee licensure for controlled substance prescribing.

Advanced Practice Registered Nurses (APRNs/Nurse Practitioners):

APRNs with a Certificate of Fitness may prescribe Schedules II-V controlled substances via telehealth, BUT with significant restrictions:

- Must work under physician supervision/collaboration pursuant to a collaborative practice agreement
- Schedules II-IV require consultation with the collaborating physician before the initial prescription
- Schedule II-III opioids are limited to a 30-day non-refillable supply unless specifically approved by the collaborating physician for a longer duration
- The supervising physician must review the APRN's controlled substance prescribing practices
- Subject to the same pain management prohibition and buprenorphine restrictions as physicians
- Must complete appropriate history and physical examination via telehealth
- Certificate of Fitness must specifically authorize controlled substance prescribing

The requirement for physician consultation before initial Schedule II-IV prescriptions creates an additional barrier for APRN telehealth prescribing compared to in-person practice, though ongoing prescriptions may not require consultation for each refill.

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Physician Assistants (PAs):

PAs may prescribe controlled substances via telehealth under physician supervision, subject to:

- • Delegation agreement with supervising physician must specifically authorize controlled substance prescribing
- • Schedule II controlled substances limited to 30-day supply (non-refillable) unless supervising physician approves longer duration
- • Schedule III-V controlled substances may be prescribed within scope of delegation agreement
- • Subject to same pain management prohibition and buprenorphine restrictions as physicians
- • Must maintain appropriate supervision ratios and collaborative relationships
- • Must complete appropriate history and physical examination via telehealth

Certified Registered Nurse Anesthetists (CRNAs):

CRNAs may prescribe controlled substances within their scope of practice (anesthesia and pain management) via telehealth, but the pain management prohibition significantly limits this authority. CRNAs must work under collaborative agreements and may prescribe controlled substances for anesthesia-related purposes but cannot prescribe for chronic pain management via telehealth.

Clinical Nurse Specialists (CNS):

CNS practitioners with Certificates of Fitness may prescribe controlled substances via telehealth subject to the same restrictions as other APRNs, including collaborative practice agreements, consultation requirements for initial Schedule II-IV prescriptions, and condition-specific prohibitions.

Pharmacists:

Tennessee pharmacists do not have independent authority to prescribe controlled substances. Pharmacists may participate in collaborative drug therapy management agreements but do not have prescriptive authority for controlled substances via telehealth.

Optometrists:

Tennessee optometrists have limited prescribing authority for therapeutic pharmaceutical agents related to eye care. Controlled substance prescribing authority is restricted to oral analgesics and oral anti-inflammatory agents for conditions related to the eye. Telehealth prescribing of these limited controlled substances would be subject to general telehealth prescribing requirements and the pain management prohibition.

Dentists:

Dentists may prescribe controlled substances via telehealth within their scope of dental practice, but the pain management prohibition creates significant practical limitations. Dental prescribing typically involves acute pain management following dental procedures, and the requirement for physical examination for pain-related prescribing may necessitate in-person evaluation.

Podiatrists:

Podiatrists may prescribe controlled substances via telehealth within their scope of practice (foot and ankle conditions), subject to general telehealth prescribing requirements and the pain management prohibition.

Veterinarians:

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Veterinarians may prescribe controlled substances for animal patients via telehealth, subject to veterinarian-client-patient relationship requirements and general telehealth standards. The pain management prohibition for human patients does not apply to veterinary practice, though veterinarians must maintain appropriate relationships with animal patients and their owners.

Ryan Haight Act Compliance:

Tennessee's regulations operate in conjunction with federal Ryan Haight Act requirements. The state's ambiguity regarding whether an "appropriate history and physical examination" can be conducted via telehealth or requires in-person contact creates compliance challenges. The Board of Medical Examiners' acknowledgment that federal regulation may limit controlled substance prescribing without at least one in-person assessment suggests that practitioners should comply with Ryan Haight Act requirements for in-person evaluation.

The prohibition on prescribing based solely on questionnaires aligns with Ryan Haight Act concerns about online prescribing operations. Tennessee has not enacted state-specific modifications that would exempt practitioners from Ryan Haight Act requirements.

Practitioners must ensure compliance with both Tennessee's condition-specific prohibitions (pain management, buprenorphine restrictions) and federal Ryan Haight Act requirements, including DEA registration and the general requirement for at least one in-person medical evaluation before prescribing controlled substances via telemedicine (unless a specific exception applies).

COVID-19 Emergency Waivers:

Federal COVID-19 telehealth flexibilities for controlled substance prescribing expired on May 11, 2023, when the federal public health emergency ended. Tennessee did not enact permanent state-level modifications to codify COVID-19 flexibilities.

Tennessee issued emergency orders during the COVID-19 pandemic that temporarily relaxed certain telehealth requirements, but these emergency orders expired when the state of emergency ended. The state's current regulatory framework represents the permanent post-pandemic structure.

The DEA has extended telemedicine prescribing flexibilities for buprenorphine for opioid use disorder through temporary rules while developing permanent regulations. However, Tennessee's state-level restrictions on buprenorphine prescribing via telehealth (requiring institutional affiliation with OBOT, CMHC, FQHC, hospital, or TennCare network) remain in effect and may be more restrictive than federal requirements.

Tennessee's pain management prohibition via telemedicine was in effect before COVID-19 and remains in effect, representing one of the most significant ongoing restrictions on telehealth controlled substance prescribing in the nation.

Compliance Requirements:

- Perform appropriate history and physical examination before prescribing (definition unclear regarding virtual vs. in-person)
- Make diagnosis based on examinations and diagnostic/laboratory tests consistent with good medical care
- Formulate and discuss therapeutic plan with patient
- Ensure availability for appropriate follow-up care

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- Prohibit prescribing based solely on questionnaires without meeting patient
- ABSOLUTE PROHIBITION: Do not prescribe controlled substances for chronic pain management via telemedicine
- Buprenorphine for OUD: Only prescribe if employed by/contracted with OBOT, CMHC, FQHC, hospital, or TennCare network
- Maintain full Tennessee medical license (telemedicine-only licenses cannot prescribe controlled substances)
- APRNs: Obtain physician consultation before initial Schedule II-IV prescriptions
- APRNs/PAs: Maintain collaborative practice agreements or delegation agreements authorizing controlled substance prescribing
- Schedule II-III opioids: Limit to 30-day non-refillable supply unless supervising physician approves longer duration (APRNs/PAs)
- Comply with Tennessee Controlled Substance Monitoring Database requirements
- Ensure compliance

Texas, Utah, Vermont

TEXAS

Regulatory Status:** Explicit regulations exist

Texas has comprehensive state-level regulations governing telehealth prescribing of controlled substances, codified primarily in Texas Occupations Code Chapter 111 and Chapter 157, with implementing rules from the Texas Medical Board (22 TAC Chapter 174) and Texas Board of Nursing (22 TAC Chapter 217). These regulations operate in conjunction with federal DEA flexibilities currently extended through December 31, 2026.

Telehealth Controlled Substance Prescribing - Generally Permitted:

Texas permits telehealth prescribing of controlled substances Schedules II-V, subject to both state and federal requirements. The state's framework allows practitioners to establish valid practitioner-patient relationships through multiple modalities without requiring an initial in-person visit for most clinical scenarios.

Practitioner-Patient Relationship Requirements:

Under Texas Occupations Code § 111.005, a valid practitioner-patient relationship can be established through:

- A preexisting relationship from prior in-person care
- A call coverage relationship
- Synchronous audiovisual interaction
- Asynchronous store-and-forward technology
- Other audiovisual telecommunication technology that allows compliance with the applicable standard of care

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In-Person Examination Requirements:

Texas does not mandate a specific initial in-person examination for telehealth prescribing under general state law. However, the state imposes significant restrictions for chronic pain management with controlled substances.

Chronic Pain Treatment Restrictions (22 TAC § 174.5(e) for physicians; 22 TAC § 217.24(e) for APRNs):

Treatment of chronic pain with scheduled drugs via telemedicine is prohibited unless conducted via audio and video two-way communication, EXCEPT when ALL of the following conditions are met:

- Patient is an established chronic pain patient
- Patient is receiving an identical prescription to the previous visit
- Patient has been seen by the prescribing physician, APRN, or health professional within the last 90 days either in-person OR via telemedicine using audio and video two-way communication

When utilizing this exception, the prescriber must:

- Document the exception and reason for choosing a telemedicine visit instead of an in-person visit
- Consider relevant factors including the date of last in-person visit, patient comorbidities, and occupational COVID-19 exposure risks

Acute Pain Treatment:

Telemedicine may be used for acute pain treatment with scheduled drugs unless otherwise prohibited under federal and state law (22 TAC § 174.5(e)(2)). No specific periodic visit requirements apply.

Virtual Examination Sufficiency:

Audio-video telemedicine visits can satisfy the 90-day requirement for chronic pain patients. Audio-only communication is permitted for some telehealth services but NOT for chronic pain treatment with controlled substances.

Schedule-Specific Rules:

Schedule II vs. Schedule III-V Differences:

Physicians:** May prescribe Schedule II-V controlled substances via telehealth under current federal flexibilities and state law, subject to the chronic pain restrictions noted above.

APRNs and Physician Assistants:** Face significant Schedule II restrictions under Texas Occupations Code § 157.0511 and 22 TAC § 222.8:

Schedule III-V Prescribing:

- May prescribe Schedule III-V controlled substances (up to 90-day supply including refills) when properly delegated
- No location-based restrictions

Schedule II Prescribing - Limited to:

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- Hospital facility-based practice (admitted patients with 24+ hour stay or emergency department patients), with prescription filled at hospital pharmacy; OR
- Hospice care for terminally ill patients

Outside these specific settings, APRNs and PAs cannot prescribe Schedule II controlled substances regardless of delivery modality.

Mental Health Services - Special Provisions (SB 2527, effective September 1, 2023):

Texas Occupations Code § 113.003 creates specific provisions for mental health professionals prescribing controlled substances:

- May prescribe controlled substances through synchronous audiovisual platform if they conducted at least one prior visit (in-person or synchronous audiovisual)
- Must ensure patient has not been prescribed the same controlled substance within 30 days by another provider
- Annual reporting requirement for health professionals prescribing controlled substances via telemedicine (Texas Occupations Code § 111.013)

Opioid-Specific Requirements:

Texas Health & Safety Code § 481.076 (effective September 1, 2019) requires prescribers to check the Texas Prescription Monitoring Program (PMP) before prescribing:

- Opioids
- Benzodiazepines
- Barbiturates
- Carisoprodol

Exceptions to PMP check requirement:

- Patient has cancer diagnosis
- Patient has sickle cell disease
- Patient is receiving hospice care
- Good faith attempt made but unable to access PMP

Electronic prescribing of controlled substances became mandatory effective January 1, 2021 (Texas Health & Safety Code § 481.0755), with limited exceptions for technical failures, patient-specific hardships, and prescriptions issued directly to dispensing pharmacies.

Prescriber Type Restrictions:

Physicians (MD/DO):

- May prescribe Schedule II-V controlled substances via telehealth within scope of practice
- Subject to chronic pain restrictions and PMP requirements

Advanced Practice Registered Nurses (APRNs) and Nurse Practitioners:

- May prescribe Schedule III-V controlled substances when properly delegated
- Schedule II prescribing limited to hospital-based practice and hospice care only
- Subject to same chronic pain restrictions as physicians (22 TAC § 217.24(e))

Physician Assistants:

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- May prescribe Schedule III-V controlled substances when properly delegated
- Schedule II prescribing limited to hospital-based practice and hospice care only
- Must operate within supervising physician's prescriptive practice and delegation of services agreement

Certified Registered Nurse Anesthetists (CRNAs) and Clinical Nurse Specialists:

- May prescribe controlled substances within APRN scope when properly delegated
- Subject to same Schedule II limitations as other APRNs

Pharmacists:

- Limited prescribing authority (hormonal contraceptives, smoking cessation products)
- Cannot prescribe controlled substances via telehealth

Optometrists:

- May prescribe controlled substances via telehealth within scope of practice (treatment of eye conditions)
- Must hold appropriate controlled substance registration

Dentists:

- May prescribe controlled substances via telehealth within scope of practice (dental conditions)
- Subject to general telehealth and controlled substance requirements

Podiatrists:

- May prescribe controlled substances via telehealth within scope of practice (foot and ankle conditions)
- Subject to general telehealth and controlled substance requirements

Veterinarians:

- May prescribe controlled substances via telehealth for animal patients
- Subject to veterinary practice act requirements

Ryan Haight Act Compliance:

Texas law requires compliance with all applicable federal laws and regulations. The state does not provide modifications or exemptions to federal Ryan Haight Act requirements. Prescribers must comply with DEA regulations, including current temporary flexibilities that allow telehealth prescribing of controlled substances without an initial in-person visit through December 31, 2026.

COVID-19 Emergency Waivers:

Texas has not made COVID-19 emergency waivers permanent through separate legislation. Instead, the state incorporated telehealth flexibilities into permanent statute through various legislative actions, including:

- SB 2527 (2023) - Mental health services provisions
- Amendments to Texas Occupations Code Chapter 111
- Updates to Texas Medical Board and Board of Nursing rules

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The chronic pain management provisions in 22 TAC § 174.5(e) and § 217.24(e) reference COVID-19 considerations but remain in effect as permanent regulations rather than temporary emergency measures.

Compliance Requirements:

- Establish valid practitioner-patient relationship through approved modalities
- For chronic pain with controlled substances: ensure 90-day contact requirement met via audio-video or in-person visit
- Check Texas PMP before prescribing opioids, benzodiazepines, barbiturates, or carisoprodol (unless exception applies)
- Use electronic prescribing for controlled substances (unless exception applies)
- For mental health prescribers: conduct at least one prior visit before prescribing controlled substances; verify no duplicate prescriptions within 30 days
- Maintain appropriate documentation including reason for telehealth visit versus in-person visit for chronic pain patients
- Submit annual reports if prescribing controlled substances via telemedicine
- APRNs/PAs: limit Schedule II prescribing to hospital-based or hospice settings only

Primary Citations:

- Texas Occupations Code § 111.005 (Practitioner-Patient Relationship)
- Texas Occupations Code § 111.013 (Annual Reporting Requirements)
- Texas Occupations Code § 113.003 (Mental Health Services)
- Texas Occupations Code § 157.0511 (APRN/PA Prescribing Authority)
- Texas Health & Safety Code § 481.076 (PMP Requirements)
- Texas Health & Safety Code § 481.0755 (Electronic Prescribing)
- 22 TAC Chapter 174 (Texas Medical Board Rules)
- 22 TAC § 174.5(e) (Physician Chronic Pain Telemedicine)
- 22 TAC Chapter 217 (Texas Board of Nursing Rules)
- 22 TAC § 217.24(e) (APRN Chronic Pain Telemedicine)
- 22 TAC § 222.8 (PA Prescribing Rules)

Supporting Citations:

- SB 2527 (88th Legislature, 2023) - Mental health telemedicine provisions
- Texas Medical Board Position Statements on Telemedicine
- Texas Board of Nursing Position Statements

Effective Dates:

- PMP check requirement: September 1, 2019
- Electronic prescribing mandate: January 1, 2021
- SB 2527 mental health provisions: September 1, 2023

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- Current chronic pain telemedicine rules: In effect as of rule adoption (specific dates vary by board)
- Federal DEA flexibilities: Extended through December 31, 2026

UTAH

Regulatory Status:** No explicit state-specific regulations beyond federal standards

Utah does not have explicit state-level regulations that specifically address telehealth prescribing of controlled substances (CII-CV) beyond requiring compliance with federal law and general telehealth practice standards. The state applies a technology-neutral approach where telehealth services are held to the same standards as traditional in-person care.

Telehealth Controlled Substance Prescribing - Generally Permitted:

Utah law does not categorically prohibit telehealth prescribing of controlled substances. Utah Code § 26B-4-704 (effective May 3, 2023) establishes general telehealth practice standards requiring providers to:

- Act within their scope of license
- Establish a provider-patient relationship
- Establish a diagnosis and identify underlying conditions before prescribing
- Comply with "all applicable state and federal laws, rules, and regulations"

The statute explicitly permits prescribing via telehealth when these conditions are met, without creating separate controlled substance restrictions.

Online Prescribing Act Limitation:

Utah's 2022 legislative bill HB0365 explicitly stated that "the division may not authorize a provider to prescribe a controlled substance" under the Online Prescribing Act. However, this limitation appears specific to asynchronous-only online prescribing platforms rather than traditional synchronous telehealth services. The restriction applies to questionnaire-based prescribing without real-time provider interaction, not to live video telemedicine consultations.

In-Person Examination Requirements:

Utah does not impose state-specific in-person examination requirements for telehealth controlled substance prescribing beyond federal Ryan Haight Act requirements.

Provider-Patient Relationship Establishment:

Utah Code § 26B-4-704 permits establishment of provider-patient relationships via telehealth using "synchronous or asynchronous interaction" and does not mandate initial or periodic in-person visits. The statute requires providers to:

- Verify patient identity
- Obtain appropriate medical history
- Perform examination adequate to establish diagnoses and identify underlying conditions
- Create and maintain health records

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No Mandatory Periodic Visits:

Utah law does not require periodic in-person visits at annual, biannual, or other intervals for continued controlled substance prescribing via telehealth.

Virtual Examination Sufficiency:

Utah law permits virtual examinations to satisfy examination requirements if they meet the standard of care. The statute does not distinguish between in-person and telehealth examinations, requiring only that the examination be "appropriate" and "adequate to establish diagnoses."

Conflicting Information Note:

One academic source claimed that "in at least one state, Utah, prescribing controlled substances in telemedicine follow-up visits is prohibited even if it occurs after an initial in-person visit." However, this claim could not be verified in current Utah statutes or regulations and appears to be outdated or incorrect based on Utah Code § 26B-4-704, which explicitly permits prescribing via telehealth.

Schedule-Specific Rules:

Utah law does not differentiate between Schedule II and Schedule III-V controlled substances for telehealth prescribing purposes. The state applies uniform standards regardless of controlled substance schedule.

No Psychiatric vs. Pain Medication Distinctions:

Utah does not create separate rules for psychiatric medications versus pain medications in the telehealth context. All controlled substance prescribing via telehealth is subject to the same general requirements.

No Opioid-Specific Telehealth Restrictions:

While Utah has general opioid prescribing requirements (continuing education, prescription monitoring program checks, electronic prescribing mandates), these apply equally to in-person and telehealth prescribing. Utah Code § 58-37-6 and Utah Admin. Code R156-37 establish controlled substance prescribing requirements but do not create telehealth-specific restrictions by drug type.

Prescriber Type Restrictions:

Utah does not restrict telehealth controlled substance prescribing by provider type beyond each provider's general scope of practice. Licensed practitioners authorized to prescribe controlled substances in-person may do so via telehealth if they hold appropriate licenses.

Physicians (MD/DO):

- May prescribe Schedule II-V controlled substances via telehealth within scope of practice
- Must hold Utah medical license and DEA registration
- Subject to general telehealth standards in Utah Code § 26B-4-704

Nurse Practitioners and Advanced Practice Registered Nurses (APRNs):

- May prescribe Schedule II-V controlled substances if holding Utah controlled substance license
- Schedule II prescribing by new graduates requires additional qualifications under Utah Code § 58-31b-803:

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• 30 credit hours of advanced pharmacology education

• 7 continuing education hours on opioid prescribing

• Mentorship requirements

• These additional Schedule II requirements sunset after one year of licensure or 2,000 clinical hours of practice

• After meeting experience thresholds, APRNs have full Schedule II prescribing authority

• No telehealth-specific restrictions beyond general APRN scope

Physician Assistants:

• May prescribe Schedule II-III controlled substances within supervising physician's prescriptive practice under Utah Code § 58-70a-501

• Must operate within delegation of services agreement

• Must hold Utah controlled substance license and DEA registration

• Schedule IV-V prescribing authority follows Schedule II-III authority

• No telehealth-specific restrictions

Certified Registered Nurse Anesthetists (CRNAs) and Clinical Nurse Specialists:

• May prescribe controlled substances if holding appropriate APRN licensure and controlled substance license

• Subject to same APRN requirements as nurse practitioners

• No telehealth-specific restrictions

Pharmacists:

• Limited prescribing authority under Utah Code § 58-17b-801

• May prescribe hormonal contraceptives and smoking cessation products

• Cannot prescribe controlled substances via telehealth (or in-person) outside collaborative practice agreements

Optometrists:

• May prescribe controlled substances via telehealth within scope of practice (eye conditions)

• Must hold controlled substance license

• Subject to Utah Code § 58-16a-501 scope limitations

Dentists:

• May prescribe controlled substances via telehealth within scope of practice (dental conditions)

• Must hold Utah dental license and controlled substance license

• No telehealth-specific restrictions

Podiatrists:

• May prescribe controlled substances via telehealth within scope of practice (foot and ankle conditions)

• Must hold Utah podiatry license and controlled substance license

• No telehealth-specific restrictions

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Veterinarians:

- • May prescribe controlled substances via telehealth for animal patients
- • Subject to Utah veterinary practice act requirements
- • No specific telehealth controlled substance restrictions identified

Controlled Substance License Requirement:

All prescribers must hold a Utah controlled substance license (in addition to their professional license) and DEA registration to prescribe controlled substances, whether via telehealth or in-person.

Ryan Haight Act Compliance:

Utah law explicitly requires compliance with federal law. Utah Code § 26B-4-704(2) requires providers to act "in accordance with the provisions of this section and all other applicable laws and rules," which incorporates federal Ryan Haight Act requirements by reference.

Utah has not enacted state-level modifications or exemptions to the Ryan Haight Act. Providers must comply with federal DEA regulations, including:

- • Current temporary flexibilities allowing telehealth prescribing of controlled substances without initial in-person visit (extended through December 31, 2026)
- • Ryan Haight Act exceptions (existing patient relationship, emergency situations, etc.)
- • DEA registration requirements

COVID-19 Emergency Waivers:

Utah has not enacted permanent legislation codifying COVID-19 emergency waivers. Instead, the state's 2023 telehealth statute (Utah Code § 26B-4-704) incorporated flexible telehealth standards into permanent law without creating separate emergency provisions.

The statute's effective date of May 3, 2023, suggests Utah updated its telehealth framework post-pandemic to reflect lessons learned during the public health emergency, but did so through comprehensive telehealth legislation rather than extending specific emergency orders.

General Controlled Substance Requirements:

While not telehealth-specific, Utah imposes general controlled substance prescribing requirements that apply to all prescribing modalities:

Prescription Monitoring Program:

- • Utah Code § 58-37-7.5 requires prescribers to check the Controlled Substance Database before prescribing controlled substances
- • Exceptions for emergency situations and other specified circumstances

Electronic Prescribing:

- • Utah Admin. Code R156-37 requires electronic prescribing of controlled substances with limited exceptions
- • Applies equally to telehealth and in-person prescribing

Continuing Education:

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- Prescribers must complete continuing education on controlled substance prescribing
- Requirements vary by profession

Compliance Requirements:

- Establish valid provider-patient relationship via synchronous or asynchronous telehealth
- Verify patient identity
- Obtain appropriate medical history
- Perform examination adequate to establish diagnosis
- Create and maintain health records
- Comply with federal Ryan Haight Act and DEA regulations
- Hold Utah controlled substance license (in addition to professional license)
- Maintain DEA registration
- Check Utah Controlled Substance Database before prescribing
- Use electronic prescribing (unless exception applies)
- Act within scope of professional license
- Meet standard of care applicable to in-person services

Primary Citations:

- Utah Code § 26B-4-704 (Telehealth Practice Standards, effective May 3, 2023)
- Utah Code § 58-31b-803 (APRN Schedule II Prescribing Requirements)
- Utah Code § 58-70a-501 (Physician Assistant Prescribing Authority)
- Utah Code § 58-37-6 (Controlled Substance Prescribing Requirements)
- Utah Code § 58-37-7.5 (Prescription Monitoring Program)
- Utah Code § 58-17b-801 (Pharmacist Prescribing Authority)
- Utah Code § 58-16a-501 (Optometry Scope of Practice)
- Utah Admin. Code R156-37 (Controlled Substance Rules)
- HB0365 (2022) - Online Prescribing Act

Supporting Citations:

- Utah Department of Health and Human Services guidance on telehealth
- Utah Division of Professional Licensing position statements

Effective Dates:

- Utah Code § 26B-4-704: May 3, 2023
- APRN Schedule II requirements (Utah Code § 58-31b-803): Varies by individual practitioner based on licensure date and clinical hours
- Federal DEA telehealth flexibilities: Extended through December 31, 2026

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VERMONT

Regulatory Status:** No explicit state-specific regulations beyond federal standards

Vermont does not have explicit state-level regulations specifically governing telehealth prescribing of controlled substances (CII-CV) that differ from in-person prescribing requirements. Instead, Vermont applies a technology-neutral approach where telehealth prescribing is held to the same standards as traditional in-person care.

Telehealth Controlled Substance Prescribing - Explicitly Permitted:

Vermont law explicitly permits prescribing controlled substances via telehealth. Under 18 V.S.A. § 9361(b), health care providers licensed in Vermont may "prescribe, dispense, or administer drugs or medical supplies" after performing "an appropriate examination of the patient in person, through telemedicine, or by the use of instrumentation and diagnostic equipment."

The statute establishes technology neutrality: "Treatment recommendations made via electronic means, including via telemedicine, shall be held to the same standards of appropriate practice as those in traditional provider-patient settings."

In-Person Examination Requirements:

Vermont does NOT impose state-level in-person examination requirements for controlled substance prescribing via telehealth. The statute requires only an "appropriate examination" which may be conducted through telemedicine.

Standard of Care Requirements:

Vermont requires providers to meet the same standard of care via telehealth as in-person care. Under 26 V.S.A. § 1354(a)(33), unprofessional conduct includes prescribing via electronic means when the licensee fails to:

- Verify patient identity
- Establish documented diagnosis through accepted medical practices
- Maintain appropriate records

The Vermont Board of Medical Practice's 2023 Telemedicine Policy emphasizes: "When the standard of care that is ordinarily applied to an in-person encounter cannot be met by virtual means, the use of telemedicine technologies is not appropriate."

No Mandatory Periodic Visits:

Vermont does not require periodic in-person visits at specified intervals (annual, biannual, etc.) for continued controlled substance prescribing via telehealth.

Buprenorphine Exception - Delayed In-Person Requirements:

Vermont Act 4 (H.411), passed March 29, 2023, specifically delayed "the application of in-person exam requirements when prescribing buprenorphine" as part of COVID-19 pandemic flexibilities. This legislative action suggests Vermont recognized federal in-person requirements exist but chose to delay their application specifically for buprenorphine treatment, likely to maintain access to medication-assisted treatment for opioid use disorder.

Virtual Examination Sufficiency:

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Vermont permits virtual examinations to satisfy examination requirements if they meet the applicable standard of care. The statute does not distinguish between in-person and telehealth examinations in terms of validity, requiring only that the examination be "appropriate."

Opioid Prescribing - In-Person Discussion Requirement:

Vermont's Rule Governing the Prescribing of Opioids for Pain (effective April 1, 2024) requires "an in-person discussion" regarding risks prior to prescribing opioids. However, this rule does not explicitly prohibit telehealth prescribing of opioids. The "in-person discussion" requirement could potentially be satisfied via live video telemedicine, though the rule's language creates some ambiguity. The rule focuses on the content and quality of the discussion rather than the physical location of the parties.

Schedule-Specific Rules:

Vermont does NOT differentiate between Schedule II and Schedule III-V controlled substances for telehealth prescribing at the state level. The state applies the same standard of care regardless of schedule.

No Psychiatric vs. Pain Medication Distinctions:

Vermont does not create separate telehealth rules for psychiatric medications versus pain medications. All controlled substance prescribing via telehealth is subject to the same technology-neutral standards.

Opioid Prescribing Requirements:

While Vermont has specific opioid prescribing requirements (informed consent discussions, prescription monitoring program checks, dosage limitations), these apply equally to in-person and telehealth prescribing. The Rule Governing the Prescribing of Opioids for Pain does not create telehealth-specific restrictions.

Prescriber Type Restrictions:

Vermont permits various prescriber types to prescribe controlled substances via telehealth within their scope of practice. The state does not impose telehealth-specific restrictions by provider type.

Physicians (MD/DO):

- May prescribe Schedule II-V controlled substances via telehealth within scope of practice
- Subject to general standard of care requirements
- Must comply with opioid prescribing rule when applicable

Nurse Practitioners and Advanced Practice Registered Nurses (APRNs):

Vermont grants full practice authority to APRNs after completing 2,400 hours and two years of nursing practice under 26 V.S.A. § 1613.

- May prescribe controlled substances within their scope under administrative rules
- 26 V.S.A. § 1616 grants NPs signature authority equivalent to physicians
- No Schedule II vs. III-V distinctions at state level
- No telehealth-specific restrictions apply
- Must meet same standard of care as physicians

Physician Assistants:

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Under 26 V.S.A. § 1735a(h), PAs may "prescribe, dispense, administer and procure drugs and medical devices to the same extent as may a physician."

- May prescribe Schedule II-V controlled substances within scope of practice
- Must operate within practice agreement requirements
- PAs who prescribe controlled substances must register with DEA
- No state-level telehealth restrictions beyond general practice agreement requirements

Certified Registered Nurse Anesthetists (CRNAs) and Clinical Nurse Specialists:

- May prescribe controlled substances within APRN scope
- Subject to same APRN requirements as nurse practitioners
- No telehealth-specific restrictions

Optometrists:

Under 26 V.S.A. § 1728, optometrists may prescribe Schedule III-V controlled substances, but authority is limited to treatment of anaphylaxis.

- Cannot prescribe Schedule II controlled substances
- Controlled substance prescribing limited to specific emergency situations
- No telehealth-specific restrictions identified

Pharmacists:

Under 26 V.S.A. § 2023, pharmacists may prescribe pursuant to collaborative practice agreements or state protocols.

- Prohibited from prescribing "regulated drugs" as defined in 18 V.S.A. § 4201 (which includes controlled substances), except within collaborative agreements
- Collaborative agreements may authorize limited controlled substance prescribing
- No telehealth-specific restrictions

Dentists:

- May prescribe controlled substances via telehealth within scope of practice (dental conditions)
- Subject to same standards as in-person care
- No specific telehealth restrictions identified

Podiatrists:

- May prescribe controlled substances via telehealth within scope of practice (foot and ankle conditions)
- Subject to same standards as in-person care
- No specific telehealth restrictions identified

Veterinarians:

- Licensed within scope may prescribe controlled substances via telehealth for animal patients
- Subject to veterinary practice act requirements
- No specific telehealth restrictions identified

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Ryan Haight Act Compliance:

Vermont does not have state-level modifications to the Ryan Haight Act. Providers must comply with federal law, which currently (through December 31, 2026) allows telehealth prescribing of controlled substances without an initial in-person visit under temporary DEA flexibilities.

Vermont's delay of in-person requirements for buprenorphine prescribing (Act 4, H.411, 2023) suggests the state recognized federal requirements but chose to exercise flexibility in their application during the transition from pandemic emergency measures.

COVID-19 Emergency Waivers:

Vermont has not made COVID-19 emergency waivers permanent through separate legislation. Instead, the state's approach has been to:

1. Maintain technology-neutral standards that permit telehealth prescribing without creating artificial barriers

2. Specifically delay application of in-person requirements for buprenorphine through Act 4 (H.411, 2023)

3. Rely on federal DEA flexibilities for controlled substance prescribing via telehealth

The Vermont Board of Medical Practice's 2023 Telemedicine Policy (updated post-pandemic) incorporates lessons learned during COVID-19 while maintaining focus on standard of care rather than modality of service delivery.

Prescription Monitoring Program Requirements:

Vermont requires prescribers to check the Vermont Prescription Monitoring System (VPMS) before prescribing controlled substances. This requirement applies equally to telehealth and in-person prescribing.

Electronic Prescribing:

Vermont requires electronic prescribing of controlled substances with limited exceptions. This requirement applies to both telehealth and in-person prescribing.

Informed Consent and Documentation:

Vermont's opioid prescribing rule requires:

- Discussion of risks and benefits
- Informed consent documentation
- Treatment agreements for chronic opioid therapy
- Regular monitoring and reassessment

These requirements apply equally to telehealth and in-person prescribing, though the "in-person discussion" language in the opioid rule creates some interpretive questions about audio-only telehealth.

Compliance Requirements:

- Perform appropriate examination (in-person, via telemedicine, or by instrumentation)
- Verify patient identity

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- Establish documented diagnosis through accepted medical practices
- Maintain appropriate medical records
- Meet same standard of care as in-person services
- For opioids: conduct discussion of risks (interpretation of "in-person" requirement unclear for telehealth)
- Check Vermont Prescription Monitoring System before prescribing controlled substances
- Use electronic prescribing (unless exception applies)
- Comply with federal Ryan Haight Act and DEA regulations
- Act within scope of professional license
- For APRNs: complete 2,400 hours and two years practice before independent practice
- For PAs: operate within practice agreement
- Maintain DEA registration

Primary Citations:

- 18 V.S.A. § 9361(b) (Telemedicine Prescribing Authority)
- 26 V.S.A. § 1354(a)(33) (Unprofessional Conduct - Electronic Prescribing)
- 26 V.S.A. § 1613 (APRN Practice Authority)
- 26 V.S.A. § 1616 (APRN Signature Authority)
- 26 V.S.A. § 1735a(h) (Physician Assistant Prescribing Authority)
- 26 V.S.A. § 1728 (Optometrist Prescribing Authority)
- 26 V.S.A. § 2023 (Pharmacist Prescribing Authority)
- 18 V.S.A. § 4201 (Regulated Drugs Definition)
- Vermont Act 4 (H.411, 2023) - Buprenorphine In-Person Requirement Delay
- Rule Governing the Prescribing of Opioids for Pain (effective April 1, 2024)

Supporting Citations:

- Vermont Board of Medical Practice 2023 Telemedicine Policy
- Vermont Prescription Monitoring System regulations
- Vermont electronic prescribing requirements

Effective Dates:

- 18 V.S.A. § 9361(b): Current statute (technology-neutral language)
- Act 4 (H.411) buprenorphine provisions: March 29, 2023
- Rule Governing the Prescribing of Opioids for Pain: April 1, 2024
- Vermont Board of Medical Practice 2023 Telemedicine Policy: 2023
- Federal DEA telehealth flexibilities: Extended through December 31, 2026

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Virginia through West Virginia

VIRGINIA

Regulatory Status:** Explicit regulations exist

Virginia has comprehensive statutory regulations governing telehealth prescribing of controlled substances, codified primarily in Va. Code § 54.1-3303 and § 38.2-3418.16, supplemented by Virginia Board of Medicine Guidance Document 85-12. The state permits telehealth prescribing of Schedule II through VI controlled substances when specific conditions are met, representing one of the more permissive regulatory frameworks in the nation.

Telehealth Controlled Substance Prescribing Authorization:

Virginia explicitly permits telehealth prescribing of Schedule II through VI controlled substances. The Commonwealth allows establishment of a bona fide practitioner-patient relationship via telehealth WITHOUT requiring an initial in-person visit. This relationship may be established through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies, providing significant flexibility for practitioners and patients.

In-Person Examination Requirements:

Virginia law does not mandate an initial in-person visit for establishing a practitioner-patient relationship for controlled substance prescribing via telehealth. However, Va. Code § 54.1-3303(B) establishes specific conditions that must be met for telehealth prescribing:

- Patient must have provided a medical history available for prescriber review
- Prescriber must obtain updated medical history at time of prescribing
- Prescriber must make a diagnosis at time of prescribing
- Prescriber must conform to standard of care expected of in-person care appropriate to patient's age and presenting condition, including diagnostic testing and physical examination when required by standard of care (may be carried out through peripheral devices)
- Prescriber must be actively licensed in Virginia and authorized to prescribe
- Prescriber must maintain practice at physical location in Commonwealth OR can make appropriate referral to Virginia-licensed practitioner for in-person examination when required by standard of care

No specific periodic in-person visit requirements are mandated by statute. However, prescribers must ensure in-person examination "when required by the standard of care." This standard-of-care approach provides clinical flexibility while maintaining patient safety requirements.

Online questionnaires alone do NOT satisfy Virginia's requirements. Board of Medicine Guidance Document 85-12 explicitly states: "Treatment, including issuing a prescription, based solely on an online questionnaire does not constitute an acceptable standard of practice." This prohibition ensures meaningful clinical evaluation occurs before controlled substance prescribing.

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Schedule-Specific and Medication-Specific Rules:

Virginia statute treats Schedules II-V identically for telehealth prescribing purposes. Both require compliance with federal requirements (Ryan Haight Act) and the bona fide practitioner-patient relationship standards. Schedule VI (non-controlled prescription drugs like antidepressants and antipsychotics) has the same requirements as controlled substances.

No explicit statutory distinction exists between psychiatric medications and pain medications. However, Board of Medicine guidance indicates certain medications "should not be prescribed through telemedicine due to safety concerns or the need for a physical examination," including narcotics, muscle relaxants, sedatives/hypnotics, and antipsychotics. This appears to be guidance rather than absolute prohibition, allowing for clinical judgment.

For Medicaid patients receiving opioid treatment services, the Board of Medicine requires weekly visits during induction phase, which may be delivered through telemedicine based on individual needs. Clinical stability must be documented before spacing visits beyond weekly frequency.

Prescriber Type Authorization:

Per Va. Code § 54.1-3303(A), the following practitioners may prescribe controlled substances via telehealth:

Authorized Prescribers:

- Physicians (medicine and osteopathy) - full authority
- Podiatrists - within scope of practice
- Dentists - within scope of practice
- Veterinarians - within scope of practice
- Advanced Practice Registered Nurses (APRNs/NPs) pursuant to § 54.1-2957.01 (with practice agreement or after 5 years full-time experience)
- Physician Assistants pursuant to § 54.1-2952.1 (with practice agreement)
- TPA-certified Optometrists pursuant to Article 5 (§ 54.1-3222 et seq.) - limited to specific analgesics and Schedule VI drugs for ocular conditions
- Certified Registered Nurse Anesthetists (CRNAs) - for Schedule II-VI substances as part of periprocedural care
- Clinical Nurse Specialists (CNSs) - with practice agreement
- Certified Nurse Midwives (CNMs) - within scope of practice

Pharmacist Authority:

Pharmacists may initiate treatment with, dispense, or administer drugs through telehealth services per 18 VAC 110-21-46, in compliance with § 54.1-3303 requirements.

Practice Agreement Requirements:

APRNs and PAs must have practice agreements with physicians that specify controlled substances they are authorized to prescribe. After 5 years of full-time practice, APRNs may practice independently without practice agreements. Practice agreements must be maintained on file and available for inspection.

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Ryan Haight Act Compliance:

Virginia statute explicitly requires compliance with federal requirements, including the Ryan Haight Act. Va. Code § 54.1-3303 references federal law requirements and does not create state-specific exemptions from Ryan Haight provisions. Practitioners must comply with DEA requirements for controlled substance prescribing, including current temporary flexibilities that allow telehealth prescribing without in-person examination through December 31, 2026.

COVID-19 Emergency Waivers:

Virginia's telehealth regulations were substantially liberalized through permanent statutory changes rather than temporary emergency waivers. The state enacted comprehensive telehealth legislation that remains in effect beyond the COVID-19 public health emergency. Va. Code § 38.2-3418.16 requires health insurers to provide coverage for telehealth services on the same basis as in-person services, and these provisions are permanent statutory requirements rather than temporary emergency measures.

Compliance Requirements:

- Establish bona fide practitioner-patient relationship via compliant telehealth modality
- Obtain and review patient medical history before prescribing
- Make appropriate diagnosis based on clinical evaluation
- Maintain standard of care equivalent to in-person treatment
- Ensure in-person examination when required by standard of care
- Maintain Virginia licensure and DEA registration
- Maintain practice location in Virginia or ability to make appropriate referrals
- Comply with federal Ryan Haight Act requirements
- Do not rely solely on online questionnaires for prescribing decisions
- Maintain practice agreements (for APRNs and PAs) specifying controlled substance authority
- Document clinical decision-making and telehealth encounters appropriately

Primary Citations:

- Va. Code § 54.1-3303 (Prescribing of drugs and devices)
- Va. Code § 38.2-3418.16 (Coverage for telehealth services)
- Va. Code § 54.1-2957.01 (APRN prescriptive authority)
- Va. Code § 54.1-2952.1 (Physician Assistant prescriptive authority)
- Va. Code § 54.1-3222 et seq. (Optometry practice provisions)
- 18 VAC 110-21-46 (Pharmacist telehealth services)
- Virginia Board of Medicine Guidance Document 85-12 (Telemedicine Guidance)

Supporting Citations:

- Virginia Board of Medicine regulations regarding opioid treatment services for Medicaid patients

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- Virginia Department of Health Professions guidance documents
- Virginia Medicaid telehealth coverage policies

Effective Dates:

Virginia's comprehensive telehealth prescribing statute became effective through legislative amendments enacted in recent years, with the most recent substantive amendments taking effect July 1, 2020. Board of Medicine Guidance Document 85-12 was issued in 2014 and remains in effect. The telehealth insurance parity provisions in § 38.2-3418.16 became effective July 1, 2020, and were expanded in subsequent legislative sessions.

WASHINGTON

Regulatory Status:** No explicit state-specific regulations beyond federal standards

Washington does not have explicit state-specific regulations that impose additional restrictions on telehealth prescribing of controlled substances beyond federal requirements. The state follows a principles-based approach where telehealth prescribing is governed by the same standards as in-person care. This regulatory framework provides maximum flexibility while ensuring patient safety through application of professional practice standards.

Telehealth Controlled Substance Prescribing Authorization:

Washington permits telehealth prescribing of controlled substances (CII-CV) by authorized practitioners. Under RCW 18.134.030 and RCW 18.134.020, practitioners may provide telehealth services, including prescribing medications, if consistent with their scope of practice, applicable professional practice standards, and federal law requirements. The Uniform Telehealth Act (Chapter 18.134 RCW, effective 2021) establishes that professional practice standards applicable to in-person care apply equally to telehealth services, including standards relating to prescribing medication.

In-Person Examination Requirements:

Washington state law does not impose separate state-level in-person examination requirements for telehealth prescribing of controlled substances. The Washington Medical Commission's 2014 Telemedicine Guideline (MD2014-03) states that "prescribing medications, whether in person or via Telemedicine, is at the professional discretion of the practitioner" and that practitioners using telemedicine are held to the same standard of care as in-person delivery.

RCW 18.134.030(3) explicitly provides that "a practitioner-patient relationship may be established through telehealth." This statutory provision eliminates any state-level requirement for an initial in-person visit before establishing a treatment relationship via telehealth.

However, practitioners must comply with federal Ryan Haight Act requirements, which currently (through December 31, 2026, per the DEA's fourth temporary extension) allow telehealth prescribing of Schedule II-V controlled substances without an in-person evaluation under COVID-19 flexibilities. Once these flexibilities expire, federal law will govern in-person requirements unless practitioners qualify for Ryan Haight exceptions or obtain special DEA registrations.

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No Washington-specific requirements exist for:

- Initial or periodic in-person visits
- Specific frequency of examinations (annual/biannual)
- Particular exam elements
- Whether questionnaires or virtual exams satisfy requirements

The governing standard is whether the practitioner meets the applicable standard of care for the condition being treated, regardless of modality. This standard-of-care approach allows clinical judgment to determine appropriate evaluation methods.

Schedule-Specific and Medication-Specific Rules:

Washington does not impose schedule-specific telehealth restrictions (CII vs CIII-V) at the state level. All schedules are treated equally under state telehealth law, subject to federal requirements. There are no state-specific distinctions between psychiatric medications versus pain medications, or opioid-specific telehealth restrictions beyond general opioid prescribing rules in WAC 246-919-850 et seq. (which apply to all prescribing, not specifically telehealth).

The state's opioid prescribing rules establish requirements for patient evaluation, informed consent, treatment agreements, and monitoring that apply regardless of whether care is delivered in-person or via telehealth. These include requirements for checking the Prescription Monitoring Program (PMP) and conducting appropriate risk assessments.

Prescriber Type Authorization:

Washington allows the following practitioners to prescribe controlled substances via telehealth within their scope of practice:

Physicians (MD/DO):

Full authority for Schedules II-V via telehealth, subject to standard of care requirements and federal law.

Advanced Registered Nurse Practitioners (ARNPs/NPs):

Full independent prescriptive authority for Schedules II-V (WAC 246-840-300, RCW 18.79.050). Washington is a full practice authority state; NPs can prescribe controlled substances independently without physician supervision or collaboration, including via telehealth. This represents one of the most expansive APRN practice authorities in the nation.

Physician Assistants (PAs):

May prescribe Schedules II-V via telehealth. PAs with fewer than 4,000 hours of practice require physician supervision; those with 4,000+ hours may work in collaboration (not supervision) if they have 2,000+ hours in their specialty. The distinction between supervision and collaboration affects practice autonomy but does not restrict prescribing authority.

Clinical Nurse Specialists (CNS), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives (CNMs):

As ARNPs, have prescriptive authority for controlled substances within scope of practice, including via telehealth.

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Dentists:

May prescribe controlled substances within dental scope of practice via telehealth, subject to standard of care requirements.

Podiatrists:

May prescribe controlled substances within podiatric scope of practice via telehealth.

Optometrists:

Limited authority - may prescribe Schedule III-V controlled substances and Schedule II hydrocodone combination products, limited to 7 days for single trauma/episode/condition (WAC 246-851-590, RCW 18.53.010 as amended by SSB 5389). This prescribing authority may be exercised via telehealth within scope of practice.

Naturopaths:

May prescribe within their authorized formulary, which includes certain controlled substances, via telehealth when consistent with scope of practice and standard of care.

Pharmacists:

Washington pharmacists have limited prescriptive authority under collaborative drug therapy agreements and may participate in telehealth services within those parameters.

Veterinarians:

May prescribe controlled substances for animal patients via telehealth within veterinary scope of practice, subject to establishment of valid veterinarian-client-patient relationship.

Ryan Haight Act Compliance:

Washington state law does not create state-specific exemptions from or modifications to the Ryan Haight Act. Practitioners must comply with federal DEA requirements for controlled substance prescribing via telehealth. The state relies on federal law to govern the specific requirements for in-person examinations and exceptions.

Under current federal temporary flexibilities (extended through December 31, 2026), practitioners may prescribe Schedule II-V controlled substances via telehealth without an in-person examination. Once these flexibilities expire, practitioners will need to either conduct in-person examinations as required by the Ryan Haight Act or qualify for one of the statutory exceptions (such as prescribing in Indian Health Service facilities, during public health emergencies, or by practitioners with special DEA registrations).

COVID-19 Emergency Waivers:

Washington's approach to telehealth during COVID-19 involved permanent statutory changes rather than temporary emergency waivers. The state enacted the Uniform Telehealth Act (Chapter 18.134 RCW) effective January 1, 2021, which codified many telehealth flexibilities on a permanent basis. These provisions remain in effect beyond the COVID-19 public health emergency.

Key permanent changes include:

- Establishment of practitioner-patient relationships via telehealth
- Insurance parity for telehealth services
- Audio-only telehealth coverage for certain services
- Interstate licensure compact participation

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The state did not implement temporary COVID-specific waivers for controlled substance prescribing that have since expired; instead, practitioners have relied on federal DEA flexibilities for Ryan Haight Act compliance.

Compliance Requirements:

- Maintain Washington state licensure and appropriate DEA registration
- Comply with federal Ryan Haight Act requirements for controlled substance prescribing
- Meet applicable standard of care for the condition being treated
- Establish valid practitioner-patient relationship (may be via telehealth)
- Comply with scope of practice limitations for practitioner type
- Check Prescription Monitoring Program (PMP) as required by opioid prescribing rules
- Maintain appropriate documentation of telehealth encounters
- Ensure informed consent for telehealth services
- Comply with HIPAA and state privacy requirements for telehealth platforms
- For opioid prescribing: comply with WAC 246-919-850 et seq. requirements regardless of modality

Primary Citations:

- RCW 18.134.030 (Uniform Telehealth Act - practitioner-patient relationship)
- RCW 18.134.020 (Uniform Telehealth Act - definitions)
- RCW 18.79.050 (ARNP prescriptive authority)
- WAC 246-840-300 (ARNP prescribing regulations)
- WAC 246-919-850 et seq. (Opioid prescribing rules)
- WAC 246-851-590 (Optometry prescribing authority)
- RCW 18.53.010 (Optometry practice act)
- Washington Medical Commission Telemedicine Guideline MD2014-03

Supporting Citations:

- Chapter 18.134 RCW (Uniform Telehealth Act - complete chapter)
- Washington State Health Care Authority telehealth coverage policies
- Washington Medical Commission policy statements on telemedicine
- DEA regulations and guidance on Ryan Haight Act compliance

Effective Dates:

The Uniform Telehealth Act (Chapter 18.134 RCW) became effective January 1, 2021, establishing the current framework for telehealth practice in Washington. The Washington Medical Commission's Telemedicine Guideline MD2014-03 was issued in 2014 and remains in effect. Optometry prescribing authority for controlled substances was expanded through SSB 5389, effective July 25, 2021. ARNP independent practice authority has been in effect for multiple years, with recent clarifications and expansions.

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WEST VIRGINIA

Regulatory Status:** Explicit regulations exist

West Virginia has explicit and comprehensive regulations governing telehealth prescribing of controlled substances, codified in state statutes and administrative rules. The state maintains one of the more restrictive regulatory frameworks in the nation, particularly regarding Schedule II controlled substances, with specific prohibitions on prescribing these substances via telehealth to new patients.

Telehealth Controlled Substance Prescribing Authorization:

West Virginia permits telehealth prescribing of controlled substances Schedules III-V without restriction for established patients, but prohibits Schedule II prescribing via telehealth for new patients. This bifurcated approach reflects the state's heightened concern about opioid diversion and misuse while recognizing the utility of telehealth for less-restricted controlled substances.

In-Person Examination Requirements:

West Virginia imposes distinct requirements based on controlled substance schedule and patient status:

Schedule II Controlled Substances:

Schedule II prescribing via telehealth is PROHIBITED for new patients unless:

- Patient is an established patient of the prescribing provider's group practice, OR
- For immediate hospital administration (non-emergency department), OR
- For chronic pain management with established patients

"Established patient" is defined as: a patient who has received professional services face-to-face from the physician, qualified healthcare professional, or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. This definition is more restrictive than many states, requiring same specialty/subspecialty for group practice relationships.

Pain-relieving Schedule II substances cannot be prescribed for chronic nonmalignant pain solely via telemedicine unless an established patient relationship exists. This restriction specifically targets opioid prescribing for chronic pain conditions.

General Telehealth Standard (All Patients):

West Virginia requires annual in-person visits: Established patients must visit an in-person healthcare practitioner within 12 months of using initial telemedicine service, or telemedicine service shall no longer be available until in-person visit obtained. This represents one of the most explicit periodic in-person visit requirements in the nation.

Exceptions to the 12-month requirement (may be suspended at practitioner's discretion) include:

- Acute inpatient care
- Post-operative follow-up checks
- Behavioral medicine

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- Addiction medicine
- Palliative care

The physician-patient relationship can be established via:

- In-person encounter
- Audio-visual telemedicine (NOT audio-only or text)
- Audio-only calls/conversations in real time (audio-visual preferred if available)

Online questionnaires alone do NOT satisfy requirements and do not constitute acceptable standard of care. This prohibition is explicitly stated in West Virginia regulations.

Schedule-Specific and Medication-Specific Rules:

Schedule II:

- Generally PROHIBITED via telehealth for new patients
- Permitted for established patients of same group practice (same specialty/subspecialty)
- Permitted for hospital inpatient immediate administration (excluding emergency department)
- Pain-relieving Schedule II for chronic nonmalignant pain: prohibited solely via telemedicine unless established patient
- Psychiatric medications for specific populations: Exception exists for minors or adults 18+ in primary/secondary education with intellectual/developmental disabilities, neurological disease, ADD, autism, or traumatic brain injury

Schedule III-V:

- Permitted via telehealth with standard telehealth requirements
- No additional restrictions beyond general prescribing authority
- Must comply with CSMP (Controlled Substance Monitoring Program) requirements
- Subject to 12-month in-person visit requirement unless exception applies

Opioid-Specific Restrictions:

- Schedule II opioids for chronic pain: prohibited via telehealth-only encounters unless established patient
- Must comply with West Virginia opioid prescribing rules (W.Va. CSR § 64-10)
- Prescribers must check CSMP before prescribing opioids
- COVID-19 waiver (expired): Previously waived 90-day in-person exam requirement for chronic pain patients receiving Schedule II opioid refills, but this waiver has expired

Prescriber Type Authorization:

Physicians (MD/DO):

- May prescribe Schedule III-V via telehealth
- May prescribe Schedule II only to established patients or in permitted circumstances
- Subject to all telehealth requirements in W.Va. Code § 30-3-13a, 30-14-12d

Physician Assistants (PAs):

- As of January 1, 2023: Same prescriptive authority as APRNs

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- May NOT prescribe Schedule I
- May prescribe up to 3-day supply of Schedule II narcotics (no refill)
- No other limitations on prescribing authority except as provided in § 16-54-1 et seq.
- Must comply with telehealth requirements same as physicians
- Authority codified in W.Va. Code § 30-3E-3

Advanced Practice Registered Nurses (APRNs/NPs):

- As of January 1, 2023: Same prescriptive authority as PAs
- May NOT prescribe Schedule I
- May prescribe up to 3-day supply of Schedule II narcotics (no refill)
- May prescribe Schedule III-V controlled substances
- Must prescribe within prescriptive authority of profession per W.Va. Code § 60A-9-9
- Must comply with all telehealth requirements including 12-month in-person visit rule
- Subject to collaborative agreement requirements per W.Va. Code § 30-7-15a

Clinical Nurse Specialists (CNS):

- Prescriptive authority within scope of practice as APRN
- Same limitations as other APRNs regarding Schedule II (3-day supply only)
- Must comply with telehealth requirements

Certified Registered Nurse Anesthetists (CRNAs):

- Prescriptive authority for controlled substances within scope of anesthesia practice
- Same Schedule II limitations as other APRNs
- Must comply with telehealth requirements

Dentists:

- May prescribe controlled substances within dental scope of practice via telehealth
- Subject to same telehealth requirements as physicians
- Must comply with Schedule II restrictions for new patients

Podiatrists:

- May prescribe controlled substances within podiatric scope of practice via telehealth
- Subject to same telehealth requirements as physicians
- Must comply with Schedule II restrictions for new patients

Optometrists:

- Limited prescriptive authority for certain therapeutic pharmaceutical agents
- Authority does not extend to most controlled substances
- Any controlled substance prescribing must comply with telehealth requirements

Pharmacists:

- West Virginia pharmacists do not have independent prescriptive authority for controlled substances
- May participate in collaborative practice agreements with prescribers

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- Cannot independently prescribe controlled substances via telehealth

Veterinarians:

- May prescribe controlled substances for animal patients via telehealth
- Must establish valid veterinarian-client-patient relationship
- Subject to telehealth requirements adapted for veterinary practice

Ryan Haight Act Compliance:

West Virginia regulations explicitly require compliance with federal Ryan Haight Act requirements. The state does not create exemptions from federal law but rather imposes additional state-level restrictions that are more stringent than federal requirements.

West Virginia's prohibition on Schedule II prescribing to new patients via telehealth is more restrictive than the Ryan Haight Act, which allows such prescribing under certain circumstances (such as through DEA-registered telemedicine sites or during public health emergencies). Practitioners in West Virginia must comply with both federal Ryan Haight requirements AND more restrictive state requirements.

Under current federal temporary flexibilities (extended through December 31, 2026), the Ryan Haight Act's in-person examination requirement is waived for Schedule II-V controlled substances. However, West Virginia's state-level restrictions on Schedule II prescribing to new patients remain in effect regardless of federal flexibilities.

COVID-19 Emergency Waivers:

West Virginia implemented temporary COVID-19 emergency waivers that have since expired. Key expired waivers included:

- Waiver of 90-day in-person examination requirement for chronic pain patients receiving Schedule II opioid refills
- Temporary expansion of audio-only telehealth for certain services
- Relaxed requirements for establishing practitioner-patient relationships

The state's 12-month in-person visit requirement for established telehealth patients remains in effect post-COVID, though exceptions for behavioral medicine and addiction medicine provide ongoing flexibility for mental health and substance use disorder treatment.

West Virginia did not make COVID emergency waivers permanent through legislation. The state returned to pre-pandemic telehealth requirements with the exceptions explicitly codified in statute (behavioral medicine, addiction medicine, palliative care, etc.).

Compliance Requirements:

- Maintain West Virginia licensure and appropriate DEA registration
- Comply with federal Ryan Haight Act requirements
- Do NOT prescribe Schedule II controlled substances to new patients via telehealth (unless qualifying exception applies)
- Establish "established patient" relationship before prescribing Schedule II via telehealth
- Ensure established patients have in-person visit within 12 months of initial telehealth service (unless qualifying exception applies)

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• Use audio-visual technology when available (audio-only acceptable but not preferred)

• Do not rely solely on online questionnaires for prescribing decisions

• Check CSMP (Controlled Substance Monitoring Program) before prescribing controlled substances

• Limit Schedule II narcotic prescriptions to 3-day supply for PAs and APRNs

• Maintain collaborative agreements (for APRNs) specifying controlled substance prescribing authority

• Document telehealth encounters appropriately

• Ensure informed consent for telehealth services

• Comply with standard of care requirements equivalent to in-person care

• For chronic pain management: establish in-person relationship before prescribing Schedule II opioids via telehealth

Primary Citations:

• W.Va. Code § 30-3-13a (Physician telemedicine requirements)

• W.Va. Code § 30-14-12d (Osteopathic physician telemedicine requirements)

• W.Va. Code § 30-3E-3 (Physician Assistant prescriptive authority)

• W.Va. Code § 30-7-15a (APRN practice and prescriptive authority)

• W.Va. Code § 60A-9-9 (Controlled substance prescribing authority)

• W.Va. Code § 16-54-1 et seq. (Controlled substance prescribing limitations)

• W.Va. CSR § 64-10 (Opioid prescribing rules)

• W.Va. Board of Medicine Legislative Rule § 11-1B (Telemedicine)

• W.Va. Board of Osteopathic Medicine Legislative Rule (Telemedicine provisions)

Supporting Citations:

• West Virginia Board of Medicine guidance documents on telemedicine

• West Virginia CSMP (Controlled Substance Monitoring Program) requirements

• West Virginia Board of Pharmacy regulations regarding controlled substances

• COVID-19 emergency orders and waivers (expired)

Effective Dates:

West Virginia's comprehensive telemedicine regulations became effective through legislative amendments, with the most recent substantive changes taking effect July 1, 2021. The PA and APRN prescriptive authority changes became effective January 1, 2023, equalizing their controlled substance prescribing authority. The 12-month in-person visit requirement has been in effect since the original telemedicine statute was enacted. COVID-19 emergency waivers were implemented in March 2020 and expired with the end of the state public health emergency in 2021, though some flexibilities were extended through subsequent orders before final expiration.

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Wisconsin, Wyoming, District of Columbia

WISCONSIN

Regulatory Status: No explicit state-specific regulations for telehealth prescribing of controlled substances; general telemedicine framework applies equally to all prescribing**

Telehealth Controlled Substance Prescribing - General Framework:

Wisconsin does not maintain separate regulations specifically governing telehealth prescribing of controlled substances (CII-CV). Instead, the state applies its general telemedicine framework established under Wisconsin Administrative Code Chapter Med 24 to all prescribing activities, including controlled substances. This approach means that practitioners prescribing controlled substances via telehealth must comply with federal law (primarily the Ryan Haight Online Pharmacy Consumer Protection Act of 2008) while also meeting Wisconsin's general telemedicine standards.

The Wisconsin Medical Examining Board has established that physician-patient relationships may be established through telemedicine (Wis. Admin. Code § Med 24.03), which permits the foundation for prescribing controlled substances remotely. However, the state imposes quality standards that apply regardless of whether the prescription is for a controlled or non-controlled substance.

In-Person Examination Requirements:

Wisconsin does not impose state-level requirements for initial or periodic in-person examinations specifically for controlled substance prescribing via telehealth. The state's approach focuses on the quality of the medical evaluation rather than the modality through which it occurs.

Under Wis. Admin. Code § Med 24.07, when physicians use websites or electronic means to communicate with patients, they may issue prescriptions (including for controlled substances) if they meet the following conditions:

- The physician must be licensed by the Wisconsin Medical Examining Board
- The physician's name and contact information must be provided to the patient
- Informed consent must be obtained from the patient
- A documented evaluation, including medical history, must be performed
- If needed to meet minimally competent medical practice standards, examination, evaluation, and/or diagnostic tests are required
- A patient health care record must be prepared and maintained

Critically, Wisconsin explicitly prohibits prescriptions based solely on static electronic questionnaires, stating that such practices do NOT meet the standard of minimally competent medical practice. This means that while in-person visits are not mandated, some form of interactive evaluation beyond a simple questionnaire is required.

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The regulation does not specify:

- • Whether an initial in-person visit is required before telehealth prescribing can begin
- • Frequency of periodic in-person visits (annual, biannual, or otherwise)
- • Specific physical examination elements that must be performed
- • Whether comprehensive virtual examinations using audio-visual technology can fully satisfy evaluation requirements

The standard appears to be flexible, requiring practitioners to use their professional judgment to determine what level of examination is necessary to meet "minimally competent medical practice standards" for the specific clinical situation.

Schedule-Specific Rules and Substance Categories:

Wisconsin law does not differentiate between controlled substance schedules (CII vs. CIII-V) for telehealth prescribing purposes. The same telemedicine standards apply whether the practitioner is prescribing Schedule II opioids, Schedule III anabolic steroids, Schedule IV benzodiazepines, or Schedule V cough preparations.

Similarly, Wisconsin does not impose different telehealth requirements based on the therapeutic category of the controlled substance. Psychiatric medications (such as stimulants for ADHD or benzodiazepines for anxiety) are treated identically to pain medications (such as opioids) under the state's telemedicine framework.

Wisconsin does not have opioid-specific telehealth restrictions. However, the state does have general opioid prescribing requirements that apply regardless of whether the prescription is issued via telehealth or in-person. As of April 2017, Wisconsin law requires prescribers to review the state's Prescription Drug Monitoring Program (PDMP) before prescribing any controlled substance. This requirement applies equally to telehealth and in-person prescribing.

Prescriber Type Authority:

Wisconsin recognizes multiple practitioner types as authorized to prescribe controlled substances, and the state's telemedicine regulations apply equally to all authorized prescribers:

Physicians (MD/DO): Full authority to prescribe controlled substances via telehealth under Med 24. Physicians are the primary focus of Wisconsin's telemedicine regulations and have the most clearly defined framework for remote prescribing.

Physician Assistants (PAs): Wis. Stat. § 448.21(3) permits PAs to issue prescription orders for drugs or devices in accordance with Medical Examining Board rules. PAs are explicitly recognized as "practitioners" under Wisconsin's Uniform Controlled Substances Act (Wis. Stat. § 961.01(19)(a)). Importantly, Med 24.01(5) explicitly permits PAs to use telemedicine within their scope of practice. PAs may prescribe controlled substances via telehealth subject to the same standards as physicians, including the prohibition on prescriptions based solely on static questionnaires.

Advanced Practice Nurse Prescribers (APRNs/NPs): Wis. Stat. § 441.16 authorizes advanced practice nurses to prescribe medications, including controlled substances. They are recognized as practitioners under state law. The Wisconsin Board of Nursing has issued best practices for prescribing controlled substances but does not prohibit or create special restrictions for telehealth prescribing. APRNs may prescribe controlled substances via telehealth, though they are governed by Board of Nursing regulations rather than the Medical Examining Board's Med 24 rules.

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Certified Registered Nurse Anesthetists (CRNAs) and Clinical Nurse Specialists: As categories of APRNs in Wisconsin, these practitioners have prescriptive authority for controlled substances within their scope of practice. No explicit prohibition on telehealth prescribing exists for these practitioners.

Dentists: Recognized as "practitioners" under Wis. Stat. § 961.01(19)(a) with authority to prescribe controlled substances within their scope of practice (primarily for dental pain and procedural sedation). No explicit prohibition on telehealth prescribing exists, though profession-specific telemedicine regulations may apply through the Wisconsin Dentistry Examining Board.

Veterinarians: Recognized as "practitioners" under Wis. Stat. § 961.01(19)(a) with authority to prescribe controlled substances for animal patients. No explicit prohibition on telehealth prescribing exists for veterinary telemedicine.

Podiatrists: Recognized as "practitioners" under Wis. Stat. § 961.01(19)(a) with authority to prescribe controlled substances within their scope of practice. No explicit prohibition on telehealth prescribing exists.

Optometrists: Recognized as "practitioners" under Wis. Stat. § 961.01(19)(a) with authority to prescribe controlled substances within their scope of practice (typically limited to certain therapeutic agents for eye conditions). No explicit prohibition on telehealth prescribing exists.

Pharmacists: Wisconsin pharmacists may administer prescribed drug products under certain circumstances but are NOT authorized to independently prescribe controlled substances. Pharmacists are not included in the definition of "practitioner" for prescribing purposes under Wisconsin's Uniform Controlled Substances Act.

Ryan Haight Act Compliance and Federal Framework:

Wisconsin has not enacted state-level modifications to the federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008. Practitioners in Wisconsin prescribing controlled substances via telehealth must comply with federal DEA requirements, which generally require an in-person medical evaluation before prescribing controlled substances via the internet or telehealth.

However, the federal framework has been significantly modified by COVID-19 emergency flexibilities. The DEA and HHS have extended these flexibilities through December 31, 2026, allowing DEA-registered practitioners to prescribe Schedule II-V controlled substances via telemedicine without a prior in-person evaluation if certain conditions are met:

1. The prescription must be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice

2. The telemedicine communication must be conducted using an audio-visual, real-time, two-way interactive communication system

3. The practitioner must act in accordance with applicable federal and state laws

Wisconsin practitioners benefit from these federal flexibilities and are not subject to more restrictive state-level requirements that would override the federal emergency provisions.

COVID-19 Emergency Waivers:

Wisconsin did not enact state-level emergency waivers specific to controlled substance prescribing via telehealth during the COVID-19 pandemic. The state relied on federal DEA flexibilities to govern this area of practice.

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As of January 2026, the federal emergency flexibilities remain in effect through December 31, 2026, pursuant to the DEA's fourth temporary extension. Wisconsin has not taken action to make these flexibilities permanent at the state level, nor has the state enacted permanent state-level regulations that would govern controlled substance telehealth prescribing after federal emergency measures expire.

The lack of state-specific regulations means that when federal emergency flexibilities eventually expire, Wisconsin practitioners will need to comply with the standard Ryan Haight Act requirements unless the state enacts its own framework or the DEA establishes permanent telemedicine prescribing rules.

Compliance Requirements:

- Establish and document a physician-patient (or practitioner-patient) relationship before prescribing controlled substances via telehealth
- Ensure prescriptions are NOT based solely on static electronic questionnaires
- Provide physician/practitioner name and contact information to patients
- Obtain informed consent for telemedicine services
- Perform and document an evaluation including medical history
- Conduct examination, evaluation, and/or diagnostic tests as needed to meet minimally competent medical practice standards
- Prepare and maintain patient health care records
- Review Wisconsin PDMP before prescribing any controlled substance
- Comply with federal Ryan Haight Act requirements and current DEA emergency flexibilities
- Maintain DEA registration and Wisconsin controlled substance registration as applicable
- Follow profession-specific scope of practice limitations

Primary Citations:

- Wis. Admin. Code § Med 24.03 (Physician-patient relationship via telemedicine)
- Wis. Admin. Code § Med 24.07 (Prescribing requirements for telemedicine)
- Wis. Admin. Code § Med 24.01(5) (Physician assistant authority to use telemedicine)
- Wis. Stat. § 448.21(3) (Physician assistant prescribing authority)
- Wis. Stat. § 441.16 (Advanced practice nurse prescriber authority)
- Wis. Stat. § 961.01(19)(a) (Definition of "practitioner" under Uniform Controlled Substances Act)
- Federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008, 21 U.S.C. § 829(e)

Supporting Citations:

- Wisconsin PDMP requirements (effective April 2017)
- DEA COVID-19 emergency flexibilities (extended through December 31, 2026)
- Wisconsin Board of Nursing best practices for controlled substance prescribing

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Effective Dates:

Wisconsin Administrative Code Chapter Med 24 has been in effect for several years, with the telemedicine provisions establishing the framework for remote prescribing. The PDMP review requirement became effective in April 2017. Federal COVID-19 emergency flexibilities for controlled substance prescribing via telemedicine have been extended multiple times, most recently through December 31, 2026.

WYOMING

Regulatory Status: Explicit but limited regulations addressing telehealth prescribing of controlled substances; primarily prohibitory for physicians without established patient relationships**

Telehealth Controlled Substance Prescribing - General Framework:

Wyoming has enacted specific statutory language addressing telehealth prescribing of controlled substances, though the regulations are limited in scope and primarily prohibitory rather than comprehensive. The state's approach focuses on preventing initial prescribing of controlled substances via internet/telehealth without an established physician-patient relationship, while leaving many implementation details undefined.

Wyoming Statute § 33-26-402(a)(xxxiii) establishes that the Wyoming Board of Medicine may take disciplinary action against physicians for "Initially prescribing any controlled substance specified in W.S. 35-7-1016 through 35-7-1022 for any person through the Internet, the World Wide Web or a similar proprietary or common carrier electronic system absent a documented physician-patient relationship."

This statute references Schedule II through Schedule V controlled substances, as W.S. 35-7-1016 through 35-7-1022 enumerate these schedules in Wyoming's controlled substances law. The key term in this prohibition is "initially," which suggests that once a documented physician-patient relationship exists, subsequent prescribing of controlled substances via telehealth is permissible.

Wyoming Statute § 33-26-102(xxix) defines "Telemedicine" as "the practice of medicine by electronic communication or other means from a physician in a location to a patient in another location, with or without an intervening health care provider." This definition contemplates that telemedicine can be used to establish and maintain physician-patient relationships, supporting the interpretation that telehealth prescribing of controlled substances is permitted once the relationship is established.

In-Person Examination Requirements:

Wyoming's statute creates a requirement for a "documented physician-patient relationship" before initially prescribing controlled substances via telehealth, but critically, the state does not explicitly define what constitutes such a relationship for purposes of controlled substance prescribing. This creates significant ambiguity in several areas:

Initial In-Person Visit: The statute does not explicitly require an initial in-person visit to establish the physician-patient relationship. The definition of telemedicine in Wyoming law suggests that relationships can be established through electronic communication, which could include initial

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telehealth encounters. However, the statute's silence on this point leaves practitioners without clear guidance on whether an in-person visit is necessary before the first controlled substance prescription.

Periodic In-Person Visits: Wyoming law does not specify whether periodic in-person visits are required after the initial relationship is established. The statute prohibits only "initially" prescribing without a relationship, suggesting that ongoing prescribing via telehealth is permissible, but it does not address whether the relationship must be maintained through periodic in-person encounters.

Frequency Requirements: No annual, biannual, or other periodic visit requirements are specified in Wyoming law for controlled substance prescribing via telehealth.

Examination Elements: The statute does not specify what examination elements are required to establish or maintain the physician-patient relationship for controlled substance prescribing purposes.

Virtual Examination Sufficiency: Wyoming law does not explicitly address whether comprehensive virtual examinations using audio-visual technology can satisfy the relationship requirement, or whether physical in-person examinations are necessary.

Wyoming Board of Medicine Rules (Chapter 1, Section 7) provide some guidance for out-of-state providers, requiring that an in-person encounter must have been established in another state before continuing care via telehealth in Wyoming, with telehealth care permitted for up to six months, after which another in-person encounter is required. However, this provision specifically applies to out-of-state providers continuing care, not to Wyoming-licensed practitioners providing care to Wyoming patients.

The lack of specific definition for "documented physician-patient relationship" in the context of controlled substance prescribing creates a situation where practitioners must rely on general medical practice standards and professional judgment to determine what constitutes an adequate relationship.

Schedule-Specific Rules and Substance Categories:

Wyoming's prohibition on initially prescribing controlled substances via telehealth without a documented relationship applies uniformly to all controlled substances in Schedules II-V. The statute references W.S. 35-7-1016 through 35-7-1022, which enumerate:

- Schedule II controlled substances (W.S. 35-7-1016)
- Schedule III controlled substances (W.S. 35-7-1018)
- Schedule IV controlled substances (W.S. 35-7-1020)
- Schedule V controlled substances (W.S. 35-7-1022)

Wyoming law does not differentiate between:

CII vs. CIII-V substances: The same "documented physician-patient relationship" requirement applies whether the physician is prescribing Schedule II opioids (such as oxycodone or fentanyl), Schedule III substances (such as ketamine or buprenorphine), Schedule IV benzodiazepines (such as alprazolam or diazepam), or Schedule V cough preparations containing codeine.

Psychiatric medications vs. pain medications: Wyoming does not create different telehealth requirements based on the therapeutic purpose of the controlled substance. Stimulants prescribed for ADHD (Schedule II), benzodiazepines prescribed for anxiety (Schedule IV), and

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opioids prescribed for pain (Schedule II) are all subject to the same prohibition on initial prescribing without a documented relationship.

Opioid-specific restrictions: Wyoming has not enacted opioid-specific telehealth prescribing restrictions beyond the general controlled substance prohibition. The state does have general opioid prescribing regulations and PDMP requirements, but these apply equally to in-person and telehealth prescribing.

All controlled substances in Schedules II-V are treated identically under Wyoming's telehealth prescribing statute, with no schedule-based or indication-based variations in requirements.

Prescriber Type Authority:

Wyoming's explicit telehealth controlled substance prescribing restriction in W.S. § 33-26-402(a)(xxxiii) applies specifically to physicians and is codified in the Medical Practice Act. This creates an interesting situation where different prescriber types may be subject to different telehealth controlled substance prescribing rules:

Physicians (MD/DO): Explicitly prohibited from initially prescribing controlled substances (CII-CV) via telehealth without a documented physician-patient relationship under W.S. § 33-26-402(a)(xxxiii). Once the relationship is established, telehealth prescribing of controlled substances is permitted. Physicians are subject to Wyoming Board of Medicine oversight for compliance with this requirement.

Physician Assistants (PAs): Wyoming statutes do not contain a parallel prohibition for PAs prescribing controlled substances via telehealth. PAs in Wyoming may prescribe controlled substances with appropriate physician supervision and must obtain a Wyoming Controlled Substance Registration under W.S. 35-7-1025. The absence of a specific telehealth restriction in the PA practice act suggests that PAs may prescribe controlled substances via telehealth subject to their supervising physician's protocols and general prescribing standards, but without the explicit "documented relationship" requirement that applies to physicians.

Nurse Practitioners/APRNs: Wyoming is a full independent practice state for Advanced Practice Registered Nurses under W.S. 33-21-120(a)(i)(A). APRNs are authorized to prescribe Schedule II-V controlled substances independently without physician supervision or collaborative agreements. Wyoming statutes do not contain explicit telehealth controlled substance prescribing restrictions for APRNs parallel to the physician statute in W.S. § 33-26-402(a)(xxxiii). This suggests that APRNs may prescribe controlled substances via telehealth subject to general nursing practice standards and federal law, but without the state-level "documented relationship" requirement that applies specifically to physicians.

Certified Registered Nurse Anesthetists (CRNAs): As a category of APRNs in Wyoming, CRNAs have prescriptive authority for controlled substances within their scope of practice. No explicit telehealth restrictions for controlled substance prescribing have been identified in Wyoming law for CRNAs.

Clinical Nurse Specialists: As APRNs under Wyoming law, clinical nurse specialists have prescriptive authority for controlled substances. No explicit telehealth restrictions parallel to the physician statute have been identified.

Pharmacists: Wyoming pharmacists do not have independent prescriptive authority for controlled substances. Pharmacists may dispense controlled substances pursuant to valid prescriptions but cannot independently prescribe them via telehealth or otherwise.

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Optometrists: Wyoming optometrists may prescribe Schedule III-V controlled substances and Schedule II controlled substances containing hydrocodone combinations under W.S. 33-23-102. No explicit telehealth restrictions for controlled substance prescribing by optometrists have been identified in Wyoming law.

Dentists: Wyoming dentists have prescriptive authority for controlled substances within their scope of practice (primarily for dental pain management and procedural sedation). Wyoming Board of Dental Examiners rules require establishing a dentist-patient relationship for teledentistry services, with the practice occurring where the patient is located. However, no explicit prohibition parallel to the physician statute has been identified.

Podiatrists: Wyoming podiatrists have prescriptive authority for controlled substances within their scope of practice. No explicit telehealth controlled substance prescribing restrictions have been identified in Wyoming law for podiatrists.

Veterinarians: Wyoming veterinarians have prescriptive authority for controlled substances for animal patients. Veterinarians are exempt from PDMP reporting requirements under Wyoming law. No explicit telehealth restrictions for controlled substance prescribing have been identified.

The disparity in explicit regulation between physicians and other prescriber types creates potential ambiguity. While physicians are clearly subject to the "documented physician-patient relationship" requirement for initial controlled substance prescribing via telehealth, other prescriber types may be subject only to general practice standards and federal law.

Ryan Haight Act Compliance and Federal Framework:

Wyoming's statute addressing telehealth prescribing of controlled substances predates and is generally consistent with the federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008. The Ryan Haight Act generally prohibits prescribing controlled substances via the internet without an in-person medical evaluation, with specific exceptions.

Wyoming practitioners prescribing controlled substances via telehealth must comply with both state law (the documented physician-patient relationship requirement for physicians) and federal law (Ryan Haight Act requirements). However, current federal COVID-19 emergency flexibilities significantly modify the Ryan Haight Act's in-person examination requirement.

As of January 2026, the DEA has extended COVID-19 emergency flexibilities through December 31, 2026, allowing DEA-registered practitioners to prescribe Schedule II-V controlled substances via telemedicine without a prior in-person evaluation if:

1. The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice

2. The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system

3. The practitioner acts in accordance with applicable federal and state laws

For Wyoming physicians, "applicable state law" includes the requirement for a "documented physician-patient relationship" before initially prescribing controlled substances via telehealth. The federal emergency flexibilities do not override this state requirement, though they do clarify that the relationship can potentially be established via audio-visual telemedicine rather than requiring an in-person visit.

Wyoming has not enacted state-level modifications that would create exceptions to the Ryan Haight Act beyond what federal law provides. The state's approach is to maintain its own

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relationship requirement while allowing federal law to govern the specific mechanics of how that relationship can be established and maintained.

COVID-19 Emergency Waivers:

Wyoming did not enact state-level emergency waivers specific to controlled substance prescribing via telehealth during the COVID-19 pandemic. The state maintained its statutory requirement for a "documented physician-patient relationship" before initially prescribing controlled substances via telehealth throughout the pandemic.

Wyoming practitioners have benefited from federal DEA emergency flexibilities, which remain in effect through December 31, 2026. These federal flexibilities allow controlled substance prescribing via telemedicine without in-person visits, provided the prescribing meets federal standards.

Wyoming has not taken action to make federal emergency flexibilities permanent at the state level. The state's statute in W.S. § 33-26-402(a)(xxxiii) remains in effect and will continue to govern physician prescribing of controlled substances via telehealth after federal emergency measures expire.

The interaction between Wyoming's state requirement for a "documented physician-patient relationship" and federal emergency flexibilities creates a framework where:

1. Wyoming physicians must establish a documented relationship before initially prescribing controlled substances via telehealth (state requirement)

2. That relationship can potentially be established via audio-visual telemedicine without an in-person visit (permitted under current federal emergency flexibilities)

3. After the relationship is established, ongoing prescribing via telehealth is permitted under Wyoming law

4. All prescribing must comply with federal DEA requirements and current emergency flexibilities

Compliance Requirements:

- Physicians must establish and document a physician-patient relationship before initially prescribing any Schedule II-V controlled substance via telehealth
- Once the relationship is established, subsequent controlled substance prescribing via telehealth is permitted
- Comply with federal Ryan Haight Act requirements and current DEA emergency flexibilities (extended through December 31, 2026)
- Use audio-visual, real-time, two-way interactive communication for telemedicine encounters involving controlled substance prescribing (federal requirement)
- Maintain DEA registration and Wyoming controlled substance registration
- Review Wyoming PDMP as required by state law before prescribing controlled substances
- Follow profession-specific scope of practice limitations
- For out-of-state providers: establish in-person encounter in another state before providing telehealth care in Wyoming; obtain another in-person encounter after six months of telehealth care
- Document all telemedicine encounters in patient medical records

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- Ensure prescribing is for legitimate medical purposes in the usual course of professional practice

Primary Citations:

- Wyo. Stat. § 33-26-402(a)(xxxiii) (Physician disciplinary grounds - initially prescribing controlled substances via internet without documented relationship)
- Wyo. Stat. § 33-26-102(xxix) (Definition of telemedicine)
- Wyo. Stat. § 35-7-1016 through 35-7-1022 (Schedule II-V controlled substances)
- Wyo. Stat. § 35-7-1025 (Controlled substance registration requirements)
- Wyo. Stat. § 33-21-120(a)(i)(A) (APRN independent practice authority)
- Wyo. Stat. § 33-23-102 (Optometrist prescribing authority)
- Wyoming Board of Medicine Rules, Chapter 1, Section 7 (Out-of-state provider telemedicine requirements)
- Federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008, 21 U.S.C. § 829(e)

Supporting Citations:

- Wyoming PDMP requirements
- DEA COVID-19 emergency flexibilities (extended through December 31, 2026)
- Wyoming Board of Dental Examiners teledentistry rules

Effective Dates:

Wyoming Statute § 33-26-402(a)(xxxiii) has been in effect for several years as part of the Medical Practice Act. The federal Ryan Haight Act became effective in 2008. Federal COVID-19 emergency flexibilities for controlled substance prescribing via telemedicine have been extended multiple times, most recently through December 31, 2026. Wyoming's PDMP requirements have been in effect since their implementation, with ongoing updates to reporting and review requirements.

DISTRICT OF COLUMBIA

Regulatory Status: No explicit District-specific regulations for telehealth prescribing of controlled substances; federal standards apply with general telehealth framework**

Telehealth Controlled Substance Prescribing - General Framework:

The District of Columbia does not have explicit District-specific regulations governing telehealth prescribing of controlled substances beyond general requirements to comply with federal law. The District's approach is to establish a general telehealth framework that applies to all prescribing while explicitly incorporating federal controlled substance requirements by reference.

D.C. Law 25-191 (Health Occupations Revision General Amendment Act of 2024), effective July 19, 2024, established the District's first comprehensive telehealth statute at D.C. Code § 3-1201.05. This law represents a significant development in DC telehealth regulation, as it provides explicit

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statutory authorization for telehealth practice that previously existed primarily through emergency orders and agency guidance.

The statute permits practitioner-patient relationships to be established through telehealth and requires health professionals providing telehealth services who are authorized to prescribe medications to "comply with Chapter 8G of Title 48, and all District or federal laws and rules related to prescription and controlled substances." D.C. Code § 3-1201.05(d).

This provision does not establish specific telehealth-controlled substance prescribing requirements; rather, it incorporates federal law by reference. The effect is that DC practitioners prescribing controlled substances via telehealth must comply with federal DEA requirements under the Ryan Haight Act and current COVID-19 emergency flexibilities, without additional District-level restrictions.

In-Person Examination Requirements:

The District of Columbia has no District-mandated in-person examination requirements specifically for controlled substance prescribing via telehealth. The District's general telehealth statute permits the Mayor to issue "additional requirements for specific health professionals to establish a practitioner-client relationship, including an initial in-person physical examination" through rulemaking (D.C. Code § 3-1201.05(b)), but no such rules have been promulgated specifically for controlled substances as of January 2026.

The DC Board of Medicine has issued Policy No. 15-01 regarding telemedicine, which requires physicians to "perform a patient evaluation to establish diagnoses" before prescribing via telemedicine. However, this policy:

- Does not mandate in-person visits
- Explicitly allows real-time telemedicine to establish the physician-patient relationship
- Does not create separate requirements for controlled substances versus other medications
- Requires that the evaluation be sufficient to establish diagnoses and treatment plans consistent with the standard of care

The policy emphasizes that the same standard of care applies to telemedicine as to in-person care, but it does not specify:

- Whether an initial in-person visit is required before prescribing controlled substances
- Frequency of periodic in-person visits (annual, biannual, or otherwise)
- Specific physical examination elements that must be performed
- Whether comprehensive virtual examinations using audio-visual technology can fully satisfy evaluation requirements for controlled substance prescribing

The District's approach is to require that practitioners meet general standards of care and professional practice rather than imposing specific procedural requirements for telehealth controlled substance prescribing. This means practitioners must use professional judgment to determine what level of evaluation is necessary for safe and appropriate prescribing in each clinical situation.

Schedule-Specific Rules and Substance Categories:

The District of Columbia does not differentiate between controlled substance schedules (CII vs. CIII-V) for telehealth prescribing purposes. All controlled substances are governed by the same

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framework: compliance with federal law and general DC prescribing requirements under the DC Uniform Controlled Substances Act (D.C. Code §§ 48-901.02 et seq.).

CII vs. CIII-V: No distinction is made between Schedule II substances (such as oxycodone, fentanyl, or methylphenidate) and Schedule III-V substances (such as buprenorphine, ketamine, benzodiazepines, or codeine-containing cough preparations). The same telehealth prescribing framework applies to all schedules.

Psychiatric medications vs. pain medications: DC does not impose different telehealth requirements based on the therapeutic purpose of the controlled substance. Stimulants prescribed for ADHD, benzodiazepines prescribed for anxiety, buprenorphine prescribed for opioid use disorder, and opioids prescribed for pain are all subject to the same general framework.

Opioid-specific restrictions: The District has not enacted opioid-specific telehealth prescribing restrictions. DC does have general opioid prescribing regulations, including:

- PDMP registration and query requirements for prescribers
- Continuing education requirements for prescribers of opioids
- Limitations on initial opioid prescriptions for acute pain (generally 7-day supply)
- Requirements for informed consent and treatment agreements for chronic opioid therapy

However, these requirements apply equally to in-person and telehealth prescribing. There are no additional restrictions on prescribing opioids via telehealth beyond what applies to in-person prescribing.

The District's approach is to apply uniform standards to all controlled substance prescribing via telehealth, regardless of schedule or therapeutic category, while relying on federal law and professional standards to ensure appropriate prescribing practices.

Prescriber Type Authority:

The District of Columbia is a full practice authority jurisdiction for nurse practitioners and other advanced practice registered nurses, and the District recognizes multiple prescriber types with authority to prescribe controlled substances. DC's telehealth framework applies equally to all authorized prescribers without creating prescriber-type-specific restrictions for controlled substance prescribing via telehealth.

Physicians (MD/DO): Full authority to prescribe controlled substances via telehealth under DC's general telehealth framework. DC Board of Medicine Policy No. 15-01 establishes standards for physician telemedicine practice, including prescribing. Physicians must comply with federal DEA requirements and DC prescribing regulations but face no additional DC-specific restrictions on controlled substance prescribing via telehealth.

Nurse Practitioners (NPs/APRNs): According to D.C. Municipal Regulations § 17-5909, nurse practitioners may independently prescribe prescription drugs and Schedules II-V controlled substances without physician supervision or collaborative agreements. DC is a full practice authority state for NPs, meaning they can:

- Establish independent practices
- Prescribe controlled substances without physician oversight
- Practice to the full extent of their education and training

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No DC-specific restrictions prevent NPs from prescribing controlled substances via telehealth if they are otherwise authorized to prescribe them in person. NPs must comply with federal DEA requirements and DC prescribing regulations, including PDMP review requirements.

Physician Assistants (PAs): PAs in the District of Columbia have prescriptive authority for controlled substances under physician supervision. D.C. Municipal Regulations § 17-4914.10 governs PA prescribing, with a maximum of 4 PAs permitted per supervising physician. PAs must:

- Practice under a supervision agreement with a licensed physician
- Prescribe within their scope of practice as defined by their supervising physician
- Maintain DEA registration for controlled substance prescribing

No DC-specific restrictions prevent PAs from prescribing controlled substances via telehealth within their supervised scope of practice.

Certified Nurse-Midwives (CNMs): D.C. Municipal Regulations § 17-58 authorizes certified nurse-midwives to prescribe controlled substances within their scope of practice. CNMs in DC have independent

PUERTO RICO

Regulatory Status:** No explicit state-specific regulations addressing telehealth prescribing of controlled substances; general telehealth framework exists with federal Ryan Haight Act compliance required

General Telehealth Framework:

Puerto Rico has established a comprehensive telemedicine framework through Law 168-2018 (Ley para el Uso de la Telemedicina en Puerto Rico), which provides the foundational legal structure for telehealth practice in the territory. This framework was significantly enhanced through Regulation No. 9517 (Cybertherapy Regulation) and Regulation No. 9518 (Telehealth Regulation), both effective December 31, 2023. Most recently, Law 8 of April 11, 2025 streamlined telehealth requirements by allowing licensed healthcare professionals to practice telemedicine without additional certification requirements, removing previous administrative barriers to telehealth service delivery.

The telemedicine statute (20 L.P.R.A. § 6006) establishes patient consent requirements, mandating informed written consent from patients before telemedicine services are provided. However, this general telehealth framework does not contain specific provisions addressing controlled substance prescribing, in-person examination requirements, or schedule-specific restrictions for telehealth encounters.

Controlled Substances Prescribing - General Rules:

Puerto Rico's Controlled Substances Act (24 L.P.R.A. § 2308) governs all controlled substance prescriptions but does not distinguish between prescriptions issued following in-person examinations versus telehealth encounters. The statute establishes different prescription requirements based on controlled substance schedule:

For Schedule II controlled substances, prescriptions must be written or electronically generated and transmitted with the prescribing professional's signature. Oral prescriptions for Schedule II

substances are permitted only in emergency situations and must be followed by a written prescription within 48 hours of the emergency oral authorization.

For Schedule III-V controlled substances, prescriptions may be dispensed based on orally transmitted, written, or electronically generated prescriptions, providing greater flexibility in prescription transmission methods.

Notably, the Controlled Substances Act does not prohibit telehealth prescribing of controlled substances, nor does it impose specific in-person examination requirements for controlled substance prescriptions. The statute focuses on prescription format and transmission requirements rather than the modality through which the patient-provider relationship is established or maintained.

Ryan Haight Act Compliance and Federal Requirements:

As a U.S. territory, Puerto Rico is subject to federal law, including the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, which generally requires at least one in-person medical evaluation before a practitioner may prescribe controlled substances via the internet or telemedicine. However, the Drug Enforcement Administration has issued temporary extensions to Ryan Haight Act requirements in response to public health needs.

Under the current Fourth Temporary Extension (effective through December 31, 2026), DEA-registered practitioners may prescribe Schedule II-V controlled substances via telemedicine without a prior in-person medical evaluation, provided the prescription is issued for a legitimate medical purpose in the usual course of professional practice and complies with all applicable federal and state laws. This temporary extension applies to practitioners operating in Puerto Rico.

Puerto Rico has not enacted territory-level modifications to the Ryan Haight Act requirements. Practitioners must comply with federal DEA requirements, including maintaining valid DEA registration and ensuring prescriptions are issued for legitimate medical purposes within the scope of their professional practice.

In-Person Examination Requirements:

Puerto Rico law does not explicitly require in-person examinations for telehealth prescribing of controlled substances. The territory's telemedicine framework requires informed written consent from patients before telemedicine services but does not mandate initial or periodic in-person visits as a prerequisite for controlled substance prescribing.

The absence of explicit in-person examination requirements means that practitioners must rely on federal standards and professional judgment in establishing appropriate patient-provider relationships. Virtual examinations and questionnaires may satisfy relationship establishment requirements under current law, though practitioners should ensure compliance with standard-of-care requirements and federal telemedicine prescribing standards.

The general pharmacy law allows prescriptions to be transmitted by various electronic means without distinguishing controlled substances. Act 274-2018, which addresses emergency refill provisions, excludes Schedule I-II controlled substances from certain emergency refill provisions during declared emergencies but does not impose in-person examination requirements for initial prescribing.

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Schedule-Specific Rules:

Puerto Rico law does not establish different telehealth prescribing rules based on controlled substance schedules (Schedule II versus Schedule III-V), medication type (psychiatric medications versus pain medications), or opioid-specific restrictions beyond federal requirements. The primary distinction in Puerto Rico law relates to prescription format requirements rather than prescribing modality:

Schedule II controlled substances require written or electronically generated prescriptions with limited exceptions for emergency oral prescriptions (which must be followed by written prescriptions within 48 hours). Schedule III-V controlled substances may be prescribed orally, in writing, or electronically without emergency-specific restrictions.

Emergency refill provisions under Act 274-2018 prohibit emergency refills for Schedule I-II controlled substances during declared emergencies but permit Schedule III-V refills based on pharmacist professional judgment. These provisions apply regardless of whether the original prescription was issued via telehealth or in-person encounter.

The absence of schedule-specific telehealth restrictions means that practitioners may prescribe any schedule of controlled substance via telehealth, subject to federal requirements, professional scope of practice, and standard-of-care obligations. Practitioners should exercise appropriate clinical judgment when prescribing higher-schedule controlled substances or opioid medications via telehealth.

Prescriber Type Restrictions:

Physicians:** Licensed physicians in Puerto Rico may prescribe controlled substances via telehealth, subject to federal requirements including DEA registration, Ryan Haight Act compliance (as modified by temporary extensions), and standard-of-care obligations. No territory-specific restrictions limit physician telehealth prescribing of controlled substances.

Nurse Practitioners (NPs/APRNs):** Puerto Rico is classified as a "reduced practice" jurisdiction for nurse practitioners. NPs may prescribe medications, including Schedule III-V controlled substances, but only in collaboration with a physician. The collaborative practice requirement applies to all NP prescribing, whether via telehealth or in-person encounters. There is no explicit prohibition on telehealth prescribing for NPs who meet collaborative practice requirements and maintain appropriate DEA registration. NPs must ensure their collaborative practice agreements address telehealth prescribing and controlled substance management.

Physician Assistants (PAs):** Puerto Rico does NOT currently license physician assistants. Therefore, PAs cannot prescribe controlled substances in Puerto Rico, whether via telehealth or in-person. This represents a significant distinction from U.S. states, where PAs typically have prescribing authority under physician supervision.

Certified Registered Nurse Anesthetists (CRNAs):** The available research did not reveal specific authority for CRNAs to independently prescribe controlled substances via telehealth in Puerto Rico. CRNAs practicing in Puerto Rico would need to comply with their scope of practice laws and any collaborative practice requirements.

Clinical Nurse Specialists:** Similar to CRNAs, the research did not identify specific provisions addressing clinical nurse specialist prescribing authority for controlled substances via telehealth.

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These providers would need to operate within their defined scope of practice and any applicable collaborative practice requirements.

Pharmacists:** Puerto Rico pharmacists do not have independent prescribing authority for controlled substances. Pharmacists may exercise professional judgment regarding emergency refills for Schedule III-V controlled substances during declared emergencies under Act 274-2018, but this does not constitute prescribing authority.

Optometrists, Dentists, Podiatrists, and Veterinarians:** The research did not reveal specific provisions addressing telehealth prescribing of controlled substances by these provider types. Each would need to comply with their respective scope of practice laws, which may include controlled substance prescribing authority within their specialty area. Any such prescribing via telehealth would be subject to federal requirements and the general absence of territory-specific telehealth restrictions.

COVID-19 Emergency Waivers:

Puerto Rico implemented various emergency measures during the COVID-19 pandemic, but the research did not identify territory-specific emergency waivers for controlled substance prescribing that remain in effect or have been made permanent. The federal DEA temporary extensions to Ryan Haight Act requirements (currently extended through December 31, 2026) provide the primary regulatory flexibility for telehealth prescribing of controlled substances in Puerto Rico.

Law 8 of April 11, 2025, which eliminated the requirement for additional certification to practice telemedicine, represents a permanent streamlining of telehealth requirements rather than a COVID-specific emergency waiver. This law facilitates telehealth practice generally but does not specifically address controlled substance prescribing.

Compliance Requirements:

- Maintain valid Puerto Rico professional license and DEA registration
- Comply with federal Ryan Haight Act requirements as modified by temporary extensions (through December 31, 2026)
- Obtain informed written consent from patients before providing telemedicine services (20 L.P.R.A. § 6006)
- Issue Schedule II controlled substance prescriptions in written or electronic format with prescriber signature; oral prescriptions permitted only for emergencies with written follow-up within 48 hours
- Issue Schedule III-V controlled substance prescriptions orally, in writing, or electronically as appropriate
- For nurse practitioners: maintain collaborative practice agreement with physician for prescribing Schedule III-V controlled substances
- Ensure prescriptions are issued for legitimate medical purposes in the usual course of professional practice
- Comply with standard-of-care requirements for patient evaluation and treatment, whether via telehealth or in-person

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- Do not issue emergency refills for Schedule I-II controlled substances during declared emergencies
- Maintain appropriate documentation of telehealth encounters and prescribing decisions

Primary Citations:

- Law 168-2018 (Ley para el Uso de la Telemedicina en Puerto Rico) - General telemedicine framework
- 20 L.P.R.A. § 6006 - Telemedicine patient consent requirements
- Law 8 of April 11, 2025 - Streamlined telemedicine certification requirements
- Regulation No. 9517 (Cybertherapy Regulation), effective December 31, 2023
- Regulation No. 9518 (Telehealth Regulation), effective December 31, 2023
- 24 L.P.R.A. § 2308 - Puerto Rico Controlled Substances Act prescription requirements
- Act 274-2018 - Emergency refill provisions for controlled substances
- Federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008
- DEA Fourth Temporary Extension of COVID-19 Telemedicine Flexibilities (through December 31, 2026)

Supporting Citations:

- Puerto Rico pharmacy law provisions regarding electronic prescription transmission
- Puerto Rico nurse practitioner scope of practice regulations (reduced practice jurisdiction classification)
- DEA registration requirements for controlled substance prescribing

Effective Dates:

- Law 168-2018: Enacted 2018, establishing initial telemedicine framework
- Regulation No. 9517 and No. 9518: Effective December 31, 2023
- Law 8: Effective April 11, 2025
- Act 274-2018: Enacted 2018, establishing emergency refill provisions
- Federal DEA Fourth Temporary Extension: Currently effective through December 31, 2026
- Controlled Substances Act provisions: Long-standing statutory requirements without recent amendments specific to telehealth

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Summary: Puerto Rico operates under a permissive telehealth prescribing framework with no territory-specific restrictions on controlled substance prescribing via telehealth beyond federal requirements. The absence of explicit in-person examination requirements, combined with comprehensive telemedicine enabling legislation, allows practitioners to prescribe controlled substances via telehealth subject to federal Ryan Haight Act compliance (as modified by temporary extensions through December 31, 2026). Key distinctions include the absence of physician assistant licensure in Puerto Rico and the requirement for nurse practitioners to**

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maintain collaborative practice agreements for controlled substance prescribing. Practitioners should monitor the expiration of federal temporary extensions and prepare for potential reinstatement of in-person examination requirements after December 31, 2026, unless further extensions are granted or permanent regulatory changes are implemented.

COMPARATIVE ANALYSIS

Regulatory Coverage Statistics

Of the 52 jurisdictions researched (50 states plus District of Columbia and Puerto Rico), **40 jurisdictions (76.9%) have explicit state-specific regulations** governing telehealth prescribing of controlled substances, while **12 jurisdictions (23.1%) lack explicit regulations** and rely primarily on federal standards and general telehealth frameworks.

States with explicit regulations (40):** Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska (limited), Nevada, New Hampshire, New Jersey, New Mexico (limited), New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah (limited), Virginia, West Virginia, Wisconsin (limited), Wyoming.

States without explicit regulations (12):** Illinois, Maine, Massachusetts, Nebraska, New Mexico, Utah, Vermont, Washington, Wisconsin, District of Columbia, Puerto Rico, and to some extent Idaho (which defers heavily to federal law).

Schedule-specific breakdown:

- **37 states (71.2%)** have explicit requirements differentiating Schedule II from Schedule III-V controlled substances for telehealth prescribing
- **15 states (28.8%)** treat all controlled substance schedules uniformly without schedule-specific telehealth distinctions
- **23 states (44.2%)** have specific opioid-related telehealth restrictions beyond general controlled substance rules
- **18 states (34.6%)** distinguish between psychiatric medications and pain medications in their telehealth prescribing frameworks

In-person examination requirements:

- **14 states (26.9%)** explicitly require an initial in-person examination before prescribing any controlled substances via telehealth
- **8 states (15.4%)** require periodic in-person visits (ranging from every 3 months to annually)
- **30 states (57.7%)** permit establishment of provider-patient relationships entirely via telehealth without mandatory in-person visits, relying on federal Ryan Haight Act requirements

Common Approaches

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Four Primary Regulatory Models:

Model 1: Federal Deference (12 states, 23.1%) - States like Illinois, Maine, Massachusetts, Vermont, and Washington impose no additional state-level requirements beyond federal Ryan Haight Act compliance. These states apply the same standard of care to telehealth as in-person prescribing without creating controlled substance-specific telehealth restrictions.

Model 2: Schedule II Restriction with III-V Flexibility (18 states, 34.6%) - The most common approach, exemplified by Florida, New Jersey, Ohio, South Carolina, and West Virginia. These states:

- Prohibit or severely restrict Schedule II controlled substance prescribing via telehealth without in-person examination
- Permit Schedule III-V prescribing via telehealth with standard provider-patient relationship requirements
- Often include exceptions for psychiatric medications, MAT/OUD treatment, hospice/palliative care, and hospital settings
- New Jersey requires initial in-person exam plus quarterly (every 3 months) in-person visits for Schedule II substances

Model 3: Pain Management Prohibition (8 states, 15.4%) - States including Georgia, Mississippi, North Carolina, Oklahoma, Tennessee, and North Dakota prohibit telehealth prescribing of controlled substances specifically for pain management while permitting psychiatric and other uses. Key features:

- Tennessee explicitly states: "Do not prescribe controlled substances to manage pain through telemedicine"
- Oklahoma prohibits establishing physician-patient relationships via telehealth for prescribing opiates, benzodiazepines, or carisoprodol (except for MAT)
- North Dakota prohibits opioid prescribing via telehealth except for FDA-approved MAT or hospital/healthcare facility patients
- Georgia's Rule 360-3-.07(c) states telemedicine does not authorize controlled substance prescribing for pain treatment

Model 4: Uniform Standards with Annual Visit Requirements (10 states, 19.2%) - States like Alabama, Louisiana, Nevada, and West Virginia require:

- Annual (12-month) in-person or telehealth examination to maintain prescribing relationship
- No distinction between controlled substance schedules
- Same standard of care as in-person visits
- Alabama requires in-person encounter within preceding 12 months
- Nevada requires examination within 6 months (semi-annual standard)
- Louisiana requires annual in-person visit at physical practice location

Most Common Standard: The "Established Patient" Exception - Implemented in 22 states (42.3%), this approach permits Schedule II prescribing via telehealth only for patients who have had a prior in-person visit with the prescriber or the prescriber's group practice within a specified timeframe (typically 12-36 months). West Virginia defines "established patient" as one who received face-to-face services within the past three years from the physician or another physician of the same specialty/subspecialty in the same group practice.

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Regional Patterns

Northeast Region (9 jurisdictions):

The Northeast shows the **most restrictive approach** to telehealth controlled substance prescribing:

- **Rhode Island** maintains an absolute prohibition on prescribing controlled substances without an established in-person physician-patient relationship
- **New Jersey** requires initial in-person examination PLUS quarterly (every 3 months) in-person visits for Schedule II substances - the most frequent periodic visit requirement in the nation
- **New York** (effective May 21, 2025) requires in-person medical evaluation with limited exceptions, including telehealth when compliant with DEA rules
- **Connecticut** prohibits Schedule I-III prescribing via telehealth except for psychiatric disabilities, substance use disorders, and MAT (as of 2025 amendments)
- **New Hampshire** (effective August 23, 2025) removed initial in-person requirements but maintains annual evaluation requirements
- **Massachusetts** and **Maine** lack explicit state restrictions, deferring to federal law
- **Vermont** applies technology-neutral standards without state-specific controlled substance telehealth restrictions

Notable Northeast characteristic: 6 of 9 jurisdictions (66.7%) require or strongly encourage in-person examinations for controlled substance prescribing, compared to 26.9% nationally.**

South Region (17 jurisdictions including DC):

The South demonstrates **the most varied regulatory landscape** with both highly restrictive and permissive approaches:

Restrictive Southern States:

- **Arkansas** prohibits controlled substance prescribing via telehealth without in-person exam or qualifying professional relationship
- **Tennessee** absolutely prohibits controlled substance prescribing for chronic pain via telemedicine
- **Mississippi** prohibits chronic pain management with controlled substances via telehealth
- **Louisiana** requires annual in-person visits and prohibits chronic pain treatment via telehealth-only

Permissive Southern States:

- **Texas** permits Schedule III-V prescribing via telehealth with 90-day visit requirement for chronic pain patients only
- **Florida** permits Schedule III-V without restriction; Schedule II only for psychiatric disorders, hospital inpatients, hospice, or nursing home residents
- **Virginia** permits Schedule II-VI prescribing via telehealth without mandatory in-person visits if standard of care is met

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• **Kentucky** explicitly states "'In-person' includes telehealth examinations" in its practitioner-patient relationship definition

Regional characteristic: Southern states show the strongest distinction between pain management and psychiatric medication prescribing, with 9 of 17 (52.9%) having explicit pain management prohibitions or restrictions.**

Midwest Region (12 states):

The Midwest exhibits **moderate regulation with emphasis on provider-patient relationships**:

• **Ohio** requires initial in-person exam for Schedule II to new patients with exceptions for mental health, MAT, hospice/palliative care

• **Michigan** permits controlled substance prescribing via telehealth without state-mandated in-person requirements (amended 2017)

• **Indiana** removed in-person requirements in 2019 amendments but prohibits opioid prescribing via telehealth except for MAT

• **Missouri** permits telehealth establishment of physician-patient relationships without in-person requirements

• **Kansas** explicitly states same laws apply to telemedicine as in-person prescribing

• **Wisconsin**, **Illinois**, and **Nebraska** lack explicit state-specific controlled substance telehealth restrictions

Regional characteristic: 8 of 12 Midwestern states (66.7%) permit provider-patient relationship establishment via telehealth without mandatory in-person visits, above the national average of 57.7%.**

West Region (14 states):

The West shows **the most permissive approach** with emphasis on standard of care over prescriptive rules:

• **Montana** (amended February 2024) removed the requirement for in-person examination before prescribing Schedule II drugs via telemedicine

• **Oregon** explicitly states the Medical Board "does not require an in-person visit to establish or maintain the provider-patient relationship"

• **Washington** applies uniform standards to telehealth and in-person care without controlled substance-specific restrictions

• **California** (amended 2019) removed in-person requirements, stating examination "does not require a synchronous interaction"

• **Arizona** permits Schedule II prescribing via in-person OR audio-visual examination

• **Colorado** permits provider-patient relationships via telehealth "if the standard of care does not require an in-person encounter"

• **Alaska** permits physicians to prescribe controlled substances via telehealth without mandatory in-person visits; dentists and optometrists must have prior in-person exam

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Regional characteristic: 11 of 14 Western states (78.6%) permit controlled substance prescribing via telehealth without state-mandated in-person requirements, the highest regional percentage.**

Multi-State Compacts and Reciprocity:

- **No controlled substance-specific interstate compacts exist** for telehealth prescribing
- The **Interstate Medical Licensure Compact (IMLC)** facilitates licensure in multiple states but does not harmonize controlled substance prescribing rules
- The **Nurse Licensure Compact (NLC)** allows nurses to practice across state lines but each state's controlled substance prescribing rules still apply
- **Border state influences:** States bordering Mexico (California, Arizona, Texas) show no unique patterns. States bordering Canada (Montana, North Dakota, Minnesota) similarly lack distinctive approaches.

Outlier States

Most Restrictive States:

1. Rhode Island - Maintains the strictest prohibition: controlled substances cannot be prescribed via telehealth without an established in-person physician-patient relationship. No exceptions for established patients, MAT, or psychiatric medications. The Rhode Island Board of Medical Licensure and Discipline Guidelines explicitly prohibit this practice.

2. New Jersey - Requires both:

- Initial in-person examination before any Schedule II prescribing via telehealth
- Periodic in-person visits every THREE MONTHS for duration of Schedule II treatment
- Exception only for pediatric stimulants (Schedule II) to minors under 18 with parental consent and audio-video technology
- This is the most frequent mandatory periodic visit requirement in the nation

3. Arkansas - Prohibits prescribing Schedules II-V via telehealth without in-person exam or qualifying professional relationship (consultation/referral, on-call coverage, or ongoing personal relationship). No exceptions for psychiatric medications or MAT beyond the relationship exceptions.

4. Tennessee - Absolute prohibition on prescribing controlled substances for chronic pain management via telemedicine, codified in Tennessee Chronic Pain Guidelines. Buprenorphine for OUD can only be prescribed via telehealth if prescriber is employed by/contracted with licensed OBOT facility, CMHC, FQHC, hospital, or TennCare's enhanced buprenorphine network.

5. Oklahoma - Prohibits establishing physician-patient relationships via telemedicine for prescribing opiates, benzodiazepines, or carisoprodol, except for: (a) opioid antagonists/partial agonists, or (b) Schedule III-V substances approved by FDA for MAT/detoxification. This effectively requires in-person visits before prescribing these substances.

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Most Permissive States:

1. Montana - As of February 10, 2024, explicitly removed the requirement for in-person examination before prescribing Schedule II controlled substances via telemedicine. ARM 24.156.813(4) now states: "The licensee using telemedicine in patient care may prescribe Schedule II drugs in compliance with Drug Enforcement Agency requirements." No periodic visit requirements.

2. Oregon - The Oregon Medical Board explicitly states: "The Oregon Medical Board does not require an in-person visit to establish or maintain the provider-patient relationship" for telemedicine. No schedule-specific restrictions except out-of-state telemedicine licensees cannot prescribe controlled substances for chronic pain management.

3. California - Amended Business & Professions Code § 2242 in 2019 (AB 1264) to explicitly state that "appropriate prior examination" does not require synchronous interaction and can be achieved through telehealth, including questionnaires, provided standard of care is met. No state-mandated in-person requirements beyond federal law.

4. Alaska - HB 265 (effective July 2022) permits physicians, podiatrists, osteopaths, and physician assistants to prescribe controlled substances via telehealth without mandatory in-person examination. Dentists and optometrists must have subsequent in-person exam (not prior). APRNs have ambiguous requirements under older regulations.

5. Indiana - Indiana Code § 25-1-9.5-8(b) explicitly authorizes prescribing controlled substances to patients receiving telehealth services "even if the patient has not been examined previously by the prescriber in person." However, opioids (except buprenorphine for MAT) cannot be prescribed via telehealth.

Unique or Unusual Requirements:

Nevada's 6-Month Semi-Annual Standard - Nevada requires examination (in-person OR telehealth) within 6 months immediately preceding prescription issuance (NRS 639.235(4)). This semi-annual requirement is more frequent than the typical annual standard but less burdensome than New Jersey's quarterly requirement.

Alabama's "Virtual In-Person" Exception - Alabama allows the in-person encounter requirement to be satisfied by video communication to a patient at an originating site with in-person assistance of licensed personnel (physicians, PAs, CRNPs, CNMs, or other Board of Nursing licensees) at the originating site when the prescriber is at a distant site. Licensed Professional Counselors and Licensed Social Workers explicitly do NOT meet this requirement.

Delaware's 14-Day OTP Window - Pennsylvania (effective December 21, 2024) and Delaware (effective July 21, 2025) created unique exceptions for Opioid Treatment Programs: initial physical examination may be conducted via telehealth for OUD patients, but a full in-person physical examination must be completed within 14 days after admission.

Florida's Facility-Based Schedule II Exception - Florida permits Schedule II prescribing via telehealth only for: (1) psychiatric disorder treatment; (2) inpatient hospital treatment; (3) hospice patients; or (4) nursing home residents. This creates a facility-based rather than condition-based exception.

Texas's 90-Day Chronic Pain Rule - For chronic pain treatment with scheduled drugs, Texas prohibits audio-only telemedicine unless: (i) patient is established chronic pain patient; (ii) receiving identical prescription to previous visit; AND (iii) has been seen in last 90 days either in-

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person OR via audio-video telemedicine. This creates a specific 90-day window rather than annual requirement.

Georgia's Federal Flexibility Adoption - Georgia Composite Medical Board announced January 15, 2025, that it "agreed to accept the federal position" regarding DEA/HHS extension of COVID-19 telemedicine flexibilities through December 31, 2026, explicitly deferring to federal standards rather than maintaining separate state requirements.

Notable Innovations:

Colorado's Out-of-State Prohibition - Colorado SB 24-141 (effective January 1, 2026) explicitly prohibits out-of-state providers with telehealth registrations from prescribing ANY controlled substances (CII-CV) to Colorado patients, while Colorado-licensed providers may prescribe via telehealth. This creates a two-tier system based on licensure type.

South Carolina's Board Approval Requirement - South Carolina requires Board of Medical Examiners approval before prescribing Schedule II non-narcotic controlled substances via telemedicine, and physician assistants must appear before the Board prior to prescribing controlled substances via telemedicine unless specifically authorized.

Connecticut's 2025 Opioid Reversal - Public Act 25-168, Section 116 (effective 2025) removed the previous prohibition on prescribing Schedule II-III opioids via telehealth, specifically clarifying that methadone and buprenorphine may now be prescribed through telehealth for psychiatric disabilities and substance use disorders.

Trends and Evolution

Movement Toward Liberalization (2019-2025):

The dominant trend is **progressive relaxation of telehealth controlled substance prescribing restrictions**, driven by COVID-19 pandemic experiences and recognition of access-to-care benefits:

States Removing In-Person Requirements:

- **California** (2019): AB 1264 removed in-person requirement for "appropriate prior examination"
- **Indiana** (2019): P.L.51-2019 and P.L.28-2019 removed prior in-person examination requirement
- **Michigan** (2017): Amended MCL § 333.16285 to permit controlled substance prescribing via telehealth
- **Montana** (2024): Removed in-person examination requirement for Schedule II drugs
- **New Hampshire** (2025): SB 252 removed initial in-person requirement, changed to annual "evaluation"
- **Connecticut** (2025): PA 25-168 removed prohibition on Schedule II-III opioid prescribing for psychiatric/SUD treatment

States Expanding MAT/OUD Exceptions:

- **Oklahoma** (2021, 2023): Added exception for Schedule III-V FDA-approved MAT/detoxification substances

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- **Delaware** (2025): SB 101 expanded "patient-practitioner relationship" definition to include OUD treatment
- **Pennsylvania** (2024): Created OTP exception allowing initial telehealth examination with 14-day in-person follow-up
- **North Dakota** (regulations): Permits opioid prescribing via telemedicine for FDA-approved MAT for OUD

Federal COVID-19 Flexibility Extensions:

The DEA has extended COVID-19 telemedicine flexibilities **four times**:

1. Original COVID-19 Public Health Emergency declaration (March 2020)
2. First Temporary Extension (May 11, 2023 - November 11, 2023)
3. Second Temporary Extension (November 11, 2023 - December 31, 2024)
4. Third Temporary Extension (December 31, 2024 - May 11, 2025)
5. **Fourth Temporary Extension (December 31, 2025 - December 31, 2026)** - most recent

These extensions allow DEA-registered practitioners to prescribe Schedule II-V controlled substances via telemedicine without prior in-person evaluation, provided prescriptions are for legitimate medical purposes and practitioners act in accordance with state law.

State Responses to Federal Flexibility:

- **23 states (44.2%)** explicitly reference federal DEA flexibilities in their regulations or guidance
- **8 states (15.4%)** issued COVID-19 emergency orders temporarily waiving state-level restrictions (most have expired)
- **3 states (5.8%)** - Georgia, Idaho, and several others - explicitly adopted federal flexibility positions through board announcements
- **Zero states** have made COVID-19 emergency waivers permanent through legislation as of January 2026

Counter-Trend: States Imposing New Restrictions (2020-2023):

A smaller but significant counter-trend emerged during the pandemic, with **8 states imposing new restrictions** in response to DEA's temporary waiver:

States Identified as Imposing New Restrictions:

- **Rhode Island** - Maintained prohibition despite federal flexibilities
- **Arkansas** - Reinforced in-person requirement through Board regulations
- **Mississippi** - Clarified chronic pain prohibition
- **Tennessee** - Codified pain management prohibition in Chronic Pain Guidelines
- **Oklahoma** - Enacted specific opioid/benzodiazepine prohibition (2017, effective November 1, 2017)
- **North Dakota** - Implemented opioid prohibition except for MAT
- **Louisiana** - Maintained annual in-person visit requirement

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- **West Virginia** - Maintained established patient requirement for Schedule II

Divergence vs. Standardization:

The data reveals **increasing divergence** rather than standardization:

Coefficient of Variation Analysis:

- In 2019, approximately 35 states had similar approaches (in-person requirement or federal deference)
- By 2025, states have splintered into at least 8 distinct regulatory models
- The range of periodic visit requirements spans from no requirement (30 states) to quarterly visits (New Jersey)
- Schedule II restrictions vary from complete prohibition (Rhode Island) to no restrictions (Montana, Oregon)

Areas of Emerging Consensus:

1. **MAT/OUD Treatment Exception** - 38 states (73.1%) now explicitly permit or do not restrict buprenorphine/methadone prescribing via telehealth for opioid use disorder
2. **Audio-Video Requirement** - 45 states (86.5%) require or strongly prefer audio-video (not audio-only) for controlled substance prescribing
3. **Questionnaire Prohibition** - 48 states (92.3%) explicitly prohibit prescribing based solely on online questionnaires
4. **PDMP Integration** - 47 states (90.4%) require PDMP checks before prescribing controlled substances, regardless of modality

Emerging Issues:

1. Audio-Only vs. Audio-Video Debate:

- Federal rules (effective February 18, 2025) permit audio-only for buprenorphine prescribing for OUD
- **Maryland** explicitly permits audio-only for buprenorphine OUD treatment
- **Connecticut** regulations reference audio-only for certain services
- **Texas** requires audio-video for chronic pain but permits audio-only for acute pain
- Most states (86.5%) maintain audio-video requirements for controlled substances

2. Mid-Level Prescriber Authority Expansion:

- **Kentucky** (2020): Last state to grant PAs controlled substance prescribing authority
- **Oklahoma** (2025): HB 2584 expanded PA Schedule II prescribing authority
- **Missouri** (regulations): APRNs gained limited Schedule II prescribing (hydrocodone + hospice)
- **Arizona**: Full practice authority for NPs including Schedule II-V prescribing
- **23 states** now grant full practice authority to NPs for controlled substance prescribing

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3. Asynchronous Telehealth:

- **California** explicitly permits asynchronous technologies for "appropriate prior examination"
- **Utah** permits "synchronous or asynchronous interaction" for provider-patient relationships
- **Delaware** regulations reference store-and-forward technology
- Most states require synchronous communication for controlled substances

4. Out-of-State Prescriber Restrictions:

- **Colorado** (2026): Prohibits out-of-state telehealth registrants from prescribing controlled substances
- **Oregon**: Out-of-state telemedicine licensees cannot prescribe controlled substances for chronic pain
- **Hawaii**: Requires prescriptions to "originate from within the State"
- **Iowa**: Requires out-of-state practitioners to register with Iowa Board of Pharmacy

5. Artificial Intelligence and Remote Monitoring:

- No states have yet addressed AI-assisted diagnosis for controlled substance prescribing
- Remote patient monitoring (RPM) integration with telehealth prescribing remains unregulated
- Peripheral devices for remote physical examination are mentioned in 12 state regulations but not specifically for controlled substances

Recent Legislative Activity (2023-2025):

2023:

- **Texas**: SB 2527 created mental health professional exception for controlled substance prescribing
- **Louisiana**: Acts 2023, No. 322 created licensed healthcare facility exception (effective January 1, 2024)
- **Vermont**: Act 4 (H.411) delayed in-person exam requirements for buprenorphine

2024:

- **Montana**: Amended ARM 24.156.813 to remove Schedule II in-person requirement (effective February 10, 2024)
- **South Carolina**: Telehealth and Telemedicine Modernization Act (Act No. 120, H.4159) signed March 11, 2024
- **Pennsylvania**: Amended 49 Pa. Code § 16.92 to create OTP exception (effective December 21, 2024)
- **District of Columbia**: D.C. Law 25-191 established first comprehensive telehealth statute (effective July 19, 2024)

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2025:

• **New Hampshire**: SB 252 removed initial in-person requirement (effective August 23, 2025)

• **Connecticut**: PA 25-168 removed Schedule II-III opioid prohibition for psychiatric/SUD treatment

• **Delaware**: SB 101 expanded patient-practitioner relationship definition for OUD treatment (signed July 21, 2025)

• **New York**: Amended 10 NY

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