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Telehealth Prescribing of Schedule II Substances in New Jersey

A Policy Analysis of New Jersey P.L.2026, c.40 (A4852), Its Relationship to Federal DEA Telemedicine Rules, and the Evidence on Remote Prescribing of Stimulants and Opioids

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Executive Summary

The Assembly Committee Substitute for Assembly Bill No. 4852 became P.L.2026, c.40 when Governor Sherrill signed it on July 8, 2026 (P.L.2026, c.40; Office of the Governor of New Jersey 2026). The law amends N.J. Stat. Ann. § 45:1-62, subsection e, which sets when a Schedule II controlled dangerous substance may be prescribed through telemedicine or telehealth (P.L.2026, c.40). Before c.40, the statute allowed Schedule II prescribing by telemedicine only after an initial in-person examination, with in-person visits every three months afterward. The exception was stimulants prescribed to minors with parental consent (P.L.2017, c.117). The enacted law keeps this default. It adds exceptions for two patient groups and one medication category. The groups are patients in active cancer treatment, hospice, palliative care, or long-term care, and patients being evaluated or treated under the Medical Aid in Dying for the Terminally Ill Act. The medication category is any medication that treats a substance use disorder. For adults prescribed Schedule II stimulants, the law allows a telehealth initial examination followed by an in-person visit within 30 days and at least annually. It requires real-time audio-video technology for all Schedule II telemedicine prescribing (P.L.2026, c.40).

The bill was introduced on May 4, 2026, after New Jersey's COVID telemedicine waiver expired on February 16, 2026 (N.J. Div. of Consumer Affs., Admin. Order No. 2020-15; N.J. Exec. Order No. 415). Executive Order No. 13 extended parts of the State of Emergency to April 2, 2026 but did not extend the Schedule II waiver (N.J. Exec. Order No. 13; Simone et al. 2026a). The bill was introduced shortly before the Drug Control Unit's transitional period ended on May 16, 2026 (New Jersey Division of Consumer Affairs, Drug Control Unit 2026a). It passed the Assembly 76-2-1 and the Senate 38-2 (N.J. Legislature, Bill Detail: A4852). As introduced, A4852 would have eliminated the in-person examination requirement for Schedule II prescribing. The committee substitutes replaced that design with targeted exemptions (S. Health, Hum. Servs. & Senior Citizens Comm. Statement; Assemb. State & Loc. Gov't Comm. Statement).

Chapter 40 depends on federal law. A New Jersey provider who prescribes a Schedule II substance through telemedicine must comply with the federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008. That Act requires at least one in-person medical evaluation by the prescribing practitioner, or a prescription by a covering practitioner, before a controlled substance is prescribed over the internet. After that evaluation, remote prescribing is federally permitted (Ryan Haight Act, Pub. L. No. 110-425;

21 U.S.C. § 829(e)). The federal in-person requirement has been suspended since March 2020 under temporary COVID-19 flexibilities that end December 31, 2026 (90 Fed. Reg. 61301). The Drug Enforcement Administration sent a final special registration rule to the Office of Information and Regulatory Affairs on August 25, 2026 (National Association of State Controlled Substances Authorities 2026). The remote initiation that c.40 permits is therefore usable only while the federal flexibilities or a replacement rule allow it. Remote follow-up care for patients whom their prescriber has evaluated in person remains federally permitted after December 31, 2026 without further federal action. Subsection a has conditioned telemedicine on federal law since 2017, and paragraph (5) adds that the use of audio-video technology must be consistent with State and federal law (P.L.2017, c.117; P.L.2026, c.40). Whether paragraph (5) also makes State authorization of each prescription depend on federal law is contested (Section 2.5).

The evidence on the law is limited and indirect. It comes mainly from observational studies of COVID-era flexibilities for telehealth treatment of opioid use disorder with buprenorphine and for telehealth stimulant prescribing for ADHD. Those studies associate telehealth with equal or better treatment retention for opioid use disorder (Jones et al. 2022; Hammerslag et al. 2023) and, among Medicare beneficiaries, with lower odds of fatal and medically treated overdose (Jones et al. 2022; Jones et al. 2023). In adjusted analyses, telehealth stimulant prescribing did not increase overall substance use disorder risk (Rao et al. 2025). Buprenorphine is a Schedule III substance, so this literature does not cover c.40's Schedule II exemption (90 Fed. Reg. 6504). No evidence exists on telehealth outcomes for Schedule II opioids prescribed for pain. A documented search found no peer-reviewed study of other states' in-person requirements for telehealth prescribing of controlled substances (Sections 1 and 6.7).

The open questions concern implementation and federal alignment. They include what "contact" means in the adult stimulant pathway; whether adults in the exempt categories who receive stimulants remain subject to that pathway, which the Drug Control Unit's guidance indicates they do for the patient categories, though no rule or court has settled it; who must conduct its in-person visits; how exemption eligibility is documented; whether the Board of Medical Examiners and other licensing boards will propose rules under subsection i; how the Drug Control Unit will revise its August 3, 2026 guidance (New Jersey Division of Consumer Affairs, Drug Control Unit 2026b) for federal compliance; and what the DEA final rule will require. Section 9 lists these as monitoring indicators.

KEY FINDINGS

P.L.2026, c.40 keeps New Jersey's default in-person requirement for Schedule II telemedicine prescribing and adds targeted exceptions. The introduced bill would have eliminated the in-person examination requirement (Assemb. B. 4852, as introduced). The enacted text keeps paragraph (1) of subsection e and adds exemptions in paragraph (3) and a separate adult stimulant pathway in paragraph (4) (P.L.2026, c.40). (Documented)

For adults prescribed Schedule II stimulants, the law relaxes the default rule. The initial examination may be conducted by telehealth, followed by an in-person visit within 30 days, contact every three months, and an in-person visit at least annually. Before c.40, these patients needed an in-person examination first and an in-person visit every three months (P.L.2017, c.117). The pathway covers any Schedule II stimulant prescribed to an adult, for any indication (P.L.2026, c.40). (Documented)

The law's operation depends on federal law that is changing. Federal telemedicine flexibilities expire December 31, 2026. The DEA special registration final rule remained under OIRA review as of October 27, 2026, and its text is not public (90 Fed. Reg. 61301; National Association of State Controlled Substances Authorities 2026; Office of Information and Regulatory Affairs 2026). (Documented) If the flexibilities lapse without replacement, remote initiation would end. Remote care for patients whom their prescriber has evaluated in person would remain federally permitted (Section 4.5). (Projected)

Evidence on the law is limited and indirect. Observational studies of COVID-era flexibilities associate telehealth with better retention (Jones et al. 2022; Hammerslag et al. 2023) and lower overdose risk (Jones et al. 2022; Jones et al. 2023) in opioid use disorder treatment, almost always with buprenorphine, a Schedule III drug. They also show no increase in overall substance use disorder risk after telehealth stimulant initiation (Rao et al. 2025). None of the studies is from New Jersey, and none examines a 30-day in-person requirement. (Documented for the populations studied; Projected for c.40) One study reports elevated stimulant use disorder risk after telehealth initiation, with a very wide confidence interval (Rao et al. 2025). (Contested) A

documented search found no peer-reviewed study of other states' in-person requirements for telehealth prescribing of controlled substances (Section 1). (Documented)

No fiscal estimate from the Office of Legislative Services was located on the bill record, and no New Jersey-specific cost information exists. Cost claims in this report are projected and qualitative. (Projected)

The statutory text leaves ambiguities for the boards, the Drug Control Unit, or courts to resolve. They include the meaning of "contact" in paragraph (4); whether adults in the paragraph (3) categories who receive a stimulant remain subject to paragraph (4) (the DCU notice indicates that those in the paragraph (3)(a) and (b) categories do); who must conduct the paragraph (4) in-person visit; how paragraph (3) eligibility is documented; the reach of paragraph (5)'s reference to federal law and its interaction with the minor stimulant exemption in paragraph (2); and the DCU notice's use of "examination" where the statute says "visit" (P.L.2026, c.40; New Jersey Division of Consumer Affairs, Drug Control Unit 2026b). Section 2.8 describes each. (Documented)

I. Introduction, Scope, and Method

New Jersey's telemedicine statute, P.L.2017, c.117 (N.J. Stat. Ann. § 45:1-61 et seq.), has restricted telemedicine prescribing of Schedule II controlled dangerous substances since it was enacted (P.L.2017, c.117). During the COVID-19 public health emergency, the Division of Consumer Affairs waived that restriction through Administrative Order No. 2020-15 and Waiver No. W-2020-14, issued August 11, 2020 (N.J. Div. of Consumer Affs., Admin. Order No. 2020-15). Executive Order No. 415, signed January 16, 2026 (N.J. Exec. Order No. 415), set the end of the remaining COVID-era administrative flexibilities, and the DCA waiver expired on February 16, 2026. Executive Order No. 13, signed by Governor Sherrill on February 13, 2026, extended parts of the State of Emergency to April 2, 2026. The extension concerned scope-of-practice and supervision waivers for advanced practice nurses and physician assistants. The Governor's announcement did not mention telemedicine or controlled substances (N.J. Exec. Order No. 13). Practitioner guidance issued after Executive Order No. 13 treated the Schedule II waiver as expired on February 16 (Simone et al. 2026a). The Drug Control Unit's guidance after the expiration allowed a transitional period until May 16, 2026, during which prescribers and patients who had established care under the waiver could arrange in-person visits (New Jersey Division of Consumer Affairs, Drug Control Unit 2026a; Simone et al. 2026a). A4852 was introduced on May 4, 2026 and became law on July 8, 2026 (Assemb. B. 4852, as introduced; P.L.2026, c.40).

Agard Research Associates Inc. (ARA) is a nonpartisan institute. This analysis neither supports nor opposes P.L.2026, c.40. Where the report presents evidence bearing on its likely effects, it presents the stated purposes of its supporters and the concerns raised by its critics with equal care, and it identifies the institutional perspective of data sources where relevant.

This report analyzes c.40 using the ARA Policy Analysis Series' institutional design framework. It examines who bears the law's duties and costs and who holds discretion under it.

Section 2 reviews the amended statute paragraph by paragraph and identifies ambiguities. Section 3 traces enactment from the introduced repeal to the enacted exemptions. Section 4 covers federal law: the Ryan Haight Act, the temporary COVID flexibilities, the January 2025 rules, the pending special registration final rule, and the federal enforcement record. Section 5 covers the fiscal record and who bears costs.

Section 6 reviews the evidence. Section 7 analyzes impacts by affected party. Section 8 applies the ARA framework. Section 9 concludes and lists the indicators ARA will monitor.

METHOD AND SOURCING

Section 2 uses the enacted text of the Assembly Committee Substitute for A4852 as published in P.L.2026, c.40 (P.L.2026, c.40; Assemb. Comm. Substitute for Assemb. B. 4852), and the introduced text of A4852 for comparison (Assemb. B. 4852, as introduced). Section 2.3 also draws on the Medical Aid in Dying for the Terminally Ill Act, P.L.2019, c.59, and the State's 2024 data summary under it (P.L.2019, c.59; New Jersey Office of the Chief State Medical Examiner n.d.).

Section 3 uses the bills; the Senate Health, Human Services and Senior Citizens Committee Statement of June 11, 2026; the Assembly State and Local Government Committee Statement of June 23, 2026; the Governor's July 8, 2026 press release and July 9, 2026 public post; a July 15, 2026 release from legislators; Executive Orders No. 415 and No. 13; and the legislative record of votes (S. Health, Hum. Servs. & Senior Citizens Comm. Statement; Assemb. State & Loc. Gov't Comm. Statement; Office of the Governor of New Jersey 2026; Sherrill 2026; New Jersey Assembly Democrats 2026; N.J. Exec. Order No. 415; N.J. Exec. Order No. 13; N.J. Legislature, Bill Detail: A4852).

Section 4 uses the Ryan Haight Act and its codified definitions; the Federal Register documents for the fourth temporary extension (December 31, 2025), the special registration proposal (January 17, 2025), and the buprenorphine and VA final rules (January 17, 2025) and the notice delaying their effective date (March 24, 2025); the opioid treatment program rules; the DEA press release of December 31, 2025; the National Association of State Controlled Substances Authorities notice on the OIRA submission (September 18, 2026); OIRA's review record for the final rule; and the Department of Justice primary records for the Done Global and Cerebral criminal cases (Ryan Haight Act, Pub. L. No. 110-425; 21 U.S.C. § 829(e); 90 Fed. Reg. 6504; 90 Fed. Reg. 6523; 90 Fed. Reg. 13410; 90 Fed. Reg. 61301; 90 Fed. Reg. 6541; 21 C.F.R. § 1306.07; 89 Fed. Reg. 7528; U.S. Drug Enforcement Administration 2025; National Association of State Controlled Substances Authorities 2026; Office of Information and Regulatory Affairs 2026; Press Release, U.S. Dep't of Just. (Nov. 19, 2025); Press Release, U.S. Dep't of Just. (July 7, 2026); Non-Prosecution Agreement with Cerebral, Inc.).

Section 6 uses peer-reviewed studies published in JAMA Psychiatry, JAMA Network Open, JAMA Health Forum, Psychiatric Services, Health Affairs, the American Journal of Psychiatry, the Journal of

General Internal Medicine, and the Journal of Medical Internet Research, and the joint DEA and FDA letter on stimulant shortages (Jones et al. 2022; Jones et al. 2023; Hammerslag et al. 2023; Huskamp et al. 2024; Nagappan et al. 2024; Stein et al. 2025; Creedon et al. 2025; Rao et al. 2025; Myran et al. 2025; Monico et al. 2026; Sousa et al. 2026; U.S. Drug Enforcement Administration and U.S. Food and Drug Administration 2023).

State administrative guidance comes from the Drug Control Unit's guidance after the waiver expired and its notice of August 3, 2026 (New Jersey Division of Consumer Affairs, Drug Control Unit 2026a; New Jersey Division of Consumer Affairs, Drug Control Unit 2026b). Comparisons to other states' online prescribing laws come from the Center for Connected Health Policy's tracker (Center for Connected Health Policy 2026). Press and practitioner coverage comes from Roman (2026), Simone et al. (2026a), and Simone et al. (2026b).

Search for studies of analogous policies. Because c.40 took effect on July 8, 2026, no study of the law itself was expected. A supplementary search looked for peer-reviewed empirical studies of analogous policies, mainly other states' requirements for an in-person examination or periodic in-person visits as a condition of telehealth prescribing of controlled substances. A study qualified if it estimated the association between such a state rule and access, prescribing, follow-up, diversion, or patient outcomes. The search was conducted on October 21, 2026 and covered publications from January 2018 through October 2026. It had four steps. First, the reference lists of Huskamp et al. (2024), Creedon et al. (2025), Rao et al. (2025), and Hammerslag et al. (2023) were sought. Second, articles citing each of the four were sought. Third, the Center for Connected Health Policy's online prescribing tracker was reviewed to identify states with comparable in-person rules (Center for Connected Health Policy 2026). Fourth, general web searches and publisher sites (JAMA Network, PsychiatryOnline, Springer, Journal of Medical Internet Research, RAND) were searched with combinations of the terms "in-person examination," "in-person requirement," "in-person visit," telehealth, telemedicine, "controlled substance," "Schedule II," stimulant, buprenorphine, "state law," "state policy," evaluation, outcomes, and "difference-in-differences." Results appear under Materials Not Obtained below and in Section 6.7.

Citations follow the American Political Science Association's Style Manual for Political Science (Revised 2018 Edition) for in-text and reference entries, with legal authorities cited in Bluebook form (22nd ed. 2025) and New Jersey session laws cited in the State's own form.

EVIDENCE TIERS

Every impact claim in this report carries one of three tiers. Documented means a primary record establishes the claim: statutory text, an official statement, published data, or peer-reviewed research. Contested means credible sources dispute the claim or the evidence supports opposing claims, and the report presents each position. Projected means the claim is a reasonable expectation based on evidence from other settings or from the law itself and has not been observed in New Jersey.

MATERIALS NOT OBTAINED

Several materials were sought and not obtained while drafting. No fiscal estimate from the Office of Legislative Services was located on the bill record (N.J. Legislature, Bill Detail: A4852). No published position from a New Jersey medical, psychiatric, pharmacy, or hospital organization on A4852 was located. Committee hearing testimony was not obtained. The text of the DEA special registration final rule is not public. The text of the Drug Control Unit's February 13, 2026 communication and of its later modified guidance setting the May 16, 2026 transitional period was not obtained directly, and this report relies on the description in Simone et al. (2026a). The complete reference lists of Huskamp et al. (2024), Creedon et al. (2025), and Rao et al. (2025), Google Scholar citation data, and PubMed and Europe PMC search results were not obtained (see Method and Sourcing above). The search for analogous-policy studies found no peer-reviewed study estimating the effect of another state's in-person requirement for telehealth prescribing of controlled substances. This null result is a finding of this report and is discussed in Section 6.7.

A NOTE ON STATUS

P.L.2026, c.40 is enacted and binding. It was approved on July 8, 2026 and took effect immediately (P.L.2026, c.40). The Drug Control Unit's August 3, 2026 notice is guidance and does not bind a board or court (New Jersey Division of Consumer Affairs, Drug Control Unit 2026b), and no board rule under subsection i was located. At the federal level, the temporary telemedicine flexibilities are in effect through December 31, 2026 (90 Fed. Reg. 61301), and the DEA's special registration final rule is pending review at the Office of Information and Regulatory Affairs, which received it on August 25, 2026 (Office of Information and Regulatory Affairs 2026). All statements of status in this report are current as of October 27, 2026.

2. What the Law Requires

2.1 Statutory Architecture and Definitions

P.L.2017, c.117 allows a licensed provider who has established a proper provider-patient relationship to deliver care through telemedicine and to use telehealth to support that care (P.L.2017, c.117). Subsection a grants that permission "[u]nless specifically prohibited or limited by federal or State law," so the statute has conditioned telemedicine on federal law since 2017. Providers must be licensed in New Jersey, remain subject to New Jersey regulation, and meet the same standard of care that applies to in-person care. Subsection e governs Schedule II substances. Subsection i directs each licensing board to adopt implementing rules and bars rules that require an initial in-person visit as a condition of telemedicine services generally.

Section 1 of c.40 rewrites subsection e and reprints the rest of the section unchanged. Section 2 makes the act effective immediately (P.L.2026, c.40).

2.2 The Retained Default Rule

Paragraph (1) keeps the prior rule but opens with "[e]xcept as otherwise provided in this subsection." A Schedule II substance may be prescribed through telemedicine only after an in-person examination "as provided by regulation," and the patient must be seen in person every three months for as long as the prescription continues.

Paragraph (2) keeps the minor-stimulant exception. No in-person examination is required when a provider prescribes a Schedule II stimulant to a patient under 18 with written consent from a parent or guardian. Prior law also required audio-video technology for this exception (P.L.2017, c.117). C.40 removes that condition from paragraph (2) and moves it to paragraph (5), where it applies to all Schedule II telemedicine prescribing.

2.3 Exemption Categories

Paragraph (3) exempts the following from paragraph (1): (a) patients in active cancer treatment, receiving hospice care from a licensed hospice or palliative care, or residing in a long-term care facility; (b) patients

being evaluated, consulted, or treated under the Medical Aid in Dying for the Terminally Ill Act (P.L.2019, c.59); and (c) any medication prescribed to treat a substance use disorder.

Subparagraphs (a) and (b) depend on the patient's status, and (c) depends on the purpose of the medication. The statute does not define "active treatment for cancer," "palliative care," or "long-term care facility," and does not say how a prescriber documents eligibility. Paragraph (3) relieves its patients of paragraph (1) only. Section 2.8 discusses whether it also relieves them of paragraph (4).

Paragraph (3)(b) and medical aid in dying. P.L.2019, c.59 permits a mentally capable adult New Jersey resident with a terminal disease expected to cause death within six months to obtain medication to end their life. The patient must make two oral requests at least 15 days apart and a written request signed before two qualified witnesses, and two physicians must confirm the diagnosis, prognosis, and capacity (P.L.2019, c.59). Aid-in-dying medications commonly include Schedule II substances. Every medication combination reported for New Jersey's 122 participating patients in 2024 included morphine, a Schedule II substance (New Jersey Office of the Chief State Medical Examiner n.d.). (Documented) Paragraph (3)(b) reaches patients "undergoing evaluation, consultation, or treatment related to" the Act. It therefore covers the evaluation stage as well as the prescription, and it covers patients who are not enrolled in hospice and would not qualify under subparagraph (a). Like the other exemptions, it removes only paragraph (1), and paragraph (5) and federal law still apply. The Ryan Haight Act has no exception for aid-in-dying prescriptions, so after the federal flexibilities end, a remote aid-in-dying prescription for a controlled substance would require a prior in-person evaluation by the prescriber or a covering practitioner (Section 4.2). The Supreme Court held that the Controlled Substances Act did not authorize the Attorney General to bar physicians from prescribing controlled substances under a state aid-in-dying law (Gonzales v. Oregon). That holding does not displace the Ryan Haight Act's in-person requirement. The statute does not say how a prescriber documents that a telemedicine encounter is "related to" the Act.

Paragraph (3)(c) and methadone. Methadone is the main Schedule II medication for substance use disorder. When it treats opioid use disorder, opioid treatment program rules largely govern it, and the program dispenses it rather than prescribing it for pharmacy fill (21 C.F.R. § 1306.07; 89 Fed. Reg. 7528). Because paragraph (3)(c) applies to medications "being prescribed," its reach over methadone treatment is limited. Section 4.4 discusses the federal rules.

2.4 The Adult Stimulant Pathway

Paragraph (4) sets separate rules for Schedule II stimulants prescribed to adults. The initial examination may be "conducted in-person or by using telehealth or telemedicine, as provided by regulation." If it is done remotely, an in-person visit is required within 30 days. After that, "[a] subsequent in-person visit or telehealth or telemedicine contact" is required every three months, and an in-person visit is required at least once a year.

Under paragraphs (1) and (2), a minor may be prescribed a Schedule II stimulant with no in-person examination if a parent consents. Under paragraph (4), an adult may start a stimulant remotely but must be seen in person within 30 days and yearly after that. Any other Schedule II substance for a patient outside paragraph (3) follows the default rule.

The pathway covers any Schedule II stimulant prescribed to an adult for any indication, including narcolepsy. S4210 as introduced would have limited its pathway to ADHD (S.B. 4210).

2.5 The Audio-Video Requirement, the Standard of Care, and Federal Law

Paragraph (5) reads in full: "Notwithstanding any provision of this subsection to the contrary, the prescription of Schedule II controlled dangerous substances to a patient through the use of telemedicine or telehealth shall be authorized only when the prescribing health care provider is using interactive, real-time, two-way audio and visual technologies when treating the patient and the use of such technologies is consistent with State and federal law, including without limitation that the provider meets the same standard of care or practice standards as are applicable to in-person settings" (P.L.2026, c.40).

The paragraph sets two conditions. The provider must use real-time audio-video technology when treating the patient, and the use of that technology must be consistent with State and federal law, which the text says includes meeting the in-person standard of care. Audio-only telehealth therefore cannot be used for any Schedule II prescription, including under paragraphs (3) and (4). Because the paragraph restates the standard of care, a remote prescription that falls short of the in-person standard is unauthorized on that ground alone.

The second condition supports two readings.

Technology-use reading. The subject of the clause is "the use of such technologies," not the prescription. On this reading, paragraph (5) requires that the provider's use of audio-video technology be lawful, for example under privacy, security, licensure, and practice-standard rules. The clause's one example, the in-person standard of care, is a condition of this kind. On this reading, paragraph (5) does not make State authorization of the prescription depend on whether federal controlled substance law permits it.

Prescribing-authorization reading. The technology is being used to prescribe a Schedule II substance, so its use is "consistent with … federal law" only if federal law permits that remote prescription. On this reading, a prescription allowed under paragraph (3) or (4) that the Ryan Haight Act does not permit is also unauthorized under State law.

This report treats the technology-use reading as the closer fit to the text, because the clause attaches to the use of the technology and its one example is a practice standard. The prescribing-authorization reading remains plausible, and a board, the Drug Control Unit, or a court could adopt it. The committee statements describe the provision without resolving the question (S. Health, Hum. Servs. & Senior Citizens Comm. Statement; Assemb. State & Loc. Gov't Comm. Statement).

The practical difference between the readings is narrow. Subsection a, unchanged by c.40, already permits telemedicine only "[u]nless specifically prohibited or limited by federal or State law" (P.L.2017, c.117; P.L.2026, c.40), and federal law binds New Jersey prescribers directly. Under either reading, a remote Schedule II prescription that federal law does not permit is unlawful, and subsection a withholds State permission for it. The readings differ on whether federal noncompliance also violates subsection e itself, which affects how a board would frame discipline. (Contested)

2.6 The Relationship Between the Statute and DCU Guidance

The Drug Control Unit issued a notice on August 3, 2026 describing the exemptions, the adult pathway, and the requirement that prescribers use real-time audio-video technology consistent with State and federal law (New Jersey Division of Consumer Affairs, Drug Control Unit 2026b). The notice is guidance and is not law. It gives the signing date as July 7, 2026, while the chapter law and the Governor's release give July 8 (P.L.2026, c.40; Office of the Governor of New Jersey 2026). It also uses "examination" for the 30-day requirement and for the default three-month requirement, where the statute uses "visit," although it uses "visit" for the annual requirement. Practitioner and press summaries published before the notice use "visit" (Simone et al. 2026b; Roman 2026).

2.7 Comparison of Prior Law, the Introduced Bill, and the Enacted Law

The table compares the provisions of prior law, the bill as introduced, and the enacted law.

PROVISION	PRIOR LAW (P.L.2017, C.117)	A4852 AS INTRODUCED	A4852 AS ENACTED (C.40)
Default rule	In-person exam first; in-person visit every 3 months	No in-person exam required if audio-video used	Retained
Minors and stimulants	Exempt with parental consent and audio-video	Same as prior law	Exempt with parental consent; audio-video moved to para. (5)
Cancer, hospice, palliative, long-term care	No exemption	No separate exemption	Exempt from para. (1); adult stimulants remain under para. (4)
Medical Aid in Dying	No exemption	No separate exemption	Exempt from para. (1); adult stimulants remain under para. (4)
Substance use disorder medications	No exemption	No separate exemption	Exempt from para. (1); adult stimulants remain under para. (4)
Adult stimulants	Default rule	No in-person requirement	Remote initial exam allowed; in-person within 30 days; contact every 3 months; in-person yearly
Technology	Audio-video for minor exception only	Audio-video for all	Audio-video for all (para. (5))
Federal law	Subsection a: telemedicine subject to federal law; no reference in subsection e	Subsection a unchanged; no reference in subsection e	Subsection a unchanged; para. (5): technology use must be consistent with State and federal law

Sources: P.L.2017, c.117; Assemb. B. 4852, as introduced; P.L.2026, c.40.

2.8 Ambiguities

What counts as "contact." Paragraph (4) does not define "contact." Telemedicine may be provided through asynchronous store-and-forward technology (N.J. Stat. Ann. § 45:1-62(c)), but paragraph (5) requires real-time audio-video "when treating the patient." It is unclear whether a three-month contact counts as treating and so must be synchronous.

Paragraphs (3) and (4) together. Paragraph (3) provides that "[t]he provisions of paragraph (1) of this subsection shall not apply" to its patients and medications. It does not mention paragraph (4). Paragraph (4) governs any Schedule II stimulant prescribed through telemedicine "to an adult patient" and has no exception for paragraph (3) patients. On the text, an adult in active cancer treatment, in hospice, receiving palliative care, residing in a long-term care facility, or undergoing evaluation under P.L.2019, c.59 who is prescribed a Schedule II stimulant appears to remain subject to paragraph (4)'s 30-day and annual in-person visits. The same applies to an adult prescribed a stimulant to treat a substance use disorder under paragraph (3)(c). Exempting these patients from paragraph (4) would rely on the purpose of paragraph (3) instead of its text. The Drug Control Unit's August 3, 2026 notice adopts the textual reading for patients in the paragraph (3)(a) and (b) categories, stating that the adult stimulant requirements "apply even if the patient may lawfully be prescribed another CDS via telemedicine or telehealth pursuant to another listed exception" (New Jersey Division of Consumer Affairs, Drug Control Unit 2026b). It does not address a stimulant that is itself prescribed to treat a substance use disorder under paragraph (3)(c). The notice is guidance and does not bind a board or court. The question does not arise for minors, whose stimulant prescriptions fall under paragraph (2).

Who must conduct the paragraph (4) in-person visit. Paragraph (4) requires "an in-person visit" within 30 days and annually. It does not say whether the visit must be with the prescriber, another clinician in the same practice, or any licensed clinician. Federal law answers a related question. The Ryan Haight Act requires the in-person medical evaluation to occur with the patient in the physical presence of the prescribing practitioner, although other health professionals may conduct portions of it, unless a covering practitioner prescribes (21 U.S.C. § 829(e); Section 4.2). A 30-day visit with the prescriber would satisfy both requirements. A visit with another clinician could satisfy State law and still leave the prescriber without the federal in-person evaluation once the federal flexibilities end. Board rules or DCU guidance could resolve the State question.

Documenting exemption eligibility. Paragraph (3) does not say what a prescriber must record to show a patient qualifies. Subsection g requires a complete record of care, and board rules could fill the gap. No such rules were located.

Indications beyond ADHD. The 30-day and annual in-person requirements apply to every Schedule II stimulant indication, and the statute makes no distinctions among them.

The reference to federal law in paragraph (5). It is unresolved whether paragraph (5) conditions only the use of audio-video technology on consistency with federal law, or also conditions State authorization of the prescription (Section 2.5).

Paragraph (5) and paragraph (2). The two do not conflict on their face, since paragraph (5) adds technology conditions and does not require an in-person exam. The "notwithstanding" clause means a minor-stimulant prescription issued by audio-only telehealth is unauthorized despite paragraph (2). On the prescribing-authorization reading of paragraph (5), a minor-stimulant prescription that federal law does not permit would also be unauthorized despite paragraph (2).

"Examination" versus "visit." The statute uses "examination" for the initial encounter and "visit" for later ones. It does not say whether a "visit" must include an examination.

Subsection i(2). Board rules may not require an initial in-person visit for telemedicine generally. Paragraph (4) delegates the form of the initial examination to regulation. A board rule requiring an in-person initial exam for some adult stimulant patients could conflict with i(2). The text does not address this.

3. How It Was Enacted

3.1 Origins: The Waiver Expiration and Transition Period

The August 2020 DCA waiver suspended subsection e's in-person requirement (N.J. Div. of Consumer Affs., Admin. Order No. 2020-15). After it expired on February 16, 2026 (N.J. Exec. Order No. 415), an adult receiving a Schedule II stimulant through telemedicine without a prior in-person exam fell outside State law. Executive Order No. 13, signed three days before the expiration, extended parts of the State of Emergency to April 2, 2026 for advanced practice nurse and physician assistant waivers and did not continue the Schedule II waiver (N.J. Exec. Order No. 13; Simone et al. 2026a). The DCU's guidance gave established patients until May 16, 2026 to be seen in person. Patients new to Schedule II telemedicine prescribing became subject to the in-person requirement immediately (New Jersey Division of Consumer Affairs, Drug Control Unit 2026a; Simone et al. 2026a). The federal flexibilities stayed in effect but did not exempt prescribers from the State requirement.

3.2 The Legislative Path

The table lists the dated steps from the expiration of the waiver to the law's approval.

DATE	EVENT
January 16, 2026	Executive Order No. 415 signed
February 13, 2026	Executive Order No. 13 signed; extends parts of the State of Emergency to April 2, 2026
February 16, 2026	DCA waiver expires
April 2, 2026	Executive Order No. 13 extension ends
May 4, 2026	A4852 introduced
May 11, 2026	S4194 and S4210 introduced

DATE	EVENT
May 16, 2026	DCU transitional period ends
June 11, 2026	Senate Health Committee reports SCS, 6-0-1
June 23, 2026	Assembly State and Local Government Committee reports ACS, 7-0
June 30, 2026	Assembly passes 76-2-1; Senate passes 38-2
July 8, 2026	Approved as P.L.2026, c.40

Sources: N.J. Legislature, Bill Detail: A4852; N.J. Exec. Order No. 415; N.J. Exec. Order No. 13; New Jersey Division of Consumer Affairs, Drug Control Unit 2026a.

3.3 The June 2026 Committee Substitutions

As introduced, A4852 states that "[a]n in-person examination or review of a patient shall not be required" for Schedule II telemedicine prescribing, provided audio-video technology was used (Assemb. B. 4852, as introduced). Its synopsis read "Permits prescription of Schedule II controlled dangerous substances via telemedicine and telehealth without in-person examination or review." S4194 took a similar approach to the Assembly bill (S.B. 4194). As introduced, S4210 would have kept the initial in-person examination for adults prescribed a Schedule II stimulant for ADHD and would have required "[a] subsequent in-person visit or telehealth or telemedicine contact" every six months instead of an in-person visit every three months (S.B. 4210).

On June 11, 2026, the Senate Health, Human Services and Senior Citizens Committee reported a substitute for both Senate bills that kept the in-person rule, added the exemptions and the adult stimulant pathway, and added the audio-video and federal-consistency requirement (S. Health, Hum. Servs. & Senior Citizens Comm. Statement; S. Comm. Substitute for S.B. 4194 & 4210). The Assembly committee reported the same text for A4852 on June 23 (Assemb. State & Loc. Gov't Comm. Statement; Assemb. Comm. Substitute for Assemb. B. 4852). The new synopsis reads "Revises certain requirements for prescription of Schedule II controlled dangerous substances via telemedicine and telehealth without in-person examination or review." Neither committee statement explains the change, and no hearing transcript was obtained.

3.4 Sponsorship, Votes, and Signing

A4852 was sponsored by Assemblywoman Andrea Katz, Assemblywoman Marisa Sweeney, Assemblyman Vincent Kearney, and Assemblyman Chris Tully (Assemb. B. 4852, as introduced). The Senate sponsors were Senators Vitale, Gopal, and Mukherji (Office of the Governor of New Jersey 2026). Both chambers passed the substitute on June 30, 2026, the Assembly 76-2-1 and the Senate 38-2 (N.J. Legislature, Bill Detail: A4852).

The published statements of purpose before enactment are the introduced bill's sponsor statement, which describes permitting Schedule II telemedicine prescribing without in-person examination (Assemb. B. 4852, as introduced), and the committee statements, which describe the substitute without giving a rationale (S. Health, Hum. Servs. & Senior Citizens Comm. Statement; Assemb. State & Loc. Gov't Comm. Statement). The Governor's signing release lists the bill without comment (Office of the Governor of New Jersey 2026). In a public post on July 9, 2026, Governor Sherrill described the law this way: "This week, I signed legislation that makes permanent certain telehealth prescription flexibilities by eliminating the need for in-person visits every three months" (Sherrill 2026). The post says the law will help college students away at school, patients with mobility issues, and patients who live far from a specialist continue to receive care (Sherrill 2026). That is the Governor's characterization. Paragraph (1) keeps the three-month in-person rule as the default. Paragraph (4) replaces it for adult stimulants with three-month contact plus 30-day and annual in-person visits, and paragraph (3) lifts it for the listed patients and medications. Whether the flexibilities can be used after December 31, 2026 depends on federal law (Section 4). A July 15, 2026 release from Legislative District 11 legislators, including Senate sponsor Vin Gopal, described the law in terms of patients in active cancer treatment and patients unable to travel to a doctor's office (New Jersey Assembly Democrats 2026). Press coverage described the law as letting ADHD patients refill medications from home (Roman 2026).

4. Federal Legal Context

4.1 The Direct Answer: Which Law Governs

A New Jersey prescriber must comply with both State and federal law, and the stricter requirement controls. Under the Ryan Haight Act, prescribing a controlled substance over the internet without at least one prior in-person medical evaluation is unlawful unless an exception applies (Ryan Haight Act, Pub. L. No. 110-425; 21 U.S.C. § 829(e)). The State exemptions and adult pathway remove State in-person requirements and leave the federal requirement in place. Subsection a has conditioned telemedicine on federal law since 2017, and paragraph (5) requires that the use of audio-video technology be consistent with State and federal law. Whether paragraph (5) also makes State authorization of the prescription depend on federal law is contested (Section 2.5). If the federal flexibilities lapse with no replacement, a prescriber who initiates a Schedule II prescription remotely under paragraph (2), (3), or (4) without a prior in-person evaluation would violate federal law. That prescription would also fall outside subsection a's grant of State permission and, on the prescribing-authorization reading, outside paragraph (5). Remote prescribing to a patient whom the prescriber has evaluated in person would remain federally permitted (Section 4.2).

4.2 The Ryan Haight Act

The Ryan Haight Act of 2008 amended the Controlled Substances Act to require at least one in-person evaluation before a controlled substance is prescribed over the internet, with defined exceptions (Ryan Haight Act, Pub. L. No. 110-425). The evaluation must occur with the patient in the physical presence of the prescribing practitioner, although other health professionals may conduct portions of it. Alternatively, a covering practitioner may prescribe at the request of a practitioner who has evaluated the patient within the previous 24 months and is temporarily unavailable (21 U.S.C. § 829(e)). The requirement is a single evaluation. Once it is met, later prescriptions issued through telemedicine are federally permitted, subject to the legitimate medical purpose requirement and state law. One exception covers practitioners holding a telemedicine "special registration," which the Act directed the Attorney General to create by regulation. Another permits suspension of the in-person requirement during a declared public health emergency, which is the basis of the COVID-era flexibilities. No special registration was created between 2008 and

the 2025 proposal (90 Fed. Reg. 6541). States add their own conditions, from no added Schedule II restriction to in-person rules like New Jersey's default (Center for Connected Health Policy 2026).

4.3 DEA Temporary Flexibilities and the December 31, 2026 Expiration

The DEA and HHS suspended the federal in-person requirement in March 2020. After the public health emergency ended in May 2023, they extended the flexibilities four times, most recently through December 31, 2026 (90 Fed. Reg. 61301). The DEA said the fourth extension ensures continued access to care while it finishes rulemaking (U.S. Drug Enforcement Administration 2025). Under the extension, a DEA-registered practitioner may prescribe Schedule II through V substances via telemedicine without a prior in-person evaluation if the prescription is for a legitimate medical purpose and complies with state law (90 Fed. Reg. 61301; U.S. Drug Enforcement Administration 2025). This is the operative federal authority as of October 27, 2026.

4.4 The Buprenorphine, VA, and Opioid Treatment Program Rules

In a final rule published January 17, 2025 and effective December 31, 2025 after two delays, the DEA and HHS permanently allowed practitioners to prescribe an initial supply of buprenorphine for opioid use disorder via telemedicine, including audio-only, without a prior in-person evaluation, with further prescribing subject to additional conditions (90 Fed. Reg. 6504; 90 Fed. Reg. 13410). A companion rule covers Department of Veterans Affairs practitioners (90 Fed. Reg. 6523).

Buprenorphine is Schedule III and was never covered by subsection e. The State exemption in paragraph (3)(c) therefore applies only to Schedule II medications used for substance use disorder, a smaller group, and federal rules will decide whether that prescribing is permitted after the flexibilities end.

Methadone is the main Schedule II medication in that group, and opioid treatment program rules largely govern its use for opioid use disorder. Under DEA regulations, a practitioner may "administer or dispense directly (but not prescribe)" a narcotic drug for maintenance or detoxification treatment, and only if separately registered as a narcotic treatment program, subject to narrow exceptions (21 C.F.R. § 1306.07). Opioid treatment programs operate under 42 C.F.R. pt. 8, which since 2024 has permitted the admission evaluation for methadone patients to be conducted by audio-video telehealth, and by audio-only telehealth only if the patient is with a licensed practitioner (89 Fed. Reg. 7528). The program dispenses the

medication. Because paragraph (3)(c) applies to medications "being prescribed," it changes little about how methadone treatment for opioid use disorder is delivered, so the affected population is small (Section 7.4). (Documented as to the rules; Projected as to the population)

4.5 The Special Registration Rulemaking

The DEA's January 17, 2025 proposed rule would create a special registration for Schedule III through V prescribing and an advanced registration for Schedule II prescribing by certain specialists. It would also create a registration for telemedicine platforms and require state-level registrations. The proposal included limits on the share of a specialist's Schedule II prescriptions issued without an in-person evaluation (90 Fed. Reg. 6541). The American Psychiatric Association (2025), the American Academy of Child and Adolescent Psychiatry (2025), and the American Medical Association (2025) objected to the limit on Schedule II prescriptions issued without an in-person evaluation. The first two also objected to the cost of separate state registrations, and the American Medical Association, which supported the framework overall, objected to a nationwide prescription monitoring check. ATA Action (2025) raised concerns about application burden, prescription monitoring checks, and pharmacy verification. No New Jersey organization's position on c.40 was located.

The DEA sent a final rule to OIRA on August 25, 2026 (National Association of State Controlled Substances Authorities 2026). OIRA had not concluded its review as of October 27, 2026, and no final rule had been published (Office of Information and Regulatory Affairs 2026). Three federal outcomes are possible after December 31, 2026, each Projected:

Further extension. A fifth extension keeps the paragraph (4) pathway usable as it is today.

Final rule takes effect. Prescribers with the required registration can keep using paragraph (4) under its conditions. Those without one must evaluate a patient in person before initiating a Schedule II prescription remotely, and may then continue remote care for that patient.

Lapse without replacement. The federal in-person requirement returns for new remote prescribing. Remote initiation under paragraphs (2), (3), and (4) becomes unavailable except under a statutory Ryan Haight exception, because the prescriber must first evaluate the patient in person or a covering practitioner must prescribe. Remote care for established patients continues. A patient whom the prescriber has evaluated in person, including at a paragraph (4) 30-day visit the prescriber conducts, may continue to

receive Schedule II prescriptions through telemedicine under federal law. A patient who began treatment remotely during the flexibilities and has never been evaluated in person by the prescriber would need that evaluation before the next prescription. Who conducts the paragraph (4) visit therefore matters (Section 2.8).

4.6 The Federal Enforcement Record

Two DOJ matters are often raised in this debate. Neither is evidence about telehealth prescribing in general.

Done Global's founder and CEO and its clinical president were convicted on November 18, 2025 in what the DOJ described as a $100 million Adderall distribution and health care fraud scheme run through a subscription telehealth platform (Press Release, U.S. Dep't of Just. (Nov. 19, 2025)). They were sentenced on July 7, 2026 to 72 and 24 months respectively. The DOJ's sentencing release describes a $90 million scheme that distributed over 37 million pills (Press Release, U.S. Dep't of Just. (July 7, 2026)). The two releases do not explain the difference between the $100 million and $90 million figures, and this report cites each as the DOJ stated it.

Cerebral, Inc. entered a non-prosecution agreement with the U.S. Attorney's Office for the Eastern District of New York on November 1, 2024, resolving an investigation into its controlled substance prescribing (Non-Prosecution Agreement with Cerebral, Inc.).

Both platforms operated under the federal flexibilities, and neither record is New Jersey-specific. Paragraph (4)'s 30-day in-person requirement is a constraint that the federal flexibilities did not impose. The records do not address whether it would have affected the schemes.

5. Fiscal Analysis

5.1 The Fiscal Record

No fiscal estimate from the Office of Legislative Services appears on the bill record for A4852 or the Senate substitute (N.J. Legislature, Bill Detail: A4852). The bill record states, “This bill has not been certified by OLS for a fiscal note” (N.J. Legislature, Bill Detail: A4852). The bill makes no appropriation and places no new duty on local government. Fiscal effects would fall on regulators through workload and on payers through utilization. Patients and practices would bear changes in the cost of care.

5.2 State Administrative Costs

The Board of Medical Examiners and other licensing boards already have a rulemaking mandate under subsection i (P.L.2017, c.117), and c.40 changes what those rules must address. The Drug Control Unit issues guidance, enforces the Controlled Dangerous Substances Act, and issued the August 3, 2026 notice (New Jersey Division of Consumer Affairs, Drug Control Unit 2026b). The Prescription Monitoring Program collects dispensing data (N.J. Stat. Ann. §§ 45:1-44 to -50.2). None of these bodies has estimated the work c.40 adds. (Projected)

5.3 Payer and NJ FamilyCare Considerations

P.L.2026, c.29, approved June 30, 2026, extends New Jersey’s telehealth payment parity requirement from July 1, 2026 to December 31, 2027 (P.L.2026, c.29). Through that date, health benefits plans must pay for telemedicine and telehealth services at the same rate as in-person services if the service is covered in person. The requirement covers commercial carriers, the State Health Benefits and School Employees’ Health Benefits programs, Medicaid, and NJ FamilyCare. It does not apply to telehealth organizations that do not offer the service in person in New Jersey. Audio-only physical health services may be paid at a contract rate of at least 50 percent of the in-person rate, and audio-only behavioral health services stay at parity. (Documented)

Because c.40 requires audio-video for every Schedule II telemedicine prescription (P.L.2026, c.40), the audio-only provisions do not reach these encounters. Through 2027, a payer’s cost per encounter does not change when a Schedule II visit moves to telehealth, so any payer effect would come from changes in

encounter volume and Schedule II utilization. No source quantifies either for New Jersey. Parity after December 31, 2027 depends on further legislation. (Projected)

5.4 Costs and Savings to Patients and Practices

For adult stimulant patients, paragraph (4) replaces up to four in-person visits a year with one annual visit, plus one within 30 days of a remote start. Paragraph (3) removes paragraph (1)'s in-person visits for the covered groups, except, on the text, for adult stimulant prescriptions (Section 2.8). Savings in travel and lost work time are plausible and unquantified. (Projected)

Practices using paragraph (4) must be able to see patients in person within 30 days and yearly, so a fully remote practice would need in-person capacity. Who must conduct the in-person visit is unresolved (Section 2.8). These costs are unquantified. (Projected)

6. The Evidence Base

6.1 Methodological Note

Nearly all available evidence comes from observational U.S. studies of the COVID-era flexibilities (2020 to 2023), when in-person care was disrupted and a national stimulant shortage began in fall 2022 (U.S. Drug Enforcement Administration and U.S. Food and Drug Administration 2023). These studies could not randomize patients to telehealth or in-person care, and the two groups differed in ways the studies only partly controlled for. Findings are Documented for the populations studied and Projected for New Jersey.

The largest body of evidence concerns buprenorphine, which subsection e never covered. The next largest concerns stimulant initiation for ADHD under a rule with no 30-day in-person requirement. No telehealth-specific outcome evidence exists for Schedule II opioids for pain or for the paragraph (3)(a) and (b) populations. Because c.40 is recent, no study of the law itself exists, and a documented search for studies of comparable rules in other states found none (Sections 1 and 6.7).

6.2 Telehealth Treatment of Opioid Use Disorder

Jones et al. (2022) compared Medicare beneficiaries starting opioid use disorder care before and during the pandemic. Receipt of opioid use disorder-related telehealth services rose from under 1 percent to about 20 percent. In the pandemic cohort, telehealth was associated with better medication retention and lower odds of medically treated overdose. Jones et al. (2023), using the same cohorts, found telehealth associated with lower odds of fatal overdose. (Documented)

Hammerslag et al. (2023) studied Medicaid enrollees in Kentucky and Ohio who started buprenorphine in 2020. Telemedicine initiation was associated with higher 90-day retention than in-person initiation in both states and was not associated with more nonfatal overdoses. (Documented)

These studies link telehealth opioid use disorder care with equal or better retention and lower overdose risk in the populations studied. (Documented for those populations) Because the medication was almost always buprenorphine, the findings apply only indirectly to paragraph (3)(c). (Projected)

6.3 Telehealth Prescribing of Stimulants

Huskamp et al. (2024) used national commercial claims from 2019 to April 2022. Adjusted monthly stimulant initiations per 100,000 enrollees changed little for children (57 before the pandemic and 56 during it) and rose for adults (27 to 33). Telemedicine's share of initiations peaked at 53 to 57 percent in April 2020 and fell to about 14 percent for children and 28 percent for adults by April 2022. Psychiatrists were more likely to initiate via telemedicine (odds ratio 3.70, 95% CI 3.38 to 4.06, for children; 3.02, 2.87 to 3.17, for adults), and rural residents were less likely (0.57, 0.40 to 0.82; 0.75, 0.61 to 0.92). Telemedicine initiation was associated with more 30-day follow-up (1.09, 1.00 to 1.19; 1.61, 1.53 to 1.69). (Documented)

Creedon et al. (2025) studied Medicaid and CHIP enrollees from 2019 through 2022. The start of the pandemic coincided with an immediate increase of 24.7 telehealth-only initiations and a decrease of 53.5 in-person initiations per 100,000 enrollees per month. By December 2022, the estimated shortfall in in-person initiations relative to the pre-pandemic trend had grown to 78.6 per 100,000 enrollees per month, while the telehealth-only increase had moderated to 12.5. Overall initiation remained below the pre-pandemic trend. The authors concluded that telehealth partially replaced in-person care and did not appear to cause overprescribing. (Documented)

Rao et al. (2025) studied 7,944 ADHD patients aged 12 and older who started stimulants between March 2020 and August 2023 in one northeastern health system. A telehealth-only prescriber relationship was not associated with later substance use disorder (aOR 0.85, 95% CI 0.60 to 1.20) or stimulant use disorder (1.28, 0.34 to 4.85). Receiving the first prescription by telehealth was not associated with substance use disorder (1.15, 0.92 to 1.44). It was associated with stimulant use disorder (6.18, 1.34 to 28.46). Only 19 patients developed stimulant use disorder, and the authors cautioned that the result may reflect chance or unmeasured differences and needs replication. (Contested)

Nagappan et al. (2024) found telehealth made up a larger and more persistent share of stimulant prescriptions after 2020 than of antidepressant or opioid prescriptions. (Documented)

None of these studies examines rules with a 30-day in-person visit requirement, so they cannot show what paragraph (4)'s requirements add. (Projected)

6.4 Schedule II Opioids for Pain

No peer-reviewed study was found comparing outcomes, diversion, or access for Schedule II opioids for pain prescribed by telehealth versus in person. Prescribing-trend data show that telehealth's share of opioid prescriptions rose from 0 percent in 2019 to 24.1 percent in the second quarter of 2020 and was 8.4 percent in 2022 (Nagappan et al. 2024), but no outcome data exist. The same gap applies to the cancer, hospice, palliative care, long-term care, and Medical Aid in Dying populations. This is an evidence gap.

6.5 Diversion, Misuse, and Supply

The DEA and FDA's August 1, 2023 letter acknowledged a national stimulant shortage and reported that stimulant dispensing rose 45.5 percent from 2012 to 2021 and that, according to a CDC report, rates in certain age groups grew by more than 10 percent during 2020 and 2021, "when virtual prescribing was permitted on a widespread basis" (U.S. Drug Enforcement Administration and U.S. Food and Drug Administration 2023). The letter does not attribute the increase to telehealth or assess clinical appropriateness. (Documented)

Myran et al. (2025) found that in Ontario, new stimulant prescriptions rose from 275.2 to 708.0 per 100,000 between 2015 and 2023, a 157 percent increase, with the fastest growth after 2020. The study does not examine modality. It is cited to show that the post-2020 rise is not unique to U.S. rules. (Documented for Ontario)

Growth in prescribing does not by itself show overprescribing, diversion, or appropriate treatment of unmet need. The studies that tested this directly did not find excess overprescribing or overall substance use disorder from telehealth initiation (Creedon et al. 2025; Rao et al. 2025), while the DOJ records document unlawful distribution by specific platforms (Press Release, U.S. Dep't of Just. (Nov. 19, 2025); Press Release, U.S. Dep't of Just. (July 7, 2026); Non-Prosecution Agreement with Cerebral, Inc.). The reason for the overall rise is contested. (Contested)

6.6 Access and Equity

Telehealth expanded adult stimulant initiation (Huskamp et al. 2024) and opioid use disorder care in Medicare (Jones et al. 2022). It partly offset lost in-person initiations in Medicaid and CHIP (Creedon et al. 2025). Creedon et al. (2025) found smaller declines relative to pre-pandemic trends among female and

young adult enrollees. Rural residents were less likely to start stimulants via telemedicine (Huskamp et al. 2024), which suggests telehealth left part of the rural gap open. (Documented for the populations studied)

In New Jersey, the equity effect of c.40 depends on who can meet its in-person requirements. Patients with travel barriers and out-of-state students gain from fewer required visits but must still come in yearly under paragraph (4). (Projected)

6.7 Studies of Analogous State Policies

The search described in Section 1 found no peer-reviewed study estimating the effect of another state's in-person requirement for telehealth prescribing of controlled substances on access, prescribing, follow-up, diversion, or patient outcomes. Hammerslag et al. (2023) cite Kentucky and Ohio rules on telemedicine buprenorphine as context and do not evaluate them. Three studies located in the search are related and do not meet the criteria. Stein et al. (2025) examined state policies adopted early in the pandemic to facilitate telehealth: private-payer parity, Medicaid payment for audio-only care, and interstate practice by physicians and psychologists. Using national pharmacy data on buprenorphine episodes, they found few significant changes in treatment, and the study did not examine in-person requirements. Sousa et al. (2026) mapped state tele-buprenorphine policies for Medicaid enrollees as of August 2025, by type of clinician (physicians, nurse practitioners, and physician assistants), and found six states that prohibited tele-buprenorphine by all three clinician types for new and established patients. The study measured no outcomes. Monico et al. (2026) reported six-month retention in a telehealth-only buprenorphine program that varied by state, from 58.4 percent in Oregon to 78.1 percent in North Carolina, and did not compare state prescribing rules. (Documented)

The Center for Connected Health Policy tracker identifies states with rules comparable to New Jersey's. Among the state entries reviewed for this report, Alabama allows a controlled substance to be prescribed via telehealth only if the prescriber has seen the patient in person at least once in the prior 12 months. Arkansas bars physicians from prescribing Schedule II through V substances via telemedicine without an in-person exam or a listed alternative relationship. Arizona permits Schedule II prescribing after an in-person or audio-visual examination, so its rule requires an examination but not an in-person one (Center for Connected Health Policy 2026). (Documented) No evaluation of these rules was located. These states are candidates for the comparative studies listed in Section 9.

There is no direct evidence, from New Jersey or elsewhere, on whether in-person requirements like those in paragraphs (1) and (4) change outcomes. This is an evidence gap.

7. Impact Analysis by Affected Party

7.1 Adults Prescribed Stimulants

Changes. Adults may start a Schedule II stimulant through a telehealth exam, followed by an in-person visit within 30 days, contact every three months, and an in-person visit yearly. Before c.40, they needed an in-person exam first and in-person visits every three months (P.L.2017, c.117; P.L.2026, c.40). (Documented)

Unchanged. Federal law, the audio-video requirement, and the in-person standard of care all still apply. (Documented)

Impact. Required in-person visits for established patients drop from four a year to one. Evidence from other settings links telehealth initiation with equal or better follow-up and no overall increase in substance use disorder, with one imprecise signal for stimulant use disorder (Huskamp et al. 2024; Rao et al. 2025). Whether the 30-day visit changes these outcomes has not been studied. (Projected)

7.2 Minors and Their Parents or Guardians

Changes. The audio-video condition moves from paragraph (2) to paragraph (5), and paragraph (5) adds that the use of the technology must be consistent with State and federal law (P.L.2026, c.40). (Documented)

Unchanged. Written parental consent is still required, and no in-person exam is required under State law. (Documented)

Impact. No practical effect under the current flexibilities. After December 31, 2026, absent further federal action, a minor could not begin a Schedule II stimulant through telehealth without a prior in-person evaluation by the prescriber or a covering practitioner, although paragraph (2) waives the State requirement. Minors already evaluated in person by their prescriber could continue remote care. Whether such a federally impermissible prescription is also unauthorized under paragraph (5) depends on the reading in Section 2.5. (Projected) In commercial claims, child stimulant initiations stayed stable during the pandemic, and telehealth's share fell to about 14 percent by April 2022 (Huskamp et al. 2024). No child-specific outcome study was found.

7.3 Patients in Cancer Treatment, Hospice, Palliative Care, Long-Term Care, and Medical Aid in Dying

Changes. These patients are exempt from paragraph (1)'s in-person requirements for Schedule II prescriptions, including opioids (P.L.2026, c.40). (Documented) Adults in these categories who are prescribed a Schedule II stimulant appear to remain subject to paragraph (4)'s 30-day and annual in-person visits, because paragraph (3) exempts its patients only from paragraph (1) (Section 2.8). The Drug Control Unit's August 3, 2026 notice takes the same view (New Jersey Division of Consumer Affairs, Drug Control Unit 2026b). (Documented as to the text and the DCU notice)

Unchanged. Federal law, the audio-video requirement, and the standard of care still apply, and the categories remain undefined. (Documented)

Impact. The exemption removes a requirement that may be hard to meet for homebound, institutionalized, or dying patients. Long-term care residents are usually treated by facility clinicians, so the effect may be limited to outside consultants. For medical aid in dying, the exemption reaches the evaluation and consultation stages as well as the prescription. Because the medications reported in New Jersey include morphine, a Schedule II substance (New Jersey Office of the Chief State Medical Examiner n.d.), the exemption applies to aid-in-dying prescriptions issued through telemedicine. After the federal flexibilities end, those prescriptions would again require a prior in-person evaluation by the prescriber or a covering practitioner (Section 2.3). No telehealth study covers these populations. (Projected)

7.4 Patients With Substance Use Disorder

Changes. Schedule II medications prescribed for substance use disorder are exempt from paragraph (1) (P.L.2026, c.40). (Documented)

Unchanged. Buprenorphine, which is Schedule III, was never under subsection e and is governed by the federal buprenorphine rule (90 Fed. Reg. 6504). Methadone, the main Schedule II medication for substance use disorder, is dispensed for opioid use disorder through opioid treatment programs under federal rules and is not prescribed for pharmacy fill (21 C.F.R. § 1306.07; 89 Fed. Reg. 7528). (Documented)

Impact. Telehealth opioid use disorder care has been associated with better retention (Jones et al. 2022; Hammerslag et al. 2023) and lower overdose risk (Jones et al. 2022; Jones et al. 2023), and those findings mostly concern buprenorphine. Because methadone treatment for opioid use disorder runs through opioid treatment programs (Section 4.4), the number of New Jersey patients affected by paragraph (3)(c) is likely small and unquantified. (Projected)

7.5 Rural, Mobility-Limited, and Out-of-State Student Patients

Changes. These patients benefit from whichever provision applies to them: fewer required visits under paragraph (4), or none under paragraph (3) for prescriptions other than adult stimulants (P.L.2026, c.40). (Documented)

Unchanged. The yearly in-person visit under paragraph (4), the three-month rule under the default, and the New Jersey licensure requirement remain. Students treated while in another state may also be subject to that state's licensure rules. (Documented)

Impact. Rural patients elsewhere were less likely to start stimulants by telehealth (Huskamp et al. 2024), so removing the in-person rule may not reach them on its own. The effect in New Jersey is unknown. (Projected)

7.6 Prescribers (Physicians, APNs, PAs)

Changes. Prescribers can start adult stimulants remotely and prescribe remotely to exempt patients. They must schedule the 30-day and yearly visits, document eligibility, use audio-video, and track federal compliance (P.L.2026, c.40). (Documented)

Unchanged. The standard of care, licensure, recordkeeping, and board discipline remain. Subsection h still protects providers from discipline solely for using telemedicine (P.L.2026, c.40). (Documented)

Impact. Compliance is the prescribers' responsibility, and after December 31, 2026 they must correctly judge federal status to avoid consequences. (Projected)

7.7 Pharmacists

Changes. None in the text. C.40 does not amend pharmacy or controlled substance law. (Documented)

Unchanged. Pharmacists keep their federal corresponding responsibility to confirm a controlled substance prescription is for a legitimate medical purpose (21 C.F.R. § 1306.04(a)). (Documented) After federal status changes, pharmacists may need to judge whether a telehealth Schedule II prescription is lawful. (Projected)

Impact. No evidence exists on pharmacist workload or refusal rates under these rules.

7.8 Telehealth Platforms and Multistate Practices

Changes. Paragraph (4) is open to any New Jersey-licensed prescriber, including platform-affiliated ones. Its in-person requirements mean a fully remote platform cannot use it without in-person capacity (P.L.2026, c.40). (Documented)

Unchanged. The ban on prescribing from an online questionnaire alone, licensure, and federal law, including any platform registration in the final rule. Telehealth organizations that do not offer a service in person in New Jersey remain excluded from payment parity (P.L.2026, c.29). (Documented)

Impact. The Done Global and Cerebral matters involved platforms operating without a State in-person requirement (Press Release, U.S. Dep't of Just. (Nov. 19, 2025); Press Release, U.S. Dep't of Just. (July 7, 2026); Non-Prosecution Agreement with Cerebral, Inc.). The records do not address whether the 30-day requirement would have constrained that conduct. (Projected)

7.9 Regulators

Changes. The licensing boards may update subsection i rules, the DCU must keep guidance aligned with State and federal law, and the boards will handle discipline under the new provisions (P.L.2017, c.117; P.L.2026, c.40; New Jersey Division of Consumer Affairs, Drug Control Unit 2026b). (Documented)

Unchanged. The boards' rulemaking mandate, the DCU's enforcement role, and the PMP's data functions. (Documented)

Impact. Regulators must resolve the ambiguities in Section 2.8, work that is not documented in any fiscal record. (Projected)

7.10 Payers

Changes. None in c.40. It does not address coverage or payment. (Documented)

Unchanged. Telehealth payment parity continues through December 31, 2027 for commercial plans, State employee plans, Medicaid, and NJ FamilyCare (P.L.2026, c.29). (Documented)

Impact. Through 2027, payers pay the same rate for an audio-video Schedule II encounter as for an in-person one, so any cost change comes from utilization and is unquantified for New Jersey. (Projected)

8. Institutional Design Analysis

This section applies the ARA framework: who holds the law's duties, who bears its costs, and who exercises discretion. Section 8.4 addresses what the law provides for learning about its own effects.

8.1 Where the Law Places Duties

Nearly every new duty falls on prescribers: scheduling the 30-day, three-month, and yearly encounters, documenting exemption eligibility, using audio-video, and tracking federal law (P.L.2026, c.40). Pharmacists keep their corresponding responsibility with no new instruction. The boards and the DCU handle interpretation and enforcement. The bill provides no appropriation or staffing, and no fiscal record mentions this (N.J. Legislature, Bill Detail: A4852). No agency is given a duty to report on or evaluate the law (Section 8.4). (Documented as to the text; Projected as to burden)

8.2 Where the Law Places Costs

The law shifts costs without stating them. Patients and practices bear the cost of the remaining in-person encounters: the 30-day and annual visits under paragraph (4), and the three-month visits under the default rule for patients outside paragraphs (2) through (4) (Section 5.4). Practices that operate remotely bear the cost of building or contracting for in-person capacity. Regulators absorb interpretation, guidance, and enforcement work without an appropriation (Section 5.2). Payers' costs move with utilization, because parity fixes the price of an audio-video encounter through December 31, 2027 (Section 5.3). Prescribers bear the legal risk of misjudging federal status after December 31, 2026 (Section 7.6). No source quantifies any of these costs for New Jersey. (Documented as to the text; Projected as to amount)

8.3 Where the Law Places Discretion

Discretion sits with State regulators through delegated rulemaking and with federal authorities through the law's references to federal law. Prescribers also hold discretion through the standard of care.

Delegation and rulemaking under subsection i. Subsection i has directed the boards to adopt implementing rules since 2017 (P.L.2017, c.117), and paragraph (4) adds a new delegation for the initial examination. Because subsection i(3) says a board's failure to adopt rules does not delay implementation,

the law operates now without rules. Until a board acts, prescribers' own judgment and the DCU's non-binding guidance answer the questions in Section 2.8. Any board rule must also respect subsection i(2)'s bar on requiring an initial in-person visit. (Documented as to the text)

Federal dependency. Subsection a has conditioned telemedicine on federal law since 2017, and federal law binds prescribers directly, so a change in federal law changes what New Jersey prescribers may do without any State action (P.L.2017, c.117). Paragraph (5) adds that the use of audio-video technology must be consistent with State and federal law. On the technology-use reading, which this report treats as the closer fit to the text, paragraph (5) does not itself make State authorization of each prescription depend on federal prescribing law. On the prescribing-authorization reading, it does (Section 2.5). Under either reading, what a prescriber may do in practice under paragraphs (3) and (4) after December 31, 2026 turns on federal action, and State guidance has to track the Federal Register. Remote initiation is the most exposed part. Remote follow-up for patients evaluated in person by their prescriber is federally permitted in every outcome in Section 4.5. The committee statements describe paragraph (5) without explaining it (S. Health, Hum. Servs. & Senior Citizens Comm. Statement; Assemb. State & Loc. Gov't Comm. Statement), and the record does not show why it was chosen. (Documented as to the text; Contested as to the reading of paragraph (5))

Standard of care and liability. Paragraph (5) restates the standard-of-care requirement already in subsection d (P.L.2026, c.40). Under it, a Schedule II telehealth prescription that does not meet the in-person standard is unauthorized under subsection e. A prescriber who follows paragraph (4)'s schedule could still issue an unauthorized prescription if the case called for an in-person exam. Subsection h's protection does not cover prescribing that fails these conditions. It is unresolved whether boards or courts will treat paragraph (4)'s schedule as setting the standard of care or only a minimum. (Documented as to the text)

8.4 No Reporting, Evaluation, or Sunset Provision

P.L.2026, c.40 has two sections. Section 1 amends subsection e, and section 2 makes the act effective immediately (P.L.2026, c.40). The law has no reporting requirement, no direction to any agency to evaluate its effects, and no sunset date. No body is assigned to collect or publish data on telehealth Schedule II prescribing under paragraphs (3) and (4). The Prescription Monitoring Program collects

dispensing data (N.J. Stat. Ann. §§ 45:1-44 to -50.2), but c.40 does not require that those data be analyzed or reported for this purpose. (Documented)

New Jersey evidence on the law's effects may never be produced unless a researcher, payer, or agency does the work on its own initiative. Without a sunset, the Legislature has no scheduled occasion to revisit paragraph (4)'s schedule, and without a reporting duty it would have no State data if it did. Given the federal dependency in Section 8.3 and the absence of studies of comparable state rules (Section 6.7), the State has no built-in way to learn whether its in-person requirements change outcomes. Section 9 lists sources from which such evidence could come. (Projected)

9. Conclusion and Monitoring Indicators

P.L.2026, c.40 is narrower than the bill as introduced. A4852 would have repealed New Jersey's in-person requirement for Schedule II telemedicine prescribing (Assemb. B. 4852, as introduced). The enacted law keeps the requirement as the default and exempts specific patient groups and substance use disorder medications from it. It also allows adults to start stimulants remotely, with in-person visits within 30 days and yearly. The committee statements record the change without explaining it (S. Health, Hum. Servs. & Senior Citizens Comm. Statement; Assemb. State & Loc. Gov't Comm. Statement).

The law depends on federal rules that are changing. Subsection a conditions telemedicine on federal law, paragraph (5) adds a reference to federal law whose reach is contested, and the federal in-person requirement is suspended only through December 31, 2026. A final DEA rule remained under OIRA review as of October 27, 2026, and its text is not public (90 Fed. Reg. 61301; National Association of State Controlled Substances Authorities 2026; Office of Information and Regulatory Affairs 2026). What the adult pathway allows for remote initiation in 2027 cannot yet be determined. Remote follow-up for patients evaluated in person by their prescriber will remain federally permitted under every outcome in Section 4.5.

The available evidence is observational and drawn from other states during the pandemic, and it fits the law's provisions unevenly. It links telehealth with equal or better retention and lower overdose risk in opioid use disorder care, and with no overall increase in substance use disorder after stimulant initiation, with one imprecise adverse signal (Jones et al. 2022; Jones et al. 2023; Hammerslag et al. 2023; Huskamp et al. 2024; Creedon et al. 2025; Rao et al. 2025). It concerns buprenorphine more than any Schedule II drug, and it does not cover Schedule II opioids for pain or the populations exempted under paragraph (3). A documented search found no study of comparable in-person rules in other states, and c.40 has no reporting, evaluation, or sunset provision that would produce New Jersey evidence.

ARA will track the indicators below; movement on any of them would prompt an update to this analysis:

DEA special registration final rule. Watch the Federal Register and reginfo.gov. Publication with an effective date by December 31, 2026 would set the federal terms for paragraph (4). Volume limits or state registration requirements would narrow it. A delayed effective date would leave a gap.

Further federal extension. Watch the Federal Register and DEA press releases in late 2026. A fifth extension would keep the status quo. No extension and no final rule would trigger the lapse scenario in Section 4.5.

Board of Medical Examiners rule proposals. Watch the New Jersey Register for amendments to N.J. Admin. Code § 13:35. A proposal defining "contact," setting documentation standards, addressing whether paragraph (4) applies to paragraph (3) patients, or addressing who conducts the in-person visit would resolve Section 2.8 questions. A proposal requiring an in-person initial exam under paragraph (4) would raise the subsection i(2) issue.

DCU guidance revisions. Watch the DCU website and registrant notices. A correction of the July 7 date and the "examination" wording would remove two inconsistencies. A revision after federal action would show how the State is applying paragraph (5).

NJPMP stimulant dispensing trends. Watch PMP reports. A rise in adult Schedule II stimulant dispensing after July 2026 would fit expanded access but would not show whether prescribing is appropriate. Stable volume would suggest a small effect.

Board disciplinary actions. Watch published actions by the Board of Medical Examiners and the Board of Nursing. Actions citing paragraphs (4) or (5), or federal noncompliance after December 31, 2026, would show how the boards read the law.

Litigation. Watch State and federal dockets for challenges to the statute, rules, or discipline, and for malpractice claims involving remote Schedule II initiation. A ruling construing "contact," "visit," or paragraph (5) would settle an open question.

First evaluations of post-2026 state regimes. Watch the journals cited in Section 6, and studies of states with comparable rules identified through the CCHP tracker (Section 6.7). A study showing that a 30-day in-person requirement, or a comparable state rule, changed initiation, follow-up, or substance use disorder outcomes would be the first direct evidence on paragraph (4).

Telehealth payment parity expiration. Watch the Legislature for bills extending or making permanent P.L.2026, c.29 before December 31, 2027 (P.L.2026, c.29). A lapse would let plans pay less for telehealth than for in-person care, which could change the economics of paragraph (4)'s remote encounters.

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This report provides general information only and does not constitute legal advice. All statements of legal and regulatory status are current as of October 27, 2026 and are subject to the developments identified in Section 9.

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