

requests for a hearing must be sent to: (1) Drug Enforcement Administration, Attn: Hearing Clerk/OALJ, 8701 Morrisette Drive, Springfield, Virginia 22152; and (2) Drug Enforcement Administration, Attn: DEA Federal Register Representative/DPW, 8701 Morrisette Drive, Springfield, Virginia 22152. All requests for a hearing should also be sent to: Drug Enforcement Administration, Attn: Administrator, 8701 Morrisette Drive, Springfield, Virginia 22152.

SUPPLEMENTARY INFORMATION: In accordance with 21 CFR 1301.34(a), this is notice that on September 23, 2026, Groff NA Hemplex, LLC, 2218 South Queen Street, York, Pennsylvania 17402, applied to be registered as an importer of the following basic class(es) of controlled substance(s):

Controlled substance	Drug code	Schedule
Marihuana Extract	7350	I
Marihuana	7360	I
Tetrahydrocannabinols ...	7370	I

The company plans to import listed controlled substances in bulk form to manufacture research grade material for clinical trial studies. Several types of Marihuana Extract compounds are listed under code 7350. No other activities for these drug codes are authorized for this registration.

Approval of permit applications will occur only when the registrant's business activity is consistent with what is authorized under 21 U.S.C. 952(a)(2). Authorization will not extend to the import of Food and Drug Administration-approved or non-approved finished dosage forms for commercial sale.

Justin Wood,

Deputy Assistant Administrator.

[FR Doc. 2026-21367 Filed 10-16-26; 8:45 am]

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DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Muhamad Aly Rifai, M.D.; Decision and Order

I. Introduction

On November 30, 2023, the Drug Enforcement Administration (DEA or Government) issued an Order to Show Cause (OSC) to Muhamad Aly Rifai, M.D. (Respondent). Request for Final Agency Action (RFAA), Exhibit (RFAAX) 3, at 1, 7. The OSC proposed the revocation of Respondent's DEA Certificate of Registration, No.

BR7552272, in Easton, Pennsylvania. *Id.* at 3. The OSC alleged that Respondent's registration should be revoked because his "continued registration is inconsistent with the public interest." *Id.* at 1 (citing 21 U.S.C. 823(g)(1)). The OSC also proposed the revocation of Respondent's registration, alleging that the "falsification of patient medical records to conceal the unlawful prescribing of controlled substances may be considered by the Agency as conduct that threatens the public health or safety and grounds to revoke or deny a DEA Registration." *Id.* at 3.

A. Procedural Background

On December 28, 2023, Respondent filed a timely hearing request with the Office of the Administrative Law Judges (ALJs). *Id.* at 2; see RFAAX 25, at 17–19. A hearing on the merits was initially scheduled for April 29, 2024. RFAAX 5, at 5. After some lengthy procedural exchanges between the parties and the ALJ,¹ the matter was terminated because the ALJ found that Respondent "desires delay, during which time he can continue to prescribe schedule II controlled substances despite very serious allegations against him." RFAAX 2, at 16. The ALJ then terminated the hearing proceedings on August 20, 2024, and concluded that the "Respondent, in fact, does *not* desire a hearing before this tribunal." RFAAX 2, at 16. The ALJ did not find that Respondent was in default. RFAAX 2.

Thereafter, on September 5, 2024, the Government submitted a request for final agency action arguing that the Administrator may enter a default final revoking Respondent's registration. RFAAX 25, at 1, 4. On July 8, 2025, the Administrator denied the Government's request to find Respondent in default because Respondent "continued to defend his case and contest the allegation on their merits." RFAAX 26, at 8; see RFAA, at 6. Instead, the Administrator found that the ALJ's Termination Order arose from her duties "to take all necessary action to avoid delay, and to maintain order." RFAAX 26, at 2 (citing 21 CFR 1316.52). The Administrator then returned the matter to the Government for further action, including an opportunity to file a new RFAA that contains substantial record evidence supporting the revocation of Respondent's registration. RFAAX 26, at 8–9.

On August 25, 2025, the Government submitted another RFAA and requested

¹ The lengthy procedural history in this matter is set forth fully in the ALJ's August 20, 2024, Order Vacating Stay and Terminating Proceedings. RFAAX 2, at 1–17.

that the Agency revoke Respondent's registration because his prescribing patterns were "outside the usual course of professional practice and not for a legitimate medical purpose" and Respondent falsified patient medical records. RFAA, at 18 (citing 21 CFR 1306.04(a) and multiple state laws).² The Government contended that these violations demonstrated that Respondent's continued registration is inconsistent with the public interest. RFAA, at 19 (citing 21 U.S.C. 824(a)(4), 823(g)(1)(B), (D)).³

After carefully reviewing the entire record and conducting the analysis as set forth in more detail below, the Agency grants the Government's RFAA and revokes Respondent's registration.

II. Law Applicable to Public Interest Determination

A. Legal Background on Public Interest Determinations

Congress enacted the Controlled Substances Act (CSA) "to conquer drug abuse and control the legitimate and illegitimate traffic in controlled substances." *Gonzales v. Raich*, 545 U.S. 1, 12 (2005). A particular concern of Congress was "the need to prevent the diversion of drugs from legitimate to illicit channels," and it "devised a closed regulatory system making it unlawful to manufacture, distribute, dispense, or possess any controlled substance except in a manner authorized by the CSA." *Id.* at 12–13.

The CSA's requirements under this closed regulatory system include that "[e]very person who dispenses, or who proposes to dispense, any controlled substance, shall obtain from the [DEA] a registration." 21 U.S.C. 822(a)(2); see also *Gonzales v. Raich*, 545 U.S. at 27–28. To protect the American people and ensure compliance with the CSA, Congress empowered the Agency⁴ to deny, suspend, or revoke a registration if it would be inconsistent with the public interest. 21 U.S.C. 823(g)(1); 21

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

³ The Government cited to 21 U.S.C. 823(f)(2), (4), which is not the current designation of the public interest factors. 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 Controlled Substances Act (CSA) and other statutes. Relevant to this matter, the MRA redesignated 21 U.S.C. 823(f), cited in the OSC, as 21 U.S.C. 823(g)(1). Accordingly, this Decision cites to the current designation, 21 U.S.C. 823(g)(1), and to the MRA-amended CSA throughout.

⁴ The CSA delegates this power to the Attorney General, who has delegated it to the Administrator of the DEA (the Agency) by 28 CFR 0.100.

U.S.C. 824(a)(4); *Gonzales v. Oregon*, 546 U.S. 243, 251 (2006).

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[, 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,” which is defined in 21 U.S.C. 802(21) to include a “physician,” Congress directed the Attorney General to consider five factors in making the public interest determination. *Gonzales v. Oregon*, 546 U.S. at 251; 21 U.S.C. 823(g)(1)(A–E). The five factors are:

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

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

(C) The applicant’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).

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 purposes, storing controlled substances at an unregistered location, failing to 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).

These 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).

B. Law Applicable to Falsified Medical Records

The OSC alleges that Respondent acted outside the public interest when he falsified the medical records of an undercover law enforcement officer (UC) purporting to seek medical treatment. RFAAX 3, at 3. The OSC notes that falsification of medical records to conceal the true nature of prescribing practices is conduct that may threaten the public health and safety. RFAAX 3, at 3; see *Jerry Neil Rand, M.D.*, 61 FR 28895, 28897 (1996) (finding that falsifying patient charts in which Respondent had prescribed controlled substances is inconsistent with the public interest).

Regarding recordkeeping, under Pennsylvania law, “[a] physician shall maintain medical records for patients which accurately, legibly and completely reflect the evaluation and treatment of the patient” and “[t]he medical record shall contain information sufficient to clearly identify the patient, the person making the entry if the person is not the physician—such as a physician assistant or a certified registered nurse practitioner—the date of the medical record entry and patient complaints and symptoms.” 49 Pa. Code § 16.95(a)–(b); see RFAAX 3, at 2–3. Moreover, Pennsylvania law provides that “[t]he medical record shall also include diagnoses, the findings and results of pathologic or clinical laboratory examination, radiology

examination, medical and surgical treatment and other diagnostic, corrective or therapeutic procedures.” *Id.* at § 16.95(d). Pennsylvania law also instructs practitioners to follow certain minimal standards when prescribing controlled substances, including recordkeeping: “[a]ccurate and complete medical records must document the evaluation and care received by patients.” 49 Pa. Code § 16.92(a)(4) (emphasis added); *see* RFAAX 3, at 2.⁵

C. Law Applicable to Improper Prescribing of Controlled Substances

The OSC also alleges that Respondent acted outside the public interest when he improperly issued controlled substance prescriptions to UC. RFAAX 3, at 3–5. According to the CSA’s implementing regulations, a lawful prescription for controlled substances 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 (5th Cir. 1979), *rehearing den.*, 598 F.2d 620 (5th Cir. 1979), *cert. denied*, 444 U.S. 866 (1979). Pennsylvania state law similarly requires that “[a] prescription for a controlled substance must be issued for a legitimate medical purpose by a licensed practitioner in the usual course of professional practice.” 28 Pa. Code § 25.52(a); *see* RFAAX 3, at 2.

Pennsylvania law also requires practitioners to take “an initial medical history” and conduct “an initial physical examination” prior to prescribing controlled substances, make “[r]evaluations of the patient’s condition and efficacy of the controlled substance . . . consistent with the condition diagnosed, the controlled substance or substances involved, expected results and possible side effects,” and counsel “[t]he patient . . . regarding the condition diagnosed and the controlled substance prescribed, administered or dispensed.” 49 Pa. Code § 16.92(a)(1)–(3); *see* RFAAX 3, at 2.

A practitioner in Pennsylvania may prescribe, administer, or dispense a controlled substance or other drug or device only under the following conditions: “(i) in good faith in the course of his professional practice, (ii) within the scope of the patient relationship, and (iii) in accordance with treatment principles accepted by a responsible segment of the medical

profession.” 35 Pa. Const. Stat. § 780–111(d); *see* RFAAX 3, at 3.

III. Findings of Fact

Respondent is a Pennsylvania-licensed psychiatrist who prescribed dextroamphetamine-amphetamine, a Schedule II stimulant, to UC on three separate occasions. RFAA, at 7–8; RFAAX 2, at 1 n. 1; RFAAX 3, at 3–5.⁶ Specifically, on May 17, 2021, Respondent prescribed 30 tablets of dextroamphetamine-amphetamine 5 mg and instructed that UC take one tablet two times per day for fifteen days. RFAAX 3, at 4. On June 11, 2021, Respondent issued UC a prescription for 60 tablets of dextroamphetamine-amphetamine 10 mg and instructed that UC take one tablet two times per day for thirty days. RFAAX 3, at 4. Finally, on August 9, 2021, Respondent issued to UC a prescription for 60 tablets of dextroamphetamine-amphetamine 15 mg to be taken two times per day for thirty days. RFAAX 3, at 5.

UC provided a declaration under penalty of perjury, pursuant to 28 U.S.C. 1746.⁷ RFAAX 28, at 1–7.

A. Falsifying Medical Records

In September 2023, DEA subpoenaed Respondent for all medical patient records related to UC. RFAAX 31, at 1. Respondent provided the following documentation dated May 17, 2021: Patient Information Sheet; Patient Symptom Intake Form; History and Personal Data Questionnaire; Authorization for Release of Confidential Information; Patient Cancellation Policy; Acknowledgement; Notice of Privacy Practices; Patient Financial Responsibility for Healthcare Services; Medication Refill Policy; Patient Laboratory Screening; Disability and Related Paperwork Protocol; Patient Medication Risk; Psychiatric Evaluation; Consent to Contract to Participate in treatment using Stimulant Medication; Urine Drug Screen—12 Panel Integrated Test Cup; The Test of Variables Attention; Audit-C; Patient Health

Questionnaire (PHQ–9); GAD–7 Anxiety; and Adult ADHD Self-Report Scale Symptom Checklist. RFAAX 32, at 1–38. Additionally, Respondent submitted the following documentation: Psychiatric Progress Notes indicating an in-person appointment on May 17, 2021; a video telemedicine follow-up on June 11, 2021; and a telehealth appointment on August 9, 2021; Urine Drug Screen—12 Panel Integrated Test Cup with results dated August 9, 2021; a letter dated August 9, 2021, to UC informing her that Respondent can no longer provide UC with psychiatric services because she has been approved for medical cannabis treatment; and a patient controlled substance report showing prescriptions for “amphetamine salt combo” issued by Respondent on May 17, 2021, June 11, 2021, and August 9, 2021. RFAAX 32, at 39–50; *see* RFAAX 35, at 1–3.

In her declaration under penalty of perjury pursuant to 28 U.S.C. 1746, which was signed and dated, UC attested that she did not produce or disclose any medical documentation from previous providers, diagnostic or testing results, or laboratory test results to Respondent. RFAAX 28, at 3. UC stated under penalty of perjury that she did not complete or orally answer questions to the following forms: Patient Symptom Intake Form, History and Personal Data Questionnaire, Patient Medical Risk, Consent and Contract to Participate in Treatment Using Stimulant Medication, Urine Drug Screen—12 Panel Integrated Test Cup dated May 17, 2021, Audit C, Patient Health Questionnaire (PHQ–9), GAD–7 Anxiety, and Adult ADHD Self-Report Scale (ASR–v1.1) Symptom Checklist. RFAAX 28, at 3–4.

UC clarified that she never provided a urine specimen during her psychiatric visit and evaluation on May 7, 2021. RFAAX 28, at 4. UC also attested that she never provided a urine specimen on August 9, 2021. RFAAX 28, at 6. Moreover, contrary to the contents of the psychiatric evaluation dated May 8, 2021, UC declared under penalty of perjury that she never stated that she needed help, had problems with low mood, low concentration or anxiety, that she had a history of antidepressants, that she was worried about harming her customers due to lack of focus, that she had a family history of siblings with depression or anxiety, that her maternal aunt committed suicide, she had a family history of alcoholism, that her sister had ADD, that her mom stated she was “all hyper,” that her family has a poor relationship, that she experienced physical and mental abuse by parents

⁵ The OSC erroneously cites to 49 Pa. Code § 16.92(b) instead of (a). RFAAX 3, at 2.

⁶ The parties stipulated, in part, to allegations 4, 5, and 6 as stated in the OSC, to the extent that the Respondent prescribed UC a specified quantity of the controlled substance on the identified date. RFAAX 5, at 2 n.1.

⁷ 28 U.S.C. 1746 allows a written unsworn declaration in proper form as true under penalty of perjury to substitute for an affidavit. While the Federal Rules of Evidence (FRE) do not apply directly to DEA administrative hearings, it may be used for guidance, where they do not conflict with agency regulations. *In the Matter of Rosalind A. Cropper, M.D.*, 66 FR 41040, 41041. The Advisory Committee Notes on FRE 56(c)(4) state that a declaration can be used to support a motion as long as it is made under penalty of perjury and dated. *See* Fed. R. Civ. P. 56(c), advisory committee’s note to 2010 amendment.

while growing up, or that she had sporadic cannabis use. RFAAX 28, at 4; see RFAAX 32, at 16–19; RFAAX 39, at 1–26; RFAAX 40, at 1–8; RFAAX 41, at 1–4.

UC stated that on June 11, 2021, she had telephone conversations with staff members at Respondent's practice but did not interact with Respondent. RFAAX 28, at 4; see RFAAX 40, at 1–8. However, Respondent's progress note shows that the appointment was with a "secure video." RFAAX 32, at 41–42. UC also stated that on August 9, 2021, she spoke with a nurse practitioner via telephone and asked that her prescription for dextroamphetamine-amphetamine be increased in strength and refilled. RFAAX 28, at 5; see RFAAX 41, at 1–4. But Respondent's progress note shows that the appointment was via "telehealth" and "Office Visit in person." RFAAX 32, at 43, 44.

Contrary to Respondent's progress notes, UC stated that she never expressed to Respondent that she struggled with ADHD symptoms, that she requested an increase in the strength of her prescription so that she would be able to focus on work, that she used cannabis periodically to alleviate anxiety or alcohol use, or that she possessed a medical marijuana card. RFAAX 28, at 6; but see RFAAX 32, 39–45. Notably, UC stated that Respondent had copied her signature from a form that she had filled out to the other medical records that she never completed, and the copy of the signature was done without her knowledge or consent. RFAAX 28, at 4.

Where Respondent's medical documents conflict with UC's statements, the Agency credits UC's statements, which have more weight than Respondent's forged and falsified medical documentation.⁸ Here, the Agency finds substantial record

evidence that Respondent falsified UC's medical records documenting telehealth examinations, in-person evaluations, diagnostic tests, and patient-doctor discussions that did not occur and falsified medical records that were not filled out or completed by UC. RFAAX 28, at 3–5; see RFAAX 32, at 2–4, 15–21, 22–29, 30–37, 46–47. In contrast, UC's declaration was signed and dated under penalty of perjury pursuant to 28 U.S.C. 1746. RFAAX 28, at 7; see *U.S. ex rel. Doe v. Heart Solution, P.C.*, 923 F.3d 308, 315 (3d Cir. 2019) (an unsworn statement pursuant to 28 U.S.C. 1746 may be considered on summary judgment). Significantly, there is no contrary evidence discrediting UC's signed declaration. See *Edge Pharmacy*, 81 FR 72092, 72101–72102 n. 23 (2016) (accepting a declaration pursuant to 28 U.S.C. 1746 as credible because it was signed and dated under the penalty of perjury).

Accordingly, based on UC's declaration pursuant to section 1746, which is signed and dated under the penalty of perjury, Agency finds substantial record evidence that Respondent's medical records for UC, including numerous diagnostic tests, were falsified.

B. Improper Prescribing

As mentioned above, UC was prescribed dextroamphetamine-amphetamine on three separate occasions. RFAAX 35, at 1–3; see RFAAX 28, at 1–2. Specifically, on May 17, 2021, UC paid \$300 in cash for the first visit, at which time she was interviewed by "students" regarding her medical history. RFAAX 28, at 2; see RFAAX 39, at 1–26. At that time, UC indicated that she had been previously prescribed medication that contained dextroamphetamine-amphetamine and another drug to help her with sleeping but that she did not remember the name of her previous practitioner. RFAAX 28, at 2; see RFAAX 39, at 5–6. UC told the students that she did not know whether she had a history of attention-deficient/hyperactivity disorder (ADHD), and that she did not possess an identification card because it had been revoked due to a driving under the influence (DUI) arrest. RFAAX 28, at 2; see RFAAX 39, at 4–11. On that day, UC also interacted with Respondent and informed him that UC had been prescribed dextroamphetamine-amphetamine by another doctor two to three years prior, and that she was again seeking prescriptions of dextroamphetamine-amphetamine because it helps her "[g]et along better." RFAAX 28, at 2; RFAAX 39, at 16. She witnessed Respondent check the state prescription drug

monitor program (PDMP) for prior prescription of dextroamphetamine-amphetamine, but he was not able to find a record of any controlled substance prescribed to UC in the past five years. RFAAX 28, at 2–3; see RFAAX 39, at 19. UC also explained to Respondent that she had been arrested for DUI, and Respondent then discussed the seriousness of alcoholism. RFAAX 28, at 3; RFAAX 39, at 23–24. Thereafter, without diagnosing or specifying the nature of UC's condition and without counseling UC regarding any condition, Respondent prescribed 30 tablets of dextroamphetamine-amphetamine 5mg to be taken two times per day for 15 days. RFAAX 28, at 3; see RFAAX 35, at 1.

Regarding the June 11, 2021, interaction, UC noted that she engaged in telephone conversations with staff members at the practice but not directly with Respondent. RFAAX 28, at 4; see RFAAX 40, at 1–8. UC communicated with one of the students working at the practice and informed her that she was taking two tablets once a day instead of one tablet twice a day. RFAAX 28, at 4; RFAAX 40, at 5. The only comment that UC made to the student was that the medication "just did not last throughout the day." RFAAX 40, at 5; RFAAX 28, at 4. The student then informed UC that she would speak to Respondent and check if UC's prescription strength could be increased. RFAAX 28, at 4–5; RFAAX 40, at 6. The student then called back and informed UC that Respondent would increase UC's prescription strength to 10mg of dextroamphetamine-amphetamine two times per day for two weeks. RFAAX 28, at 5; RFAAX 40, at 7–8. Ultimately, without speaking to or reevaluating UC, Respondent prescribed 60 tablets of dextroamphetamine-amphetamine and increased the prescription strength to 10 mg to be taken two times per day for 30 days. RFAAX 28, at 5; RFAAX 35, at 2.

Regarding UC's third interaction with Respondent's office on August 9, 2021, UC spoke to a student working for Respondent about again increasing the strength of dextroamphetamine-amphetamine. RFAAX 28, at 5; see RFAAX 41, at 1–4. When the student inquired about the reason for the request to increase the prescription strength, UC responded that "I just think it doesn't last long enough." RFAAX 41, at 2; RFAAX 28, at 5. The student called back and informed UC that Respondent, who did not speak to UC or reevaluate UC in person, was increasing the dextroamphetamine-amphetamine prescription to 15 mg for two times per day for 30 days. RFAAX 28, at 5; see RFAAX 41, at 3; RFAAX 35, at 3. The

⁸ When comparing the documents that UC stated that she did not complete with the ones that she did, the signatures of the two sets of documents appear to be different. For example, UC completed the Authorization For Release of Confidential Information and the Patient Cancellations forms, and her signature shows a space between her first name and last name. RFAAX 32, at 6, 8. But on the forms that UC declared that she did not complete, such as the Patient Medication Risk form and the Consent and Contract to Participate in treatment using Stimulant Medication form, her signature is devoid of the space between the first and last name. RFAAX 32, at 15, 20; see RFAAX 28, at 3–4. In fact, UC attested in her declaration that Respondent had copied her signature from the Disability Related Paperwork Protocol form, which she had signed, to other forms that she never filled out. RFAAX 28, at 4; see RFAAX 32, at 14. In this case, when comparing the documents and reviewing the evidence of record, the Agency finds that UC's statement regarding her forged signature is true and correct.

student also mentioned to UC that Respondent had requested an in-office visit for the next appointment to perform a urine drug screen. RFAAX 28, at 5; RFAAX 41, at 3.

Supporting UC's statements regarding the prescriptions, the record shows that a DEA diversion investigator also provided a declaration under penalty of perjury pursuant to 28 U.S.C. 1746 that he generated a spreadsheet report from Pennsylvania PDMP, which is a state-run program that includes a computerized platform administered by the Pennsylvania Department of Health. RFAAX 29, at 2–3. The Pennsylvania PDMP shows that prescriptions for amphetamine salt combo in tablet forms were written and filled by Respondent on May 17, 2021, June 11, 2021, and August 9, 2021. RFAAX 34, 1–3; RFAAX 32, 48–50.

As previously mentioned, there was substantial evidence that UC never completed the above-mentioned medical documents or underwent diagnostic tests. Based on the transcript of UC's initial visit and two phone conversations and UC's signed and dated declaration, there is substantial record evidence that Respondent improperly prescribed controlled substances by failing to diagnose UC or counsel UC regarding the medical condition prior to issuing the three prescriptions.⁹ Furthermore, the Agency finds substantial record evidence that Respondent prescribed controlled substances to UC on three separate occasions without providing an accurate and complete initial evaluation or any reevaluation.

IV. 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 11–19. 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).¹⁰

⁹ The August 9, 2021, prescription shows diagnoses of major depressive disorder and ADHD. RFAAX 35, at 3. However, the transcripts of one in-person visit and two phone conversations do not reflect Respondent's diagnoses of such disorders or any counseling regarding the conditions that were diagnosed. See RFAAX 39, at 1–26; RFAAX 40, at 1–8; RFAAX 41, at 1–4.

¹⁰ Historically, the Agency has analyzed Factors B and D together. However here, the Agency will analyze Factors B and D separately to capture the conduct Congress intended the Agency to consider under Factor B that is not captured under Factor D.

A. Factor D: Compliance With Applicable State, Federal, or Local Laws Relating to Controlled Substances

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). In the current matter, the Government has alleged that Respondent violated Pennsylvania laws and federal law related to controlled substances. RFAAX 3, at 1–7. Specifically, the OSC alleges that Respondent did not comply with 49 Pa. Code § 16.92(a)(4) and 49 Pa. Code § 16.95(a)–(e) because he failed to maintain medical records that are accurate, legible, and complete, and thereby failed to meet minimum Pennsylvania standards involving the prescribing of controlled substances. RFAAX 3, at 2–5. The OSC also alleges that Respondent was not compliant with 21 CFR 1306.04(a) when he issued the prescription without a legitimate medical purpose. RFAAX 3, at 1.

1. False Medical Records

Specifically, the Agency finds that Respondent submitted multiple documentations that were not completed or filled out by UC. See RFAA, at 15–18. UC attested that she never filled out the Patient Symptom Intake Form, History and Personal Data Questionnaire, Patient Medication Risk, Consent and Contract to Participate in Treatment Using Stimulant Medication, Urine Drug Screen—12 Panel Integrated Test Cup dated May 17, 2021, Audit C, Patient Health Questionnaire (PHQ–9), GAD–7 Anxiety, and Adult ADHD Self-Report Scale Symptom Checklist. RFAAX 28, at 3–4. However, Respondent produced those documents pursuant to DEA's subpoena. See RFAAX 32, at 2–4, 15–21, 30–38. Crediting UC's attestation, it appears that Respondent submitted numerous falsified documents to give the appearance that he was in compliance with the law.

Not only were the relevant documents not completed by UC as they purported to be, but the contents of the documents are inaccurate. For example, UC stated that she never told Respondent that she had used cannabis to alleviate anxiety or lessen alcohol use, or that she possessed a medical marijuana card. RFAAX 28, at 6. The transcripts of UC's interaction with Respondent and his staff confirm UC's statement that she never told Respondent that she had

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").

used cannabis or possessed a marijuana card. See RFAAX 39, at 1–26; see also RFAAX 28, at 1–7. However, Respondent's records include an evaluation stating that "[UC] admits to periodic cannabis use to help anxiety, less alcohol use. Reports Medical Marijuana Card. Could not find her name in the Medical Cannabis Registry." RFAAX 32, at 43. The records also include a letter indicating that Respondent had to terminate his "professional relationship" with UC because of her cannabis use. RFAAX 32, at 47. UC never received the purported patient termination letter or other notice that she was discharged as a patient. RFAAX 26, at 6.

Based on the entire record, including UC's credible declaration, the Respondent's falsification of medical records displays a clear violation of state law. Specifically, the Agency finds substantial record evidence that Respondent violated 49 Pa. Code § 16.92(a)(4) by failing to maintain medical records that were accurate and complete when prescribing controlled substances. See RFAAX 28, at 1–7; RFAAX 39, at 1–26; RFAAX 40, at 1–8; RFAAX 41, at 1–4. Similarly, the Agency finds substantial record evidence that Respondent violated 49 Pa. Code § 16.95(a) by failing to provide accurate, legible and complete records regarding the evaluation and treatment of UC. See RFAAX 28, 1–7. Therefore, the Agency finds that Respondent failed to comply with applicable state laws involving the recordkeeping of controlled substances.

2. Improper Prescribing

Moreover, as discussed above, the Agency found that Respondent prescribed dextroamphetamine-amphetamine on three separate occasions without performing an initial examination that included a diagnostic test or an objective evaluation, conducting a reevaluation when increasing the strength of the controlled substances, and counseling the patient regarding the diagnosed condition. See RFAAX 28, at 1–7; RFAAX 39, at 1–26; RFAAX 40, at 1–8; RFAAX 41, 1–4. For instance, UC never completed a form related to her medical history or her symptoms and did not undergo any diagnostic tests. RFAAX 28, at 3–6; see RFAAX 39, at 1–26; RFAAX 40, at 1–8; RFAAX 41, 1–4. Respondent did not reevaluate UC's condition when she requested that her prescription be refilled with a higher dosage. See RFAAX 40, at 1–8; RFAAX 41, at 1–4.

Additionally, Respondent never counseled UC regarding the condition diagnosed and the controlled substance

prescribed; instead, he merely stated, “[h]opefully[,] you’ll be able to uh focus and concentrate and work on your sobriety.” RFAAX 39, at 23. As such, the Agency finds substantial record evidence that Respondent’s prescribing practices violated Pennsylvania’s minimum standards required to be carried out when prescribing controlled substances. 49 Pa. Code § 16.92(a)(1)–(3).

Furthermore, the Agency finds that Respondent’s improper prescribing violated both federal and state law, namely 21 CFR 1306.04(a) and 28 Pa. Code § 25.52(a), when he prescribed controlled substances without a proper examination and diagnosis,¹¹ RFAAX 35, at 1–3, and falsified medical records in an attempt to conceal the unlawful prescribing practices. See RFAAX 32, at 21, 22–38, 46. Respondent seems to have falsified medical records and fabricated diagnostic test results and the urine test result because he knew that he lacked a legitimate medical purpose¹² for prescribing dextroamphetamine-amphetamine. See *Hunt*, 75 FR at 50003 (finding that falsifying medical records demonstrates a practitioner’s knowledge or awareness of a lack of legitimate medical purpose when prescribing controlled substances).

Accordingly, because Respondent was not in compliance with state and federal laws relating to controlled substances, the Agency finds that Factor D weighs in favor of revoking Respondent’s registration and, thus, finds Respondent’s continued registration to be inconsistent with the public interest. See *John X. Qian*, 87 FR 8039, 8055 (2022) (“DEA’s ability to assess whether controlled substances registrations are consistent with the public interest is predicated upon the ability to consider the evidence and rationale of the practitioner at the time that he prescribed a controlled substance—adequate documentation is critical to that assessment.”).

As Respondent’s case was properly terminated by the ALJ, he has waived the opportunity to present evidence and, therefore, to rebut the Government’s *prima facie* case.¹³ See RFAAX 26, 1–9.¹⁴ The Government’s *prima facie* case was established by substantial record evidence. Accordingly, the Agency finds that there is substantial and uncontroverted record evidence supporting the revocation of Respondent’s registration based on Factor D alone. 21 U.S.C. 823(g)(1)(D); see *John X. Qian*, 87 FR 8039, 8055 (revoking the respondent’s registration, in part, because the Agency found that “recordkeeping is not only important for compliance, but also for the safety of the patients”).

3. Factor B: The Applicant’s Experience in Dispensing With Respect to Controlled Substances

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.¹⁵

Historically, the Agency’s Factor B¹⁶ analysis considered “both the

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.”

JM Pharmacy Group, 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

cites to the current designation, 21 U.S.C. 823(g)(1)(B), “Factor B.”

¹¹ The Government typically establishes that a practitioner issued prescriptions without a legitimate medical purpose or outside the usual course of professional practice in violation of 21 CFR 1306.04(a) through, or with the support of, expert testimony. However, prior DEA decisions have found that the nature of the allegations and the evidence on the record can establish violations of Section 1306.04(a) without necessitating the support of expert opinion. *Zeljko Stjepanovic, M.D.*, 85 FR 80152, 80155–56 (2020) (citing DEA decisions that found that even without expert testimony, prescriptions can lack a legitimate medical purpose). For example, a prior DEA decision found that a physician lacked legitimate medical purpose based on statements made during undercover visits and falsification of patient chart. *Robert F. Hunt, D.O.*, 75 FR 49995, 50003 (2010).

¹³ The Administrative Procedure Act (APA) provides that “administrative law judges” can “preside at the taking of evidence.” 5 U.S.C. 556(b)(3). Furthermore, 21 CFR 1316.52 provides that a “presiding officer,” such as this ALJ, has a “duty to conduct a fair hearing, to take all necessary action to avoid delay, and to maintain order.” *Id.*

¹⁴ The Agency issued an interim order indicating that the ALJ had the authority to terminate the case.

¹⁵ The only limitation discussed in the legislative history on DEA’s authority under Factor B is that DEA should not “construe[this factor] in any way 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).

¹⁶ 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 Controlled Substances Act (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 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

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 not explicitly defined in the CSA, but Congress identifies the primary "public interest" 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 he or she 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.¹⁷

Of course, the Agency is not only concerned with acts of intentional diversion¹⁸ but also with acts of

"[c]areless or negligent handling of controlled substances[, which] 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)); *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.¹⁹ 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."²⁰ However,

(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.

¹⁹ Additional questionable conduct outside the public interest includes postdating prescriptions, issuing prescriptions despite concerns from other physicians or pharmacists, continuing to prescribe controlled substances to patients even after the practitioner had indicated that he would stop issuing them, ignoring signs that patients were abusing the controlled substances or were serious risk of doing so, ignoring the possibility that multiple accident and injuries reported by the patients could be drug-seeking behavior, and failing to maintain any patient file. *Caragine*, 63 FR at 51599–51600.

²⁰ *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. "[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 substances prescribed by a practitioner are prescribed for a

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." *Krishna-Iyer*, 74 FR at 463. Accordingly, the Agency has consistently rejected registrants' 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 the 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 prescribings to thousands of other patients do not . . . render her prescribings to the undercover officers any less unlawful, or any less acts which are inconsistent with the public interest") (internal quotations and citations omitted).²¹

Here, as the Agency found above, Respondent repeatedly issued improper prescriptions for controlled substances to UC because he did not order or perform diagnostic tests in order to provide a proper diagnosis, counsel UC regarding her condition, or reevaluate UC prior to increasing the dosage of the prescriptions. The Agency finds that Respondent's repeated issuance of prescriptions without adhering to the minimum standards of Pennsylvania's medical practice reflects "experience in dispensing . . . controlled substances" that created an opportunity for the abuse or diversion of controlled substances and was outside the public interest. Respondent also failed to maintain accurate and complete records of controlled substances which created further opportunities for abuse and diversion. Moreover, as noticed in the OSC, falsification of medical records to conceal the true nature of prescribing practices is conduct which threatens the public health and safety. RFAAX 3, at 3. Such questionable prescribing

legitimate medical purpose and in accordance with relevant laws. See *Dewey C. Mackay, M.D.*, 75 FR at 49977 (citing *Krishna-Iyer*, 74 FR at 463) (pointing out that a "registration [to prescribe controlled substances] is limited to those who have authority to dispense controlled substances in the course of professional practice.").

²¹ 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.'").

¹⁷ 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).

¹⁸ 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

patterns reflected in the record are outside the public interest.

Moreover, Respondent failed to provide the Agency with any evidence related to its “experience in dispensing” that served the public’s interest. Accordingly, the Agency finds that Factor B also weighs strongly against Respondent’s continued registration.²²

III. Sanction

Where, as here, the Government has met its *prima facie* burden of showing that Respondent’s continued registration would be inconsistent with the public interest, the burden shifts to Respondent to show why he 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 (2018). The issue of trust is necessarily a fact-dependent determination based on the circumstances presented by the individual respondent. *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, DEA Administrators have required that a registrant who has committed acts inconsistent with the public interest must accept responsibility for those acts and demonstrate that it will not engage in future misconduct. *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). A registrant’s acceptance of responsibility must be unequivocal. *Jones Total Health Care Pharmacy*, 881 F.3d at 830–31. In addition, a registrant’s candor during the investigation and hearing has been an important factor in determining acceptance of responsibility and the appropriate sanction. *Id.* Further, the Agency has found that the egregiousness and extent of the misconduct are significant factors in determining the appropriate sanction. *Id.* at 834 n.4. The Agency has also considered the need to deter similar acts by the respondent and by the community of registrants. *Jeffrey Stein, M.D.*, 84 FR at 46972–73.

Regarding these matters, there is no record evidence that Respondent takes

responsibility, let alone unequivocal responsibility, for the founded violations. Therefore, it is not reasonable to believe that Respondent’s future controlled substance-related actions will comply with legal requirements. In fact, instead of admitting that Respondent failed to adhere to federal and state laws, he falsified medical records to conceal his unlawful prescribing practices. Accordingly, Respondent did not meet his burden of convincing the Agency that he can be entrusted with a registration.

Further, the interests of specific and general deterrence weigh in favor of revocation. Given the foundational nature of Respondent’s noncompliance of state laws by failing to properly document UC’s medical condition and treatment and Respondent’s noncompliance of federal law by repeatedly issuing prescriptions without a legitimate medical purpose, a sanction less than revocation would send a message to the existing and prospective registrant community that compliance with the law is not essential to maintaining a registration.

Here, Respondent has made no representation regarding his future compliance with the CSA nor made any demonstration that he can be trusted with registration. On the other hand, the evidence submitted by the Government shows that Respondent cannot be entrusted with a registration; in particular, the falsification of medical records during the investigation shows a complete lack of candor of Respondent. *See Jones Total Health Care Pharmacy*, 881 F.3d at 830–31.

Accordingly, the Agency finds that the factors weigh in favor of sanction and will order revocation of Respondent’s registration as contained in the Order below.

Order

Pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 824(a) and 21 U.S.C. 823(g)(1), I hereby revoke DEA Certificate of Registration No. BR7552272, in Easton, Pennsylvania, issued to Muhamad Aly Rifai, M.D. 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 application of Muhamad Aly Rifai, M.D., to renew or modify this registration, as well as any other pending application of Muhamad Aly Rifai, M.D., for additional registration in Pennsylvania. This Order is effective November 18, 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.

[FR Doc. 2026–21258 Filed 10–16–26; 8:45 am]

BILLING CODE 4410–09–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Proposed Consent Decree Under the Clean Air Act

On October 9, 2026, the Department of Justice lodged a proposed Consent Decree with the United States District Court for the Southern District of Ohio in the lawsuit entitled *United States and State of Ohio v. Renergy, Inc., Dovetail Energy, LLC, and Emerald Bioenergy, LLC*, Civil Action No. 2:26–CV–01286.

The United States and the State of Ohio filed this action under the Clean Air Act. The complaint seeks injunctive relief and civil penalties for violations at Defendants’ biogas facilities located at 1156 Herr Road in Fairborn, Ohio (Dovetail Facility) and at 2279 County Road 156 in Cardington, Ohio (Emerald Facility). The consent decree requires Defendants to perform injunctive relief and pay a \$15,000 civil penalty, which is based on Defendants’ demonstrated limited ability to pay a penalty.

The publication of this notice opens a period for public comment on the proposed Consent Decree. Comments should be addressed to the Principal Deputy Assistant Attorney General, Energy and Natural Resources Division, and should refer to *United States and State of Ohio v. Renergy, Inc., Dovetail Energy, LLC, and Emerald Bioenergy, LLC*, D.J. Ref. No. 90–5–2–1–12791. All comments must be submitted no later than thirty (30) days after the publication date of this notice. Comments may be submitted either by email or by mail:

²² While the Agency has determined that Respondent’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. 823(g)(1)(E). Respondent’s repeated dispensing of controlled substances without a proper diagnosis of UC’s condition and without complete and accurate documentation of UC’s treatment, and Respondent’s falsification of medical records may threaten the public health and safety by creating the risk that controlled substances may leave the CSA’s closed distribution system and be abused or diverted.