Executive Committee Meeting

Virginia Board of Medicine
August 1, 2025
8:30 a.m.

Executive Committee

Friday, August 1, 2025 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201, Board Room 4
Henrico, VA 23233

Call to Order and Roll Call

Adoption of Agenda

Public Comment on Agenda Items

Reports of President and Executive Director

New Business

11. Adjourn

====No motion needed to adjourn if all business has been conducted====

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Board Room 4

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Agenda Item: **Approval of Minutes of the April 4, 2025**

Staff Note: Draft minutes that have been posted on Regulatory Townhall and the Board's website are presented. Review and revise if necessary.

Action: Motion to approve minutes.

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE

EXECUTIVE COMMITTEE MINUTES

Friday, April 4, 2025 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Clements called the Executive Committee to order at 8:34 a.m.

ROLL CALL: Ms. Brown called the roll; a quorum was established.

MEMBERS PRESENT:
John R. Clements, DPM – President, Chair
Peter Apel, MD – Vice President
Leroy Vaughan, Jr., MD – Secretary-Treasurer
William Hutchens, MD
L. Blanton Marchese
Jennifer Rathmann, DC

MEMBERS ABSENT:
Oliver Kim, JD
Deborah DeMoss Fonseca

COUNSEL PRESENT: Jim Rutkowski, JD – Senior Assistant Attorney General

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Exec. Director for Discipline
Michael Sobowale, LLM - Deputy Exec. Director for Licensure
Colanthia Morton Opher - Deputy Exec. Director
Barbara Matusiak, MD - Medical Review Coordinator
Arnie Owens - DHP Director
Erin Barrett - Director for DHP Legislative and Regulatory Affairs
Matt Novak – Policy and Economic Analyst
Deirdre Brown - Executive Assistant

OTHERS PRESENT:
Tamika Hines – Discipline and Compliance Case Manager
Roslyn Nickens – Licensing Supervisor
Sonya Armstead – Licensing Specialist
Allyson Flinn – Medical Society of Virginia
Ben Traynham – Hancock, Daniel & Johnson, P.C.
Meredith Joyner – Virginia Nurses Association

EMERGENCY EGRESS INSTRUCTIONS

Dr. Clements provided the emergency egress instructions for all in the meeting.

APPROVAL OF MINUTES FROM APRIL 5, 2024

Dr. Apel moved to approve the meeting minutes from April 5, 2024, as presented. The motion was seconded by Mr. Marchese and carried unanimously.

ADOPTION OF AGENDA

Dr. Apel moved to adopt the agenda as presented. The motion was seconded by Dr. Hutchens and carried unanimously.

PUBLIC COMMENT

There was no public comment.

DHP DIRECTOR'S REPORT

Mr. Owens, DHP Director, remarked that in Washington, DC, a lot of reorganization and restructuring is occurring which also affects the Department of Health and Human Services. He directed those interested in further information to the HHS website. Mr. Owens noted that former Board of Medicine member, Tom Corry, is no longer with HHS.

Mr. Owens shared that DHP's current budget has been approved. Staff are preparing the next biennial budget for presentation to the 2026 Session of the General Assembly. Currently, there are no operational problems with any of DHP's boards. He stated that a couple of boards are working on an increase in licensing fees.

Mr. Owens said that the DHP bill to eliminate the Board of Health Professions was passed by the General Assembly. He reported that legislation was passed to expand Licensure by Endorsement for all professions that don't currently have such a pathway.

Lastly, Mr. Owens shared that former Chief Deputy, Jim Jenkins, is now with the Virginia Department of Health as the Deputy Director for the Office of Licensure and Certification.

PRESIDENT'S REPORT

None.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp thanked Deputies Michael Sobowale, Jennifer Deschenes and Co-Co Morton Opher for running their sections so well.

Budget Report

Dr. Harp reviewed the Board's FY2025 budget which began July 1, 2024 and ends June 30, 2025. The numbers reviewed were from July 1, 2024, to February 28, 2025. He stated that the Board has 33% of the budget year left. He pointed out that the Board was projected to bring in $11,712,510.52. On February 28, 2025, $9,409,345.00 had been received, which is 80% of

projected revenue. Dr. Harp then reviewed the direct expenditures, stating that the Board was budgeted for $4,144,468.00. As of February 28, 2025, the Board has expended $2,452,180.73, which leaves 41% of budgeted funds remaining. This puts the Board ahead in revenue and behind in expenditures.

License Count Report

Dr. Harp reviewed the counts for various professions and noted that people tend to keep their license in Virginia, as evidenced by a large percentage of out-of-state licensees. Current MD active licenses in Virginia number 23,218 with an additional 20,302 current active out-of-state licenses for a total of 44,868 current active MD licenses. This pattern holds for many professions. Dr. Harp noted that the business of telemedicine has increased the number of out-of-state professionals licensed in Virginia. The total number of Board licensees is now 93,796, which does not include Advanced Practice Registered Nurses, Licensed Certified Midwives, and the newest profession, Anesthesiologist Assistants.

Case Action Update

Dr. Harp reviewed the disciplinary actions that have been taken since July 1, 2024. He explained that a Mandatory Suspension is effected by the DHP Director when someone's license is suspended or revoked by another state or is convicted of a felony in Virginia or another state.

NEW BUSINESS

1. 2025 General Assembly Report

Ms. Barrett stated that the General Assembly reconvened on Wednesday, April 2, 2025 to consider the Governor's amendments or vetoes. The Governor will take action on any pending legislation between May 1-3, 2025.

This report was for informational purposes only and did not require any action.

2. Current Regulatory Actions

Mr. Novak reviewed the Current Regulatory Actions as of March 14, 2025, and provided updates as some statuses had changed in the last 3 weeks. One updated regulation from the Governor's Office, 18VAC85-80 (elimination of active practice for renewal for Occupational Therapists), has been approved and will be published on April 21, 2025, to become effective on June 5, 2025.

This report was for informational purposes only and did not require any action.

3. Adoption of Proposed Regulatory changes - Respiratory Therapist

Mr. Novak reported that a legislator had objected to the Board's proposed amendments to the scope of practice for respiratory therapists as a fast-track action. Substitute language was

proposed regarding the 2022 periodic review of 18VAC85-40.

MOTION: Mr. Marchese moved to adopt the proposed regulatory action amending Chapter 40 as presented. The motion was seconded by Dr. Hutchens and carried unanimously.

4. Adoption of Notice of Intended Regulatory Action (NOIRA) to Implement PA Licensure Compact

Mr. Novak stated that the 2024 General Assembly entered Virginia in the PA Licensure Compact. The Board's first step towards implementation of the Compact is the adoption of a Notice of Intended Regulatory Action.

MOTION: Mr. Marchese moved to adopt a Notice of Intended Regulatory Action to implement the PA Licensure Compact and make all regulatory changes required consistent with the Compact. The motion was seconded by Dr. Apel and carried unanimously.

5. Revision of Guidance Document 85-16

Ms. Barrett stated that changes to 18VAC85-20-235 became effective on February 27, 2025 which included a reduction in continuing education hours. Previously it was 30 hours of Type 1 and 30 hours of Type 2, for a total of 60 hours each biennium. Type 2 has been removed, and Guidance Document 85-16 needs to be amended to reflect this change and remove any references to audits.

MOTION: Dr. Apel moved to revise Guidance Document 85-16 as presented. The motion was seconded by Mr. Marchese and carried unanimously.

6. Adoption of Fast-Track Regulatory Amendment to Clean up Reference to Continuing Education

Ms. Barrett said that when the 60 hours of continuing education was reduced to 30 hours of Type 1 per biennium, the language was revised in Chapter 20 but now needs to be amended in 18VAC85-20-330.

MOTION: Mr. Marchese moved to adopt Fast-Track regulatory changes to 18VAC85-20-330 for consistency with the reduced continuing education hours. The motion was seconded by Dr. Rathmann and carried unanimously.

ANNOUNCEMENTS

Dr. Clements informed the Board of the updated guideline for travel reimbursement. Effective immediately, Board members need to submit their request for reimbursement within 30 days for approval. After the 30-day deadline, no exceptions will be granted.

The next meeting of the Executive Committee will be August 1, 2025, at 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 9:49 a.m.

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William L. Harp, MD
Executive Director

Agenda Item: **DHP Agency Director's Report**

Staff Note: All items for information only

Action: None.

Agenda Item: **Board President's Report**

Staff Note: All items for information only.

Action: None.

Agenda Item: **Executive Director's Report**

Staff Note: All items for information only.

Action: None.

Agenda Item: **Regulatory Actions as of July 17, 2025**

Staff Note: Ms. Barrett will speak to legislation of interest to the Board of Medicine.

Action: If any action is required, guidance will be provided.

Board of Medicine
Regulatory Actions
As of July 17, 2025

In the Governor's Office

None.

In the Secretary's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-50	NOIRA	Implementation of the PA Compact	4/14/2025	87 days	Regulatory amendments necessary for entry into the PA Compact

At DPB or OAG

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-20	Fast-Track	Removal of requirement to provide documentation of continuing competency for reactivation of a license	10/29/2024	DPB; 1 day	This will make only attestation required, similar to renewal of licenses
18VAC85-20	Fast-Track	Clean up of continuing education requirement references following regulatory reduction	4/8/2025	OAG; 100 days	Removes references to CE requirements that were removed in a previous regulatory action
18VAC85-40	Proposed	Implementation of 2022 Periodic Review for Chapter 40	4/8/2025	OAG; 100 days	Implements changes following 2022 periodic review. Fast-track received an objection from a

					legislator pursuant to Va. Code § 2.2-4012.1., which converted the fast-track into a NOIRA. This action will now undergo the full regulatory process.
18VAC85-50	Fast-Track	Creation of reinstatement process for physician assistants with lapsed licenses	10/29/2024	DPB; 1 day	Missing process for PAs
18VAC85-80	Fast-Track	Expansion of options for reinstatement of lapsed occupational therapy or occupational therapy assistant license	7/1/2025	OAG; 16 days	Amends reinstatement and reactivation regulations to allow quicker return to practice

Recently effective/awaiting publication

VAC	Stage	Subject Matter	Submitted for publication	Effective Date	Notes
18VAC85-20	NOIRA	Licensure of foreign physicians through provisional and restricted licenses	3/24/25	4/23/2025	The legislative committee is currently creating proposed stage language for recommendation to the Board.
18VAC85-50	Fast-Track	Implementation of Periodic Review for Chapter 50	6/2/2025	7/17/2025	Implements changes following 2022 periodic review
18VAC85-110	Fast-track	Implementation of 2022 Periodic Review for Chapter 110	5/19/2025	7/3/2025	Implements changes following 2022 periodic review

18VAC85-130	Fast-track	Implementation of 2022 Periodic Review for Chapter 130	5/19/2025	7/3/2025	Implements changes following 2022 periodic review
18VAC85-150	Fast-track	Implementation of 2022 Periodic Review for Chapter 150	5/19/2025	7/3/2025	Implements changes following 2022 periodic review
18VAC85-170	Fast-track	Implementation of 2022 Periodic Review for Chapter 170	5/19/2025	7/3/2025	Implements changes following 2022 periodic review
18VAC85-130	Fast-Track	General disclosure requirement amendment consistent with statutory changes	7/28/2025	9/11/2025	Updates requirements for midwife disclosures consistent with 2023 legislative changes

Agenda Item: Consideration of Notice of Intended Regulatory Action to License Anesthesiology Assistants

Included in your Agenda Package:

- Chapter 507 of the 2025 General Assembly

Action Needed:

- Motion to issue a Notice of Intended Regulatory Action to license anesthesiology assistants.

CHAPTER 507

An Act to amend the Code of Virginia by adding in Article 4 of Chapter 29 of Title 54.1 a section numbered 54.1-2957.23, relating to Board of Medicine; licensure of anesthesiologist assistants.

[S 882]

Approved March 24, 2025

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 4 of Chapter 29 of Title 54.1 a section numbered 54.1-2957.23 as follows:

§ 54.1-2957.23. Licensure of anesthesiologist assistants.

A. As used in this section, "anesthesiologist" means a physician who is licensed by the Board and who has completed a residency in anesthesiology approved by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology.

B. No person shall use or assume the title "anesthesiologist assistant" or hold himself out as an anesthesiologist assistant unless such person holds a license as an anesthesiologist assistant issued by the Board. Nothing in this section shall be construed as prohibiting any professional licensed, certified, or registered by a health regulatory board from acting within the scope of his profession.

C. The Board shall establish criteria for licensure as an anesthesiologist assistant that shall include the following:

1. Successful completion of an anesthesiologist assistant program accredited by the Commission on Accreditation of Allied Health Education Programs or its predecessor or successor organizations; and

2. Passage of the certifying examination administered by the National Commission for Certification of Anesthesiologist Assistants or other examination required by the Board.

D. Pending the outcome of the next examination described in subdivision C 2, the Board may grant a provisional license to a graduate of an anesthesiologist assistant program accredited by the Commission on Accreditation of Allied Health Education Programs or its predecessor or successor organizations.

E. Nothing in this section shall prohibit a student anesthesiologist assistant who is enrolled in an anesthesiologist assistant program accredited by the Commission on Accreditation of Allied Health Education Programs or its predecessor or successor organizations from engaging in acts that would constitute practice as an anesthesiologist assistant as part of such program.

F. An anesthesiologist assistant licensed pursuant to this section shall practice within the scope of his clinical and professional training and the limits of his knowledge and experience and under the supervision of an anesthesiologist.

G. The Board shall adopt regulations governing the practice of anesthesiologist assistants, including regulations for (i) application for and issuance of a license or renewal of a license, (ii) standards of practice for licensed anesthesiologist assistants, and (iii) requirements for supervision of anesthesiologist assistants by anesthesiologists.

Agenda Item: Consideration of Proposed Action for Reduction of Requirements for Consultation and Collaboration

Included in your Agenda Package:

- Draft language as approved by the PA advisory board; and
- Comments received on TownHall

Staff Note: These draft regulations were presented to the PA advisory board in June for consideration and recommended to the Board in their current form.

Action Needed:

- Motion to adopt proposed stage regulations for reduction of requirements for consultation and collaboration.

Project 7656 - Proposed

Board of Medicine

Amendment to requirements for patient care team physician or podiatrist consultation and collaboration

18VAC85-50-110. Responsibilities of the patient care team physician or podiatrist.

A patient care team physician or podiatrist shall:

1. ~~Review the clinical course and treatment plan for any patient who presents for the same acute complaint twice in a single episode of care and has failed to improve as expected. A physician or podiatrist shall be involved with any patient with a continuing illness as noted in the written or electronic practice agreement for the evaluation process.~~ Provide appropriate consultation and collaboration for clinical cases and patient emergencies, as noted in the written or electronic practice agreement for the patient evaluation process.

2. Be available at all times to collaborate and consult with the physician assistant.

Action: Amendment to requirements for patient care team physician or podiatrist consultation and collaboration [6295 / 10088]

Commenter	Title	Comment	Date/ID
Erika Francis, Shenandoah University	Support of Petition to Remove Redundant Physician Review Requirement	As the Interim Program Director of the Shenandoah University Physician Assistant (PA) Program, I strongly support the petition to remove the requirement that a patient care team physician review the clinical course and treatment plan when a patient presents for the same acute complaint twice in a single episode of care. This regulation imposes an unnecessary administrative burden without clear benefits to patient safety or clinical outcomes. PAs are highly trained, licensed medical professionals who practice within a defined scope of practice and in collaboration with physicians. They are fully capable of evaluating and managing patients who return with the same acute complaint, using their medical expertise to adjust treatment plans as needed. Mandating a physician review in these cases undermines the trust in PA clinical decision-making and contributes to inefficiencies in patient care. Removing this requirement would improve workflow, reduce unnecessary delays, and allow PAs to practice more effectively within their scope while maintaining high standards of patient care. I urge the Virginia Board of Medicine to approve this petition and modernize regulations to reflect the essential role of PAs in Virginia’s healthcare system. Sincerely, Erika Francis, DMS, PA-C Interim Program Director Shenandoah University PA Program	3/11/25 5:47 pm CommentID:233008
Kim Ketchersid	In support	In specialty practices, emergency departments, and hospitals, patients are often seen for in subsequent visits for the same chief complaint. This rule only increases the burdens on physicians. Removing it would expand access and lessen the physician workload.	3/12/25 6:29 am CommentID:233010
Laura DeWitz PA-C	support to remove this language	Please help up remove the language that an MD review clinical course and treatment for patients that present for acute complaint twice in a single episode of care. This adds to burden for providers, especially physicians and no proven benefit to patients. I work psychiatry and often need to try multiple medications before finding the one that works best. How is contacting a physician who is often not on site and not familiar with my patient and interrupting the MD's patient care helpful? We all benefit from team approach in medical care and PAs are trained to ask for help and involve the MD when needed. Please trust us to do this and help prevent provider burnout by removing antiquated rules that just don't make any sense when thoughtfully considered. Thank you for your consideration.	3/12/25 8:46 am CommentID:233014
Kristina	In Support	Please remove this antiquated language - it unnecessarily	3/12/25 2:49 pm

Kinsella, PA		increases everyone's workload without improving patient care.	CommentID:233016
Melissa Shaffron, DMSc, PA-C	Support of Removing the Requirement for Physician Review of Repeated Acute Complaints	As a practicing PA and PA Medicine program director, I strongly support the petition to remove the requirement that a patient care team physician must review the clinical course and treatment plan when a patient presents twice for the same acute complaint in a single episode of care. This requirement creates unnecessary administrative burdens without improving patient outcomes. PAs are highly trained, licensed professionals who evaluate, diagnose, and manage acute complaints within their scope of practice. Requiring a physician to review every repeated acute visit does not add clinical value but instead introduces delays, increases workload inefficiencies, and disrupts the continuity of care. Patients often return for follow-up due to the natural progression of illness or to assess treatment effectiveness. PAs are fully capable of managing these cases and determining when physician consultation is necessary based on clinical judgment —not outdated regulatory mandates. Many states have already recognized the autonomy of PAs in similar situations, streamlining care without compromising safety. Updating this regulation would allow PAs to focus more on patient care and less on redundant administrative requirements. It would improve workflow efficiency, reduce delays in treatment, and ultimately enhance the patient experience. I encourage the regulatory board to support this petition and help modernize healthcare delivery in Virginia.	3/13/25 3:42 pm CommentID:233021
Kathleen Scarbalis PA-C	Support regulatory action	*I support the proposed regulatory change to language regarding physician/PA appropriate consultation rather than required review after the same complaint twice.* *PAs provide professional, team-based medical care. When a consultation or referral is needed, it will be sought, if the patient is there for the first, second or third visit. As a team member, the PA will assess the patient and provide the best care, including consultation as needed. The second visit rule is too restrictive.* *There are many patients that may require an expected second, or subsequent, visit with the same complaint. I work in pediatrics. I do not often prescribe medication for the initial visit runny nose and cough and recommend follow up-for the 'same acute complaint' if there is not improvement. Then the patient returns with the same complaint in three weeks. Do I need to have this case reviewed by a physician when seeing this patient? Right now, by regulation, I do. Is this a waste of time and resources for the physician? Absolutely! Does this patient truly need to be seen by a physician? Not likely, but if I thought they did, I would for best patient care.* *PAs will make the best use of time for their time, the physician and the patient.*	3/16/25 1:22 pm CommentID:233216
Bobby	Support	Physician Assistants practice collaboratively with physicians	3/17/25 6:14 pm

Cockram, DMSc PA-C	removing this language	just as physicians practice collaboratively with other physicians, meaning, the care team which consists of physicians, PAs, NPs, and other providers are all trained to seek assistance whenever needed. Access is a major issue for patients everywhere, including the commonwealth. Language like this creates additional access issues that patients should not be subject to. We should be doing everything we can to increase access and not place requirements like this in the way of providing care. There is absolutely no data to suggest this provides any safer care, in fact, there are many studies that show PAs provide care that is at least equal to the quality of care that is provided by our physician colleagues.	CommentID:233263
Dara Wotherspoon, PA-C	Support Changes	Support proposed change to patient care team review requirements	3/18/25 8:12 pm CommentID:233277
Mark Ford	Unneeded regulation	Good morning, Please remove requirement/legislation that requires physicians on the care team to review patient/chart after 2 visits. It is not helpful and does not improve patient care. Patient care teams coordinated consistently after one , two or five visits. Regulations like this become simply "sign offs" and check a box for rules and regulations. Let the providers treat the patient not treat the chart. Even with my 26 years of experience, my teams coordinate care on multiple fronts and multiple times. Help us to clean up the regulations to allow for our time to be spent with the patient. Thank you Mark Ford	3/21/25 7:56 am CommentID:233287
Olushola Ilogho, PA-C	Support to remove language	PAs receive rigorous training, and having this language in the law unnecessarily restricts patient access to care. The practice of medicine is a collaborative effort, and PAs know when to seek input, much like other healthcare providers do when consulting one another. I fully support eliminating the requirement for a physician to review the clinical course and treatment plan when a patient presents with the same acute complaint twice within a single episode of care.	3/23/25 6:07 pm CommentID:233300
Christie L Meek	Support to remove language	Good evening, As an experienced PA, I ask that you remove the language requiring MD evaluation after repeated complaints and no improvement. We already collaborate and utilize colleagues to consult on our patients and having such wording creates unneeded hardship for patient care.	3/23/25 7:44 pm CommentID:233303
Tara Villano	Support removal of unnecessary and burdensome regulation	I am writing to support this legislation to improve the patient care process by removing unnecessary and burdensome regulations for Physician assistant practice. PA's have proven more than competent to manage their patient's care plan under such circumstances as this regulation addresses. When patient's access to care increases by streamlining processes and removing unnecessary burdens, all the people of Virginia benefit.	3/24/25 10:43 am CommentID:233306

Nicole Lando, MSHS, PA-C	I support removing this language	As a practicing PA in the acute care setting (ICU), this regulation is both unnecessary and will delay patient care. PAs are highly trained and skilled individuals who work collaboratively with physicians to provide comprehensive care to patients. They are qualified to assess, diagnose, treat, and manage a wide variety of medical conditions within the scope of their practice. The current requirement for physician oversight and signature on every treatment plan places unnecessary administrative burdens on both the physician and the PA, reducing the efficiency of care delivery and delaying timely treatment for patients. In my own practice caring for the sickest patients in the hospital, delivery of safe and effective patient care can be a matter of life and death. Amending this requirement will not only streamline workflows but will also empower PAs to practice to the full extent of their training, allowing them to make more immediate decisions that are in the best interest of patients while prioritizing patient safety.	3/24/25 11:48 pm CommentID:233309
Kimberly Gordon, PA-C	Support for regulatory change	I support removing this practice regulation. As PAs, we collaborate and utilize colleagues to offer our patients optimal care and having such wording creates unneeded hardship for patients. As a surgical PA, I am often much more readily available to manage postoperative concerns immediately and having such wording limits access to timely care.	3/25/25 10:48 am CommentID:233313
Max Doyle, PA-C	I support removing this requirement	I support removing this requirement, and reducing barriers to care and improving collaboration between PAs and physicians without increased logistic barriers	3/25/25 6:28 pm CommentID:233317
Meredith Dhillon Latitude Psych	Please remove this language	This is another barrier to care, PAs are skilled and knowlegeable providers and this slows down access to care.	4/7/25 10:59 am CommentID:233537
Bart Gillum	Romoval of Name of Physician	I support these proposed regulatory changes because they reflect the modern realities of PA practice and foster a more efficient, team-based approach to care. Removing outdated supervisory language aligns with current standards in many other states and empowers PAs to practice at the top of their license.	4/7/25 11:11 am CommentID:233540
Anonymous	Not in support	A patient who presents the second time deserves a physician to ensure nothing was missed and give a second opinion. Just the same as often for a second visit, even a primary care physicians might want a second opinion from a consultant. Patient care isn't about the ego of the provider- it is about giving the best patient care.	4/7/25 11:31 am CommentID:233543
Carolyn Herrera	I support this change	I support this change	4/7/25 4:47 pm CommentID:233553
Terry Carlisle PAC	Support to remove language	I support this language to remove restrictions on physician review	4/8/25 7:27 am CommentID:233558
Alison Moran	In support	I support this language to remove restrictions on physician review. It limits access to care and places unnecessary burdens on the healthcare team.	4/8/25 7:42 am CommentID:233560

Agenda Item: Consideration of Proposed Action for Removal of Patient Care Team Physician or Podiatrist from Prescriptions

Included in your Agenda Package:

- Draft language as approved by the PA advisory board; and
- Comments received on TownHall

Staff Note: These draft regulations were presented to the PA advisory board in June for consideration and recommended to the Board in their current form.

Action Needed:

- Motion to adopt proposed stage regulations for removal of patient care team physician or podiatrist from prescriptions.

Project 7655 - Proposed

Board of Medicine

Removal of patient care team physician or podiatrist name from prescriptions issued by physician assistants

18VAC85-50-160. Disclosure.

A. ~~Each prescription for a Schedule II through V drug shall bear the name of the patient care team physician or podiatrist and of the physician assistant.~~

~~B.~~ The physician assistant shall disclose to the patient that he is a licensed physician assistant, and also the name, address and telephone number of the patient care team physician or podiatrist. Such disclosure shall ~~either be included on the prescription or~~ be given in writing to the patient.

Action: Removal of patient care team physician or podiatrist name from prescriptions issued by physician assistants [6294 / 10087]

Commenter	Title	Comment	Date/ID
Josh Detrick	Support removal of physician name from controlled substance prescriptions	As a practicing surgical physician associate, I support the removal of the physicians name from controlled substance prescriptions. Many EMRs lack this capability and since it is required to transmit those ordered electronically this inherently causes some level of non compliance. Also, I question the utility as many PAs work at a different site from their physician. We have prescriptive authority to order the medications, what purpose does their name serve? We have our DEA on the prescription already. Please consider removing this antiquated process.	3/11/25 4:36 pm CommentID:233003
Evan Turnbull, UVA Health	Agree	This change would be immensely helpful. I have received calls from pharmacists from Walmart and CVS stating they need additional physician information in order to fill the prescription I wrote. The prescription includes the physician's name and NPI, but the computer program does not generate the DEA. While that is not required by law, and my prescription is otherwise compliant with current law, they will not proceed until they have the DEA. Removing the physician name requirement all together will help eliminate confusion and improve patient experience, not to mention reduce delays and additional time burden on the prescribing PA.	3/11/25 4:36 pm CommentID:233004
Erika Francis, Shenandoah University	Support of Petition to Remove Physician Name Requirement on Prescriptions	As the Interim Program Director of the Shenandoah University Physician Assistant (PA) Program, I strongly support the petition to remove the requirement that a patient care team physician's name be included on prescriptions for Schedule II-V medications. This change is a necessary step in recognizing the autonomous prescribing authority of PAs within the collaborative practice framework. PAs are rigorously trained medical professionals who provide high-quality patient care, and their ability to prescribe controlled substances is already regulated through state licensure, DEA registration, and collaborative practice agreements. Requiring a supervising physician's name on prescriptions does not enhance patient safety but rather creates administrative burdens that can delay care, contribute to confusion at the pharmacy, and misrepresent the prescribing provider's role in the patient's treatment plan. Removing this requirement aligns with best practices in other states and supports a more efficient and transparent healthcare system. I urge the Board of Medicine to approve this petition and modernize regulations to better reflect the evolving role of PAs in Virginia's healthcare workforce. Sincerely, Erika Francis, DMS, PA-C	3/11/25 5:44 pm CommentID:233006

		Interim Program Director Shenandoah University PA Program	
Samantha Buhler	Support of Action	As a licensed Physician Assistant in Virginia with an independent DEA registration, the removal of the requirement for including the supervising physician's or podiatrist's name on prescriptions for Schedule II-V controlled substances is a necessary and logical step. This adjustment reflects the professional accountability of PAs, as listing a physician's name does improve patient care but instead creates unnecessary administrative burdens.	3/11/25 5:44 pm CommentID:233007
Kim Ketchersid, VCU Health	Support in removing this barrier to care	Requiring a physician or podiatrists' name on scripts for controlled substances has caused patients to experience delays in having their pain medications filled. PAs hold their own DEA licenses, have completed the required pharmacology training, and have access to the Prescription Monitoring Program. Removing this requirement only increases access to care.	3/12/25 6:26 am CommentID:233009
Jerry Weniger, PhD, PA-C	Please change this obsolete regulation	As the Director of the PA Program at James Madison University, I strongly support the removal of the current requirement that a patient care team physician’s name be included on prescriptions for Schedule II-V medications. PAs already have prescriptive authority at the state level via licensure, are registered with the DEA federally, and have a practice agreement locally. Requiring a physician name on a script serves no meaningful purpose. On the contrary, the rule in fact delays patient care when pharmacists are made to contact PA prescribers when the physician’s name is missing, mostly due to incapable EMR systems. At best, this rule creates some level of unintentional non-compliance. And at worst, it is completely illogical and administratively burdensome. Sincerely, Jerry Weniger, PhD, PA-C Director, PA Program James Madison University	3/12/25 8:12 am CommentID:233011
Laura DeWitz PA-C	antiquated rule not benefitting patient care	Most PAs have been there, we are in clinic seeing patients when we get the call. The pharmacy needs you to resend the prescription with the collaborating physician's name on it. We must stop everything and either call the pharmacy or resend the prescription. This takes away from patient care and adds ONE MORE additional bureaucracy to our day. ONE MORE rule that does not make any sense or add benefit to patients. This rule wastes pharmacy's time and takes away from PA's time we could/should be spending with patients. It adds to burn out with PAs, clinic staff and pharmacy staff. Please tell me how this is value-added to the patient? Often times my prescription will make it onto the PMP in Virginia for my collaborating physician. The	3/12/25 8:33 am CommentID:233012

		MD/DO doesn't even know the patient, and now MY PATIENTS' controlled meds are falsely elevating the MDs' list of prescribed controlled meds. This is a liability. Perhaps this is another reason it can be hard to find collaborators in psychiatry; add that to the critical shortages of psychiatrists. Please help us rid these antiquated rules that hinder patient care and steal valuable time from providers.	
Kristina Kinsella	Support in Removing this antiquated rule that hinders care	Please remove this antiquated rule. All it does is hinder patient care and unnecessarily increase workload.	3/12/25 2:43 pm CommentID:233015
Olushola Ilogho, PA-C	Call to action.	I fully support the removal of physician name on schedule II-V drug prescriptions written by Virginia PAs. As highly trained medical professionals, PAs possess the expertise to safely and effectively prescribe these medications within their scope of practice. Eliminating this requirement will: 1. Enhance Efficiency and Patient Care 2. Expand Access to Care: PAs are essential healthcare providers, particularly in rural and underserved areas. This regulatory change will empower PAs to provide comprehensive care where physician shortages are present. 3. Reduce Administrative Burden: Removing this requirement will alleviate administrative workload, including pharmacy calls, allowing healthcare teams to focus more on patient care. 4. Reduce unnecessary emergency room visits.	3/12/25 11:28 pm CommentID:233017
Melissa Shaffron, DMSc, PA-C	Support of Petition to Remove the Physician Name Requirement on Schedule II-V Prescriptions	As a practicing PA and a PA Medicine program director, I strongly support the petition to remove the requirement that a patient care team physician’s name be included on prescriptions for Schedule II-V medications in Virginia. This outdated requirement places an unnecessary administrative burden on PAs and their collaborating physicians without providing any added benefit to patient safety or care quality. PAs are highly trained, licensed medical professionals who prescribe these medications within their scope of practice and in accordance with state and federal regulations. The current rule creates inefficiencies that can delay patient access to necessary medications and adds redundant documentation requirements that do not enhance oversight or accountability. Furthermore, this requirement does not align with the prescribing practices in many other states where PAs can prescribe independently within the bounds of their scope of practice. Removing this requirement would modernize Virginia’s approach, reducing administrative barriers and improving workflow efficiency while maintaining high	3/13/25 3:37 pm CommentID:233020

		standards of patient care. I urge the regulatory board to support this petition and remove this requirement, ensuring that PAs can continue to provide timely, effective, and patient-centered care without unnecessary administrative constraints.	
Amber Balzer	Support removing a barrier to adequate patient care	I support removing this barrier to patient care	3/14/25 2:31 am CommentID:233022
Grace Burman	Support this in order to reduce care barriers	As the healthcare field & scopes of practice change, it is important that legislation change with it in order to support patient-centered, accessible care.	3/14/25 10:30 pm CommentID:233086
Kathleen Scarbalis PA-C	Support regulatory action	*I support the proposed regulatory change to PA prescribing requirements.* *PAs have individual DEA license numbers. The PA prescribing is responsible, and educated. PAs have pharmacology training. PAs are trained, licensed and credentialed to appropriately prescribe in Virginia. Should a pharmacist or patient have questions regarding the prescription, the prescriber/PA is the best contact.* *PAs work in a variety of environments. Many EMRs prove difficult to navigate, Adding a note to the prescription with the collaborating physician can be cumbersome. This has created delays care for the patient if the pharmacy must be called, in my experience. Many hours on hold have been wasted waiting to speak with a pharmacist to clarify. Physicians have been contacted in lieu of the prescribing PA. PAs are capable and will provide excellent care.*	3/16/25 1:10 pm CommentID:233215
Anonymous	Removal of need for physician name on PA prescriptions	In today's day and time PA's practice in all fields of medicine and all states, so why do we still have this obsolete clause. This is unfair to PA's and their patients and creates unnecessary delays in patient care. PA's have their own DEA license (similar to NP's) and should not need any other physician's name / DEA to write any prescriptions which their DEA allows them to. PA's and NP's have the same scope of practice, however just because NP's have a bigger lobby, they are exempt from this while PA's are still required to have a physician name on a PA's prescription. PA's undergo more vigorous training and education than NP's, are held to much higher standards of certification maintenance than NPs , are licensed by Board of Medicine similar to physicians and despite that have to deal with these unfair regulations. It' s high time that these unfair regulations are put to an end.	3/16/25 9:04 pm CommentID:233241
Daniel Dollison PA-C	Support the Regulatory Action	I've been a PA for 30 years both in rural as well as urban settings. I feel we need to remove barriers to the most effective use of PA's. My home state of Nebraska fully removed the need for the supervising physician's name	3/16/25 9:09 pm CommentID:233242

		being added to PA prescriptions in 2020 via LB 755. Nebraska more progressive than Virginia?	
Anonymous	FNP in Support of Petition to Remove the Physician Name Requirement on Schedule II-V Prescriptions	As a Family Nurse Practitioner, I strongly support the petition to remove the requirement that a patient care team physician's name be included on prescriptions for Schedule II-V medications in Virginia. This outdated requirement places an unnecessary administrative burden on PAs and their collaborating physicians without providing any added benefit to patient safety or care quality. PAs are highly trained, licensed medical professionals who prescribe these medications within their scope of practice and in accordance with state and federal regulations. The current rule creates inefficiencies that can delay patient access to necessary medications and adds redundant documentation requirements that do not enhance oversight or accountability. Furthermore, this requirement does not align with the prescribing practices in many other states where PAs can prescribe independently within the bounds of their scope of practice. Removing this requirement would modernize Virginia's approach, reducing administrative barriers and improving workflow efficiency while maintaining high standards of patient care. I urge the regulatory board to support this petition and remove this requirement, ensuring that PAs can continue to provide timely, effective, and patient-centered care without unnecessary administrative constraints.	3/17/25 9:37 am CommentID:233254
Bobby Cockram, DMSc PA-C	Support removal of the need for physician name on controlled rx written by PAs	As a leader of approximately 1600 advanced practice providers across northern Virginia I have seen first-hand how the current language requiring a physician's name to be present on a controlled substance prescription by a PA has caused significant delay in care for patients, significant burden on physicians and PAs delivering care, and broad confusion among pharmacies, leading to their own interpretation of this language, further complicating patients filling prescriptions for needed medications. I have countless examples of how this language has delayed or prevented patients from receiving medications. Imagine a patient being discharged from the hospital after major surgery and being unable to pick up pain medications for a full day. Imagine a patient receiving cancer treatment being delayed in picking up much needed medications. These are 2 quick examples of real-world scenarios happening regularly across the commonwealth. This language needs to be removed right away and align our prescriptive requirements with our NP colleagues. This language has no benefit to patient care at all.	3/17/25 5:55 pm CommentID:233261
Anonymous	In support of removing requirement for	As a practicing PA of 12 years, I fully support the removal of the requirement to have a physician's name on prescriptions for controlled substances. It is illogical as we	3/18/25 2:16 pm CommentID:233272

	physician's name on controlled substances	already have a DEA number and ability to independently prescribe controlled substances, and it does nothing to improve patient care or access to care. It does, however, add administrative burden to an already overworked group of professionals who just want to care for our patients.	
Dara Wotherspoon, PA-C	Support Removal of Physician Name on Controlled Substance Prescriptions	In support of removing physician names from controlled substances.	3/18/25 8:11 pm CommentID:233276
Jared Ng, PA-C	Allow providers to practice to maximum of their licensure	Hello, I'm a PA practicing for nearly 10 years. I believe the current language within the Virginia physician assistant langugage requiring name to be on prescriptions is not necessary and provides a barrier to patient care and confusion. Nurse practitioners do not currently utilize these same regulations. Physician assistant function similarly as advanced practice providers. Medications and management of patients happen with the care of physicians.	3/19/25 4:13 pm CommentID:233279
Mark Ford	Remove restrictions	Good morning, Simply ask that you remove the unneeded MD name to prescriptions. It is cumbersome, stimulates call backs from pharmacies and just delays care for the patient. I have 26 years of experience and I am all for patient safety. This does not improve safety or patient care. Thank you Mark Ford, PA-C Fredericksburg, VA	3/21/25 7:49 am CommentID:233286
Jenna Rolfs	Support Removing Barriers in Order to Improve Access to Patient Care	Please support the removal of the physician name on schedule II-V drug prescriptions written by Virginia PAs. As highly trained medical professionals, PAs possess the expertise to safely and effectively prescribe these medications within their scope of practice. Eliminating this requirement will: 1. Enhance Efficiency and Patient Care 2. Expand Access to Care: PAs are essential healthcare providers, particularly in rural and underserved areas. This regulatory change will empower PAs to provide comprehensive care where physician shortages are present. 3. Reduce Administrative Burden: Removing this requirement will alleviate administrative workload, including pharmacy calls, allowing healthcare teams to focus more on patient care. 4. Reduce unnecessary emergency room visits.	3/23/25 5:54 pm CommentID:233299
Grace Allison Beers - Direct	Statement of support	Statement in Support of Removing the Requirement for a Collaborating Physician’s Name on Controlled Substance	3/23/25 7:30 pm CommentID:233301

Wellness RVA		Prescriptions **=30=** I am a Physician Assistant with 10 years of experience in both emergency medicine and primary care, and I have seen firsthand the delays and barriers caused by Virginia's outdated requirement for a collaborating physician's name to be included on controlled substance prescriptions. This antiquated rule leads to unnecessary pharmacy call-backs, confusion for patients, and delays in accessing essential medications. Nurse Practitioners in Virginia are not subject to this requirement, yet PAs function similarly as advanced practice providers. This discrepancy places an undue burden on PAs and creates unnecessary hurdles for patients who are already facing long wait times and increased healthcare costs due to provider shortages. As a PA serving my hometown community, I witness daily the impact of these regulatory barriers. Removing this outdated requirement will allow PAs to practice more efficiently, ensuring patients receive the care they need without unnecessary delays. I urge the state to modernize its regulations, eliminate unnecessary restrictions, and empower PAs to help address Virginia's healthcare access shortage.	
Christie Meek, PA-C	MD name on prescription	Good Evening, As providers approved by the DEA and trained in prescribing, please remove the requirement for MD name on the prescription. The DEA is the organization that confirms we have been adequately trained and gives us authorization to prescribe. Duplication isn't helpful, rather cumbersome. Sincerely, Christie L Meek, PA-C graduation 8/1993	3/23/25 7:40 pm CommentID:233302
Tara Villano, PA-C	Support removal of unnecessary and burdensome regulation	Hello, I am writing to support this legislation to improve the patient care process by removing unnecessary and burdensome regulation for Physician Assitant practice. PA's have proven more than competent to manage their patient's care plan under such circumstances as this regulation addresses. When patient's access to care	3/24/25 10:38 am CommentID:233305

		increases by streamling processes and removing unnecessary burden's, all the people of Virginia benefit.	
Nicole Lando, MSHS, PA-C	I support removing this regulatory language	As a critical care PA, I am a member of a large and interdisciplinary care team. Because of this, it is quite rare that I work with my designated supervising physician. I am always working collaboratively with attending physicians, but this changes every 12 hours based on the nature of my work and shift work in general. Adding the requirement for physician signature for controlled substances seems both redundant in the setting of my training and DEA certifications; it also adds confusion for pharmacies filling said prescriptions. The language should align with that of our NP colleagues, who do not have this proposed requirement when writing prescriptions.	3/24/25 11:53 pm CommentID:233310
Kimberly Gordon PA-C	Support for regulatory change	I support removal of the current requirement that a physician's name be included on prescriptions for Schedule II-V medications. PAs already have prescriptive authority at the state level and DEA via licensure. PAs undergo pharmacological education both during initial training and through ongoing CME. Requiring a physician name on a prescription serves no meaningful purpose and creates unnecessary administrative burden. In the scenario of EMR downtimes or network issues, it creates delays in patient care when pharmacists are made to contact PA prescribers when the physician's name is missing.	3/25/25 10:27 am CommentID:233312
Max Doyle, PA-C	I support removing this requirement	I support removing this requirement	3/25/25 6:25 pm CommentID:233316
Carolyn Herrera	I support removal of this requirement.	I am in support of the petition to remove this requirement and to increase access to care for patients by PAs.	3/28/25 6:00 pm CommentID:233333
Emily Frank	See below	I support removal of this requirement	3/29/25 1:59 pm CommentID:233356
Emory and Henry School of Health Sciences Masters in Physician Assistant Pr	COMMENT NO PRESCRIPTION REQUIREMENT	Physician Assistants are licensed and credentialed providers most of whom are also registered with the DEA for prescribing controlled substances. Physicians are not liable for prescriptions that PAs write so having physician's name on the prescriptions is an unnecessary administrative requirement.	4/7/25 10:49 am CommentID:233534
Meredith Dhillon	Please remove this barrier to care	Please remove the SP requirement for controlled substances. Its a barrier to care and causes issues with patients getting their script filled if missing. Pharmacies are always calling about it. Its not necessary if I pay all that money for my DEA.	4/7/25 10:53 am CommentID:233535

Aaron Horton PA-C	Statement of support	I support the petition to remove the requirement that a patient care team physician’s name be included on prescriptions for Schedule II-V medications in Virginia. This is an unnecessary administrative redundancy that doesn’t benefit patients or providers in any way.	4/7/25 10:55 am CommentID:233536
J. Barton Gillum,	Romoval of Name of Physician	I support these proposed regulatory changes because they reflect the modern realities of PA practice and foster a more efficient, team-based approach to care. Removing outdated supervisory language aligns with current standards in many other states and empowers PAs to practice at the top of their license.	4/7/25 11:08 am CommentID:233539
Terry Carlisle PAC	Removing physician name from prescription for controlled substances	I support this change of removing the physicians name	4/8/25 7:21 am CommentID:233557
Alison Moran	I support removal of this requirement	I am in support of removing the requirement for a physician signature on prescriptions. This is an unnecessary administrative burden and limits access to care. Let's make it easier for our patients to receive the care they need and for providers to give appropriate care!	4/8/25 7:37 am CommentID:233559
Tara Elkins, PA-C	I support this initiative🔲	I support this initiative.	4/8/25 10:02 pm CommentID:233577

Agenda Item: Consideration of Petition for Rulemaking

Included in your Agenda Package:

- Petition for Rulemaking (Grawert) in which the petitioner requests the Board amends regulations pertaining to buprenorphine prescriptions;
- Received public comments; and
- 18VAC85-21-150 and 18VAC85-21-160
- FDA Statement on Opioid Use Disorder Treatment

Staff Note: There were 66 comments left on TownHall and two additional comments sent to the Board. 65 comments were in support of the petition, while one did not provide a position.

Action Needed:

- Motion to either:
    - Accept the petition and initiate a NOIRA; or
    - Take no action on the petition, clearly stating why

COMMONWEALTH OF VIRGINIA
Board of Medicine

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4600 (Tel)
(804) 527-4426 (Fax)
Coco.Morton@dhp.virginia.gov

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)		
Grawert, Dr. Lauren H on behalf of the Virginia Society of Addiction Medicine (VASAM)		
Street Address	**Area Code and Telephone Number**	
805 N Daniel Street	864-506-0848	
City	**State**	**Zip Code**
Arlington	Virginia	22201
Email Address (optional)	**Fax (optional)**	
lauren.grawert@gmail.com		

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

   18VAC85-21-150 & 18VAC85-21-160

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

   18VAC85-21-150-I: We respectfully request removal of the requirement for "Documentation of the rationale for prescribed doses exceeding 24 mg of buprenorphine per day." The prevalence of high potency synthetic opioids like fentanyl now requires routine use of buprenorphine at doses higher than 24 mg daily.
   18VAC85-21-160-A: We respectfully request removing the restriction on "prescribing buprenorphine for addiction to patients under the age of 16 unless approved by the FDA." This is overly restrictive and limits clinicians' authority to provide individualized care for adolescents in Virginia with an imminent risk of lethal overdose.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

   The Virginia Board of Medicine has the authority to amend or repeal the regulations referenced above under VA54.1-2400 of the Code of Virginia, which grants substantitive authority, as well as VA2.2-400 (Administrative Process Act), which grants procedural authority. These sections collectively give the Board both the power and the process to legally revise the above referenced rules.

Signature: Lauren H Grawert, MD **Date:** May 2, 2025

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Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing Prescribing of Opioids and Buprenorphine [18 VAC 85 - 21]**

66 comments

All good comments for this forum Show Only Flagged

Next Back to List of Comments Page 1 of 2 50 comments per page go

Commenter: Lauren Grawert 6/2/25 9:13 am

Strongly in support of this proposed change

As a busy Addiction Psychiatrist in the NOVA area, I am strongly in support of this proposed change. I've personally had 5 patients under the age of 15 with opioid use disorder die of opioid overdose in the past 2 years. This would not have happenned if physicians were allowed to prescribe Suboxone to those under 15. Let's update the regulations and save more of our childrens' lives.

-Lauren Grawert, MD

CommentID: **236829**

Commenter: Jackson Grawert 6/2/25 9:24 am

please make these proposed changes to save teen lives

I've had several friends under the age of 16 die of opioid overdoses over the past few years in Virginia. Suboxone would have saved their lives. Please make these changes to protect future Virginia teens.

-Jackson G

CommentID: **236830**

Commenter: Anonymous 6/2/25 9:30 am

Strong support

I'm strongly in support of making these changes.

CommentID: **236831**

Commenter: Carrie Grassi 6/2/25 9:37 am

In support of saving lives

As a healthcare professional and advocate for evidence-based addiction treatment, I strongly support the petition to amend these regulations governing the prescribing of buprenorphine (Suboxone). The proposed changes would reduce unnecessary barriers to care and better align clinical practice with current scientific understanding of opioid use disorder (OUD). These changes are practical, patient-centered, and supported by leading medical organizations. I urge the Board to adopt them ***in the interest of saving lives*** and improving access to timely, individualized care.

Carrie Grassi, MSN, ANP, CARN-AP

CommentID: **236832**

Commenter: Greg Yarrow 6/2/25 9:48 am

Proposed Change in Current Regulations

I'm strongly in favor of the proposed changes! In makes sense and provides better patient care! Thank you!

CommentID: **236833**

Commenter: Keith Grawert 6/2/25 10:42 am

Strongly support these proposed changes.

These changes will save lives.

CommentID: **236834**

Commenter: Mary G McMasters 6/2/25 11:19 am

Buprenorphine prescribing

I strongly support the prescribing of buprenorphine (Suboxone) to patients age 16 and under.

CommentID: **236835**

Commenter: H Siddiqi 6/2/25 11:22 am

Buprenorphine access

As a psychiatrist that treats addictions, Buprenorphine is life saving, and we need to consider allowing it to those under the age of 16. There are real instances of opioid overdose and there are dangrously few options for middle and high school age adolescents who are very much at high risk given limited resources and lack of knowledge of how deadly these substances can be. We also need to think about the dosing of this not all people metabolize the same and the dose restrictions of 24mg may need to be reconsidered. I strongly support making these changes.

CommentID: **236836**

Commenter: Cayli C. 6/2/25 11:39 am

Strongly support expanding

I find it interesting and saddening that addiction indiscriminately affects all demographics and that we see children younger and younger losing their lives to substance use disorder, yet proven treatments are reserved for those above the age of 16. I firmly believe this should change.

CommentID: **236837**

Commenter: Stephanie Gum 6/2/25 11:47 am

Support for Regulatory Change to Expand Access to Buprenorphine

I've worked in the addiction field for 12 years and bring my own lived experience with opioid use disorder to the work I do every day. I've seen firsthand how critical timely access to treatment can be, especially for young people.

I fully support the proposed changes to the regulations governing the prescribing of buprenorphine (Suboxone). These updates would remove outdated barriers, align treatment practices with current medical evidence, and expand access to life-saving care for those who need it most, including adolescents.

This change isn't just about policy, it's about people. It's about families. And it's about protecting our children. I urge the Board to adopt these changes in the interest of saving lives and providing compassionate, evidence-based care to all who need it, regardless of age.

CommentID: **236838**

Commenter: Souhaila rtoubi 6/2/25 12:39 pm

I support this

I support this life changing decision to make access easier

CommentID: **236840**

Commenter: Imran Pasha 6/2/25 12:44 pm

Supporting these important changes

I am in strong support of making these changes.

CommentID: **236841**

Commenter: Bal K Sharma MDMS, MD Psychiatry Consultants 6/2/25 2:13 pm

Support for children to get Suboxone

I as a practicing Psychiatrist, very strongly support for these children on opiates to receive Suboxone , helping save children's lives and for them to help enjoy their daily living life very well . To save these children is very important, since children are a backbone for our country . So please help them , help them providing them with Suboxone, they deserve for the opiates treatment .

CommentID: **236843**

Commenter: Masaru Nishiaoki, MD, FASAM, Virginia Society of Addiction Medicine 6/2/25 4:58 pm

Strongly endorse proposed changes to regulations

As President of the Virginia Chapter of the American Society of Addiction Medicine (VASAM), I strongly endorse the evidence-based proposal to allow buprenorphine prescribing to minors under the age of 16 and remove burdensome documentation requirements to prescribe buprenorphine at daily doses higher than 24 mg.

CommentID: **236849**

Commenter: Gayle W. Highland 6/2/25 7:47 pm

Strongly in favor of changes

People are dying. Make changes fast!

CommentID: **236853**

Commenter: Jill Snauser, RN 6/2/25 7:50 pm

Yes make Changes/Update

This is urgent. People need help faster.

CommentID: **236854**

Commenter: Barbie Griffon, Public Health Official 6/2/25 7:53 pm

Yes, we need changes now!

People need affordable and quick options -- current system too slow to help.

CommentID: **236855**

Commenter: Aneta Brocato 6/2/25 7:56 pm

Needed changes to save lives!

I am strongly in support of these proposed changes which will undoubtedly save lives.

CommentID: **236856**

Commenter: Karla Bernard,Paramedic 6/2/25 7:58 pm

Supporting immediate changes

We need immediate, compassionate emergency care, now!

CommentID: **236857**

Commenter: Don Boggs 6/2/25 8:01 pm

Support in favor of Changes

We need a better way to get people emergency treatment ASAP -- yes to updating the outdated way.

CommentID: **236858**

Commenter: Lynn Potts 6/2/25 8:04 pm

Strongly supportive of changes

One life lost is a thousand too many. Let's hasten accessibility.

CommentID: **236859**

Commenter: Linda Chamblee 6/2/25 8:06 pm

Yes to changes

Strongly support changes in favor of helping more people get access to emergency care!

CommentID: **236860**

Commenter: Bill Carraway, Paramedic 6/2/25 8:09 pm

Supporting immediate changes as needed

Too much is at stake not to make emergency care user friendly.

CommentID: **236861**

Commenter: Jan Miller, Occupational Therapist 6/2/25 8:12 pm

Yes to Altering/Updating cHANGES

People in these circumstances need viable resources to emergency treatments.

CommentID: **236862**

Commenter: Sean B. 6/2/25 8:45 pm

I strongly support these changes! This is A THUNDEROUS CRUSADE for CHANGE! SIGN NOW, SHAPE DESTINY!

Reference comment subject.

CommentID: **236863**

Commenter: Tucker Wrenn, Aware Recovery Care 6/3/25 12:02 am

I support this!

I primarily work with young adults. I'm noticing a trend of kids earlier and earlier using substances such as cocaine and fentanyl. Having access to MAT is crucial for all patients seeking support. The goal is helping clients get in the door, and with substances literally killing people at a rapid pace we need policies like this to change in order to mitigate.

CommentID: **236866**

Commenter: Shannon Garrett, FNP-C, CARN-AP 6/3/25 12:53 pm

Support for the petition to amend 18VAC85-21-150 and 18VAC85-21-160

I support the petition to remove documentation requirements of the rationale for prescription of doses of buprenorphine which exceed 24 milligrams per day. We have seen in this era of high potency synthetic opioids that individuals clearly benefit from plasma concentrations of buprenorphine higher than what we are able to achieve with 24mg daily. We have long-term experience with this medication that reflects excellent safety profile. The higher plasma concentrations achieved with injectable buprenorphine as just as safe, and even more effective in reducing opioid agonist misuse. Individuals remain in treatment for sustained periods without developing tolerance for buprenorphine-naloxone. Most importantly, individuals who remain in treatment at therapeutic doses show success in recovery in well-rounded aspects of their lives.

I also support the petition to remove the provision of counseling services or referral for counseling services to all patients prescribed buprenorphine. I believe many individuals do benefit from licensed counseling services, however, not all want or need licensed counseling, and even those who gain benefit from those services will continue to benefit from medication treatment long after they have completed a typical duration of substance use related counseling. Counseling as a requirement in a program limits an individual's ability to transition between providers, or to establish with a community provider that might be more accessible to them. Medications for opioid use disorder are so effective that any barriers to treatment for individuals motivated to take them should be carefully considered, and wherever possible removed.

Finally, I also believe the Board should also remove the restriction on age-limit for prescription of buprenorphine. While we would like to wish that substance use disorders would only occur to older individuals, that is not reality. Providers, and individuals who need treatment, need the best tools available for managing substance use disorders. Buprenorphine has proven to be incredibly effective and safe in individuals 16 and older. Providers and individuals in need of treatment should be able to weigh the risks and benefits of that treatment in individual cases, not be prohibited from considering it by the Board.

CommentID: **236867**

Commenter: Rachel Kasperitis 6/3/25 4:10 pm

Important changes necessary!

Firmly advocate for expanding access to emergency care!

CommentID: **236869**

Commenter: Robert Glenn 6/3/25 4:25 pm

Highly recommended

The proposed regulatory changes are life saving. I am highly supportive of these changes.

CommentID: **236870**

Commenter: Dr. Jonathan Snipes, MD Psychiatrist 6/4/25 9:17 am

please make these proposed evidence based changes -they are very much needed

As a Psychiatrist, I've personally had several teen (15 year olds) patients experience serious opioid overdoses. They clinically need to be prescribed Suboxone, but I am unable to do so in Virginia until this regulation is changed. Additionally, prescribing Suboxone doses of 24 mg and above is now routine practice (not the exception to the rule) with stronger synthetic opioids. Additional documentation requirements is unnecessary, burdenson, and a barrier to care for busy physicians.

Please make both of these proposed evidence based changes to the regulations.

Respectfully,

Jon Snipes, MD

Psychiatrist

CommentID: **236872**

Commenter: Ryan Yarrow 6/6/25 7:43 am

Strongly Support Changes!

I am at a loss for why Virginia believes that children cannot become addicted to opioids. The notion that people under the age of 16 cannot suffer from the same addictions as someone over the age of 16 is starry-eyed and ignores the reality of the epidemic we are currently facing with opioids. If I'm being entirely honest, I believe the only reason Buprenorphine is restricted from this population is due to a biased phobia against products like Suboxone. Some medical professionals don't agree with the concept of how this medicine works, thus they try to slip in restrictions to vulnerable populations. But this phobia ignores the science and stats behind the medicine. Buprenorphine saves lives.

Children can become addicted to opioids. Why would we prevent a life-saving drug from being used on a child who is addicted to opioids? I cannot think of a single reason why this restriction would exist, and after reviewing the other comments, it's clear that no one else can think of a reason. A doctor should not have to risk their license to provide the appropriate medical treatment to a child. The current restrictions are wildly outdated, and they are an affront to the Hippocratic Oath.

CommentID: **236880**

Commenter: Lauren Hughes 6/6/25 8:38 am

Change needed now!

Drugs are killing our youth- and some are asking for treatment. Our providers should not have to choose between saving their client or losing their license because of antiquated regulations. Lower the age for people to receive buprenorphine so lives can start being transformed and saved.

CommentID: **236881**

Commenter: Patricia Bell 6/6/25 9:30 am

Don't let our kids keep dying

Please allow doctors to prescribe this life saving medication to our young people.

CommentID: **236882**

Commenter: MArk Horowitz Pharmacist 6/6/25 9:56 am

Make Buprenorphine available for children with substance use disorder

Getting rid of the X waiver was the first step in making buprenorphine available now get rid of the age restriction. We need to save lives!

CommentID: **236883**

Commenter: Gary Hughes 6/6/25 12:23 pm

Support for Petition

I am an adult living in Virginia. I strongly support the petition as published.

CommentID: **236884**

Commenter: AnneMoss Rogers 6/6/25 4:23 pm

Teens don't always have the maturity to do a recovery program without medicines

I am in favor of approving buprenorphine for teenagers with SUD.

My son died by suicide while going through heroin withdrawal in 2015. He was just 20 years old. I saw then how difficult it was for 15-25 year olds to stay in recovery, how few skills they had at that point in their lives.

In conversations I had with Dr. Peter Coleman, a respected recovery specialist now retired, he shared that while he didn't often prescribe buprenorphine long-term for adults, he made an exception for adolescents. Because the teenage brain is still developing, and teens often lack the maturity and life experience to fully engage in recovery, he saw long-term buprenorphine as a lifeline at least until they had more maturity. This was to keep them alive until they had time to grow, stabilize, and build the skills needed for a sustained recovery effort and program.

Lapses in recovery for young people can be not only discouraging and costly, but deadly. Medication-assisted treatment, including longer-term use of buprenorphine, can save the lives of teenagers.

CommentID: **236885**

Commenter: Anonymous 6/6/25 6:07 pm

Conversation between parents and teens

Teens must talk with their parents as to the danger of experimenting with drugs, whether in pill form, or any other form. This conversation should be ongoing.

CommentID: **236886**

Commenter: Dr. Linda Chamblee, School Counselor 6/8/25 1:49 am

Yes, we need changes now!

Middle and High School students need the same medical support as others being impacted by the opioid epidemic. Please make needed changes ASAP.

CommentID: **236887**

Commenter: Robin Alexander, First Responder (Fireman) 6/8/25 1:51 am

Supporting changes

First responders know the impact of emergency care to save lives of people old and young, regardless of age. Let's update emergency medical treatment so that all can be protected.

CommentID: **236888**

Commenter: Michael Sanders, Radiologist 6/8/25 1:56 am

Update and support changes

Medical professionals across the board are weary from the news of death from opioid overdoses, so it is time to make affordable care available to the people who need it -- quick access. We don't even have enough people trained in the U.S. to get care to everyone as it is. Telemedicine is the way to go. Age is not the issue -- death is the issue.

CommentID: **236889**

Commenter: David Saliny, Paramedic 6/8/25 2:01 am

Change and Upgrade Regulations ASAP

Even one teenage death from a person too young to officially qualify for this medicine in Virginia is unacceptable. The current descriptions for who can receive care are antiquated. Let's fix this now! Please.

CommentID: **236890**

Commenter: Paula Doolittle, RN 6/8/25 2:04 am

Supporting immediate changes for the better

It takes great determination to get the nerve and willpower to overcome addiction, and this is something that few middle schools or young high schoolers have. Please revise the regulations to support those too young to go it alone, without medicine.

CommentID: **236891**

Commenter: Johnna Hayes, Paramedic 6/8/25 2:08 am

Revise the Rules/Save Lives Now

There's not one reason why younger persons cannot have the same medical support as those who are considered adults. If our society is in such a bind that younger Americans can get the drugs that are killing them, then it is our moral obligation to put the medicine in their reach to overcome such a travesty. Please change the regulations ... soon!

CommentID: **236892**

Commenter: Ann Raughton, RN 6/8/25 2:14 am

Change the Age Limits, Broaden the Spectrum

With a society in crisis as drugs spiked with deadly consequences kill our children, we need greater access to emergency care for all. Make changes to accommodate the emergency.

CommentID: **236893**

Commenter: Sheryl Link, RN 6/8/25 2:17 am

Strongly in favor of changes

We need current access to reflect the crisis at hand. Please update regulations to reflect the depth of trouble that people who are addicted are in. Nobody chose to be an addict. People of all ages need a better, quicker, emergency support system.

CommentID: **236894**

Commenter: Dave Lindsay, Firefighter 6/8/25 2:23 am

First Responders in Favor of Change

The problem we face today is much broader and monstrous than the place our society was in when these regulations were enacted. We need greater access to people who can help -- but there are not enough medical professionals out there to allow all who need it to get help, not to mention the cost of medical care. Please make this care available to a broader section of society to lessen the burden on those who show up when it is too late.

CommentID: **236895**

Commenter: Donald Gassaway, M.D. 6/8/25 2:27 am

In Favor of Changes

Yes we need the changes. Everyone I speak to is worried about the situation and thinks it cannot get any worse, but it can. Upgrade and widen the circle of who can receive care. We all need to

know that getting help is for everyone... old, young, smart, not so smart, just everyone.
CommentID: **236896**

Commenter: Jen Coppinger 6/9/25 8:15 am

I'm in favor

I'm in favor of these changes

CommentID: **236897**

Commenter: Andrea Lake 6/9/25 1:52 pm

In favor

I am in favor.

CommentID: **236899**

Commenter: Kate Gibson, DNP, RN, CPRS 6/10/25 6:06 pm

I support this.

We cannot ignore the necessity prescribe to individual needs.

CommentID: **236901**

Virginia Chapter
Incorporated in Virginia
American Academy of Pediatrics

June 30, 2025

Erin Barrett
Director of Legislative and Regulatory Affairs
Department of Health Professions
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Re: Comments for Petition to Amend 18VAC85-21-150 and 18VAC85-21-160: Regulations Pertaining to Prescribing Buprenorphine

Dear Director Barrett:

On behalf of the Virginia Chapter of the American Academy of Pediatrics (VA-AAP), thank you for your leadership in promoting the safe and evidence-based practice of medicine in our state. Today, we write to comment on the recent petition to amend **18VAC85-21-150 and 18VAC85-21-160.**

To best care for children and adolescents in Virginia affected by the opioid crisis, we strongly support the following evidence-based recommendations proposed by the Virginia Society of Addiction Medicine (VASAM):

1. Remove the restriction on prescribing buprenorphine to patients younger than 16 years of age
2. Remove documentation requirements of the rationale for prescriptions of buprenorphine which exceed 24 mg per day
3. Remove provision of counseling services or provision of a referral for counseling services to the patient

Data from the Virginia Department of Health showed that from 2020-2024, **Virginia lost 39 children (under the age of 16) to an opioid overdose death**. This is still an underestimate, as data for 2024 is incomplete. From 2020-2023, there were over 500 pediatric emergency department (ED) visits per year related to an opioid or unspecified overdose for children under the age of 16. Furthermore, in 2024, the rate of opioid or unspecified overdose ED visits for adolescents 12-15 years old was 50/100,000 Virginia residents, making them the 2nd highest pediatric age group affected. This data still does not capture the negative health impacts for children who have adults and caretakers in their lives struggling with opioid use disorder.

§18VAC85-21-160 regulates treatment for special populations with opioid use disorder (OUD), and states that patients under 16 years old "shall not be prescribed buprenorphine for addiction treatment unless such treatment is approved by the FDA." The American Society of Addiction Medicine National

Practice Guideline (ASAM NPG) notes that there are no major safety concerns with buprenorphine in the treatment of OUD for adolescents younger than 16.[1] Several studies also note superiority of buprenorphine-containing treatment plans, in comparison to those without, for adolescents as young as 13 years of age.[2-3] Benefits included better retention in treatment and less opioid and injection drug use. Removal of this unnecessarily restrictive regulation would allow providers to offer individualized care to adolescents in need of medication for OUD.

While §18VAC85-21-150 highlights the importance of basing treatment dosages on a patient's opioid usage, it also places additional administrative burden for doses of buprenorphine exceeding 24 mg. The potency of synthetic opioids has increased significantly, leading to the need for higher doses of medication to address a patient's treatment needs. Providers should have the ability to adjust buprenorphine doses based on a patient's history and current needs without additional documentation barriers which may delay care or treatment coverage.

Lastly, §18VAC85-21-150 also requires that practitioners prescribing medication for OUD also incorporate counseling or document referral to a mental health service provider. While we strongly support concurrent mental health counseling for adolescents and adults with OUD, a patient's initial decline or inability to access counseling should not prevent or delay the start of pharmacotherapy. Allowing providers to meet patients where they are at can help decrease barriers to initiating care and promote trust, while affording providers the opportunity to encourage and navigate counseling services for their patients in the long-run.

As pediatric providers, our goal is to promote the health and well-being of all children. In summary, to continue to address the opioid crisis in Virginia, we support the petition brought forth by VASAM and their recommendations to limit barriers for adolescents and adults accessing evidence-based medication for opioid use disorder.

Sincerely,

Natasha Sriraman, MD
President
Virginia Chapter of the American Academy of Pediatrics

Virginia Society of Addiction Medicine
A Chapter of American Society of Addiction Medicine

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December 12, 2024

Erin Barrett
Director of Legislative and Regulatory Affairs
Department of Health Professions
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Re: Comments and Requested Revisions on Proposal to Amend 18VAC85-21: Regulations Governing Prescribing of Opioids and Buprenorphine

Dear Director Barrett:

On behalf of the Virginia Society of Addiction Medicine (VASAM), thank you for your important work to ensure that the practice of medicine is safe and regulated in our state. Today, we write to comment on the recent proposal to amend **18VAC85-21: Regulations Governing the Prescribing of Opioids and Buprenorphine.**

In brief, to most effectively combat the opioid crisis in Virginia with the latest evidence-based guidelines, we respectfully recommend:

1. Removing psychosocial interventions such as counseling as a requirement for MOUD prescribing

2. Removing additional documentation requirements for buprenorphine doses above 24 mg

3. Removing the restriction on prescribing buprenorphine to patients under 16

While the 18VAC85-21 updated proposal makes tangible improvements compared to the previous iteration, several sections are still out of alignment with clinical best practices in treating opioid use disorder (OUD) and can serve as a barrier to delivering life-saving evidence-based treatment. Specifically, sections restricting MOUD prescribing only to those receiving counseling, restricting the usage of high dosage buprenorphine, and restricting buprenorphine prescribing in adolescents under 16 years conflict with clinical best practice and should be revised.

The regulations for treating OUD with buprenorphine are set forth in Part IV of this section. Specifically, the regulation requires that practitioners engaged in prescribing MOUD also provide either counseling or refer patients to mental health counselors in the

area. While assessing a patient's psychosocial needs is an integral part of the treatment process, we are concerned that this strict requirement may be a barrier to care. Some patients may decline counseling, and some practitioners, especially those in rural or underserved areas, may not have access to readily available mental health counselors.[1] As such, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management. **As such, we urge the Board to revise this section to be in alignment with the Substance Abuse and Mental Health Service Administration's current recommendations that psychosocial interventions such as counseling are strongly encouraged but are not a required condition of treatment.**

Additionally, §18VAC85-21-150 set out further requirements for the treatment of OUD with buprenorphine, including daily dosing. The previous iteration of the regulation set a hard limit on buprenorphine prescriptions of greater than 24 mg per day. This current proposal improves upon that standard and allows for prescriptions of above 24 mg per day with a documented rationale. However, we still believe that requiring documentation for practitioners to prescribe above 24 mg is onerous. For many practitioners, facts on the ground have changed primarily due to the proliferation of high potency synthetic opioids—specifically fentanyl—within the drug supply. In turn, what used to be considered high dosages for stabilization is now standard practice in many cases. For example, the American Society of Addiction Medicine (ASAM) released updated clinical considerations for Buprenorphine Treatment of OUD for Individuals Using High-Potency Synthetic Opioids (HPSOs).[2] Crucially, the clinical considerations reference high quality studies showing improved treatment retention, reduced opioid use, and lack of adverse events at 16-32 mg doses of buprenorphine. These results are echoed by other recent studies of higher dose buprenorphine.[3] **As such, we urge that the dosing guidance be revised to reflect this reality and allow practitioners sufficient flexibility to prescribe at doses above 24 mg per day without additional documentation requirements.**

Finally, §18VAC85-21-160 regulates treatment for special populations with OUD, including adolescents under the age of 16. Specifically, the regulation states that patients under 16 'shall not be prescribed buprenorphine for addiction treatment unless such treatment is approved by the FDA.' This blanket prohibition of providing buprenorphine treatment to patients under 16 is overly restrictive and limits clinicians' authority to provide individualized care, including for adolescents with an imminent risk of overdose. Indeed, ASAM's National Practice Guideline (NPG) [4] stresses the importance of designing specified plans of care to meet each unique circumstance in treating adolescents and encourages clinicians to consider pharmacotherapy, including buprenorphine, as part of 'a full range of treatment options.' Further, ASAM's NPG notes that there are no major safety concerns with pharmacotherapy at a younger age than 16. **As such, VASAM strongly recommends that the Board remove the restriction on prescribing to patients under 16 to allow clinicians the flexibility to treat patients according to their specific needs, including allowing buprenorphine to be prescribed as practicable under federal/state law and sound clinical judgement.**

Thank you for the opportunity to share our comments and concerns regarding the proposed revisions to §18VAC85-21. As stated, we commend the Board for proposing improvements to the previous iteration of this section. However, we still see areas for change.

In summary, to best combat the opioid crisis in Virginia with the latest evidence-based guidelines, we respectfully recommend:

1. Removing counseling as a required component for MOUD prescribing
2. Removing additional documentation requirements for buprenorphine doses above 24 mg
3. Removing the restriction on prescribing buprenorphine to patients under 16

As treatment providers, our primary goal is to ensure that all Virginians can access high-quality treatment for OUD, and we hope to work together with the Board to achieve this goal. Please do not hesitate to contact us if you have any questions or concerns. We appreciate your consideration.

Sincerely,

Debra O'Beirne, MD, FASAM

Debra O'Beirne, MD, FASAM
President, Virginia Society of Addiction Medicine (VASAM)

CC: Dr. William L. Harp, Virginia Department of Health Professions
Fairfax - Falls Church Community Services Board
George Mason University Bridge Mason And Partners Clinic
National Capital Treatment & Recovery

[1] Fenstemaker, C., Abrams, E. A., Obringer, B., King, K., Dhanani, L. Y., & Franz, B. (2024). Primary care professionals' perspectives on tailoring buprenorphine training for rural practice. *The Journal of Rural Health*, *40*(4), 671–680. https://doi.org/10.1111/jrh.12832

[2] Weimer, M. B., Herring, A. A., Kawasaki, S. S., Meyer, M., Kleykamp, B. A., & Ramsey, K. S. (2023). ASAM Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-potency Synthetic Opioids. Journal of Addiction Medicine, 17(6), 632–639. https://doi.org/10.1097/adm.0000000000001202

[3] Chambers, L. C., Hallowell, B. D., Zullo, A. R., Paiva, T. J., Berk, J., Gaither, R., Hampson, A. J., Beaudoin, F. L., & Wightman, R. S. (2023). Buprenorphine Dose and Time to Discontinuation Among Patients With Opioid Use Disorder in the Era of Fentanyl. JAMA Network Open, 6(9). https://doi.org/10.1001/jamanetworkopen.2023.34540

[4] American Society of Addiction Medicine - ASAM. (2020). The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder: 2020 Focused Update. Journal of Addiction Medicine, 14(2S), 1–91. https://doi.org/10.1097/adm.0000000000000633

18VAC85-21-150. Treatment with buprenorphine for opioid use disorder.

A. Buprenorphine without naloxone (buprenorphine mono-product) shall not be prescribed except:

1. When a patient is pregnant;

2. When converting a patient from methadone or buprenorphine mono-product to buprenorphine containing naloxone for a period not to exceed seven days;

3. In formulations other than tablet form for indications approved by the FDA; or

4. For patients who have a demonstrated intolerance to naloxone; such prescriptions for the mono-product shall not exceed 3.0% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient's medical record.

B. Buprenorphine mono-product tablets may be administered directly to patients in federally licensed opioid treatment programs. With the exception of those conditions listed in subsection A of this section, only the buprenorphine product containing naloxone shall be prescribed or dispensed for use off site from the program.

C. The evidence for the decision to use buprenorphine mono-product shall be fully documented in the medical record.

D. Due to a higher risk of fatal overdose when buprenorphine is prescribed with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol (an atypical opioid), the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

E. Prior to starting medications for opioid use disorder, the practitioner shall perform a check of the Prescription Monitoring Program.

F. During the induction phase, dosage shall be based on the patient's history and current usage, including exposure to high-potency opioids. The patient shall be evaluated by the prescriber at least once a week.

G. During the stabilization phase, the prescriber shall increase the daily dosage of buprenorphine in safe and effective increments to achieve the lowest dose that avoids intoxication, withdrawal, or significant drug craving.

H. Practitioners shall take steps to reduce the chances of buprenorphine diversion and misuse by using the lowest effective dose, appropriate frequency of office visits, pill counts, and checks of the Prescription Monitoring Program. The practitioner shall also require urine drug screens or serum medication levels at least every three months for the first year of treatment and at least every six months thereafter.

I. Documentation of the rationale for prescribed doses exceeding 24 milligrams of buprenorphine per day shall be placed in the medical record.

J. The practitioner shall incorporate relapse prevention strategies into counseling or document referral to a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia.

18VAC85-21-160. Special populations in treatment for opioid use disorder.

A. Patients younger than 16 years of age shall not be prescribed buprenorphine for addiction treatment unless such treatment is approved by the FDA.

C. The progress of patients with chronic pain shall be assessed by reduction of pain and functional objectives that can be identified, quantified, and independently verified.

D. Practitioners shall (i) evaluate patients with medical comorbidities by history, physical exam, appropriate laboratory studies and (ii) be aware of interactions of buprenorphine with other prescribed medications.

Food & Drug Administration Releases Statement Today Regarding Opioid Use Disorder Treatment

July 8, 2025 - Washington, DC - In December 2024, the FDA published a **Federal Register notice** to encourage manufacturers of buprenorphine-containing transmucosal products for the treatment of opioid dependence (BTODs) to change their labels to empower clinicians to use their own judgment in determining the appropriate dose for patients, including doses higher than 24 mg/day. The manufacturers of Suboxone and Zubsolv then submitted updated labeling language, which the FDA approved in May 2025.

Until recently, the FDA-approved labeling for BTODs had stated “Doses higher than 24 mg daily have not been demonstrated to provide a clinical advantage,” and it referred to dosage of 16 mg as a “target dosage.” This was misinterpreted by some clinicians and insurers as establishing 16 or 24 mg/day as the maximum allowable dose of buprenorphine. The new language eliminates reference to a target dosage and clarifies that doses higher than 24 mg/day may be appropriate for some patients.

In recent years, prescribers, patients, and professional societies have expressed the concern that misperception that there was a maximum daily buprenorphine dose has limited access to this medication for patients who may benefit from higher doses, for instance because of a history taking high-potency synthetic opioids like fentanyl. The worry that higher doses may be inefficacious or unsafe has inhibited many providers from prescribing clinically sufficient doses and has led some insurance providers to limit coverage for BTODs and/or impose prior-authorization requirements that may delay a patient from getting their medication.

As you know, buprenorphine and other medications for opioid use disorder (MOUD) are critical tools for treating opioid use disorder and for addressing the overdose crisis that continues to claim more than 80,000 lives annually in the U.S. This change in buprenorphine labeling will encourage prescribers to use their own best judgment in determining the best dosages for their patients and encourage insurers to cover those dosages, thus enabling more patients to receive dosages of this medication that are appropriate to their individual therapeutic need.

For further information on the buprenorphine labeling changes and the FDA’s rationale, please see: **https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-changes-labeling-transmucosal-buprenorphine-products-indicated-treat-opioid-use**.

To review the newest labeling for the Suboxone and Zubsolv buprenorphine products, see: **https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm**.

Agenda Item: Consideration of Exempt Endorsement Regulatory Action for Behavior Analysts

Included in your Agenda Package:

- Draft changes to 18VAC85-150 as recommended by the BA advisory board

Staff Note: These draft changes were presented to the advisory board in June and recommended to the Board in their current form.

Action Needed:

- Motion to amend 18VAC85-150 by exempt action.

Part II
Requirements for Licensure as a Behavior Analyst or an Assistant Behavior Analyst

18VAC85-150-50. ~~Application~~ Initial licensure requirements.

An applicant for initial licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-150-40.

2. Verification of certification as required in 18VAC85-150-60.

3. Verification of practice as required on the application form.

4. If licensed or certified in any other jurisdiction, verification that there has been no disciplinary action taken or pending in that jurisdiction.

5. Verification from the BACB on disciplinary action taken or pending by that body.

18VAC85-150-51. Licensure by endorsement

An applicant for licensure by endorsement shall submit the following:

1. Evidence of a current, active license in a United States jurisdiction or Canada that is in good standing;
2. A completed application and fee;
3. Verification of certification as required om 18VAC85-150-60; and
4. A current report from the National Practitioner Data Bank

18VAC85-150-60. Licensure requirement.

An applicant for ~~a license~~ licensure to practice as a behavior analyst or an assistant behavior analyst shall hold current certification as a BCBA® or a BCaBA® obtained by meeting qualifications and passage of the examination required for certification as a BCBA® or a BCaBA® by the BACB.

Agenda Item: Consideration of Exempt Endorsement Regulatory Action for Genetic Counselors

Included in your Agenda Package:

- Draft changes to 18VAC85-170 as recommended by the BA advisory board

Staff Note: These draft changes were presented to the advisory board in June and recommended to the Board in their current form.

Action Needed:

- Motion to amend 18VAC85-170 by exempt action.

Part II. Requirements for Licensure as a Genetic Counselor.

18VAC85-170-50. ~~Application~~ Initial licensure requirements.

An applicant for initial licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-170-40.

2. Verification of a professional credential in genetic counseling as required in 18VAC85-170-60.

3. Verification of practice as required on the application form.

4. If licensed or certified in any other jurisdiction, documentation of any disciplinary action taken or pending in that jurisdiction.

18VAC85-170-51. Licensure by endorsement

An applicant for licensure by endorsement shall submit the following:

1. Evidence of a current, active license in a United States jurisdiction or Canada that is in good standing;
2. A completed application and fee;
3. Evidence of a current, valid certificate issued by the ABGC or ABMG to practice genetic counseling; and
4. A current report from the National Practitioner Data Bank

18VAC85-170-60. Licensure requirements.

A. An applicant for ~~a~~ an initial license to practice as a genetic counselor shall provide documentation of (i) a master's degree from a genetic counseling training program that is accredited by the Accreditation Council of Genetic Counseling and (ii) a current, valid certificate issued by the ABGC or ABMG to practice genetic counseling.

~~B. Pursuant to § 54.1-2957.19 D of the Code of Virginia, applicants for initial licensure who do not meet the requirements of subsection A of this section may be issued a license provided they (i) apply for licensure before December 31, 2018; (ii) comply with the board's regulations relating to the NSGC Code of Ethics; (iii) have at least 20 years of documented work experience practicing genetic counseling; (iv) submit two letters of recommendation, one from a genetic counselor and another from a physician; and (v) have completed, within the last five years, 25 hours of continuing education approved by the NSGC or the ABGC. For the purpose of this subsection, the board deems the provisions of Part IV (18VAC85-170-110 et seq.) of this chapter to be consistent with the NSGC Code of Ethics.~~

~~C.~~ B. An applicant for a temporary license shall provide documentation of having been granted the active candidate status by the ABGC. Such license shall expire 12 months from issuance or upon failure of the ABGC certification examination, whichever comes first.

Agenda Item: Consideration of Exempt Endorsement Regulatory Action for Occupational Therapists

Included in your Agenda Package:

- Draft changes to 18VAC85-80 as recommended by the BA advisory board

Staff Note: These draft changes were presented to the advisory board in June and recommended to the Board in their current form.

Action Needed:

- Motion to amend 18VAC85-80 by exempt action.

Part II. Requirements of Licensure as an Occupational Therapist.

18VAC85-80-30. (Repealed)

18VAC85-80-35. ~~Application~~ Initial licensure requirements.

An applicant for initial licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-80-26.

2. Verification of professional education in occupational therapy as required in 18VAC85-80-40.

3. Documentation of passage of the national examination as required in 18VAC85-80-50.

~~4. If licensed or certified in any other jurisdiction, verification that there has been no disciplinary action taken or pending in that jurisdiction.~~

18VAC85-80-36. Licensure by endorsement requirements.

An applicant for licensure by endorsement shall submit the following:

1. Evidence of a current, active license in a United States jurisdiction or Canada that is in good standing;
2. A completed application and fee;
3. Verification of a professional credential in occupational therapy as required in 18VAC85-80-40; and
4. A current report from the National Practitioner Data Bank

18VAC85-80-40. Educational requirements for initial licensure.

A. An applicant who has received his professional education in the United States, its possessions or territories, shall successfully complete all academic and fieldwork requirements of an accredited educational program as verified by the ACOTE.

B. An applicant who has received his professional education outside the United States, its possessions or territories, shall successfully complete all academic and clinical fieldwork requirements of a program approved by a member association of the World Federation of Occupational Therapists as verified by the candidate's occupational therapy program director and as required by the NBCOT and submit proof of proficiency in the English language by passing the Test of English as a Foreign Language (TOEFL) with a score acceptable to the board. TOEFL may be waived upon evidence of English proficiency.

C. An applicant who does not meet the educational requirements as prescribed in subsection A or B of this section but who has received certification by the NBCOT as an occupational therapist or an occupational therapy assistant shall be eligible for licensure in Virginia and shall provide the board verification of his education, training and work experience acceptable to the board.

~~**18VAC85-80-60. Practice requirements.**~~

~~An applicant who has been practicing occupational therapy in another jurisdiction and has met the requirements for licensure in Virginia shall provide evidence that he has engaged in the active practice of occupational therapy as defined in 18VAC85-80-10. If the applicant has not engaged in active practice as defined in 18VAC85-80-10, he shall serve a board-approved practice of 160 hours, which is to be completed within 60 consecutive days, under the supervision of a licensed occupational therapist.~~

Agenda Item: Consideration of Exempt Endorsement Regulatory Action for Polysomnographic Technologists

Included in your Agenda Package:

- Draft changes to 18VAC85-140

Staff Note: These draft changes were presented to the advisory board in June, however they did not have a quorum and were unable to recommend these changes to the Board. Their input was considered in the creation of this draft.

Action Needed:

- Motion to amend 18VAC85-140 by exempt action.

Part II
Requirements for Licensure as a Polysomnographic Technologist

18VAC85-140-50. ~~Application~~ Initial licensure requirements.

An applicant for initial licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-140-40.

2. Verification of a professional credential in polysomnographic technology as required in 18VAC85-140-60.

3. Verification of practice as required on the application form.

~~4. If licensed or certified in any other jurisdiction, documentation of any disciplinary action taken or pending in that jurisdiction.~~

18VAC85-140-51. Licensure by endorsement

An applicant for licensure by endorsement shall submit the following:

1. Evidence of a current, active license in a United States jurisdiction or Canada that is in good standing;
2. A completed application and fee;
3. Verification of a professional credential in polysomnographic technology as required in 18VAC85-140-40; and
4. A current report from the National Practitioner Data Bank

18VAC85-140-60. Licensure requirements.

A. An applicant for ~~a license~~ initial licensure to practice as a polysomnographic technologist shall provide documentation of one of the following:

1. Current certification as a Registered Polysomnographic Technologist (RPSGT) by the Board of Registered Polysomnographic Technologists;

2. Documentation of the Sleep Disorders Specialist credential from the National Board of Respiratory Care (NBRC-SDS); or

3. A professional certification or credential approved by the board from an organization or entity that meets the accreditation standards of the Institute for Credentialing Excellence.

B. An applicant for licensure shall provide documentation of current certification in Basic Life Support for Health Care Providers with a hands-on practice training evaluation segment.

Next Meeting Date of the Executive Committee is

December 5, 2025

Please check your calendars and advise staff of any known conflicts that may affect your attendance.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher **within 30 days after completion of their trip"**. (CAPP Topic 20335, State Travel Regulations, p.7). Vouchers submitted after the 30-day deadline can not be approved.

In order for the agency to be in compliance with the travel regulations, please submit your request for today's meeting on or before

September 1, 2025