AMERSA
Association for Multidisciplinary Education and Research in Substance use and Addiction

March 18, 2025

Drug Enforcement Administration
8701 Morrissette Drive
Springfield, VA 22152

RE: Docket No. DEA-407

To Whom It May Concern,

On behalf of AMERSA, we submit this comment in response to the Drug Enforcement Administration's (DEA) proposed rule, "Special Registrations for Telemedicine and Limited State Telemedicine Registrations" [Docket No. DEA-407] RIN 1117-AB40.

AMERSA (Association for Multidisciplinary Education and Research in Substance Use and Addiction) supports the DEA's efforts to update federal regulations related to the expansion of buprenorphine treatment via telehealth. However, we raise several concerns related to key provisions in the current DEA proposal as outlined below and recommend further revision before finalizing the ruling.

AMERSA, founded in 1976, is a non-profit professional organization with a mission to improve health and well-being through interdisciplinary leadership and advocacy in substance use education, research, clinical care, and policy. Its membership consists of 550 experts in the field of addiction from multiple disciplines, including but not limited to physicians, nurses, social workers, psychologists, dentists, pharmacists, and public health professionals. Many of us serve on the frontlines of the overdose crisis as scientists, teachers, treatment providers, and expert public health consultants, including to the DEA.

We would like to express our appreciation to the DEA for incorporating public feedback into the proposed rule and for recognizing the critical role that telehealth holds in expanding access to buprenorphine treatment, particularly during the COVID-19 pandemic. The provisions allowing for up to six months of buprenorphine prescribing via telehealth without an in-person visit and the allowance of audio-only telehealth care codifies a vital step towards reducing barriers to care and ensuring that individuals with opioid use disorder (OUD) can access life-saving treatment. These policies acknowledge the realities of patients' needs and the growing evidence supporting telehealth as a safe and effective modality for OUD treatment.

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However, we hold significant reservations about this policy as it stands written presently. We strongly advise against the requirement for prescribers to consult a national prescription drug monitoring program (PDMP) as a condition of telehealth prescribing beyond the initial six months. Currently, no national PDMP exists, and the creation of such a system would necessitate extensive collaboration between states, substantial infrastructure development, and data-sharing agreements that do not yet exist. Building this infrastructure would require significant time and resources, which could lead to unnecessary delays in implementing the final rule. In the context of the ongoing overdose crisis, where over 100,000 lives are lost annually in the United States, any delay in access to evidence-based treatment is both unacceptable and unethical. We urge the DEA to reconsider this requirement and instead rely on existing state PDMP systems, which already provide critical information to prescribers.

Additionally, we share concerns that the special registration process may inadvertently recreate the same unnecessary barriers posed by the now-eliminated DEA X-waiver. The X-waiver requirement significantly restricted access to buprenorphine and imposed an unnecessary barrier to treatment for decades, contributing to the underutilization of this life-saving medication. If a special registration is deemed necessary, we strongly recommend that the application process be as minimally burdensome as possible. The process should be modeled after the DEA's existing exemption for 72-hour emergency methadone administration, which allows prescribers to register quickly and efficiently. A complex or onerous special registration process would deter providers from offering buprenorphine treatment and perpetuate inequitable access to care.

In conclusion, we commend the DEA for taking steps to expand telehealth access to buprenorphine treatment, and we urge the agency to ensure that final regulations prioritize patient access and provider flexibility. The overdose crisis demands policies that facilitate—not hinder—access to evidence-based treatment. We appreciate the opportunity to provide feedback on this important issue and look forward to continued collaboration to promote increased access to addiction treatment.

Sincerely,

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