also are recommended to complete the screening process for malignancies.''

Non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage must cover without cost-sharing the services and screenings listed on the updated Women's Preventive Services Guidelines for plan years (in the individual market, policy years) that begin 1 year after this date. Thus, for most plans, this update will take effect for purposes of the Section 2713 coverage requirement in 2027. Additional information regarding the Women's Preventive Services Guidelines can be accessed at the following link: *https://www.hrsa.gov/womens-guidelines.*

Authority: Section 2713(a)(4) of the Public Health Service Act, 42 U.S.C. 300gg–13(a)(4).

Thomas J. Engels,

Administrator.

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DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. DEA–1568E]

Established Aggregate Production Quotas for Schedule I and II Controlled Substances and Assessment of Annual Needs for the List I Chemicals Ephedrine, Pseudoephedrine, and Phenylpropanolamine for 2026

AGENCY: Drug Enforcement Administration, Department of Justice.

ACTION: Final order.

SUMMARY: This final order establishes the initial 2026 aggregate production quotas for controlled substances in schedules I and II of the Controlled Substances Act and the assessment of annual needs for the list I chemicals ephedrine, pseudoephedrine, and phenylpropanolamine.

DATES: This order is effective January 5, 2026.

FOR FURTHER INFORMATION CONTACT: Heather Achbach, Regulatory Drafting and Policy Support Section, Diversion Control Division, Drug Enforcement Administration; Telephone: (571) 776–3882.

SUPPLEMENTARY INFORMATION:

I. Legal Authority

Section 306 of the Controlled Substances Act (CSA) (21 U.S.C. 826) requires the Attorney General to establish production quotas for each basic class of controlled substance listed in schedule I and II and ephedrine, pseudoephedrine, and phenylpropanolamine. The Attorney General has delegated this function to the Administrator of the Drug Enforcement Administration (DEA) pursuant to 28 CFR 0.100.

II. Background

The 2026 aggregate production quotas (APQ) and assessment of annual needs (AAN) represent those quantities of schedule I and II controlled substances and the list I chemicals ephedrine, pseudoephedrine, and phenylpropanolamine that may be manufactured in the United States in 2026 in order to provide for the estimated medical, scientific, research, and industrial needs of the U.S., lawful export requirements, and the establishment and maintenance of reserve stocks. These quotas include imports of ephedrine, pseudoephedrine, and phenylpropanolamine, but do not include imports of controlled substances for use in industrial processes.

On November 28, 2025, a notice titled ''Proposed Aggregate Production Quotas for Schedule I and II Controlled Substances and Assessment of Annual Needs for the List I Chemicals Ephedrine, Pseudoephedrine, and Phenylpropanolamine for 2026'' was published in the **Federal Register**.[1] This notice proposed the 2026 APQs for each basic class of controlled substance listed in schedules I and II and the 2026 AANs for the list I chemicals ephedrine, pseudoephedrine, and phenylpropanolamine. All interested persons were invited to comment on or object to the proposed APQs and the proposed AANs on or before December 15, 2025.

III. Comments Received

Within the public comment period, DEA received 5,044 comments from DEA registrants, chronic pain patients, patients with attention deficit/hyperactivity disorder (ADHD), pain advocacy associations, U.S. professional associations, U.S. doctors and nurses, and others. The comments included concerns about perceived domestic opioid drug shortages due to further quota reductions; patient difficulty filling authorized opioid and stimulant prescriptions; increases in drug overdose deaths despite a continued decrease in production quotas; concerns that medical professionals might be impeded from exercising their medical expertise regarding opioid prescriptions; concerns of ADHD medication efficacy and shortages based on quotas associated with isomer ratios; ordering thresholds for pharmacies, data collection and methodology; tools used to determine diversion estimates; adequate quotas for research purposes, stake holder collaboration; requests for a public hearing; requests for an extension to the comment period; and comments not pertaining to DEA-regulated activities. While all comments were posted to *regulations.gov*, DEA restricted the attachments to 22 comments from public view due to confidential business information and/or confidential personal identifying information.

Pain Medication (Schedule II Opioids)

Issue (Medication Out of Stock at Pharmacy Level): Many commenters expressed that due to the decreases in the aggregate production quotas for oxycodone and hydrocodone, they have had difficulty filling legitimate prescriptions. They stated they often experienced delays or have to visit multiple pharmacies to get their prescriptions filled. These issues have negatively impacted their quality of life and caused mental health-related issues, possibly leading to suicide. Additionally, commenters expressed concerns over the cardiovascular effects they experienced when pain is left untreated for an extended period of time due to the delay in getting medications.

DEA Response: DEA is committed to ensuring an adequate and uninterrupted supply of controlled substances in order to meet legitimate medical, scientific, and export needs of the United States. DEA utilizes the available, reliable data and information received by the agency at the time APQs are proposed and proactively monitors drug production, distribution and supply during the year. However, drug shortages may occur due to factors outside of DEA's control such as manufacturing and quality problems, processing delays, supply chain disruptions, or discontinuations. In such circumstances, if the drug manufacturer notifies the Food and Drug Administration (FDA) Drug Shortage Staff, FDA will coordinate with DEA to address and minimize the impact of drug shortages if both agencies believe action is warranted. Currently, FDA has not listed on its Drug Shortage website any nationwide shortages of oxycodone and hydrocodone products. Additionally, if a patient is faced with a delay in

[1] Proposed Aggregate Production Quotas for Schedule I and II Controlled Substances and Assessment of Annual Needs for the List I Chemicals Ephedrine, Pseudoephedrine, and Phenylpropanolamine for 2026, 90 FR 54745 (November 28, 2025).

receiving their medications, the patient may request a one-time transfer of initial dispensing of an electronic prescription for Schedules II–V controlled substances from one retail pharmacy to another retail pharmacy if authorized under state law. If the medication is a controlled substance in Schedules III–V and includes authorized refills, the refills can also be transferred with the initial prescription to the receiving pharmacy.

Issue: (Shortage of injectable opioid products): DEA received comments from palliative care associations, healthcare companies, and manufacturers regarding the listing of injectable opioid medications including fentanyl, hydromorphone, and morphine on the FDA's Drug Shortage website and the proposed reduction of the APQs for fentanyl, hydromorphone, and morphine.

DEA Response: DEA is committed to ensuring an adequate and uninterrupted supply of controlled substances in order to meet the estimated legitimate medical, scientific, research, and industrial needs of the United States, for lawful export requirements, and for the establishment and maintenance of reserve stocks. Opioid injectable products utilize less than 5% of the relevant APQ. The remainder of the APQ is used to manufacture other opioid dosage forms. Therefore, injectable shortages do not usually require changes to the relevant APQ. Based on the data that DEA is required to consider for setting the APQs, DEA has determined that the established APQs for opioids are sufficient to meet all legitimate needs for 2026. As mentioned above, DEA proactively monitors drug production, distribution and supply during the year. Additionally, DEA and FDA are required to, and routinely do, coordinate efforts to prevent or alleviate drug shortages pursuant to 21 U.S.C. 826(h). Such efforts may include adjusting the APQ, adjusting individual domestic manufacturers' quotas, FDA approval of additional market competitors, and coordination between the agencies to allow importation of foreign-manufactured drug products that meet FDA approval.

Issue (Opioid Prescribing Hesitancy): Many self-identified chronic pain patients expressed that they are obtaining opioid pain medications legally and taking them as prescribed. Commenters stated that many chronic pain patients experience a decreased quality of life, and some have died by suicide, due to the inability to get prescriptions from their providers, which they allege is directly related to the APQ reductions made by DEA. Many commenters also stated that restrictions imposed by DEA have caused opioid medications to be under-prescribed due to fear of prosecution. Commenters said doctors should have latitude in making treatment decisions to prescribe opioid pain medications based on individual patient needs.

DEA Response: DEA's regulations do not impose restrictions on the amount and the type of medication that licensed practitioners can prescribe. DEA has consistently emphasized and supported the authority of individual practitioners under the CSA to administer, dispense, and prescribe controlled substances for the legitimate treatment of pain within acceptable medical standards, as outlined in DEA's policy statement ''Dispensing Controlled Substances for the Treatment of Pain'' published in the **Federal Register** on September 6, 2006.[2]

Issue (Patients Switching to Illicit Fentanyl or Medications Obtained from Illegal Sources): Several commenters expressed concerns that chronic pain sufferers will turn to illegal fentanyl or medications obtained from illegitimate sources for relief if they are unable to fill their legitimate prescriptions due to the reduction of quotas for opioids. They stated that overdose deaths in the United States continue to rise as a result of illegal fentanyl or illegitimate medications, rather than from legally prescribed medications for the treatment of chronic pain.

DEA Response: DEA considered various factors such as the estimation of legitimate medical need provided by the Department of Health and Human Services (HHS), as well as the extent of any diversion, when proposing and establishing the APQs for opioids to ensure there is an adequate supply to meet legitimate medical demand while preventing diversion (21 CFR 1303.11(b)). Pursuant to the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Pub. L. 115–271), DEA is mandated to estimate diversion for fentanyl, hydrocodone, hydromorphone, oxycodone and oxymorphone, and this estimation includes the consideration of rates of overdose deaths. While overdose deaths may still occur from the use of illicit substances, DEA implemented quota regulations such that the occurrences of overdose and death caused by the misuse and diversion of pharmaceutical controlled substances are reduced. Patients are encouraged to work closely with their licensed healthcare practitioners to utilize FDA-approved medications for their conditions and to fill their prescriptions only from DEA-registered pharmacies. Medications received from unregistered internet sources may, in fact, be manufactured or laced with illicit substances including illicit fentanyl, which contribute to rates of overdose deaths.

Attention Deficit/Hyperactivity Disorder (ADHD) Medication

Issue (isomer ratio): Several self-identified ADHD patients claimed that they have been negatively impacted by the poor quality and ineffectiveness of their prescribed Adderall or amphetamine mixed salt products. They claimed that the manufacturing of Adderall dosages requires a 3:1 isomeric ratio of d-amphetamine to l-amphetamine, and that dosage form manufacturers are unable to procure the proper ratio of isomers because DEA is allocating d-amphetamine and l-amphetamine to dosage manufacturers in a fixed one-to-one ratio, thus affecting the effectiveness and quality of the medication and a shortage of the medication.

Response: The FDA is a regulatory agency under HHS that has the authority to oversee and regulate the safety, efficacy and manufacturing quality of drugs sold in the United States. The FDA monitors and ensures manufacturers' compliance with all applicable requirements, including Current Good Manufacturing Practices (cGMP) regulations. Patients should raise concerns with their licensed healthcare provider or pharmacist if they find that their prescribed medications are ineffective in treating their conditions.

DEA does not allocate d-amphetamine and l-amphetamine quotas in a fixed one-to-one ratio because the manufacturers do not request d-amphetamine and l-amphetamine quotas in a 1:1 ratio. When DEA upgraded the quota application process from paper to electronic, DEA noticed that manufacturers did not request quota for l-amphetamine but, preferred to request quota for d,l-amphetamine. The d,l-amphetamine APQ represents the racemic mixture of d- and l-amphetamine expressed as base. A racemic mixture is considered a 50:50 ratio of left and right-handed mirror images, in this instance, the 50:50 ratio is of d-amphetamine and l-amphetamine. Therefore, the currently established and proposed aggregate production quotas of d,l-amphetamine and d-amphetamine are allocated to

[2] Dispensing Controlled Substances for the Treatment of Pain, 71 FR 52716 (September 6, 2006).

manufacturers in a proper ratio such that amphetamine mixed salt products can be manufactured in accordance with the drug's approval, following cGMP standards and quality control practices as required by FDA.

Ordering Thresholds for Pharmacies

Issue: Commenters mentioned that as a result of the national opioid settlements, wholesale drug distributors have increasingly imposed ordering thresholds or limits on pharmacies, thereby impacting patient access to opioids. According to the commenters, distributors often flag an increase in controlled substance orders by pharmacies as suspicious, which can lead to denials or contract termination. Pharmacies with a record of distributor-initiated contract terminations may then face difficulties in securing new contracts with other distributors, as prior terminations are viewed as red flags. Therefore, pharmacies may be unwilling to increase their purchasing orders to meet legitimate medical need for fear that doing so could trigger distributors to cancel their contract. A commenter also expressed concerns that valid prescriptions to patients in hospice may not be fulfilled because pharmacies are unwilling to increase their controlled substances orders in fear of contract cancellations. The commenters encourage DEA to ensure that distributors are properly identifying and evaluating suspicious orders, and to allow pharmacies that were unintentionally suspended or terminated by their distributors to undergo a voluntary DEA inspection to verify that the prescriptions they filled were legitimate.

DEA Response: The APQs established by DEA set a limit to the total quantity of a controlled substance that may be produced by all manufacturers in a calendar year, and do not impose any ordering thresholds or limits to pharmacies purchasing controlled substance medications from distributors.

Establishing APQs in Terms of Dosage Forms

Issue: DEA received a comment from a healthcare company suggesting DEA establish the annual APQs in terms of pharmaceutical dosage forms.

DEA Response: Pursuant to 21 U.S.C. 826(a)(1), ''production quotas shall be established in terms of quantities of each basic class of controlled substance and not in terms of individual pharmaceutical dosage forms prepared from or containing such a controlled substance.'' DEA sets APQ in a manner to support legitimate domestic medical need, exports, scientific research and product development, as well as maintaining reserve stocks. In turn, the APQ takes into consideration all FDA approved dosage forms to meet the estimated medical needs of the United States. 21 U.S.C. 826(a)(2) provides an exception to that general rule by allowing, but not requiring, DEA to grant quotas in terms of dosage forms if DEA determines that doing so will assist in avoiding the overproduction, shortage, or diversion of controlled substances. DEA has utilized this authority to issue individual manufacturing quotas in terms of dosage form when necessary, where it can be more effective in averting potential shortages. Since quotas set at the individual dosage-form manufacturing level are more directly connected to distributions of FDA-approved drug products, DEA can use its dosage-form authority to alleviate any potential shortage in a more timely manner at the individual manufacturing quota level than at the aggregate production quota level. By issuing a single APQ covering all dosage forms of the basic class, rather than estimating an APQ for each dosage form, DEA retains the flexibility to alleviate potential shortages and to react to unforeseen emergencies by adjusting the individual quotas granted to manufacturers under that APQ.

Data Collection and Methodology

Issue (Lack of Real-Time Data): A few commenters opined that DEA lacks real-time data on opioid inventory, production and distribution. They suggested this lack of real-time data makes it difficult for DEA to accurately assess legitimate medical needs of patients and ensure adequate supply of opioid pain medications.

DEA Response: DEA has access to current sales data provided by manufacturers from the Quota and Year-end Reporting Management System (QMS), Automation of Reports and Consolidated Orders System (ARCOS) reports, and monthly IQVIA data when determining legitimate medical needs to ensure an adequate supply of medications containing schedule II-controlled substances. While manufacturers and distributors have a choice on reporting their distributions monthly or quarterly under 21 CFR 1304.33, at the DEA Annual Supply Chain Conferences in April 2024 and April 2025, DEA requested manufacturers and distributors to report sales data into the ARCOS database on a monthly basis, which improves the timeliness and accuracy of data points DEA uses to estimate legitimate medical needs.

Issue (over-reliance on historical trends): Several commenters opined that the quota-setting process overly relies on historical trends that do not adequately reflect patient population changes and new prescribing trends, stating that DEA relies on data that is outdated and incomplete, resulting in arbitrary cuts to the APQs of opioids and suppression of APQs for ADHD medications.

DEA Response: When developing the annual APQs, DEA routinely evaluates data from multiple sources to ensure that all the legal factors specified in 21 CFR 1303.11(b) are adequately addressed. DEA's quota process not only relies on current and historical trends, but it also incorporates the most up to date information provided by the FDA and registered manufacturers. For example, DEA utilizes information provided by quota applicants to derive the estimates of scientific, research, and industrial needs, lawful export requirements, as well as current reserve stocks. The information DEA receives from FDA includes the observed and projected domestic usage of schedule II-controlled substances, new drug application and abbreviated new drug application approvals, manufacturers discontinuing production, product shortages, and clinical trials for schedule I and II controlled substances. FDA utilizes a variety of data sources in developing its estimates and describes certain caveats regarding the forecasts it provides. The data provided by FDA, as well as the data obtained from registered manufacturers, DEA's internal databases, and third party prescription data from IQVIA and MIDAS, all contributed to DEA's proposed APQs to meet legitimate estimated domestic manufacturing needs for the controlled substances listed in the table.

Diversion Estimates

Issue (red flags): Commenters raised concerns with DEA's methodology for estimating diversion using PDMP ''red flags'' data. Commenters state that the data captured in these ''red flags'' metrics can also represent legitimate patient care such as changing doctors, doctors retiring, multi-specialty care, and paying cash due to loss of health insurance.

DEA Response: DEA has worked with investigators and subject matter experts to select potential indicators of diversion. DEA's Diversion Control Division identified over-prescribing, doctor shopping, and cash payments as risk indicators related to its quota setting function. While it is possible that a legitimate prescription for an opioid might meet one of these criteria, in

DEA's experience the number of such legitimate prescriptions would be minimal and unlikely to significantly impact the diversion calculation.

Comments From Pharmaceutical Manufacturers

Issue (Request for Data Sharing): DEA received a comment from a pharmaceutical manufacturer stating that the data DEA utilizes to determine quotas should be shared with manufacturers.

DEA Response: DEA considers ARCOS data which is provided by registered manufacturers and distributors. DEA provides access to manufacturers and distributors of this data through the use of the ''ARCOS lookup'' tool available to DEA registrants on DEA's website. Additionally, DEA cannot provide access to the underlying data used in calculating the manufacturing, procurement, or import quotas because it includes confidential business information.

While DEA has stated it considers prescription data from IQVIA, a third party, DEA purchases this data under contract and is not permitted to share the data. Any pharmaceutical company can contract to purchase data from IQVIA or any other company that supplies prescription data.

Issue (APQ adjustment for research): DEA received comments from pharmaceutical companies regarding advanced research and clinical trials of several schedule I controlled substances, requesting the APQs be established at sufficient levels to allow for their manufacturing to meet research and scientific needs.

DEA Response: DEA considered these comments and matched them to the contracted DEA-registered manufacturers and determined that the specific schedule I controlled substance APQs are sufficient to support the legitimate research and scientific efforts toward an FDA-approved drug product.

Stakeholder Collaboration

Issue: Several commenters including palliative care associations and a healthcare company suggested that DEA should collaborate with a broad range of stakeholders on how DEA can address the opioid crisis while ensuring legitimate medical needs are met.

DEA Response: DEA has and will continue to collaborate with federal agencies, industry, and medical associations to combat the opioid crisis, prevent diversion, and set appropriate manufacturing quantities of controlled substances and chemicals to meet legitimate need and preparedness for unforeseen circumstances within the United States. In addition, DEA has engaged with pharmaceutical manufacturers and private sector entities with relevant pharmaceutical information through roundtable discussions and data sharing efforts. DEA is willing to meet with relevant private organizations upon request when presented with good cause.

Request for Hearing

Issue: Sixty commenters suggested that DEA consider holding a public hearing to provide patient testimony regarding the APQs and AANs economic impact on public health.

DEA Response: The decision whether to grant a hearing on the issues raised by the commenters lies solely within the discretion of the Administrator. While hearings are required when requested by states in certain situations, these requests were not submitted by states. These requests did not include any evidence that would lead to the conclusion that a hearing is necessary or warranted. DEA appreciates the written comments provided by patients and has addressed specific points raised by the commenters in the issues and responses above.

Comment Period Length

Issue: DEA received 15 comments questioning why the comment period was compressed to 15 calendar days and 10 comments requesting an extension of the comment period.

DEA Response: The comment period was compressed to 15 calendars days in part due to the government shutdown from October 1 to November 12, 2025. DEA provides the opportunity for comment on the 2026 proposed APQ and AAN as required by 21 CFR 1303.11(c) and 1315.11(d), which establish that the Administrator shall permit any interested person to file written comments on or objections to the proposal and shall designate in the notice the time during which such filings may be made.

Out of Scope Comments

DEA received comments that are outside the scope of this order. The comments were general in nature and included but not limited to issues such as specific medical illnesses, medical treatments, perceived ineffectiveness of suboxone and its potential side effects, and medication costs. These comments are outside the scope of this Final Order and do not impact the analysis involved in establishing the 2026 APQs.

IV. Determination of 2026 Aggregate Production Quotas and Assessment of Annual Needs

In determining the established 2026 APQs and AANs, DEA has considered the above comments along with the factors set forth in 21 CFR 1303.11 and 21 CFR 1315.11, in accordance with 21 U.S.C. 826(a). These factors include, but are not limited to, the 2025 manufacturing quotas, current 2025 sales and inventories, anticipated 2026 export requirements, industrial use, additional applications for 2026 quotas, and information on research and product development requirements.

Schedule I Controlled Substances

On July 25, 2025, DEA established a specific listing for dipentylone in schedule I of the Controlled Substances Act (CSA) because it is a positional isomer of N-ethylpenthylone, which is a schedule I hallucinogen (90 FR 38396), making all regulatory controls pertaining to schedule I controlled substances applicable to the manufacture of this substance, including the requirement to establish an aggregate production quota pursuant to 21 U.S.C. 826 and 21 CFR part 1303. This final order establishes an aggregate production quota for this substance.

On August 15, 2025, DEA published a temporary scheduling order placing N-pyrrolidino metonitazene and N-pyrrolidino protonitazene in schedule I of the CSA (90 FR 39314), making all regulatory controls pertaining to schedule I controlled substances applicable to the manufacture of these substances, including the requirement to establish an aggregate production quota pursuant to 21 U.S.C. 826 and 21 CFR part 1303. This final order establishes an aggregate production quota for these substances.

On October 15, 2025, DEA published a temporary scheduling order placing Ethyleneoxynitazene, Methylenedioxynitazene, 5-methyl etodesnitazene, N-desethyl etonitazene, N-desethyl protonitazene, N,N-dimethylamino etonitazene, and N-pyrrolidino isotonitazene in schedule I of the CSA (90 FR 48259), making all regulatory controls pertaining to schedule I controlled substances applicable to the manufacture of these substances, including the requirement to establish an aggregate production quota pursuant to 21 U.S.C. 826 and 21 CFR part 1303. This final order establishes an aggregate production quota for these substances.

DEA published a final rule on September 18, 2025 placing *beta*-methylacetyl fentanyl, *meta*-

fluorofuranyl fentanyl, *ortho*-chlorofentanyl, *ortho*-methylcyclopropyl fentanyl, *para*-chlorofentanyl, *para*-fluoro valeryl fentanyl, and tetrahydrothiofuranyl fentanyl in schedule I of the CSA (90 FR 44979), and also published a final rule on November 17, 2025 placing 4-Chloromethcathinone in schedule I of the CSA (90 FR 51102), making all regulatory controls pertaining to the schedule I controlled substances applicable to the manufacture of these substances, including the requirement to establish an aggregate production quota pursuant to 21 U.S.C. 826 and 21 CFR part 1303. This final order establishes an aggregate production quota for these substances.

Schedule II Controlled Substances

Based on all of the above, the Administrator establishes the 2026 APQs for d, l-amphetamine, d-amphetamine (for conversion), dimethyltryptamine, lisdexamfetamine, morphine (for sale), oripavine, psilocybin, and psilocyn at higher levels than were proposed.

Estimates of Diversion

As specified in the proposal, and as required by 21 U.S.C. 826(i), DEA calculated a national diversion estimate for each of the five covered controlled substances. This data, which remains unchanged, was published in the *Proposed Aggregate Production Quotas for Schedule I and II Controlled Substances and Assessment of Annual Needs for the List I Chemicals Ephedrine, Pseudoephedrine, and Phenylpropanolamine for 2026*.[4]

In accordance with 21 U.S.C. 826, 21 CFR 1303.11, and 21 CFR 1315.11, the Administrator hereby establishes the 2026 APQs for the following schedule I and II controlled substances and the 2026 AANs for the list I chemicals ephedrine, pseudoephedrine, and phenylpropanolamine, expressed in grams of anhydrous acid or base, as follows:

Basic class	Established 2026 quotas (g)
Temporary Schedule I	
5-Methyl Etodesnitazene	30
Ethyleneoxynitazene	30
Methylenedioxynitazene	30
N,N-Dimethylamino Etonitazene	30
N-Desethyl Etonitazene	30
N-Desethyl Protonitazene	30
N-Pyrrolidino Isotonitazene	30
N-pyrrolidino Metonitazene	30
N-pyrrolidino Protonitazene	30
Schedule I	
1-[1-(2-Thienyl)cyclohexyl]pyrrolidine	20
1-(1-Phenylcyclohexyl)pyrrolidine	30
1-(2-Phenylethyl)-4-phenyl-4-acetoxypiperidine	10
1-(4-Methoxyphenyl)-N-methylpropan-2-amine (Para-methoxymethamphetamine)	30
1-(5-Fluoropentyl)-3-(1-naphthoyl) indole (AM2201)	30
1-(5-Fluoropentyl)-3-(2-iodobenzoyl) indole (AM694)	30
1-Benzylpiperazine	25
1-Methyl-4-phenyl-4-propionoxypiperidine	10
1′[1-(2-Thienyl)cyclohexyl]piperidine	15
2'-Fluoro 2-fluorofentanyl	30
2,5-Dimethoxy-4-Ethylamphetamine (DOET)	25
2,5-Dimethoxy-4-[N]-Propylthiophenethylamine	25
2,5-Dimethoxyamphetamine	25
2-(2,5-Dimethoxy-4-(N)-propylphenyl)ethanamine (2C-P)	30
2-(2,5-Dimethoxy-4-ethylphenyl)ethanamine (2C-E)	30
2-(2,5-Dimethoxy-4-methylphenyl)ethanamine (2C-D)	30
2-(2,5-Dimethoxy-4-nitro-phenyl)ethanamine (2C-N)	30
2-(2,5-Dimethoxyphenyl)ethanamine (2C-H)	100
2-(4-Bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe; 2C-B-NBOMe; 25B; Cimbi-36)	30
2-(4-Chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe; 2C-C-NBOMe; 25C; Cimbi-82)	25
2-(4-Chloro-2,5-dimethoxyphenyl)ethanamine (2C-C)	30
2-(4-Ethoxybenzyl)-5-Nitro-1-(2-(Piperidin-1-yl)Ethyl)-1H-Benzimidazole (N-Piperidinyl Etonitazene)	30
2-(4-Iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe; 2C-I-NBOMe; 25I; Cimbi-5)	30
2-(4-Iodo-2,5-dimethoxyphenyl)ethanamine (2C-I)	30
2-(Ethylamino)-2-(3-Methoxyphenyl)Cyclohexan-1-One (Methoxetamine)	30
2-Methyl AP-237	30
2-[4-(Ethylthio)-2,5-dimethoxyphenyl]ethanamine (2C-T-2)	30
2-[4-(Isopropylthio)-2,5-dimethoxyphenyl]ethanamine (2C-T-4)	30
3,4,5-Trimethoxyamphetamine	30
3,4-Methylenedioxyamphetamine (MDA)	12,000
3,4-Methylenedioxy-N-ethylamphetamine (MDEA)	40
3,4-Methylenedioxy-N-methylcathinone (methylone)	30,000
3,4-Methylenedioxymethamphetamine (MDMA)	12,000
3,4-Methylenedioxypyrovalerone (MDPV)	35
3-FMC; 3-Fluoro-N-methylcathinone	25

[4] 90 FR 54745 (November 28, 2025).

Basic class	Established 2026 quotas (g)
3-Methylfentanyl	30
3-Methylthiofentanyl	30
3-Methylmethcathinone	30
4′-Methyl acetyl fentanyl	30
4'-Methyl-alpha-pyrrolidinohexiophenone (MPHP)	25
4,4′-Dimethylaminorex	30
4-Bromo-2,5-dimethoxyamphetamine (DOB)	30
4-Bromo-2,5-dimethoxyphenethylamine (2-CB)	5,100
4-Chloro-alpha-pyrrolidinovalerophenone (4-chloro-alpha-PVP)	25
4-Chloromethcathinone	30
4-CN-Cumyl-Butinaca	25
4-Fluoroisobutyryl fentanyl	30
4-FMC; Flephedrone	25
4-MEC; 4-Methyl-N-ethylcathinone	25
4-Methoxyamphetamine	150
4-Methyl-2,5-dimethoxyamphetamine (DOM)	25
4-Methyl-alpha-ethylaminopentiophenone (4-MEAP)	25
4-Methyl-alpha-pyrrolidinopropiophenone (4-MePPP)	25
4-Methyl-N-methylcathinone (mephedrone)	45
4-Methylaminorex	25
4F-MDMB-BUTICA	30
5-(1,1-Dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol	50
5-(1,1-Dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (cannabicyclohexanol or CP-47,497 C8-homolog)	40
5-Fluoro-PB-22; 5F-PB-22	25
5-Fluoro-UR144, XLR11 ([1-(5-fluoro-pentyl)-1Hindol-3-yl](2,2,3,3-tetramethylcyclopropyl)methanone	25
5-Methoxy-3,4-methylenedioxyamphetamine	25
5-Methoxy-N,N-diisopropyltryptamine	25
5-Methoxy-N,N-dimethyltryptamine	30,000
5F-AB-PINACA; (1-Amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide	25
5F-ADB; 5F-MDMB-PINACA (methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate)	25
5F-AMB (methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3-methylbutanoate)	25
5F-APINACA; 5F-AKB48 (N-(adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide)	25
5F-CUMYL-P7AICA; 1-(5-Fluoropentyl)-N-(2-phenylpropan-2-yl)-1H-pyrrolo[2,3-b]pyridine-3carboximide	25
5F-CUMYL-PINACA	25
5F-EDMB-PICA	30
5F-EDMB-PINACA	25
5F-MDMB-PICA	25
A-PIHP; 4-methyl-1-phenyl-2-(pyrrolidin-1-yl)pentan-1-one (alpha-PiHP)	30
AB-CHMINACA	30
AB-FUBINACA	50
AB-PINACA	30
Acetorphine	25
Acetyl Fentanyl	100
Acetyl-alpha-methylfentanyl	30
Acetyldihydrocodeine	30
Acetylmethadol	25
Acryl Fentanyl	25
ADB-4en-PINACA	30
ADB-BUTINACA	30
ADB-FUBINACA (N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide)	30
ADB-PINACA (N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide)	50
AH-7921	30
All other tetrahydrocannabinol	1,166,130
Allylprodine	25
alpha-Ethyltryptamine	25
alpha-Methylfentanyl	30
alpha-Methylthiofentanyl	30
alpha-Methyltryptamine (AMT)	25
alpha-Pyrrolidinobutiophenone (α-PBP)	25
alpha-pyrrolidinoheptaphenone (PV8)	25
alpha-pyrrolidinohexabophenone (alpha-PHP)	25
alpha-Pyrrolidinopentiophenone (α-PVP)	25
Alphacetylmethadol	25
Alphameprodine	25
Alphamethadol	25
Amineptine	30
Aminorex	25
Anileridine	20
APINCA, AKB48 (N-(1-adamantyl)-1-pentyl-1H-indazole-3-carboxamide)	25
Benzethidine	25
Benzylmorphine	30

Basic class	Established 2026 quotas (g)
beta-Hydroxy-3-methylfentanyl	30
beta-Hydroxyfentanyl	30
beta-Hydroxythiofentanyl	30
beta-Methyl fentanyl	30
beta-Methylacetyl fentanyl	30
Beta′-Phenyl fentanyl	30
Betacetylmethadol	25
Betameprodine	25
Betamethadol	4
Betaprodine	25
Brorphine	30
Bufotenine	15
Butonitazene	30
Butylone	25
Butyryl fentanyl	30
Cathinone	40
Clonazolam	30
Clonitazene	25
Codeine methylbromide	30
Codeine-N-oxide	192
Crotonyl Fentanyl	25
CUMYL-PEGACLONE	30
Cyclopentyl Fentanyl	30
Cyclopropyl Fentanyl	20
Cyprenorphine	25
delta-9-Tetrahydrocannabinol	1,523,040
Desomorphine	25
Dextromoramide	25
Diapromide	20
Diclazepam	30
Diethylthiambutene	20
Diethyltryptamine	25
Difenoxin	9,300
Dihydromorphine	639,954
Dimenoxadol	25
Dimepheptanol	25
Dimethylthiambutene	20
Dimethyltryptamine	25,000
Dioxyaphetyl butyrate	25
Dipentylone	30
Dipipanone	25
Drotebanol	25
Ethylmethylthiambutene	25
Ethylone	25
Ethylphenidate	30
Etizolam	30
Etodesnitazene	30
Etonitazene	25
Etorphine	30
Etoxeridine	25
Eutylone	30
Fenethylline	30
Fentanyl carbamate	30
Fentanyl related substances	600
Flualprazolam	30
Flubromazolam	30
Flunitazene	30
FUB-144	25
FUB-AKB48	25
FUB-AMB, MMB-Fubinaca, AMB-Fubinaca	25
Furanyl fentanyl	30
Furethidine	25
Gamma-Hydroxybutyric acid	49,675,266
Heroin	150
Hydromorphinol	40
Hydroxypethidine	25
Ibogaine	210
Isobutyryl Fentanyl	25
Isotonitazine	25
JWH-018 and AM678 (1-Pentyl-3-(1-naphthoyl)indole)	35
JWH-019 (1-Hexyl-3-(1-naphthoyl)indole)	45

Basic class	Established 2026 quotas (g)
JWH-073 (1-Butyl-3-(1-naphthoyl)indole)	45
JWH-081 (1-Pentyl-3-[1-(4-methoxynaphthoyl)]indole)	30
JWH-122 (1-Pentyl-3-(4-methyl-1-naphthoyl)indole)	30
JWH-200 (1-[2-(4-Morpholinyl)ethyl]-3-(1-naphthoyl)indole)	35
JWH-203 (1-Pentyl-3-(2-chlorophenylacetyl)indole)	30
JWH-250 (1-Pentyl-3-(2-methoxyphenylacetyl)indole)	30
JWH-398 (1-Pentyl-3-(4-chloro-1-naphthoyl)indole)	30
Ketobemidone	30
Levomoramide	25
Levophenyacylmorphan	25
Lysergic acid diethylamide (LSD)	1,200
MAB-CHMINACA; ADB-CHMINACA (N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide)	30
Marijuana	6,675,000
Marijuana extract	1,000,000
MDMB-4EN-PINACA	30
MDMB-CHMICA; MMB-CHMINACA(methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate)	30
MDMB-FUBINACA (methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate)	30
Mecloqualone	30
Mescaline	1,200
Mesocarb	30
Meta-Fluorofuranyl fentanyl	30
Methaqualone	60
Methcathinone	25
Methiopropamine	30
Methoxyacetyl fentanyl	30
Methyl 2-(1-(4-fluorobutyl)-1h-indazole-3-carboxamido)-3,3-dimethylbutanoate (4F-MDMB-BINACA)	30
Methyldesorphine	5
Methyldihydromorphine	25
Metodesnitazene	30
Metonitazene	30
MMB-CHMICA; (AMB-CHIMCA); Methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3-methylbutanoate	25
MMB-FUBICA	30
Morpheridine	25
Morphine methylbromide	5
Morphine methylsulfonate	5
Morphine-N-oxide	150
MT-45	30
Myrophine	25
N,N-Dimethylamphetamine	25
N-Ethyl-1-phenylcyclohexylamine; N-Ethyl-1-phenylcyclohexylamine	25
N-Ethyl-2-(2-(4-isopropoxybenzyl)-5-nitro-1h- benzimidazol-1-yl)ethan-1-amine; N-Desethyl Isotonitazene	30
N-Ethyl-3-piperidyl benzilate	10
N-Ethylamphetamine	24
N-Ethylhexedrone	25
N-Ethylpentylone, ephylone	30
N-Hydroxy-3,4-methylenedioxyamphetamine	24
N-Methyl-3-piperidyl benzilate	30
N-Pyrrolidino Etonitazene	30
Naphyrone	25
Nicocodeine	25
Nicomorphine	25
NM2201: Naphthalen-1-yl 1-(5-fluorpentyl)-1H-indole-3-carboxylate	25
Noracymethadol	25
Norlevorphanol	2,550
Normethadone	25
Normorphine	40
Norpipanone	25
Ocfentanil	25
ortho-Chlorofentanyl	30
ortho-Fluoroacryl fentanyl	30
ortho-Fluorobutyryl fentanyl	30
ortho-Fluorofentanyl,2-Fluorofentanyl	30
ortho-Fluoroisobutyryl fentanyl	30
ortho-Methyl acetylfentanyl	30
ortho-Methylcyclopropyl fentanyl	30
ortho-Methyl methoxyacetyl fentanyl	30
para-Chlorofentanyl	30
para-Chloroisobutyrl fentanyl	30
para-Flourobutyryl fentanyl	25
para-Fluorofentanyl	25

Basic class	Established 2026 quotas (g)
para-Fluoro furanyl fentanyl	30
para-Fluoro valeryl fentanyl	30
para-Methoxybutyrl fentanyl	30
para-Methylfentanyl	30
Parahexyl	5
PB-22; QUPIC	20
Pentedrone	25
Pentylone	25
Phenadoxone	25
Phenampromide	25
Phenomorphan	25
Phenoperidine	25
Phenyl fentanyl	30
Pholcodine	5
Piritramide	25
Proheptazine	25
Properidine	25
Propiram	25
Protonitazene	30
Psilocybin	50,000
Psilocyn	80,000
Racemoramide	25
SR-18 and RCS-8 (1-Cyclohexylethyl-3-(2-methoxyphenylacetyl)indole)	45
SR-19 and RCS-4 (1-Pentyl-3-[(4-methoxy)-benzoyl]indole)	30
Tetrahydrofuranyl fentanyl	15
Tetrahydrothiofuranyl fentanyl	30
Thebacon	25
Thiafentanil	25
Thiofentanyl	25
Thiofuranyl fentanyl	30
THJ-2201 ([1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl)methanone)	30
Tilidine	25
Trimeperidine	25
U-47700	30
UR-144 (1-pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone	25
Valeryl fentanyl	25
Zipeprol	30
Schedule II	
1-Phenylcyclohexylamine	15
1-Piperidinocyclohexanecarbonitrile	25
4-Anilino-N-phenethyl-4-piperidine (ANPP)	937,874
Alfentanil	5,000
Alphaprodine	25
Amobarbital	20,100
Bezitramide	25
Carfentanil	20
Cocaine	60,492
Codeine (for conversion)	942,452
Codeine (for sale)	19,262,516
d-Amphetamine (for conversion)	34,602,790
d-Amphetamine (for sale)	26,450,000
d-Methamphetamine (for conversion)	485,020
d-Methamphetamine (for sale)	47,000
d,l-Amphetamine	24,234,443
d,l-Methamphetamine	150
Dexmethylphenidate (for conversion)	5,374,683
Dexmethylphenidate (for sale)	6,200,000
Dextropropoxyphene	35
Dihydrocodeine	115,227
Dihydroetorphine	25
Diphenoxylate (for conversion)	14,100
Diphenoxylate (for sale)	770,800
Ecgonine	60,492
Ethylmorphine	30
Etorphine hydrochloride	32
Fentanyl	731,236
Glutethimide	25
Hydrocodone (for conversion)	1,250
Hydrocodone (for sale)	26,978,077

Basic class	Established 2026 quotas (g)
Hydromorphone	1,949,378
Isomethadone	30
l-Amphetamine	30
l-Methamphetamine	587,229
Levo-alphacetylmethadol (LAAM)	25
Levomethorphan	30
Levorphanol	20,000
Lisdexamfetamine	51,290,743
Meperidine	681,184
Meperidine Intermediate-A	30
Meperidine Intermediate-B	30
Meperidine Intermediate-C	30
Metazocine	15
Methadone (for sale)	25,619,700
Methadone Intermediate	27,673,600
Methamphetamine	150
Methylphenidate (for conversion)	19,975,468
Methylphenidate (for sale)	58,283,000
Metopon	25
Moramide-intermediate	25
Morphine (for conversion)	2,393,200
Morphine (for sale)	23,000,000
Nabilone	62,000
Norfentanyl	25
Noroxymorphone (for conversion)	24,756,979
Noroxymorphone (for sale)	2,500
Oliceridine	25,100
Opium (powder)	250,000
Opium (tincture)	530,837
Oripavine	45,721,950
Oxycodone (for conversion)	437,827
Oxycodone (for sale)	50,237,652
Oxymorphone (for conversion)	31,773,105
Oxymorphone (for sale)	464,367
Pentobarbital	40,000,000
Phenazocine	25
Phencyclidine	35
Phenmetrazine	25
Phenylacetone	100
Piminodine	25
Racemethorphan	5
Racemorphan	5
Remifentanil	4,000
Secobarbital	172,100
Sufentanil	4,000
Tapentadol	10,390,226
Thebaine	57,137,944
List I Chemicals	
Ephedrine (for conversion)	41,100
Ephedrine (for sale)	3,933,336
Phenylpropanolamine (for conversion)	14,878,320
Phenylpropanolamine (for sale)	7,990,000
Pseudoephedrine (for conversion)	1,000
Pseudoephedrine (for sale)	186,617,466

The Administrator also establishes APQs for all other schedule I and II controlled substances included in 21 CFR 1308.11 and 1308.12 at zero. In accordance with 21 CFR 1303.13 and 21 CFR 1315.13, upon consideration of the relevant factors, the Administrator may adjust the 2026 APQ and AAN as needed.

Signing Authority

This document of the Drug Enforcement Administration was signed on December 31, 2025, by Administrator Terrance 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**.

Leslie Mayer,

Federal Register Liaison Officer, Drug Enforcement Administration.

[FR Doc. 2025–24277 Filed 1–2–26; 8:45 am]

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NUCLEAR REGULATORY COMMISSION

[NRC–2025–0001]

Sunshine Act Meetings

TIME AND DATE: Weeks of January 5, 12, 19, and 26, and February 2 and 9, 2026. The schedule for Commission meetings is subject to change on short notice. The NRC Commission Meeting Schedule can be found on the internet at: *https://www.nrc.gov/public-involve/public-meetings/schedule.html*.

PLACE: The NRC provides reasonable accommodation to individuals with disabilities where appropriate. If you need a reasonable accommodation to participate in these public meetings or need this meeting notice or the transcript or other information from the public meetings in another format (*e.g.,* braille, large print), please contact the Reasonable Accommodations Resource by email at *Reasonable_Accommodations.Resource@nrc.gov*. Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

STATUS: Public.

Members of the public may request to receive the information in these notices electronically. If you would like to be added to the distribution, please contact the Nuclear Regulatory Commission, Office of the Secretary, Washington, DC 20555, at 301–415–1969, or by email at *Betty.Thweatt@nrc.gov* or *Samantha.Miklaszewski@nrc.gov*.

MATTERS TO BE CONSIDERED:

Week of January 5, 2026

There are no meetings scheduled for the week of January 5, 2026.

Week of January 12, 2026—Tentative

There are no meetings scheduled for the week of January 12, 2026.

Week of January 19, 2026—Tentative

There are no meetings scheduled for the week of January 19, 2026.

Week of January 26, 2026—Tentative

There are no meetings scheduled for the week of January 26, 2026.

Week of February 2, 2026—Tentative

There are no meetings scheduled for the week of February 2, 2026.

Week of February 9, 2026—Tentative

There are no meetings scheduled for the week of February 9, 2026.

CONTACT PERSON FOR MORE INFORMATION: For more information or to verify the status of meetings, contact Wesley Held at 301–287–3591 or via email at *Wesley.Held@nrc.gov*.

The NRC is holding the meetings under the authority of the Government in the Sunshine Act, 5 U.S.C. 552b.

Dated: December 31, 2025.

For the Nuclear Regulatory Commission.

Wesley W. Held,

Policy Coordinator, Office of the Secretary.

[FR Doc. 2025–24239 Filed 12–31–25; 11:15 am]

BILLING CODE 7590–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–104528; File No. SR–IEX–2025–36]

Self-Regulatory Organizations; Investors Exchange LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend the IEX Fee Schedule Concerning Certain Connectivity Fees

December 30, 2025.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the ''Act'') [2] and Rule 19b–4 thereunder,[3] notice is hereby given that on December 19, 2025, the Investors Exchange LLC (''IEX'' or the ''Exchange'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

Pursuant to the provisions of Section 19(b)(1) under the Act,[4] and Rule 19b–4 thereunder,[5] the Exchange is filing with the Securities and Exchange Commission (''Commission'') a proposed rule change to amend its Fee Schedule,[6] pursuant to IEX Rules 15.110(a) and (c), to increase the fee for physical connectivity at its Primary Data Center, add a fee for physical connectivity at the Disaster Recovery Data Center, and add a fee for Drop Copy logical port fees. Changes to the Fee Schedule pursuant to this proposal are effective upon filing,[7] and will be operative beginning on January 1, 2026.

The text of the proposed rule change is available at the Exchange's website at *https://www.iexexchange.io/resources/regulation/rule-filings* and at the principal office of the Exchange.

II. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

IEX is proposing to amend the Connectivity Fees section of its Fee Schedule, pursuant to IEX Rules 15.110(a) and (c), to increase fees for physical port connections to its Primary Data Center,[8] add a fee for physical port connections to its Disaster Recovery Data Center,[9] and add a fee for logical Drop Copy Ports.[10] Specifically, the

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] 15 U.S.C. 78s(b)(1).

[5] 17 CFR 240.19b–4.

[6] *See* IEX Fee Schedule—Connectivity Fees table, available at *https://www.iexexchange.io/resources/trading/fee-schedule#connectivity-fees.*

[7] 15 U.S.C. 78s(b)(3)(A)(ii).

[8] All connections to the IEX Primary Data Center (including for order entry and market data receipt) are made through IEX's point-of-presence (''IEX POP'') in Secaucus, NJ. From the IEX POP, messages travel to IEX's Primary Data Center. The only connections offered to the Primary Data Center are 10 gigabit (''10G'') physical port connections. The Exchange offers both 10G and 1 gigabit (''1G'') physical port connections to the IEX Testing Facility (''ITF'') included with a Primary Data Center connection and as discussed below, the Exchange is not proposing to add fees for the connections to the ITF itself.

[9] The Disaster Recovery Data Center, also known as the ''Secondary Data Center,'' is the physical location of IEX's backup trading platform. It is located in Chicago, Illinois.

[10] Confirmations of orders and execution reports are transmitted by the Exchange over the Order Entry Port that was used to enter the order. A ''drop

Continued