

prepare a public service list containing the names and addresses of all persons, or their representatives, who are parties to the investigations. As provided in section 207.20 of the Commission's rules, the Director of the Office of Investigations will circulate draft questionnaires for the final phase of the investigations to parties to the investigations, placing copies on the Commission's Electronic Document Information System (EDIS, <https://edis.usitc.gov>), for comment.

Background

On July 29, 2026, the Hydraulic Cylinders Fair Trade Coalition and its individual members—Aggressive Hydraulics Inc., Cedar, Minnesota; Hol-Mac Corporation, Bay Springs, Mississippi; Ligon Hydraulics, Tonawanda, New York; Prince Manufacturing Corporation, Lexington, South Carolina; PTC Alliance LLC, Wexford, Pennsylvania; Rosenboom Machine and Tool Inc., Sheldon, Iowa; Scot Industries Inc., Lone Star, Texas; Stillwell Inc., Burnsville, Minnesota; and Texas Hydraulics Inc., Temple, Texas—filed petitions with the Commission and Commerce, alleging that an industry in the United States is materially injured or threatened with material injury by reason of subsidized imports of linear hydraulic cylinders from China, India, and Mexico and LTFV imports of linear hydraulic cylinders from Canada, China, India, Mexico, and South Korea. Accordingly, effective July 29, 2026, the Commission instituted countervailing duty investigation Nos. 701-TA-802-804 and antidumping duty investigation Nos. 731-TA-1799-1803 (Preliminary).

Notice of the institution of the Commission's investigations and of a public conference to be held in connection therewith was given by posting copies of the notice in the Office of the Secretary, U.S. International Trade Commission, Washington, DC, and by publishing the notice in the **Federal Register** of August 4, 2026 (91 FR 49442).⁴ The Commission conducted its conference on August 19, 2026. All persons who requested the opportunity were permitted to participate.

The Commission made these determinations pursuant to §§ 703(a) and 733(a) of the Act (19 U.S.C. 1671b(a) and 1673b(a)). It completed and filed its determinations in these

investigations on October 9, 2026. The views of the Commission are contained in USITC Publication 5800 (October 2026), entitled *Linear Hydraulic Cylinders from Canada, China, India, Mexico, and South Korea: Investigation Nos. 701-TA-802-804 and 731-TA-1799-1803 (Preliminary)*.

By order of the Commission.

Issued: October 9, 2026.

Lisa Barton,

Secretary to the Commission.

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DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Katherine Curtis, N.P.; Decision and Order

On December 15, 2025, the Drug Enforcement Administration (DEA or Government) issued an Order to Show Cause (OSC) to Katherine Curtis, N.P., of Carmel, Indiana (Registrant). Request for Final Agency Action (RFAA), Exhibit (RFAAX) 1, at 1, 9. The OSC proposed the revocation of Registrant's DEA Certificate of Registration No. MS5411765, alleging that Registrant has no state authority to handle controlled substances and that Registrant's continued registration would be inconsistent with the public interest. *Id.* at 1 (citing 21 U.S.C. 823(g)(1), 824(a)(3), 824(a)(4)).¹

Specifically, the OSC alleged that Registrant is “currently without authority to prescribe, administer, dispense, or otherwise handle controlled substances in the State of Indiana, the state in which [she is] registered with DEA.” *Id.* at 3 (citing 21 U.S.C. 824(a)(3)). The OSC further alleged that Registrant “issued multiple prescriptions that were not for a legitimate medical purpose and which did not adhere to the Indiana standard of care.” *Id.*, at 3; see 21 U.S.C. 823(g)(1)(B), (D)).²

On February 4, 2026, the Government submitted an RFAA requesting that the Agency issue a default final order revoking Registrant's registration. RFAA, at 3. After carefully reviewing

the entire record and conducting the analysis as set forth in detail below, the Agency grants the Government's request for final agency action and revokes Registrant's registration.

I. Default Determination

Under 21 CFR 1301.43, a registrant entitled to a hearing who fails to file a timely hearing request “within 30 days after the date of receipt of the [OSC] . . . shall be deemed to have waived their right to a hearing and to be in default” unless “good cause” is established for the failure. 21 CFR 1301.43(a) & (c)(1). In the absence of a demonstration of good cause, a registrant who fails to timely file an answer also is “deemed to have waived their right to a hearing and to be in default.” 21 CFR 1301.43(c)(2). Unless excused, a default is deemed to constitute “an admission of the factual allegations of the [OSC].” 21 CFR 1301.43(e).

Here, the OSC notified Registrant of her right to file a written request for hearing, and that if she failed to file such a request, she would be deemed to have waived her right to a hearing and be in default. RFAAX 1, at 8 (citing 21 CFR 1301.43). According to the Government's RFAA, Registrant failed to request a hearing. RFAA, at 1–2. Thus, the Agency finds that Registrant is in default and therefore has admitted to the factual allegations in the OSC. 21 CFR 1301.43(e).

II. Loss of State Authority

A. Findings of Fact

According to the OSC, on October 31, 2025, Registrant's Indiana advanced practice registered nurse (APRN) license expired by its own terms. RFAAX 1, at 3. On October 31, 2025, Registrant's Indiana controlled substance registration (CSR) license expired by its own terms. *Id.* On November 20, 2025, Registrant's APRN license was suspended. *Id.* According to Indiana online records, of which the Agency takes official notice,³ both Registrant's Indiana APRN license and Registrant's Indiana CSR license are expired. State of Indiana License Search, <https://mylicense.in.gov/everification> (last visited date of signature of this Order). Accordingly, the Agency finds that Registrant is not licensed to practice as an APRN nor to handle controlled

⁴ Due to the notice of extension of the deadline for determining the adequacy of the antidumping and countervailing duty petitions by Commerce, the Commission revised its schedule for this proceeding. The revised schedule was published in a subsequent notice in the **Federal Register** on August 26, 2026 (91 FR 55112).

¹ Based on the Government's submissions in its RFAA dated February 4, 2026, the Agency finds that service of the OSC on Registrant was adequate. Specifically, the included Form DEA-12, signed by Registrant, indicates that on December 29, 2025, a DEA Diversion Investigator (DI) personally served Registrant with the OSC. RFAAX 2.

² The Agency need not adjudicate the criminal violations alleged in the OSC. *Ruan v. United States*, 597 U.S. 450 (2022) (decided in the context of criminal proceedings).

³ Under the Administrative Procedure Act, an agency “may take official notice of facts at any stage in a proceeding—even in the final decision.” United States Department of Justice, Attorney General's Manual on the Administrative Procedure Act 80 (1947) (Wm. W. Gaunt & Sons, Inc., Reprint 1979).

substances in Indiana, the state in which she is registered with DEA.⁴

B. Discussion

Pursuant to 21 U.S.C. 824(a)(3), the Attorney General is authorized to suspend or revoke a registration issued under 21 U.S.C. 823 “upon a finding that the registrant . . . has had his [or her] State license or registration suspended . . . [or] revoked . . . by competent State authority and is no longer authorized by State law to engage in the . . . dispensing of controlled substances.” With respect to a practitioner, DEA has also long held that the possession of authority to dispense controlled substances under the laws of the state in which a practitioner engages in professional practice is a fundamental condition for obtaining and maintaining a practitioner’s registration. *Gonzales v. Oregon*, 546 U.S. 243, 270 (2006) (“The Attorney General can register a physician to dispense controlled substances ‘if the applicant is authorized to dispense . . . controlled substances under the laws of the State in which he practices.’ . . . The very definition of a ‘practitioner’ eligible to prescribe includes physicians ‘licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices’ to dispense controlled substances. [21 U.S.C.] 802(21).”). The Agency has applied these principles consistently. See, e.g., *Ashley Vermillion, N.P.*, 91 FR 35270 (2026); *Benson Sergiles, P.A.*, 90 FR 32016 (2025); *Mark D. Beale, M.D.*, 85 FR 48564 (2020).⁵

⁴ Pursuant to 5 U.S.C. 556(e), “[w]hen an agency decision rests on official notice of a material fact not appearing in the evidence in the record, a party is entitled, on timely request, to an opportunity to show the contrary.” The material fact here is that Registrant, as of the date of this Decision and Order, is not licensed to practice as an APRN nor to handle controlled substances in Indiana. Accordingly, Registrant may dispute the Agency’s finding by filing a properly supported motion for reconsideration of findings of fact within fifteen calendar days of the date of this Order. Any such motion and response shall be filed and served by email to the other party and to the DEA Office of the Administrator, Drug Enforcement Administration, at dea.addo.attorneys@dea.gov.

⁵ This rule derives from the text of two provisions of the Controlled Substances Act (CSA). First, Congress defined the term “practitioner” to mean “a physician . . . or other person licensed, registered, or otherwise permitted, by . . . the jurisdiction in which he practices . . . , to distribute, dispense, . . . [or] administer . . . a controlled substance in the course of professional practice.” 21 U.S.C. 802(21). Second, in setting the requirements for obtaining a practitioner’s registration, Congress directed that “[t]he Attorney General shall register practitioners . . . if the applicant is authorized to dispense . . . controlled substances under the laws of the State in which he practices.” 21 U.S.C. 823(g)(1). Because Congress has clearly mandated that a practitioner possess state authority in order to be deemed a practitioner

According to Indiana statute, and subject to exceptions irrelevant here, “[e]very person who dispenses or proposes to dispense any controlled substance within Indiana must have a registration issued by the [Indiana Board of Pharmacy] in accordance with the board’s rules.” Ind. Code § 35–48–3–3(b) (2025). Further, “dispense” means “to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner and includes the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery.” *Id.* § 35–48–1.1–11 (2025).

Here, the undisputed evidence in the record is that Registrant lacks authority to handle controlled substances in Indiana because her Indiana CSR license is expired. As discussed above, a person must hold an Indiana controlled substance registration to dispense a controlled substance in Indiana. Thus, because Registrant lacks authority to handle controlled substances in Indiana, Registrant is not eligible to maintain a DEA registration. Accordingly, the Agency finds that Registrant’s lack of state authority to handle controlled substances provides an independent basis for revocation of Registrant’s DEA registration. 21 U.S.C. 824(a)(3).

III. Public Interest Determination

A. Overview of Law

The Attorney General “may deny, suspend, or revoke [a] registration if . . . the [registrant’s] registration would be ‘inconsistent with the public interest.’” *Gonzales v. Oregon*, 546 U.S. at 251 (quoting 21 U.S.C. 824(a)(4)). The Attorney General’s “discretion in exercising [the authority to register and deregister practitioners] is spelled out in very broad terms.” *Id.* at 292 (Scalia, J., dissenting); see also *Neumann’s Pharmacy, L.L.C. v. Drug Enf’t Admin.*, 167 F.4th 320, 323 (5th Cir. 2026) (“DEA unquestionably has broad authority to deregister pharmacies and substantial discretion to shape policy within statutory bounds.”). In executing this broad mandate, DEA must continuously balance the CSA’s public interest goals of curbing the “illegal . . . distribution[,] and possession[,] and improper use of controlled substances[,

under the CSA, DEA has held repeatedly that revocation of a practitioner’s registration is the appropriate sanction whenever he or she is no longer authorized to dispense controlled substances under the laws of the state in which he or she practices. See, e.g., *Hooper*, 76 FR at 71371–72; *Sheran Arden Yeats, M.D.*, 71 FR 39130, 39131 (2006); *Dominick A. Ricci, M.D.*, 58 FR 51104, 51105 (1993); *Bobby Watts, M.D.*, 53 FR 11919, 11920 (1988); *Blanton*, 43 FR at 27617.

which has] a substantial and detrimental effect on the health and general welfare of the American people,” while ensuring that the public has access to medications that “have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.” 21 U.S.C. 801(1), (2); see Joanna R. Lampe, Cong. Rsch. Serv., R45948, *The Controlled Substances Act (CSA): A Legal Overview for the 119th Congress* (2025), <https://www.congress.gov/crs-product/R45948>.

In the case of a practitioner, Congress directed the Attorney General to consider five factors in making the public interest determination. 21 U.S.C. 823(g)(1)(A)–(E).⁶ Just as the phrase “inconsistent with the public interest” is broad, the five factors that Congress directed DEA to consider in determining the public interest are similarly broad, suggesting that Congress intended for DEA to have discretion and flexibility to interpret this language as necessary to implement its critical mission to protect the public from drug abuse and diversion. See *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 394–95 (2024) (noting that “[i]n a case involving an agency . . . the statute’s meaning may well be that the agency is authorized to exercise a degree of discretion,” such as where the statute uses terms or phrases like “‘appropriate or reasonable’” (internal citations omitted)). Indeed, courts have recognized the Agency’s broad discretion to deny applications and deregister practitioners for a wide variety of conduct that the Agency has determined is inconsistent with the public interest. See, e.g., *Orusa v. Drug Enf’t Admin.*, No. 22–3132, 2023 WL 3886403 (6th Cir. June 8, 2023) (physician issuing prescriptions outside the usual course of professional practice and beneath the standard of care); *St. Croix v. Drug Enf’t Admin.*, No. 21–1116, 2022 WL 2092177 (D.C. Cir. June 10, 2022) (physician failing to maintain adequate records, prescribing controlled substances without a legitimate medical purpose, storing controlled substances at an unregistered location, failing to

⁶ The five factors are:

(A) The recommendation of the appropriate State licensing board or professional disciplinary authority.

(B) The [registrant’s] experience in dispensing, or conducting research with respect to controlled substances.

(C) The [registrant’s] conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(D) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(E) Such other conduct which may threaten the public health and safety.

21 U.S.C. 823(g)(1)(A)–(E).

provide effective controls to guard against theft or diversion of these substances); *Suntree Pharmacy v. Drug Enf't Admin.*, No. 20–14626, 2022 WL 444357 (11th Cir. Feb. 14, 2022), cert. denied, 143 S. Ct. 305 (2022) (pharmacy filling prescriptions outside the usual course of practice).

The CSA's five public interest factors are considered in the disjunctive. *Gonzales v. Oregon*, 546 U.S. at 292–93 (Scalia, J., dissenting) (“It is well established that these factors are to be considered in the disjunctive,” quoting *In re Arora*, 60 FR 4447, 4448 (1995)); *Robert A. Leslie, M.D.*, 68 FR 15227, 15230 (2003). Each factor is weighed on a case-by-case basis. *David H. Gillis, M.D.*, 58 FR 37507, 37508 (1993); see *Morall v. Drug Enf't Admin.*, 412 F.3d 165, 181 (D.C. Cir. 2005) (describing the Agency's adjudicative process as “applying a multi-factor test through case-by-case adjudication,” quoting *LeMoyne-Owen Coll. v. N.L.R.B.*, 357 F.3d 55, 61 (D.C. Cir. 2004)). Any one factor, or combination of factors, may be decisive, *David H. Gillis, M.D.*, 58 FR at 37508, and the Agency “may give each factor the weight . . . deem[ed] appropriate in determining whether a registration should be revoked or an application for registration denied.” *Morall*, 412 F.3d. at 185 n.2 (Henderson, J., concurring) (quoting *Robert A. Smith, M.D.*, 70 FR 33207, 33208 (2007)); see also *Penick Corp. v. Drug Enf't Admin.*, 491 F.3d 483, 490 (D.C. Cir. 2007).

Moreover, while the Agency is required to consider each of the factors, it “need not make explicit findings as to each one.” *MacKay v. Drug Enf't Admin.*, 664 F.3d 808, 816 (10th Cir. 2011) (quoting *Volkman v. U.S. Drug Enf't Admin.*, 567 F.3d 215, 222 (6th Cir. 2009)); *Jones Total Health Care Pharmacy, LLC v. Drug Enf't Admin.*, 881 F.3d 823, 830 (11th Cir. 2018); *Hoxie v. Drug Enf't Admin.*, 419 F.3d 477, 482 (6th Cir. 2005). “In short, . . . the Agency is not required to mechanically count up the factors and determine how many favor the Government and how many favor the registrant. Rather, it is an inquiry which focuses on protecting the public interest; what matters is the seriousness of the registrant's misconduct.” *Jayam Krishna-Iyer, M.D.*, 74 FR 459, 462 (2009). Accordingly, as the Tenth Circuit has recognized, Agency decisions have explained that findings under a single factor can support the revocation of a registration. *MacKay*, 664 F.3d at 821.

The Government has the burden of proof in this proceeding, 21 CFR. 1301.44(e), and the Agency must make its findings based on “substantial

[record] evidence.” 5 U.S.C. 556(d); see 5 U.S.C. 706(2); 21 U.S.C. 877. If the Government meets its burden of establishing a *prima facie* case that Registrant's registration is not in the public interest, then the burden shifts to Registrant to rebut the Government's case. *Pharmacy Doctor Enters., Inc. v. Drug Enf't Admin.*, 789 Fed. Appx. 724, 729 (11th Cir. 2019) (citing *Jones Total Health Care Pharmacy*, 881 F.3d at 830).

Registrant is registered in Indiana, and the OSC has alleged violations of state laws in Indiana. RFAAX 1, at 3–8. Accordingly, the Agency must evaluate the Government's evidence under Indiana law. See *Henry Emery, M.D.*, 90 FR 46927, 46929 (2025) (explaining the Agency analyzes public interest allegations according to the laws in the state where registrant is registered with DEA); see also 21 U.S.C. 903 (“No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together.”).

B. Applicable State Law

According to the CSA's implementing regulations, a lawful controlled substance prescription is one that is “issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.” 21 CFR 1306.04(a); see *Gonzales v. Oregon*, 546 U.S. at 274; *United States v. Hayes*, 595 F.2d 258, 260 (5th Cir. 1979), *rehearing den.*, 598 F.2d 620 (5th Cir. 1979), *cert. denied*, 444 U.S. 866 (1979); RFAAX 1, at 2. “A practitioner must establish and maintain a *bona fide* doctor-patient relationship in order to act ‘in the usual course of . . . professional practice’ and to issue a prescription for a ‘legitimate medical purpose.’ ” *Dewey C. MacKay, M.D.*, 75 FR 49956, 49973 (2010).

As for state law, Indiana statute requires a practitioner who uses telehealth to establish a provider-patient relationship, and at a minimum, requires obtaining the patient's medical history and other information required to establish a diagnosis. Ind. Code § 25–1–9.5–7; RFAAX 1, at 2. Further, Indiana statute prohibits a prescriber from issuing a prescription for an opioid through telehealth when the prescriber has not previously examined the patient

in person. Ind. Code § 25–1–9.5–8; RFAAX 1, at 2.

Additionally, Indiana regulations set the standards for each nurse practitioner, which include, but are not limited to, diagnosing health problems, developing and implementing nursing treatment plans, and using appropriate critical thinking skills to make independent decisions. 848 Ind. Admin. Code § 4–2–1; RFAAX 1, at 2. Indiana regulations also require nurse practitioners to perform a focused history and physical exam on the patient, review records, complete an objective pain assessment tool, and assess the mental health of the patient and risk for abuse. 848 Ind. Admin. Code § 5–4–4; RFAAX 1, at 2.

Lastly, Indiana regulations require that an APRN with prescriptive authority consult Indiana's Prescription Drug Monitoring Program (INSPECT) prior to prescribing an opioid medication to a patient, at least annually thereafter run another report through INSPECT for the patient, and document in the patient's chart whether the INSPECT reports are consistent with the APRN's knowledge of the patient's controlled substance use history. Ind. Admin. Code § 5–4–7; RFAAX 1, at 7.

C. Findings of Fact

In light of Registrant's default, the factual allegations in the OSC are deemed admitted. 21 CFR 1301.43(e). Accordingly, Registrant admits and the Agency finds that from June 2024 to May 2025, Registrant repeatedly issued controlled substance prescriptions that were not for a legitimate medical purpose and which did not adhere to the Indiana standard of care. RFAAX 1, at 3–8.

Improper Prescribing to J.H.

Registrant admits that approximately monthly, between July 2024 and May 2025, she prescribed dextroamphetamine-amphetamine (a Schedule II stimulant), oxycodone (a Schedule II opioid), oxycodone-acetaminophen, and fentanyl (a Schedule II opioid), in various doses, to J.H. *Id.* at 4. Registrant also admits that approximately monthly, between July 2024 and May 2025, she prescribed pregabalin 75 mg (a Schedule V anticonvulsant) to J.H. *Id.*

Registrant admits that she issued the above prescriptions to J.H. despite failing to establish a medical condition sufficient to support the use of controlled substances. *Id.* Registrant admits that, among other things, she: failed to establish a proper provider-patient relationship, specially failing to obtain a proper medical history and

information necessary to establish a diagnosis; failed to conduct a psychiatric, addiction, or physical evaluation that could result in a diagnosis or support a treatment plan for the use of controlled substances; between March 2025 and May 2025, prescribed oxycodone, dextroamphetamine-amphetamine, and fentanyl without justification or notation in the patient record; and failed to monitor patient compliance with the medication regimen by ordering and reviewing urine drug screening. *Id.* Registrant also admits that she prescribed opioids via telehealth without first examining J.H. in person. *Id.*

Registrant admits that her prescribing of the above controlled substances to J.H. constituted a departure from the standard of care in Indiana and was outside the usual course of professional practice in violation of federal and state law. *Id.*

Improper Prescribing to C.D.

Registrant admits that between October 2024 and May 2025, Registrant prescribed clonazepam 1 mg (a Schedule IV benzodiazepine), hydrocodone-acetaminophen (a Schedule II opioid), oxycodone-acetaminophen, tramadol 50 mg (a Schedule IV opioid), dextroamphetamine-amphetamine, alprazolam 1 mg (a Schedule IV benzodiazepine), and zolpidem tartrate 5 mg (a Schedule IV sedative) to C.D. *Id.* Registrant admits that between October 2024 and May 2025, Registrant also administered ketamine (a Schedule III anesthetic) and esketamine (a Schedule III anesthetic/anti-depressant) to C.D. *Id.*

Registrant admits that she issued the above prescriptions to C.D. despite failing to establish a medical condition sufficient to support the use of controlled substances. *Id.* Registrant admits that, among other things, she: failed to establish a proper provider-patient relationship, specifically failing to obtain a proper medical history and information necessary to establish a diagnosis; failed to conduct a psychiatric, addiction, or physical evaluation that could result in a diagnosis or support a treatment plan for the use of controlled substances; failed to monitor the evolution of depressive symptoms in C.D.; inappropriately prescribed and administered overlapping controlled substances without articulating a need for such combinations, which placed C.D. at risk of psychiatric, addiction-related, medical, and lethal

consequences;⁷ and failed to monitor patient compliance with the medication regimen by ordering and reviewing urine drug screening. *Id.* at 4–5.

Registrant admits that her prescribing of the above controlled substances to C.D. constituted a departure from the standard of care in Indiana and was outside the usual course of professional practice in violation of federal and state law. *Id.* at 5.

Improper Prescribing to DC

Registrant admits that between June 2024 and May 2025, Registrant prescribed dextroamphetamine-amphetamine in various doses, clonazepam 1 mg, alprazolam 1 mg, zolpidem tartrate 5 mg, and esketamine 84 mg to DC *Id.*

Registrant admits that she issued the above prescriptions to DC despite failing to establish a medical condition sufficient to support the use of controlled substances. *Id.* Registrant admits that, among other things, she: failed to establish a proper provider-patient relationship, specifically failing to obtain a proper medical history and information necessary to establish a diagnosis; failed to conduct a psychiatric, addiction, or physical evaluation that could result in a diagnosis or support a treatment plan for the use of controlled substances; prescribed and administered esketamine in excess of the recommended amounts without documented medical analysis; and failed to monitor patient compliance with the medication regimen by ordering and reviewing urine drug screening. *Id.*

Registrant admits that her prescribing of the above controlled substances to DC constituted a departure from the standard of care in Indiana and was outside the usual course of professional practice in violation of federal and state law. *Id.* at 6.

Improper Prescribing to J.S.

Registrant admits that between February 2025 and April 2025, she issued four prescriptions for oxycodone in various doses and one prescription for dextroamphetamine-amphetamine 10 mg to J.S. *Id.*

Registrant admits that she issued the above prescriptions to J.S. despite failing to establish a medical condition sufficient to support the use of controlled substances. *Id.* Registrant admits that, among other things, she: failed to establish a proper provider-

patient relationship, specifically failing to obtain a proper medical history and information necessary to establish a diagnosis; failed to conduct a psychiatric, addiction, or physical evaluation that could result in a diagnosis or support a treatment plan for the use of controlled substances; on April 9, 2025, prescribed dextroamphetamine-amphetamine without justification or notation in the patient record and without informed consent regarding the potential adverse consequences that the combination of and opioid and a stimulant presented; and failed to monitor patient compliance with the medication regimen by ordering and reviewing urine drug screening. *Id.* Registrant also admits that she prescribed opioids via telehealth without first examining J.S. in person. *Id.*

Registrant admits that her prescribing of the above controlled substances to J.S. constituted a departure from the standard of care in Indiana and was outside the usual course of professional practice in violation of federal and state law. *Id.*

Improper Prescribing to K.T.

Registrant admits that between February 2025 and March 2025, she issued two prescriptions for oxycodone in various dosages and one prescription for alprazolam 1 mg to K.T. *Id.*

Registrant admits that she issued the above prescriptions to K.T. despite failing to establish a medical condition sufficient to support the use of controlled substances. *Id.* Registrant admits that, among other things, she: failed to establish a proper provider-patient relationship, specifically failing to obtain a proper medical history and information necessary to establish an appropriate diagnosis; on March 18, 2025, prescribed oxycodone and alprazolam without justification or notation in the patient record and without informed consent regarding the potential adverse consequences that the combination presented; failed to either consult INSPECT or to consider prior prescribing in her decision to prescribe opioids; and failed to monitor patient compliance with the medication regimen by ordering and reviewing urine drug screening. *Id.* at 6–7. Registrant also admits that she prescribed opioids via telehealth without first examining K.T. in person. *Id.* at 7.

Registrant admits that her prescribing of the above controlled substances to K.T. constituted a departure from the standard of care in Indiana and was outside the usual course of professional

⁷ Registrant admits that, for example, she inappropriately prescribed ketamine and esketamine in excessive doses despite the heightened risk of side effects and no additional benefit. RFAAX 1, at 5.

practice in violation of federal and state law. *Id.*

Improper Prescribing to T.H.

Registrant admits that between January 2025 and March 2025, she issued three prescriptions for oxycodone-acetaminophen in various dosages, three prescriptions for dextroamphetamine-amphetamine 30 mg, and two prescriptions for oxycodone in various doses to T.H. *Id.*

Registrant admits that she issued the above prescriptions to T.H. despite failing to establish a medical condition sufficient to support the use of controlled substances. *Id.* Registrant admits that, among other things, she: failed to establish a proper provider-patient relationship, specifically failing to obtain a proper medical history and information necessary to establish an appropriate diagnosis; failed to provide a diagnosis supported by an independent psychiatric evaluation prior to prescribing a stimulant and, instead, relied on T.H.'s representation that she was prescribed stimulants by a prior practitioner; prescribed high doses of opioids in rapidly increasing quantities to a patient who was not previously prescribed opioids (*i.e.*, an opioid-naïve patient) without determining the cause of the pain; failed to either consult INSPECT or to consider prior prescribing in her decision to prescribe opioids; and failed to monitor patient compliance with the medication regimen by ordering and reviewing urine drug screening. *Id.* at 7–8. Registrant also admits that she prescribed opioids via telehealth without first examining T.H. in person. *Id.* at 8.

Registrant admits that her prescribing of the above controlled substances to T.H. constituted a departure from the standard of care in Indiana and was outside the usual course of professional practice in violation of federal and state law. *Id.*

DEA retained an independent medical expert who reviewed materials including Registrant's medical records for J.H., C.D., DC, J.S., K.T., and T.H. and information concerning the controlled substance prescriptions that Registrant issued. *Id.* Based upon Registrant's deviations from the standard of care, the medical expert concluded that the above controlled substance prescriptions violated minimal medical standards applicable to the practice of medicine in Indiana. *Id.*

In consideration of the above, the Agency has found substantial record evidence that from June 2024 to May 2025, Registrant repeatedly issued

controlled substance prescriptions to six individuals that lacked a legitimate medical purpose and were issued outside the usual course of professional practice in Indiana.

D. Discussion

While the Agency has considered all the public interest factors of 21 U.S.C. 823(g)(1), the Government's evidence in support of its *prima facie* case primarily implicates Factors B and D. RFAA, at 2–3; RFAAX 1, at 3–8. Evidence is considered under Factor B when it reflects experience dispensing controlled substances and under Factor D when it reflects compliance or non-compliance with laws related to controlled substances. *Kareem Hubbard, M.D.*, 87 FR 21156, 21162 (2022). Although Factors B and D have some overlap, such that the Agency has frequently analyzed them together, Congress must have intended Factor B to encompass conduct that is not captured under Factor D. *See Kungys v. United States*, 485 U.S. 759, 778 (1988) (referencing the “cardinal rule of statutory interpretation that no provision should be construed to be entirely redundant”).

i. Factor B

As already discussed, the CSA gives the Attorney General authority to revoke a registration if he determines that the registrant “has committed such acts as would render his registration . . . inconsistent with the public interest as determined under [section 823].” 21 U.S.C. 824(a). One of the five factors that the Attorney General must consider in making this determination is the registrant's “experience in dispensing . . . controlled substances.” 21 U.S.C. 823(g)(1)(B) (Factor B). Neither the statute nor the implementing regulations define the term “experience” or places any limitations on the type of conduct that may be considered as “experience” under Factor B.⁸

Historically, the Agency's Factor B⁹ analysis considered “both the

⁸ The only limitation discussed in the legislative history on DEA's authority under Factor B is that DEA should not “construe[this factor] in anyway to hinder registration of recent graduates of professional schools who may have no professional experience dispensing or conducting research with controlled substances.” H.R. REP. NO. 98–835, pt. 1, at 14 (1984).

⁹ Historically, the Agency referred to “Factor B” as “Factor Two.” Effective December 2, 2022, the Medical Marijuana and Cannabidiol Research Expansion Act, Public Law 117–215, 136 Stat. 2257 (2022) (Marijuana Research Amendments or MRA), amended the CSA and other statutes. Relevant to this matter, the MRA redesignated the public interest factors outlined at 21 U.S.C. 823(f)(1)–(5), which the Agency referred to as Factors One

qualitative manner and quantitative volume of the [practitioner's] experience . . . as expressed through his patients and employees,” and concluded that the record must contain quantitative evidence regarding the practitioner's experience for the Agency to find that Factor B weighs against a practitioner. *E.g., Clair L. Pettinger*, 78 FR 61592, 61619 (2013). In 2015, the Agency abandoned this language, observing that the text of Factor B did not require DEA to consider the practitioner's “quantity” of prescribing. *See JM Pharmacy Group, Inc.*, 80 FR 28667, 28667–68 (2015); *see also Wesley Pope, M.D.*, 82 FR 14944, 14982 (2017). The Agency reviewed dictionary definitions of “experience,” including:

(1) The “direct observation of or participation in events as a basis for knowledge,” (2) “the fact or state of having been affected by or gained knowledge through direct observation or participation,” (3) “practical knowledge, skill, or practice derived from direct observation of or participation in events or in a particular activity,” and (4) “the length of such participation.”

80 FR at 28667 n.2 (citing *Webster's Collegiate Dictionary* 409 (10th ed. 1998); *The Random House Dictionary of the English Language* 681 (2d ed. 1987)).

The word “dispense” means “to deliver a controlled substance[] to an ultimate user or research subject by, or pursuant to the lawful order of a practitioner, including the prescribing or administering of a controlled substance and the packaging, labeling or compounding necessary to prepare the substance for such delivery.” 21 U.S.C. 802(10). This definition encompasses, among other things, practitioners who prescribe controlled substances and pharmacies who fill controlled substance prescriptions. *Id.* The term “controlled substance” simply means “a drug or other substance . . . included in schedule I, II, III, IV, or V” 21 U.S.C. 802(6). Thus, the phrase “experience in dispensing” means the direct participation in the act of delivering, prescribing, dispensing, or administering a controlled substance to an ultimate user.

The phrase “experience in dispensing” must be considered within the context of DEA's broad mandate under 21 U.S.C. 824(a) to deregister practitioners who “ha[ve] committed such acts as would render [their] registration . . . inconsistent with the public interest.” 21 U.S.C. 824(a)(4). In other words, in determining what type

through Five, as 21 U.S.C. 823(g)(1)(A)–(E), which the Agency now refers to as Factors A through E. Accordingly, this Decision cites to the current designation, 21 U.S.C. 823(g)(1)(B), “Factor B.”

of conduct is relevant under Factor B, DEA's primary focus is to determine whether a registrant's "experience in dispensing" is "inconsistent with the public interest" or whether a registrant's dispensing constitutes "acts" that are inconsistent with the public interest. 21 U.S.C. 823(g)(1), 824(a)(4).

The word "inconsistent" is not defined in the CSA, but it is commonly defined as "lacking consistency: such as (a) not compatible with another fact or claim, [and] (b) containing incompatible elements." *Inconsistent*, Merriam-Webster, <https://www.merriam-webster.com/dictionary/inconsistent> (last visited on the date of signature). "Public interest" is a broad, discretionary term not explicitly defined in the CSA, but Congress identifies the primary goals in the CSA's introductory section as ensuring access to controlled substances used for a "legitimate medical purpose" while protecting the public from the "illegal . . . distribution . . . and improper use of controlled substances[, which] have a substantial and detrimental effect on the health and general welfare of the American people." 21 U.S.C. 801(1) & (2).

Considering these goals, DEA's Factor B analysis primarily concerns whether a registrant's "experience in dispensing" reflects illegal distribution or improper use of controlled substances that is inconsistent with the public interest. *Id.* In the context of a practitioner, this would require the Agency to evaluate whether the practitioner has dispensed controlled substances in a manner that is improper, illegal, or inconsistent with the public interest; for example, by issuing prescriptions without conducting a proper examination or developing a supported diagnosis; ignoring patient indications of abuse, diversion, or improper use; issuing a prescription in a manner that is inconsistent with state law or the state's standards of practice; or issuing prescriptions for controlled substances in a way that creates a risk of diversion.¹⁰

Of course, the Agency is not only concerned with acts of intentional diversion,¹¹ as DEA has explained that

"[c]areless or negligent handling of controlled substances creates the opportunity for diversion and [can] justify the revocation of an existing registration . . ." *Samson K. Orusa, M.D.*, 87 FR 2986, 3018 (2022) (quoting *Paul J. Caragine, Jr.*, 63 FR 51592, 51602 (1998)); *see also Dewey C. MacKay, M.D.*, 75 FR 49956, 49974 n.35 (2010) ("Accordingly, under the public interest standard, DEA has authority to consider those prescribing practices of a physician, which, while not rising to the level of intentional or knowing misconduct, nonetheless create a substantial risk of diversion."). Indeed, neither 21 U.S.C. 824(a) nor 21 U.S.C. 823(g) requires DEA to find that a registrant has intentionally diverted controlled substances. Ultimately, a registrant whose dispensing practices create an environment that encourages or is indifferent to the abuse or diversion of controlled substances is acting outside the public's interest. As the opioid epidemic surges and other controlled substances, such as amphetamines, ketamine, and benzodiazepines, are increasingly abused, DEA must remain vigilant to protect the public against registrants who fail to employ the CSA's safeguards to ensure the health and general wellness of the American public.

Registrants "may continue to introduce evidence as to . . . lawful . . . dispensing activities."¹² However, the Agency has found that "evidence that a practitioner has treated thousands of patients does not negate a *prima facie* showing that the practitioner has committed acts inconsistent with the public interest."¹³ *Krishna-Iyer*, 74 FR at 463. Accordingly, the Agency has consistently rejected registrants'

(4th Cir. 2006) (quoted in *Laurence T. McKinney*, 73 FR 43260, 43266 (2008)). *Compare* 21 U.S.C. 823 and 824, with 21 U.S.C. 841, 842, 843.

¹² *Randall L. Wolff, M.D.*, 77 FR 5106, 5153 (2012) (finding that evidence of lawful prescribing is "entitled to some evidentiary weight only in cases where a practitioner credibly demonstrates an acceptance of responsibility and reform of past practices"); *see also Roberto Zayas, M.D.*, 82 FR 21410, 21422 n.27 (2017) ("[T]he Agency properly considers a [registrant's] evidence of a lengthy history of compliance after the Government makes out its *prima facie* case, as determining what sanction is necessary to protect the public interest is the ultimate purpose of these provisions."). In other words, this evidence may be relevant to the Agency's sanctions analysis.

¹³ "[E]very registrant can undoubtedly point to an extensive body of legitimate prescribing over the course of [their] professional career." *Krishna-Iyer*, 74 FR at 463. Accordingly, except where the Agency has found in its decision that a prescription was issued outside the public interest or in violation of law, the Agency assumes that all controlled substance prescriptions dispensed by a pharmacy are dispensed for a legitimate medical purpose and in accordance with relevant laws. *See Dewey C. Mackay, M.D.*, 75 FR at 49977.

arguments that acts of unlawful prescribing were mitigated by years of lawful prescribing. *See, e.g., Syed-Jawed Akhtar-Zaidi*, 80 FR 42961, 42967 (2015), *pet. for rev. denied*, 841 F.3d 707, 713 (6th Cir. 2016) (rejecting respondent's argument that he was denied a "fair adjudication" because the Government seized 400 patient files but only proved the illegality of a handful of prescriptions issued during undercover visits, and finding that "the physician's prescriptions to thousands of other patients do not . . . render her prescriptions to the undercover officers any less unlawful, or any less acts which are inconsistent with the public interest") (internal quotations and citations omitted).¹⁴

Here, as found above, Registrant is deemed to have admitted, and the Agency finds, that from June 2024 to May 2025, Registrant repeatedly issued controlled substance prescriptions to six individuals, including dangerous combinations of controlled substances, that lacked a legitimate medical purpose and were issued outside the usual course of professional practice in Indiana. RFAAX 1, at 3–8. DEA's medical expert concluded that the controlled substance prescriptions "violated minimal medical standards applicable to the practice of medicine in Indiana." *Id.*, at 8. Indiana regulations require nurse practitioners to perform an initial evaluation that includes a focused history and physical examination, and to assess the mental health of the patient and the patient's risk for abuse. *See* 848 Ind. Admin. Code § 5–4–4. Additionally, Indiana regulations require nurse practitioners to diagnose health problems, develop and implement nursing treatment plans, and use appropriate critical thinking skills to make independent decisions. *See* 848 Ind. Admin. Code § 4–2–1.

As found above, Registrant repeatedly failed to conduct an appropriate medical evaluation and obtain a proper medical history that would support the development of a treatment plan or a diagnosis to justify prescribing controlled substances to the six individuals. Registrant also prescribed dangerous combinations of controlled substances in excessive doses without justification in the record. For example, Registrant prescribed and administered

¹⁴ In an unreported opinion, the Sixth Circuit affirmed DEA's conclusion that the respondent's acts of unlawful prescribing outweighed his years of work experience. *Orusa v. Drug Enf't Admin.*, 2023 WL 3886403 at *5 ("Orusa's credentials and years of work experience, which the agency acknowledged, do nothing to disturb the agency's detailed review of his prescribing history—the relevant 'experience in dispensing . . . controlled substances.'").

¹⁰ Analysis of whether a prescription is illegally filled, distributed, prescribed, or possessed also fit within Factor D, "Compliance with applicable State, Federal, or local laws relating to controlled substances." 21 U.S.C. 823(g)(1)(D).

¹¹ Only criminally unlawful conduct requires an act of intentional diversion such as proof that a physician "used 'his authority to prescribe controlled substances . . . not for treatment of a patient, but for the purpose of assisting another in the maintenance of a drug habit' or some other illegitimate purposes, such as his own 'personal profit.'" *United States v. McIver*, 470 F.3d 550, 559

esketamine in excess of the recommended amounts without documented medical analysis. Registrant's prescribing reflects "experience in dispensing . . . controlled substances" that created an opportunity for the abuse or diversion of controlled substances and was outside the public interest. Registrant did not request a hearing and thus did not provide the Agency with any evidence related to her "experience in dispensing" that served the public's interest. Accordingly, the Agency finds that Factor B weighs strongly against Registrant's continued registration.

ii. Factor D

Under Factor D, the Agency considers a registrant's "[c]ompliance with applicable State, Federal, or local laws relating to controlled substances." 21 U.S.C. 823(g)(1)(D). Here, based on Registrant's admissions, the Agency finds that Registrant prescribed to J.H., J.S., K.T., and T.H. by telehealth without first establishing a provider-patient relationship, including obtaining the patient's medical history and establishing a diagnosis in violation of Ind. Code § 25–1–9.5–7. Further, the Agency finds that Registrant issued opioid prescriptions to J.H., J.S., K.T., and T.H. through telehealth without first examining the patient in person. Ind. Code § 25–1–9.5–8.

Additionally, based on Registrant's admissions, the Agency finds that Registrant issued numerous opioid prescriptions to K.T. and T.H. without first consulting INSPECT and/or running annual INSPECT reports, and/or documenting the INSPECT reports in the patient's chart in violation of Ind. Admin. Code § 5–4–7.

Additionally, Registrant is deemed to have admitted and the Agency finds that from June 2024 to May 2025, Registrant repeatedly issued controlled substance prescriptions to six individuals that violated Indiana law, lacked a legitimate medical purpose and were issued outside the usual course of professional practice in Indiana. Accordingly, the Agency finds substantial record evidence that Registrant violated 21 CFR 1306.04; Ind. Code §§ 25–1–9.5–7, 25–1–9.5–8; and 848 Ind. Admin. Code § 5–4–7. The Agency finds that after considering the public interest factors of 21 U.S.C. 823(g)(1), Factors B and D weigh in favor of revocation of Registrant's registration.¹⁵

¹⁵ While the Agency has determined that Registrant's dispensing conduct is relevant to Factors B and D, to the extent that the found conduct does not fall within these factors, it would nevertheless constitute "other conduct which may threaten the public health and safety." 21 U.S.C.

Accordingly, the Government has satisfied its prima facie burden of showing that Registrant's continued registration would be "inconsistent with the public interest." 21 U.S.C. 824(a)(4). The Agency also finds that there is insufficient mitigating evidence to rebut the Government's prima facie case. Thus, the only remaining issue is whether, in spite of the public interest determination, Registrant can be trusted with a registration.

IV. Sanction

Where, as here, the Government has met its burden of showing that Registrant's registration is inconsistent with the public interest, the burden shifts to Registrant to show why she can be entrusted with a registration. *Morall*, 412 F.3d at 174; *Jones Total Health Care Pharmacy*, 881 F.3d at 830; *Garrett Howard Smith, M.D.*, 83 FR 18882, 18904 (2018). The issue of trust is necessarily a fact-dependent determination based on the circumstances presented by the individual registrant. *Jeffrey Stein, M.D.*, 84 FR 46968, 46972 (2019); *see also Jones Total Health Care Pharmacy*, 881 F.3d at 833. Moreover, as past performance is the best predictor of future performance, the Agency requires that a registrant who has committed acts inconsistent with the public interest accept responsibility for those acts and demonstrate that the registrant will not engage in future misconduct. *See Jones Total Health Care Pharmacy*, 881 F.3d at 833; *ALRA Labs, Inc. v. Drug Enf't Admin.*, 54 F.3d 450, 452 (7th Cir. 1995). The Agency requires a registrant's unequivocal acceptance of responsibility. *Janet S. Pettyjohn, D.O.*, 89 FR 82639, 82641 (2024); *Mohammed Asgar, M.D.*, 83 FR 29569, 29573 (2018); *see also Jones Total Health Care Pharmacy*, 881 F.3d at 830–31. In addition, a registrant's candor during the investigation and hearing is an important factor in determining acceptance of responsibility and the appropriate sanction. *See Jones Total Health Care Pharmacy*, 881 F.3d at 830–31; *Hoxie*, 419 F.3d at 483–84. Further, the Agency considers the egregiousness and extent of the misconduct as significant factors in determining the appropriate sanction. *See Jones Total Health Care Pharmacy*, 881 F.3d at 834

823(g)(1)(E). Registrant's repeated issuing of controlled substances that lacked a legitimate medical purpose and were issued outside the usual course of professional practice in Indiana may threaten the public health and safety by threatening the health and safety of individuals and by creating the risk that controlled substances may leave the CSA's closed distribution system and be abused or diverted.

& n.4. The Agency also considers the need to deter similar acts by a registrant and by the community of registrants. *Stein*, 84 FR at 46972–73.

Here, Registrant did not request a hearing or answer the allegations in the OSC and was therefore deemed to be in default. *See supra* I. To date, Registrant has not filed a motion with the Office of the Administrator to excuse the default. 21 CFR 1301.43(c)(1). Registrant has thus failed to answer the allegations contained in the OSC and has not otherwise availed herself of the opportunity to refute the Government's case. As such, Registrant has not accepted responsibility for the proven violations, has made no representations regarding his future compliance with the CSA, and has not demonstrated that she can be trusted with registration. Accordingly, the Agency will order the revocation of Registrant's registration.

Order

Pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 824(a), I hereby revoke DEA Certificate of Registration No. MS5411765 issued to Katherine Curtis, N.P. Further, pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 823(g)(1), I hereby deny any pending applications of Katherine Curtis, N.P., to renew or modify this registration, as well as any other pending application of Katherine Curtis, N.P., for additional registration in Indiana. This Order is effective November 13, 2026.

Signing Authority

This document of the Drug Enforcement Administration was signed on October 5, 2026, by DEA Administrator Terrance C. Cole. That document with the original signature and date is maintained by DEA. For administrative purposes only, and in compliance with requirements of the Office of the Federal Register, the undersigned DEA Federal Register Liaison Officer has been authorized to sign and submit the document in electronic format for publication, as an official document of DEA. This administrative process in no way alters the legal effect of this document upon publication in the **Federal Register**.

Heather Achbach,

Federal Register Liaison Officer, Drug Enforcement Administration

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