Beyond the Green: Navigating Clinical Impacts and Kentucky Cannabis Law

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UofL Health

Disclosures

Neither Dr. Dawson nor Dr. Roberts have any relevant financial interests to disclose

Objectives

- Evaluate clinical evidence for medicinal cannabis in managing oncology-related symptoms such as chemotherapy-induced nausea and vomiting (CINV), cancer-associated pain, cancer associated cachexia, and depression/anxiety

- Describe medicinal cannabis pharmacokinetics and identify potential drug-drug interactions

- Review Kentucky medicinal cannabis regulations including qualifying conditions, legal possession limits, and professional compliance responsibilities

Definitions

- **Cannabis:** products from the *Cannabis sativa* plant
- **Cannabinoids:** group of substances in the plant
  - Cannabidiol (CBD)
  - Tetrahydrocannabinol (THC)
- **Marijuana:** parts of the plant that contain THC
- **Delta-9:** most abundant form of THC

Contains ~540 different substances

Cannabis sativa plant

https://www.nccih.nih.gov/health/cannabis-marijuana-and-cannabinoids. Accessed January 2024.
Picture from: https://assessment.ifas.ufl.edu/assessments/cannabis-sativa/

Human Endocannabinoid System (ECS)

ECS = neuromodulatory system

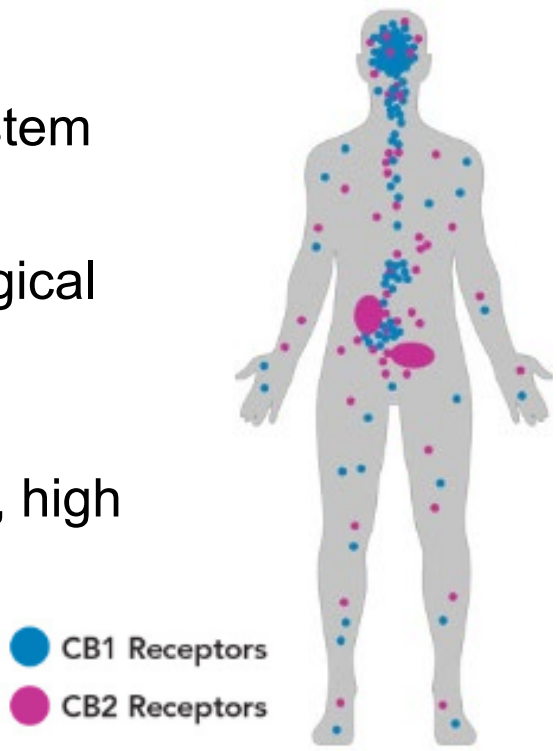
CNS development	Synaptic plasticity	Environmental responses

Cannabinoid receptors

- CB1: Brain, central, and peripheral nervous system
- CB2: Spleen, cardiovascular system, G tract
  - Expressed by some neurons under pathological conditions

Endogenous cannabinoids

- Arachidonoylethanolamine (AEA): CB1 agonist, high affinity
- 2-arachidonoyl glycerol (2-AG): CB1 and CB2 agonist, low-moderate affinity



CB: Cannabinoid | GI: gastrointestinal

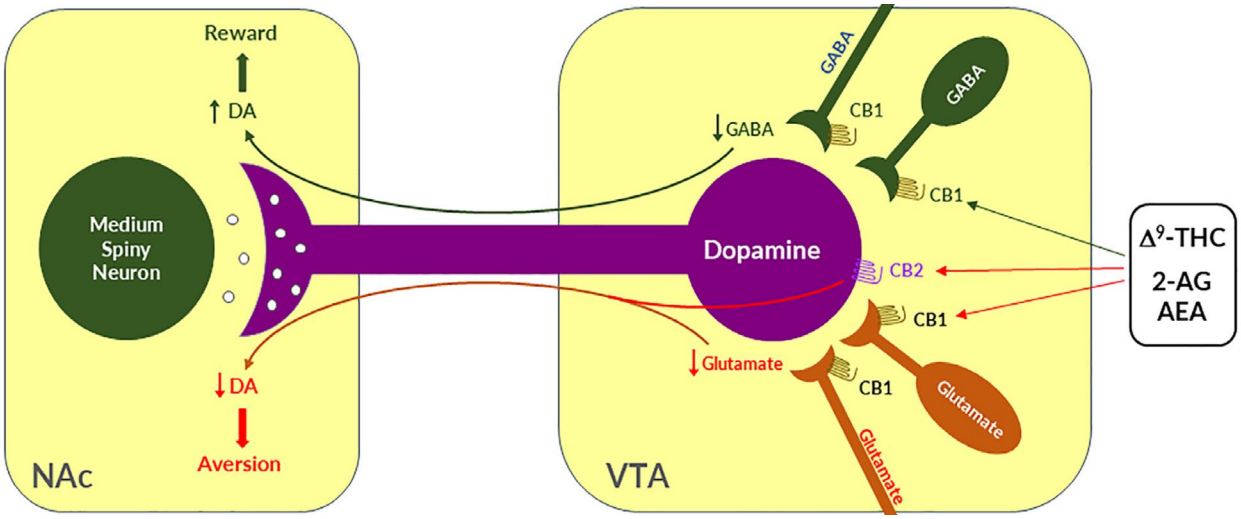
Lu HC, et al. Biol Psychiatry. 2016; 79(7): 516-525. | Zou S, et al. Int J Mol Sci. 2018; 19(3): 833.
Picture from: https://www.neuroscienceinc.com/news/2020/one-of-your-bodys-best-kept-secrets

Human Endocannabinoid System (ECS)

Endogenous and Exogenous Cannabinoid Signaling

THC: Elicits psychoactive effects via CB1 binding

CBD: Low CB1/CB2 affinity; may ↑ plasma levels of AEA



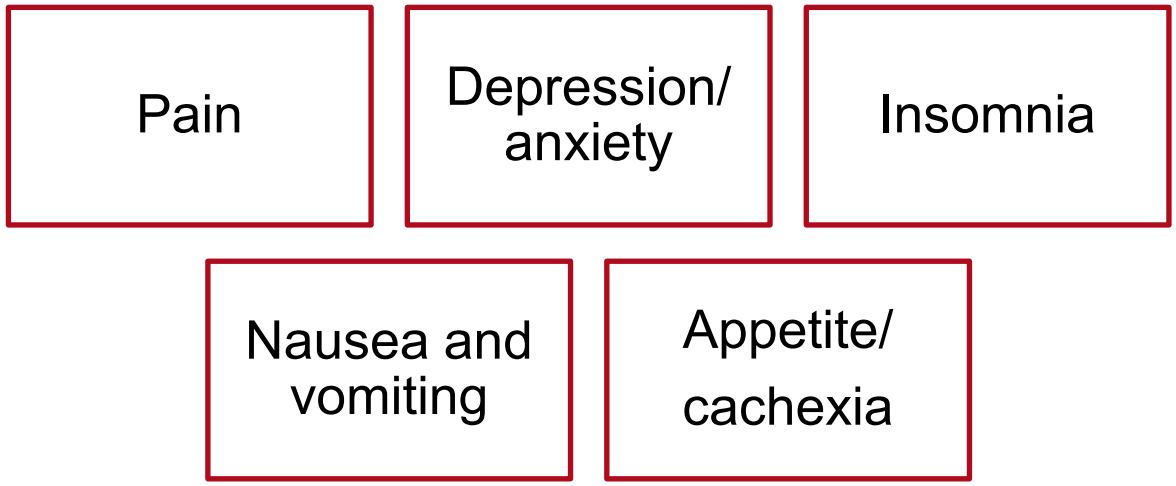
DA: Dopamine | VTA: Ventral tegmental area | NAc: Nucleus accumbens

Soler-Cedeno O, et al. Cells. 2022; 11(2): 3262.
Batalla A, et al. Front Pharmacol. 2021; 11:618184.

Medicinal Uses of Cannabinoids

Cannabinoids for Medicinal Uses

***Potential Uses:**



Survey of medicinal cannabis users, N = 1,429

- 61.2% used for pain, 50.3% for anxiety, 27.4% for nausea

Survey of medicinal cannabis users, N = 808

- Improvement in symptoms: pain (28%), sleep (18%), mood (11%)

*Select therapeutic uses, may not reflect all potential uses of medicinal cannabis

Sexton M, et al. Cannabis and Cannabinoid Research. 2016; 1(1): 131-138.
Garcia-Romeu A, et al. Front Pharmacol 2022;13:965535.

Cannabinoids for Medicinal Uses

Whiting, et al. 2015 – Meta-Analysis of Cannabinoids for Medical Use	
Design	▪ 79 RCTs of cannabinoids for: CINV, appetite stimulation (HIV/AIDs patients), chronic pain, muscle spasms, mood disorders, sleep, psychosis, glaucoma, and Tourette syndrome ▪ All compared cannabinoids to placebo or usual care ▪ N = 6,462
Chronic pain trials (28 studies, n = 2,454) ▪ Included nabilone, dronabinol, nabiximols, and THC (various routes) Results: ▪ Pain reduction > 30% with CBN: OR 1.41, [95% CI 0.99-2.00] – 8 trials ▪ Nabiximols > reduction in numerical pain scale ratings: weighted mean difference -0.46, [95% CI -0.80, -0.11] – 6 trials ▪ No differences in QOL scores – 3 trials	

CINV: Chemotherapy induced nausea and vomiting | CBN: cannabinoids
CI: Confidence interval | QOL: Quality of life

Whiting PF, et al. JAMA. 2015; 313(24):2456-2473.

Cannabinoids for Medicinal Uses

Whiting, et al. 2015 – Meta-Analysis of Cannabinoids for Medical Use

Depression trials – No trials met inclusion criteria

- 5 studies of other indications reported depression as an outcome
- 3 studies: no difference
- 1 study: worsened depression with nabiximols (high doses), no difference with other doses

CINV trials (28 studies, n = 1,772) – 14 nabilone, 6 THC, 3 dronabinol, 5 others

- All studies suggested benefit of cannabinoids vs placebo or active comparator
  - Did **not** achieve statistical significance
- 3 studies: Complete nausea/vomiting response > with dronabinol than placebo
  - OR 3.82, [95% CI 1.55-9.42]

Whiting PF, et al. JAMA. 2015;313(24):2456-2473.

Cannabinoids for Medicinal Uses

Whiting, et al. 2015 – Meta-Analysis of Cannabinoids for Medical Use

Sleep trials (2 studies, n = 54)

- 1 study: nabilone improved sleep apnea index, mean difference -19.64, p = 0.02
- 1 study: nabilone compared to amitriptyline, nabilone significantly improved:
  - Insomnia scores, -3.25 from baseline, [95% CI -5.26, -1.24]
  - Restfulness scores, 0.48 from baseline, [95% CI 0.01-0.95]

Appetite trials (4 studies, n = 255), all assessed dronabinol vs placebo or megestrol

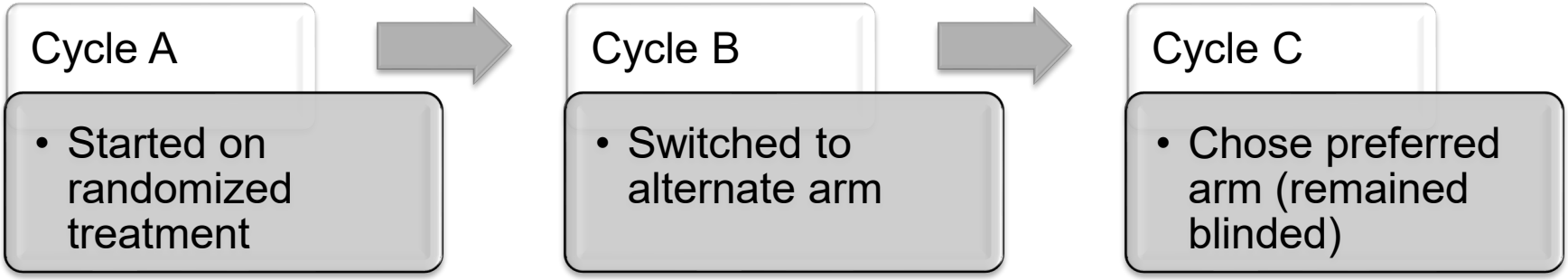
- Some evidence dronabinol increased weight
- Limited evidence for increased appetite

No statistical significance

Whiting PF, et al. JAMA. 2015;313(24):2456-2473.

Cannabinoids for Medicinal Uses

Grimison, et al. 2020 – Oral THC:CBD Cannabis for Refractory CINV	
Design	▪ Multicenter, double-blind, crossover placebo-controlled trial **Population (N = 81)** Patients receiving IV chemotherapy (moderate to high emesis risk) Refractory CINV, ECOG ≤ 2
Intervention	▪ Guideline CINV prophylaxis + THC:CBD (THC) or placebo (PCB) starting day prior to chemo and TID from days 1-5 ▪ THC:CBD 2.5 mg each, titrated from 1-4 capsules/dose



CINV: Chemotherapy induced nausea and vomiting | CBN: cannabinoids
CI: Confidence interval | QOL: Quality of life

Grimison P, et al. Ann Oncol. 2020;31 (11): 1553-1560

Cannabinoids for Medicinal Uses

Grimison, et al. 2020 – Oral THC:CBD Cannabis for Refractory CINV		
Results (THC:CBD vs Placebo)		
Efficacy No. (%)	Complete response (CR)* 18 (25) vs 10 (14), RR 1.9, **P = 0.04** CR + no significant nausea 9 (13) vs 4 (6), RR 2.1, P = 0.12	Mean nausea score 3.2 ± 0.2 vs 4.7 ± 0.2, **P < 0.001** No significant nausea** 15 (21) vs 7 (10), RR 2.0, **P = 0.03**
Self-reported cannabinoid-related adverse events (rated as moderate or severe)		
No. (%)	Any: 22 (31) vs 5 (7), **P = 0.002** Dizziness: 8 (10) vs 1 (1), **P = 0.03**	Sedation: 15 (19) vs 3 (4), **P = 0.002** Anxiety: 1 (1) vs 1 (1), P = 1.0
Conclusions: THC:CBD **decreased** vomiting and significant nausea, but had more patient-reported side effects		

83% preferred THC:CBD combination after cycle B

*Complete response = no vomiting or rescue medication use during time 0 to 120 hours post chemotherapy
**No significant nausea = nausea < 2 on a 10-point scale

Grimison P, et al. Ann Oncol. 2020;31 (11): 1553-1560

Cannabinoids for Medicinal Uses

Hardy, et al. 2022 – CBD Oil for Symptom Relief in Advanced Cancer	
Design	▪ Single-center, dose-escalated, placebo-controlled trial **Population (N = 144)** Age > 18 years with advanced cancer, TSDS ≥ 10/90, negative baseline THC urine test
Intervention	▪ CBD oil 100 mg/mL vs placebo ▪ Starting dose: 0.5 mL (50 mg) once daily ▪ Titrated to maximum of 2 mL (200 mg) TID ▪ Standard palliative care provided to **all** participants ▪ Assessments: phone (every 3-4 days), in-person (week 0, 2, 4)
Primary outcome: TSDS change from baseline to week 2 ▪ Placebo: -6.2 (SD 14.5), CBD: -3.2 (SD 15.2), p = 0.24	
*No differences between arms in TSDS scores in physical, emotional, or well-being subsets	
Conclusions: CBD oil did not reduce TSDS scores compared to palliative care alone	

TSDS: Total symptom distress score, measured by Edmonton Symptom Assessment Scale

Hardy J, et al.. J Clin Oncol. 2022;41(7):1444-1452.

Cannabinoids for Medicinal Uses

Boland, et al. 2020 – Meta-Analysis – Cannabinoids for Cancer-related Pain	
Design	▪ 5 RCTs, N = 1,442 patients ▪ Included cannabinoids (THC:CBD oromucosal spray, THC extract) vs other active agents for pain (or placebo)
Results:	
Neuropathic Pain:	▪ 1 study (n = 18), compared nabiximols vs placebo for chemotherapy-induced neuropathic pain ▪ Mean pre-treatment NRS for pain intensity: 6.75 ▪ Mean post-treatment (4 weeks) NRS for pain intensity: 6.00 (nabiximols vs 6.38, P = 0.29
Pain Intensity	▪ Change in mean NRS pain score: -0.21 (-0.48-0.07, p = 0.14)
ADEs	Cannabinoid arms: ▪ Higher odds of somnolence (OR 2.69, **P < 0.001**), and dizziness: (OR 1.58, **P = 0.05**) ▪ Numerically higher, not significant: nausea (OR 1.41, P = 0.08), vomiting (OR 1.34, P = 0.21)

NRS: Numeric rating scale | ADEs: Adverse drug events

Cannabinoids for Medicinal Uses

Simon, et al. 2021 – Meta-Analysis – Cannabinoids for Cancer-related Cachexia	
Design	▪ 10 studies (4 RCTs, 6 NSRIs, N = 804 patients) ▪ Included medical marijuana (smoked, ingested), THC, CBD, and synthetic cannabinoids (dronabinol, nabilone)
Results:	
Weight	▪ 8 trials evaluated weight change ▪ 1 RCT: megestrol resulted in > weight gain compared to dronabinol (**P = 0.02**) ▪ 1 RCT: **No difference** between placebo vs nabilone in weight gain ▪ 4 NSRIs: Slight weight gain in experimental arms (1 trial: mean ↑ 0.3 kg, 1 trial: median ↑ 1-1.3 kg, 2 reported ↑ of 7.7-21.6%)
Appetite	▪ 3 RCTs (n = 297), no change in appetite with cannabinoids vs placebo, SMD -0.02, P = 0.93) *7 NSRIs evaluated appetite, data not suitable for statistical analysis ▪ 2 trials: greater appetite improvement in control arm ▪ 3 trials: Experimental arm: improvement in appetite and calorie counts, less complaints appetite loss

NSRIs: Non-randomized studies of interventions | SMD: Standard mean difference

Simon L, et al. J Cachexia Sarcopenia Muscle. 2022;13(1):23-41

Cannabinoids for Cancer Symptoms

2024 ASCO Guidelines:

Outcome	Certainty of Evidence	Direction of Effect	Recommendation
CINV	Moderate: Dronabinol, nabilone Low: THC:CBD extract	Benefit	Weakly favor
Total Symptom Burden	Low: Oral CBD	No clear evidence of benefit or harm	Weakly against
Cancer Pain	Moderate: Nabiximols	No clear evidence of benefit or harm	None
Sleep	Moderate: Nabiximols, nabilone	No clear evidence of benefit or harm	None
Weight/poor appetite	Low: Dronabinol, nabilone, THC/CBD extract, THC	No clear evidence of benefit or harm	None
Anxiety/ depression	Very low: THC, THC:CBD, dronabinol, nabiximols	No clear evidence of benefit or harm	None

Braun IM, et al. J Clin Oncol. 2024;41(13): 1575-1593.

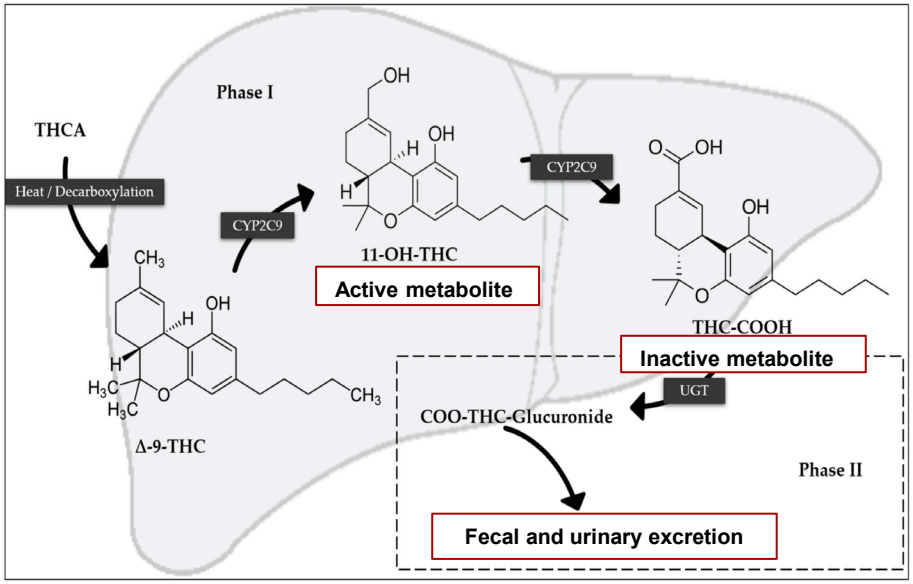
Cannabinoids and Drug Interactions

Cannabinoid Pharmacokinetics

THC

- **Bioavailability**: 4-12% (oral), 10-35% (inhaled)
- **Distribution:** Lipophilic → accumulates in fat, released slowly into bloodstream
- **Metabolism**: Primarily CYP2C9, CYP2C19, CYP3A4 in liver, undergoes hydroxylation and glucuronidation into active and inactive metabolites
- **Excretion:** Feces (65-80%), urine (20-35%)
- **Half-life**: 1-3 days (occasional use), 5-13 days (chronic use)

Main Metabolic Pathways:



CYP: Cytochrome

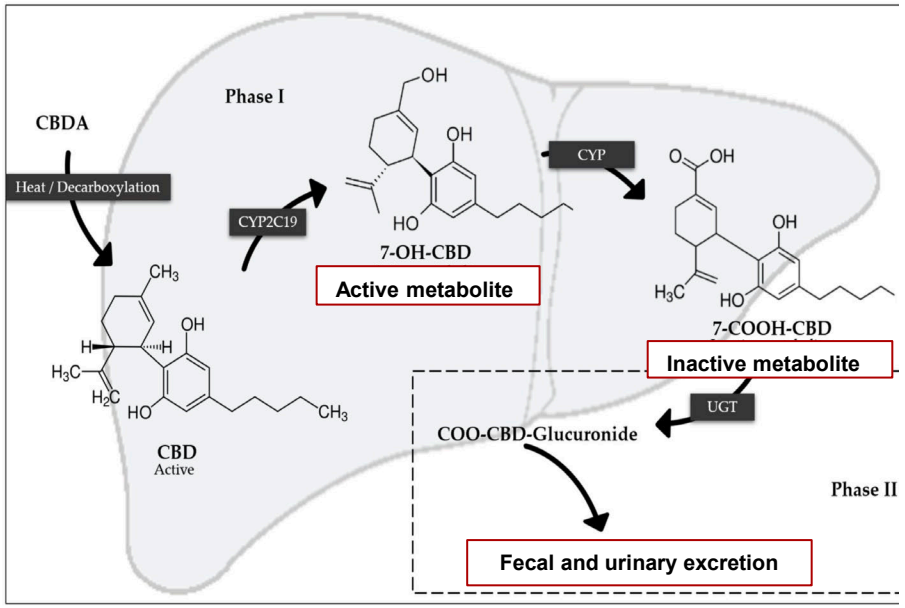
Chayasirisobhon S. Perm J. 2020; 25:1-3.
Caicedo D, et al. Pharmaceutics. 2025; 17(3):319.

Cannabinoid Pharmacokinetics

CBD

- **Bioavailability**: variable, ~6% (oral), 11-45% (inhaled)
- **Distribution:** Brain, adipose tissue; low water-solubility
- **Metabolism**: Primarily CYP2C19 and CYP3A4, undergoes hydroxylation into active and inactive metabolites
- **Excretion:** Feces, unchanged (~33%), remaining active and inactive excreted via urine
- **Half-life**: 18-32 hours

Main Metabolic Pathways:



Chayasirisobhon S. Perm J. 2020; 25:1-3.
Caicedo D, et al. Pharmaceutics. 2025; 17(3):319.

Cannabinoid Pharmacokinetics

CBD and THC's Impact on Metabolic Enzymes:		
	Competitive Inhibition	**Time-Dependent Inhibition**
CBD	CYP2E1 ($K_{i,u}$: 0.021 μM) **CYP2D6** ($K_{i,u}$: 0.074 μM) **CYP2C19** ($K_{i,u}$: 0.050–1.1 μM) **CYP3A4** ($K_{i,u}$: 0.093 μM) **CYP2C9** ($K_{i,u}$: 0.093–1.3 μM) CYP2B6 ($K_{i,u}$: 3.4 μM)	**CYP1A2** (K_i: 0.11–0.59 μM) CYP1B1 (K_i: 3.1 μM) CYP1A1 (K_i: 5.9 μM)
THC	**CYP2C9** ($K_{i,u}$: 0.073 μM) **CYP1A2** ($K_{i,u}$: 0.090 μM) **CYP2D6** ($K_{i,u}$: 0.11 μM) CYP2B6 ($K_{i,u}$: 0.25 μM)	CYP2A6 (K_i: 0.86 μM) CYP1A1 (K_i: 1.2 μM)
Ki = inhibition constant (lower number = higher binding affinity)		

*Other studies note THC may inhibit CYP3A4 as well, but likely weaker inhibition compared to CBD

Clinical Impact?

- CBD: Moderate to strong increase in substrate's AUC at doses > 300 mg/day
- THC: Minimal impact observed at oral doses < 30 mg/day

Qian L, et al. Pharmaceutics. 2024;16(4):484. | Herdegen T, et al. Dtsch Arztebl Int. 2023;120(49)833-840

Cannabinoids and Drug Interactions

2024 ASCO Guidelines:

Statements:

- Cannabinoids may inhibit: CYP3A4, UGT1A9, UGT2B7, CYP1A2, CYP2B6, CYP2C8, CYP2C9, and CYP2C19
- “Potential for drug interactions through altered metabolism pharmacokinetics”
- Warfarin = “very high-risk” drug interaction
- Buprenorphine, tacrolimus = “high risk” drug interaction
- “Scant” data available, unable to provide “informed, scientifically supported answers” on potential interaction with anticancer drugs

Braun IM, et al. J Clin Oncol. 2024;41(13): 1575-1593.

Cannabinoids and Immunotherapy

2024 ASCO Guidelines:

Recommendations:

- Preliminary data indicates potential poor clinical outcomes in patients receiving immunotherapy and using cannabis
- Advise caution in patients receiving immunotherapy and considering using cannabis

Rationale:

- Cannabis alters various components of the immune system:

Proliferation, activation, and cytotoxic activity of T cells	Production of cytokines and chemokines	Function of dendritic and NK cells	Recruitment of immuno-suppressive myeloid cells

NK cells: Natural killer cells

Braun IM, et al. J Clin Oncol. 2024;41(13): 1575-1593.

Cannabinoids and Immunotherapy

Taha, et al. 2019 – Cannabis Impacts Tumor Response Rate to Nivolumab		
Design	Retrospective, observational study, single-center	
Population/ Intervention	Adults, stage IV NSCLC, RCC or advanced melanoma, newly on nivolumab • Compared cannabis users (both THC and CBD) to non-users • N = 140 (IO alone = 89 patients, IO + Cannabis = 51 patients)	
Results: IO alone vs IO + Cannabis:		
Response Rate:	<u>NSCLC:</u> 33% vs 17.6% p = 0.128, OR = 0.43 95% CI 0.14-1.28)	<u>RCC + Melanoma:</u> 43.3% vs 10% p = 0.084, OR = 0.15 (95% CI 0.02-1.3)
Multivariate analysis: Only factor affecting treatment was cannabis, p = 0.031, adjusted OR 2.74, (95% CI 1.09-6.85)		
No impact on RR: THC or CBD percentages, method of use (smoked/inhaled vs CBD oil)		
Conclusions: • Cannabis use correlated with decreased RR to nivolumab (not statistically significant) • Limitations: Small study, larger study needed to valid results		

NSCLC: Non-small cell lung cancer | RCC: Renal cell carcinoma
IO: Immunotherapy

Taha T, et al. Oncologist. 2019;24(4): 549-554.

Cannabinoids and Immunotherapy

Bar-Sela, et al. 2020 – Cannabis Consumption during Immunotherapy Correlates with Poor Clinical Outcomes	
Design	Prospective (September 2016-September 2018), single-center
Population/ Intervention	Adults, stage IV malignancy, initiated on any immunotherapy • Compared cannabis users (both THC and CBD) to non-users • N = 102 (IO alone = 68 patients, IO + Cannabis = 34 patients) • Significant differences between: site of metastases, line of treatment, single agent vs combination immunotherapy
Results: IO alone vs IO + Cannabis:	
TTP (1° endpoint)	13.1 months vs 3.4 months, **p = 0.025**
OS	28.5 months vs 6,4 months, **p = 0.00094**
ORR	59% vs 39%, **p = 0.035**
Conclusions: • Cannabis use associated with decreased TTP, OS, ORR • Limitations: Small study, heterogenous population (unbalanced arms)	

Bar-Sela G, et al. Cancers. 2020. 12(9): 2447.

Cannabinoids and Immunotherapy

Xiong X, et al. 2022:
Cannabis Suppresses Antitumor Immunity by Inhibiting JAK/STAT Signaling in T-cells

Methods:

- Population: Mice with MC38 cell (colon carcinoma) or B16 cells (melanoma)
- Intervention:
  - Administered PD-1 antibodies ± THC or AEA

Control: No treatment	**THC:** THC, no PD-1	**PD-1:** PD-1, no THC	**Combination:** PD-1 and THC
• PD-1 antibodies: 200 mcg given 2x weekly • THC and AEA: 10 mg/kg every 2 days x 2 weeks			

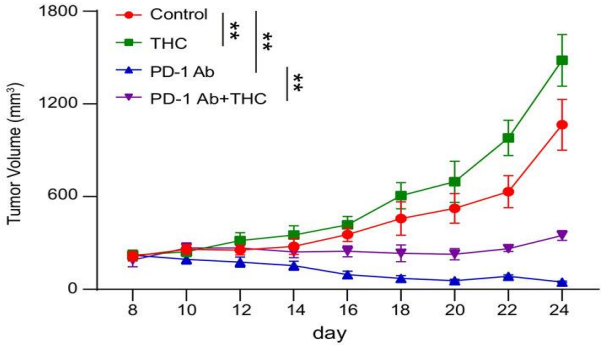
  - Tumor volume measured every other day

AEA: anandamide

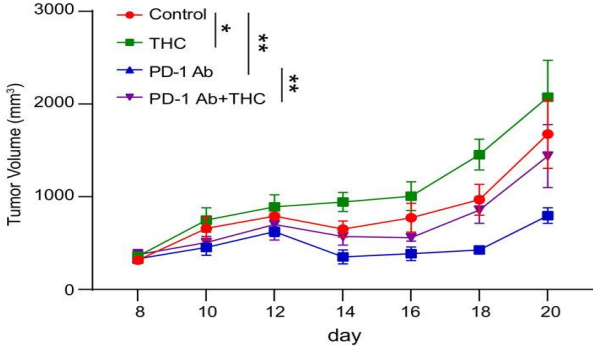
Cannabinoids and Immunotherapy

Tumor Volume after THC Administration:

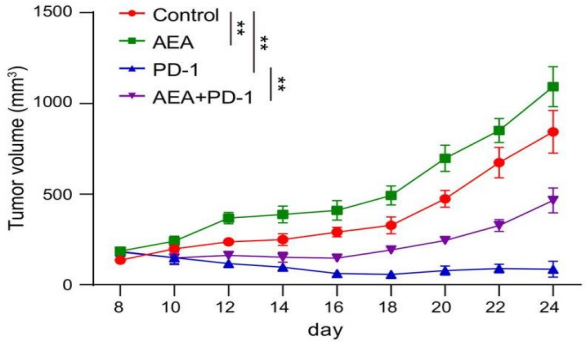
MC38 – Colon Cancer

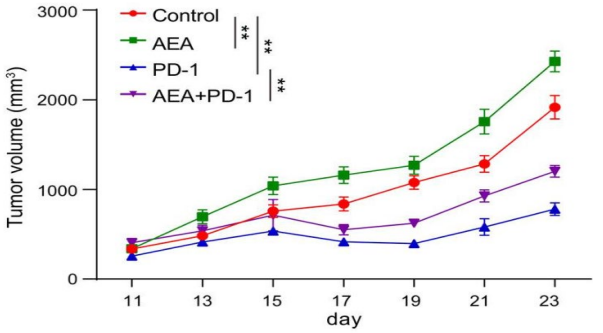


B16 – Melanoma



Tumor Volume after AEA Administration:





Conclusions:

- THC and AEA reduced efficacy of PD-1 blockade
- Molecular analysis: cannabis inhibited JAK1-STAT signaling in T cells via CNR2

CNR2: Cannabinoid receptor 2; Expressed in immune system; THC and AEA = selective agonists

Xiong X, et al. Singal Transduct Target Thera. 2022;7(1):99:

2024 ASCO Guidelines

Recommendation:

- Avoid **≥ 300 mg** oral CBD per day due to lack of efficacy and possible liver dysfunction

Data:

- 2023 meta-analysis; N = 28 trials (1,533 patients on CBD vs 494 on placebo)
  - 89% administered CBD via oral solution
- Liver enzyme elevation:
  - CBD: n = 159 cases (10.5%); Placebo: n = 2 cases (0.40%)
    - OR 5.85 (95% CI 3.84-8.92), **p < 0.001**
- DILI:
  - CBD: n = 57 cases (4.43%); Placebo: n = 1 (0.20%)
    - OR 4.82 (95% CI 2.46-9.45), **p < 0.001**

No DILI cases reported at doses < 300 mg/day

OR: Odds ratio | DILI: Drug-induced liver injury

Braun IM, et al. J Clin Oncol. 2024;41(13): 1575-1593.
Lo LA, et al. J Intern Med. 2023;293(6): 724-752.

Summary and Current Limitations

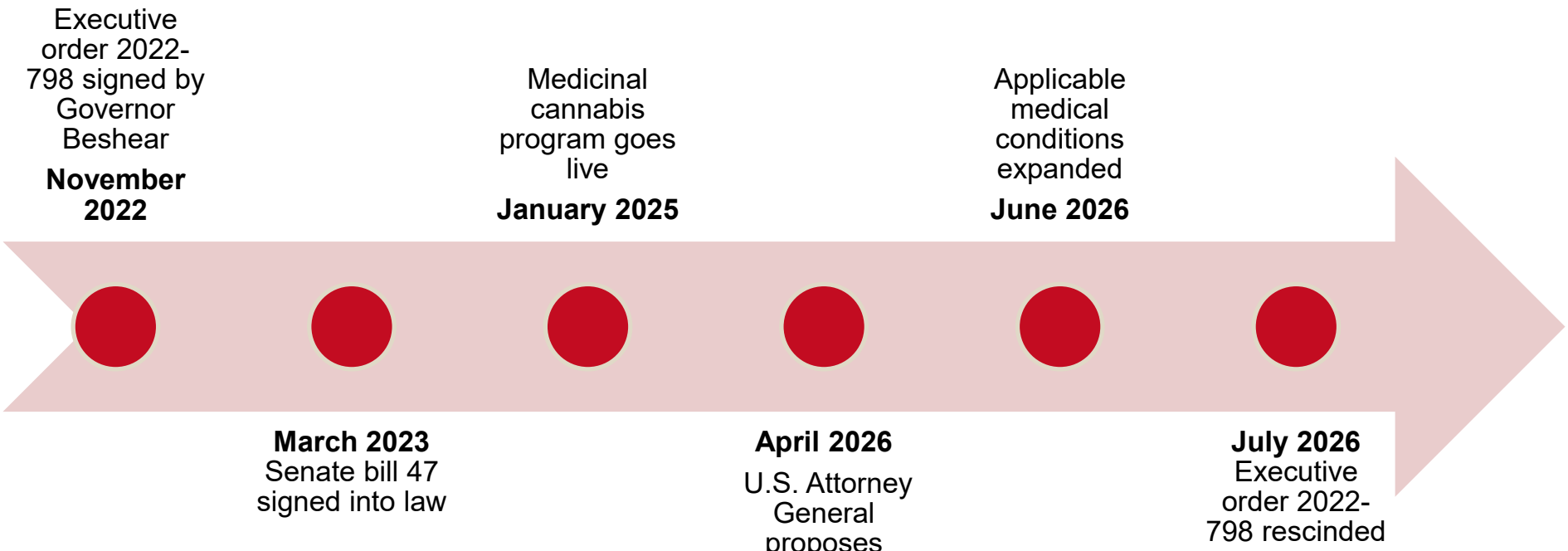
- Medicinal cannabis may be useful in alleviating some cancer-related symptoms, but clinical data is limited by many factors:
  - Small sample sizes, primarily observational data, no standardized dosing/formulation, lack of long term follow up
- Cannabis may negatively impact efficacy of immunotherapy and clinicians should discuss with patients
- THC and CBD inhibit many CYP 450 isoenzymes which may impact antineoplastic drug metabolism; data on clinical impact is lacking

Medicinal Cannabis Regulations

Disclosure

None of the comments and material provided regarding legal content constitutes legal advice and should not be utilized as such.

Timeline of Legislation



Mallatt, CM et al. The national law review. Published 2025 Dec 19.
Regulations. Kentucky office of medicinal cannabis. Accessed 21 Jul 2026.

Application Process

Obtain a written certification from a medical cannabis practitioner **in person**

Create an account on the patient and caregiver registration portal and start an application

Submit the application with a **notarized** signature form

Application will be reviewed and accepted by the CHFS

Cabinet will acknowledge receipt of the application within 15 calendar days	Cabinet will approve or deny the application within 30 calendar days of receiving an application	Approved applicants will receive registry ID cards within 5 days of approval

Cabinet for health and family services. Qualified patient and designated caregiver guide. Accessed 2026 Jul 21.

Medical Cannabis Practitioners

- Physician or an Advanced Practice Registered Nurse who is authorized to prescribe controlled substances
- Authorized through their respective licensing boards
- Eligibility requirements:
  - Good standing with DEA credentials
  - Access to the state's PDMP
  - Six hours of continued medical education on medical cannabis
  - NO ownership, investment in or compensation agreement with a licensed medical cannabis business

Applicable Medical Conditions

- Any type or form of cancer
- Chronic or severe pain
- Epilepsy or other intractable seizure disorder
- Multiple sclerosis, muscle spasms, or spasticity
- Chronic nausea or cyclical vomiting syndrome
- Post-traumatic stress disorder

New Additions

- “Terminal Illness”
- Sickle Cell Anemia
- ALS
- HIV/AIDS
- Huntington’s Disease
- Muscular Dystrophy
- Cachexia/Wasting Syndrome
- Crohn’s Disease
- Ulcerative Colitis
- Neuropathies
- Severe arthritis
- Fibromyalgia
- Glaucoma

Office of the Governor. Executive order 2026 – 318. Accessed 21 Jul 2026.

Cards and Fees

- In-state registry ID card
- Minor patient registry ID card
  - In-state individual less than 18 years of age
- Designated caregiver registry ID cards
- Visiting patient registry ID cards
  - Individual out-of-state registry card and documentation of a qualifying medical condition
  - In KY for less than 30 days and at least 21 years old
- All cards: $25
- Cards expire 1 year from the date of issuance
  - Ability to purchase medical cannabis expire on date of written certification
  - Applications must be complete no later than 30 calendar days prior to expiration date on the card

Registry Requirements

	In-state qualified patient[17]	In-state minor qualified patient[18]	Designated caregiver[19]	Visiting qualified patient[20]
Applicant's identifiable information	X	X	X	X
Name and registry ID card number of qualified patient			X	
Written certification from medical cannabis practitioner	X	X		
Medical cannabis practitioner information	X	X		
Designated caregiver information and attestation (if applicable)	X (If applicable)	X	X	
Notification of clinical trials	X	X		
Attestation of information sharing	X	X	X	X
Notarized signature form	X	X	X	X
Documentation that the applicant has been diagnosed with a qualifying condition*		X		X
Statement from custodial parent or legal guardian		X		
Copy of valid out-of-state registry ID card				X

** This documentation must consist of one (1) or more medical records containing an express statement of diagnosis from a physician or advanced practice registered nurse (APRN) of a qualifying medical condition.[1] For in-state minor patients, this documentation must be provided from a practitioner other than the medical cannabis practitioner who provided the written certification for the use of medical cannabis.*

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Cabinet for health and family services. Qualified patient and designated caregiver guide. Accessed 2026 Jul 21.

Product Packaging and Labeling

Packaging

- Tamper-evident and child resistant seal
- Light resistant, opaque, and minimizes oxygen exposure
- Provides telephone number for National Poison Control Center

Labeling

- Total mg of THC/CBD per serving/package
- Data of harvest, processing, and packaging
- Manufacturer name, batch ID, expiration
- Directions for use
- QR code linking directly to certificates of analysis to verify safety

Kentucky general assembly. 915 KAR 1:100. Accessed 21 Jul 2026.

Allowable Medical Cannabis Products

Form of medical cannabis	10-day supply limit	30-day supply limit*	Example products
Raw plant material	37.5 grams	112 grams	N/A
Concentrates	9.5 grams	28 grams	▸ Vape cartridges ▸ Nebulizer solutions
THC-infused products	1,300 milligrams	3,900 milligrams	▸ Edibles ▸ Pills ▸ Capsules ▸ Oils ▸ Liquids ▸ Beverages ▸ Tinctures ▸ Suppositories ▸ Dermal patches
Non-consumable (topical) products	N/A**		▸ Gels ▸ Creams/lotions ▸ Ointments ▸ Cosmetics ▸ Soaps

Cabinet for health and family services. Qualified patient and designated caregiver guide. Accessed 2026 Jul 21.

Required Notifications

- Cardholders are required to make the following notifications (notification time):
  - Change in name/address (10 days)
  - Loss of the card (10 days)
  - Termination of a designated caregiver relationship (10 days)
  - Cardholder ceases to suffer from the medical condition (30 days)
  - Designated caregiver becomes aware that patient is deceased (30 days)
- New registry ID cards will be issued within 10 days of receiving updated information
- **When a cardholder provides the cabinet with any of the notifications above, the cardholder must, within ten (10) days of notification, return any unused medical cannabis products to a licensed dispensary for destruction.**

Purchasing Restrictions

In-state qualified patients are permitted to purchase the amount of medical cannabis specified by the patient's medical cannabis practitioner, **up to a thirty (30) day supply** during a twenty-five (25) day period.[32]

Designated caregivers are permitted to purchase the amount of medical cannabis specified by the medical cannabis practitioner for the qualified patient(s) they assist, **up to a thirty (30) day supply per each registered qualified patient** during a twenty-five (25) day period.[33]

Visiting qualified patients are permitted to purchase an amount of medical cannabis **up to a ten (10) day supply** as specified by the program supply limits during an eight (8) day period.[34]

The following medical cannabis consumption methods are **prohibited** by KRS Chapter 218B:

- Consuming medical cannabis by combustion, such as smoking, by any patient[35]
- For patients under 21 years old, medical cannabis products intended for consumption by vaporizing are not allowed[36]

Packages for medical cannabis products cultivated, processed, produced, tested, and sold in the Commonwealth will have the standardized symbol below indicating that the products contain THC and were made and sold by licensed cannabis business in Kentucky.

Cabinet for health and family services. Qualified patient and designated caregiver guide. Accessed 2026 Jul 21.

Restrictions for Use

- **<u>Medical cannabis cardholders may not</u>**:
  - Operate vehicles or machinery while under the influence of medical cannabis
  - Keep medical cannabis in arm's reach when operating machinery
  - Use medical cannabis if it impairs their ability to perform tasks safely
  - Possess or use medical cannabis on school property
  - Possess or use medical cannabis at correctional facilities, or on federal property
  - Consume medical cannabis by combustion
  - Grow their own medical cannabis without a cannabis business license

Cabinet for health and family services. Qualified patient and designated caregiver guide. Accessed 2026 Jul 21.

Open Dispensary Locations

- Bowling Green
- Elizabethtown
- Georgetown
- Florence
- Frankfort
- Nicholasville
- Nortonville
- London
- Lexington
- Oak Grove
- Paducah
- Louisville
- Ferguson
- Princeton
- Beaver Dam
- Erlanger
- Ashland
- Corbin

Find a dispensary. Office of medical cannabis.. Updated 2026 Jul 9. Accessed 2026 Jul 21..

Schedule III Status

- Strictly applies to FDA approved drug products containing marijuana (i.e. Dronabinol) and any form of cannabis for anyone holding a qualified state medical marijuana license
  - **Requires DEA registration**
- Benefits:
  - Tax relief for those registering
  - **Broader access to research**
- The BIG problem
  - Only schedule 3 medications are available at pharmacies and only pursuant to a prescription
- Hearing on July 10, 2026
  - Post hearing briefs to be posted August 17, 2026

Mallatt, CM et al. The national law review. Published 2025 Dec 19.
United states drug enforcement administration. Marijuana rescheduling regulatory actions. Accessed 2026 July 21.

21 U.S.C. § 811(c)

Considerations for Scheduling

1. Its actual or relative potential for abuse.
2. Scientific evidence of its pharmacological effect, if known.
3. The state of current scientific knowledge regarding the drug or other substance.
4. Its history and current pattern of abuse.
5. The scope, duration, and significance of abuse.
6. What, if any, risk there is to the public health.
7. Its psychic or physiological dependence liability.
8. Whether the substance is an immediate precursor of a substance already controlled under this subchapter.

Cornell law school. 21 U.S. § Code 811. Accessed 2026 Jul 21.

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Key Takeaways

- Consider optimal dosing recommendations based on THC/CBD content
- Carefully examine drug metabolism when reviewing medication lists for interactions
- Expect a minimum 35-day processing to obtain medicinal cannabis
- Cannabis dispensed is still federally a Schedule I substance

Beyond the Green: Navigating Clinical Impacts and Kentucky Cannabis Law

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