

# MNHGCanarx

## Introduction:

**MNHGCanarx** is a voluntary international prescription drug program that is available to eligible Employees, Non-Medicare eligible Retirees and their Dependents enrolled in the HSA qualified High Deductible Health Plans (HSAQs) with the Minuteman Nashoba Health Group. Only preventive medications are available to you through this program. A list of eligible medications is located on the back of this page.

## Program Savings:

All member copayments have been **waived** for this program **only**. In addition, by enrolling in this program you will save your health plan substantially on the cost of these medications. It is truly a WIN/WIN for both you and the health plan.

✓ **FREE Brand Name Medications - ZERO Cost!**

✓ **No Shipping and Handling Charges to You!**

## Ordering Instructions:

To place your first order please submit: a completed enrollment form; a new prescription for each medication; and a copy of your photo identification\*.

*\*Similar to a number of states in the US, some Canarx pharmacies require a copy of photo ID be provided prior to dispensing the medications. In order to prevent order delays, we encourage patients to include a clear copy of their photo identification with their enrollment form or upload directly to our secure site [www.CanarxDocs.com](http://www.CanarxDocs.com). If not included, a Canarx representative will contact you when required by the pharmacy dispensing your medications.*

Ask your doctor for a prescription for a **3 month supply** with **3 refills**. We will call you prior to each renewal to ensure that you have a continuous supply. Please allow 4 weeks for delivery.

Medications must be tried for 30 days before ordering through **MNHGCanarx**.

**RETURN YOUR COMPLETED AND SIGNED ENROLLMENT FORM AND ORIGINAL PRESCRIPTIONS:**



**BY FAXING TO: 1-866-715-MEDS (6337) TOLL FREE**

*Faxed prescriptions are **ONLY** accepted if sent directly from the physician's office.*

**OR**



**BY MAILING TO: MNHGCanarx**

235 Eugenie St. West  
Suite 105D  
Windsor, ON, Canada  
N8X 2X7

**OR**

P.O. Box 3009  
Windsor, ON, Canada  
N8N 2M3



Receive a one-time **\$25 Gift Card** for enrolling in the **MNHGCanarx** program with a qualifying prescription for a 90 day supply with 3 refills!

*\*Offer available to new program members only.*



## More forms are available:

Additional forms may be obtained at the Human Resources Office, by printing them from the website at [www.MNHGCanarx.com](http://www.MNHGCanarx.com) or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

**WELCOME TO MNHGCanarx**

ADVAIR DISKUS 100MCG  
 ADVAIR DISKUS 250MCG  
 ADVAIR DISKUS 500MCG  
 ADVAIR HFA 45/21MCG  
 ADVAIR HFA 115/21MCG  
 ADVAIR HFA 230/21MCG  
 ALOMIDE 0.1%  
 ALPHAGAN-P 0.15%  
 ALREX 0.2%  
 ALVESCO 80MCG 100MCG  
 ALVESCO 160MCG 200MCG  
 ANAPROX DS 550MG  
 ANORO ELLIPTA 62.5/25MCG  
 APTIOM 200MG  
 APTIOM 400MG  
 APTIOM 600MG  
 APTIOM 800MG  
 ARNUITY ELLIPTA 100MCG  
 ARNUITY ELLIPTA 200MCG  
 ASTAGRAF XL 5MG  
 ATROVENT HFA 20UG  
**AVODART (G) 0.5MG**  
 AZOPT 1%  
 BEPREVE 1.5%  
 BETIMOL 0.25%  
 BETIMOL 0.5%  
 BETOPTIC S 0.25%  
 BEYAZ  
 BIKTARVY 50MG-200MG-25MG  
 BINOSTO 70MG  
 BREO ELLIPTA 100/25MCG  
 BREO ELLIPTA 200/25MCG  
 BRILINTA 60MG  
 BRILINTA 90MG  
 BYSTOLIC 2.5MG  
 BYSTOLIC 5MG  
 BYSTOLIC 10MG  
 BYSTOLIC 20MG  
 COMBIGAN 0.2-0.5%  
 COMBIVENT RESPIMAT  
 20MCG/100MCG  
 COMTAN 200MG  
**CRESTOR (G) 5MG**  
**CRESTOR (G) 10MG**  
**CRESTOR (G) 20MG**  
**CRESTOR (G) 40MG**  
 DALIRESP 500MCG  
 DEPAKOTE 250MG  
 DEPAKOTE 500MG  
 DEXILANT DR 30MG  
 DEXILANT DR 60MG  
**DIOVAN (G) 40MG**  
**DIOVAN (G) 80MG**  
**DIOVAN (G) 160MG**  
**DIOVAN (G) 320MG**  
 DULERA 100MCG/5MCG  
 DULERA 200MCG/5MCG  
 EDARBI 40MG  
 EDARBI 80MG  
 EDARBYCLOR 40MG/12.5MG  
 EDARBYCLOR 40MG/25MG  
 EDECRIN 25MG  
 EDURANT 25MG  
 ELIQUIS 2.5MG  
 ELIQUIS 5MG  
 ENTRESTO 24MG-26MG  
 ENTRESTO 49MG-51MG  
 ENTRESTO 97MG-103MG  
 EUCRISA 2%  
 EXFORGE HCT 160/12.5/5MG  
 EXFORGE HCT 160/12.5/10MG  
 EXFORGE HCT 160/25/5MG  
 EXFORGE HCT 160/25/10MG  
 EXFORGE HCT 320/25/10MG  
 FARESTON 60MG  
 FARXIGA 5MG  
 FARXIGA 10MG  
 FETZIMA 20MG  
 FETZIMA 40MG  
 FETZIMA 80MG  
 FETZIMA 120MG  
 FLOVENT 44MCG 50MCG  
 FLOVENT 110MCG 125MCG  
 FLOVENT 220MCG 250MCG  
 FLOVENT DISKUS 100MCG  
 FLOVENT DISKUS 250MCG  
 FOSRENOL CHEW 500MG  
 FOSRENOL CHEW 750MG  
 FOSRENOL CHEW 1000MG

FOSRENOL POWDER 750MG  
 FOSRENOL POWDER 1000MG  
 GENVOYA 150-150-200-10MG  
 GILENYA 0.5MG  
 GLYXAMBI 10MG/5MG  
 GLYXAMBI 25MG/5MG  
 IBRANCE 75MG  
 IBRANCE 100MG  
 IBRANCE 125MG  
 ILEVRO 0.3%  
 INCRUSE ELLIPTA 62.5MCG  
 INVOKAMET 50MG-500MG  
 INVOKAMET 50MG-1000MG  
 INVOKAMET 150MG-500MG  
 INVOKAMET 150MG-1000MG  
 INVOKANA 100MG  
 INVOKANA 300MG  
 JAKAFI 5MG  
 JAKAFI 10MG  
 JAKAFI 15MG  
 JAKAFI 20MG  
 JANUMET 50/500MG  
 JANUMET 50/1000MG  
 JANUMET XR 50MG/500MG  
 JANUMET XR 50MG/1000MG  
 JANUMET XR 100MG/1000MG  
 JANUVIA 25MG  
 JANUVIA 50MG  
 JANUVIA 100MG  
 JARDIANCE 10MG  
 JARDIANCE 25MG  
 JENTADUETO 2.5MG-500MG  
 JENTADUETO 2.5MG-850MG  
 JENTADUETO 2.5MG-1000MG  
 JULUCA 50MG-25MG  
 KAZANO 12.5/500MG  
 KAZANO 12.5/1000MG  
**KEPPRA (G) 250MG**  
**KEPPRA (G) 500MG**  
**KEPPRA (G) 750MG**  
**KEPPRA (G) 1000MG**  
 KOMBIGLYZE XR 2.5MG/1000MG  
 KOMBIGLYZE XR 5MG/500MG  
 KOMBIGLYZE XR 5MG/1000MG  
 LATUDA 20MG  
 LATUDA 40MG  
 LATUDA 60MG  
 LATUDA 80MG  
 LATUDA 120MG  
 LEXIVA 700MG  
 LUMIGAN 0.01%  
 MESTINON TS 180MG  
 MIRVASO 0.33%  
 MOTEGRITY 1MG  
 MOTEGRITY 2MG  
 MULTAQ 400MG  
 NATAZIA 3/2-2/2-3/1MG  
 NESINA 6.25MG  
 NESINA 12.5MG  
 NESINA 25MG  
 NEUPRO 1MG  
 NEUPRO 2MG  
 NEUPRO 3MG  
 NEUPRO 4MG  
 NEUPRO 6MG  
 NEUPRO 8MG  
**NEXIUM (G) 20MG**  
**NEXIUM (G) 40MG**  
 NEXLETOL 180MG  
 NEXLIZET 180MG-10MG  
 ONGLYZA 2.5MG  
 ONGLYZA 5MG  
 OSPHENA 60MG  
 OTEZLA 30MG  
 PRADAXA 75MG  
 PRADAXA 150MG  
 PRESTALIA 3.5MG/2.5MG  
 PRESTALIA 7MG/5MG  
 PRESTALIA 14MG/10MG  
 PRISTIQ 50MG  
 PRISTIQ 100MG  
 QTERN 10-5MG  
 QVAR REDHALER 40MCG  
 QVAR REDHALER 80MCG  
 RANEXA 500MG  
 RAPAMUNE 0.5MG  
 RAPAMUNE 1MG  
 RAPAMUNE 2MG  
 RENAGEL 800MG

**RENEVA (G) 800MG**  
 RESTASIS MULTIDOSE 0.05%  
 RESTASIS VIALS 0.05%  
 REXULTI 0.25MG  
 REXULTI 0.5MG  
 REXULTI 1MG  
 REXULTI 2MG  
 REXULTI 3MG  
 REXULTI 4MG  
 RYBELSUS 3MG  
 RYBELSUS 7MG  
 RYBELSUS 14MG  
 SAPHRIS 5MG  
 SAPHRIS 10MG  
 SEGLUROMET 2.5MG-500MG  
 SEGLUROMET 2.5MG-1000MG  
 SEGLUROMET 7.5MG-500MG  
 SEGLUROMET 7.5MG-1000MG  
**SENSIPAR (G) 30MG**  
**SENSIPAR (G) 60MG**  
 SEREVENT DISKUS 50MCG  
 SIMBRINZA 1%/0.2%  
 SOOLANTRA 1%  
 SPIRIVA 18MCG  
 SPIRIVA RESPIMAT 2.5MCG  
 STEGLATRO 5MG  
 STEGLATRO 15MG  
 STEGLUJAN 5MG-100MG  
 STEGLUJAN 15MG-100MG  
 STIOLTO RESPIMAT 2.5/2.5MCG  
 STRATTERA 10MG  
 STRATTERA 18MG  
 STRATTERA 25MG  
 STRATTERA 40MG  
 STRATTERA 60MG  
 STRATTERA 80MG  
 STRATTERA 100MG  
 SYNJARDY 5MG/500MG  
 SYNJARDY 5MG/1000MG  
 SYNJARDY 12.5MG/500MG  
 SYNJARDY 12.5MG/1000MG  
 TASMAR 100MG  
 TECFIDERA 120MG  
 TECFIDERA 240MG  
 TIVICAY 50MG  
 TOBI PODHALER 28MG  
 TOBREX OINT 0.3%  
 TRADJENTA 5MG  
 TRAVATAN Z 0.004%  
 TRELEGY ELLIPTA  
 100-62.5-25MCG  
**TRILEPTAL (G) 150MG**  
**TRILEPTAL (G) 300MG**  
**TRILEPTAL (G) 600MG**  
 TRINTELLIX 5MG  
 TRINTELLIX 10MG  
 TRINTELLIX 20MG  
 TRIUMEQ 600-50-300MG  
 TUDORZA PRESSAIR 400MCG  
 ULORIC 80MG  
 UROCIT-K 10MEQ  
 VELPHORO 500MG  
 VENTOLIN HFA 90MCG  
 VIIBRYD 10MG  
 VIIBRYD 20MG  
 VIIBRYD 40MG  
**VIREAD (G) 300MG**  
 VRAYLAR 1.5MG  
 VRAYLAR 3MG  
 VRAYLAR 4.5MG  
 VRAYLAR 6MG  
 WELCHOL 625MG  
 WELCHOL PACKET 3.75G  
**WELLBUTRIN XL (G) 150MG**  
**WELLBUTRIN XL (G) 300MG**  
 XARELTO 2.5MG  
 XARELTO 10MG  
 XARELTO 15MG  
 XARELTO 20MG  
 XELJANZ 5MG  
 XELJANZ 10MG  
 XELJANZ XR 11MG  
 XIGDUO XR 5/1000MG  
 XIGDUO XR 10/500MG  
 XIGDUO XR 10/1000MG  
 YAZ 3/0.02MG  
 ZIANA 1.2%-0.025%  
 ZYCLARA PACKET 3.75%  
 ZYCLARA PUMP 3.75%

**NOTE:** Medication names appearing with **(G)** are available in a Generic version from your local or U.S. mail order pharmacy. This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.



# MEMBER ENROLLMENT FORM

For more information, please call:  
TOLL-FREE PHONE: 1-866-893-6337

<b>Please return completed enrollment form by one of the following methods:</b> MAIL: CANARX, PO Box 3009, WINDSOR, ONTARIO CANADA N8N 2M3 SECURE UPLOAD: <a href="http://www.CANARXDocs.com">www.CANARXDocs.com</a> FAX: 1-866-715-6337 (NOTE: Faxed <u>prescriptions</u> must be sent <b>directly</b> from the <b>physician's</b> office.)	WEBID (CALL IF UNSURE)
	NAME OF EMPLOYER

<b>PATIENT INFORMATION</b> (PLEASE PRINT)		DATE OF BIRTH (MM/DD/YYYY)		MEMBER ID # (IF AVAILABLE)
HOME PHONE	MOBILE PHONE	WORK PHONE	EXT.	EMAIL ADDRESS
FIRST NAME		INITIAL	LAST NAME	
STREET ADDRESS				
CITY		STATE	ZIP CODE	SUBSCRIBER DEPENDENT

**CURRENT MEDICATIONS / VITAMINS** THIS IS NOT A PRESCRIPTION.  
LIST ALL: PRESCRIPTION, NON-PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS; HERBAL, NUTRITIONAL AND VITAMIN SUPPLEMENTS.

NAME OF MEDICATION Ex. JANUVIA	DOSAGE Ex. 50MG	TIME(S) TO TAKE Ex. TWICE DAILY	DATE STARTED Ex. 08/20/2019	REASON FOR TAKING Ex. DIABETES

**NEW-TO-YOU MEDICATIONS** MUST BE DOMESTICALLY PRESCRIBED, FILLED AND TAKEN FOR A PERIOD OF **NO LESS THAN 30 DAYS** BEFORE ORDERING THROUGH THIS PROGRAM. **PLEASE ASK YOUR PHYSICIAN TO ISSUE A PRESCRIPTION FOR A 3-MONTH SUPPLY OF MEDICATION WITH 3 REFILLS.**

PREScription IS ATTACHED	PREScription WILL FOLLOW BY MAIL	PREScription WILL BE FAXED FROM PHYSICIAN'S OFFICE
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**MEDICAL HISTORY** (If you require more space, please attach a separate piece of paper.)

1. **OPERATIONS** (EX. HYSTERECTOMY, GALL BLADDER, HEART OPERATIONS, ETC.):

2. **HOSPITALIZATIONS** (STAYS IN HOSPITAL DURING THE PAST 5 YEARS):

3. **MEDICAL CONDITIONS** (ONGOING - EX. TYPE 1 DIABETES MELLITUS, VASCULITIS, OSTEOPOROSIS, ETC.) — **NOTE:** Please refrain from using generic terms such as **"heart disease"** as this could indicate any number of conditions such as valvular heart disease, heart failure, a bradyarrhythmia, a tachyarrhythmia, a ventricular conduction delay, etc.

4. **DRUG ALLERGIES:** YES NO IF YES, PLEASE SPECIFY.

**AUTHORIZATION - IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18**

I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that he/she has been, and will be, regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided above is accurate and true.

Parent's/Guardian's Signature:	Date:	(MM/DD/YYYY)
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**AUTHORIZATION - IF THE PATIENT IS THE SUBSCRIBER, SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER**

I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided by me is accurate and true.

Patient's Signature:	Date:	(MM/DD/YYYY)
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## CONFIRMATION AND REPRESENTATIONS

*I enter into this agreement with CANARX Group Inc. at Christ Church, Barbados (referred to as “CANARX”) so that I may obtain access to medically-necessary and lawfully prescribed drugs at low costs. I represent:*

1. I am of the age of majority in the jurisdiction in which I ordinarily reside.
2. I am not restricted from making my own medical decisions under the laws of the jurisdiction in which I ordinarily reside.
3. I certify that I am a resident of the United States and not a resident of any other country.
4. I am under the care of a duly qualified and licensed physician in the United States (my “U.S. physician”) and the medicine that I ask CANARX to assist me in obtaining was prescribed for me by my U.S. physician.
5. My U.S. physician has examined me within the last 12 months and will examine me at least once every 12 months while I am taking medicine.
6. Any medicine that I ask CANARX to assist me in obtaining is medicine that I have already taken, under my U.S. physician’s orders and supervision, for at least 30 days prior to placing an order for the medicine through CANARX.
7. My care by my U.S. physician is ongoing and I do not seek and will not rely on any medical information from CANARX or any CANARX selected physician.
8. I have not violated any laws in the jurisdiction in which I ordinarily reside (or, if different, in the jurisdiction in which the prescription was issued) in obtaining the prescription for the ordered product.
9. The prescription issued by my U.S. physician has not been altered in any way nor has it been filled previously.
10. I will use any medications obtained for me through CANARX strictly in accordance with the instructions provided by my U.S. physician.
11. The medicine dispensed in accordance with my prescription will not be used in any way whatsoever except as directed by my U.S. physician.
12. I will not permit anyone else to use the prescription or any medications which I receive.
13. In the event that I suffer any side effects from any medication obtained for me by CANARX, I will immediately contact my U.S. physician.
14. All information that I give to CANARX is true.

## AUTHORIZATION AND CONSENT

*I consent to, and authorize, the following:*

1. I hereby appoint CANARX and its delegates and contractors (collectively referred to as “CANARX”) as my paid agents and attorneys-in-fact for the purposes of obtaining prescriptions which correspond to the prescriptions issued by my U.S. physician; selecting physicians, pharmacies, and other professionals as necessary to serve me outside the U.S.; and of arranging for pharmacies to dispense to me medications as prescribed.
2. CANARX may perform any act that I could myself perform in having my prescription reviewed by any physician, pharmacist, or pharmacy technician and in having the prescribed medication dispensed by a pharmacy and delivered to me by mail.
3. CANARX may arrange the purchase and delivery of the medications prescribed to me, on the terms set forth in this agreement, as if I personally took such actions.
4. I authorize and instruct my U.S. physician to release to CANARX (and any CANARX selected physician, pharmacist, and pharmacy technician) any and all personal medical information pertaining to me (“Personal Medical History”), including but not limited to all medical records, medical reports, progress notes, nurses’ notes, reports on diagnostic tests, medical opinions, Xray records, imaging records, laboratory reports, and/or any other knowledge or information which my U.S. physician may possess.
5. I agree to instruct my U.S. physician to issue my prescription on paper (if necessary for dispensing by a pharmacy located outside my U.S. physician’s jurisdiction) and to send (by mail, by fax, via the internet or otherwise) to CANARX from my U.S. physician’s office the original signed copy of the prescription.
6. CANARX and its selected physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
7. CANARX selected physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
8. CANARX may make payments on my behalf to pharmacies for dispensing medicine in accordance with my prescriptions and to physicians for services rendered on my behalf.
9. I request and authorize my employer or plan holder, as my appointed agent, to pay for all products and services relating to the prescription medicine that I obtain through CANARX in such amounts as are found appropriate by my employer or plan holder in accordance with the benefits plan.

## ACKNOWLEDGEMENT AND RELEASE

*I hereby make the following acknowledgements and releases to CANARX and all its employees, delegates, agents, and contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:*

1. My U.S. physician is my primary physician. Any CANARX selected physician is being asked to review the information contained in my Personal Medical History only for the purpose of authorizing the medicine prescribed for me by my U.S. physician to be dispensed to me by a CANARX selected pharmacy.
2. CANARX has made no representations or warranties to me, including, without limitation, representations or warranties regarding the use of fitness for any particular purpose of the medications delivered (including, without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease, or its potential or actual side or adverse effects whether previously known or unknown).
3. I wish to obtain a prescription from a CANARX selected physician and have enlisted the services of CANARX to facilitate it. I understand that the physician will rely on the accuracy of the examination performed, and the prescription provided, by my U.S. physician.
4. I release CANARX and all of its officers and directors, agents, delegates, employees and contractors from any and all liability, claims, and causes of action with respect to errors or omissions by the company or agency responsible for transporting my order.
5. I acknowledge that I have purchased my medications internationally for personal use and understand that my medications may be subject to U.S. border inspection. I specifically confirm, acknowledge and agree that title to my medications passes to me when my medications are shipped from the CANARX selected pharmacy.
6. I acknowledge that CANARX, as my paid agent, requires payment in full prior to shipment and that my order may not be returned for a refund or an exchange.

## PRIVACY NOTICE AND ACKNOWLEDGEMENT

*I consent to the following terms regarding the collection and use of information about me, and I acknowledge that I can review the CANARX Privacy Policy in detail as provided below:*

1. CANARX may receive and collect any and all information about me and my health, including but not limited to my full name, address, telephone number, e-mail address, Social Security Number, personal medical information, and payment information, and may maintain such information on file as necessary to verify and process future orders and to obtain payment and reimbursement for them. CANARX and CANARX selected physicians and pharmacists may share any and all information received from or about me with my U.S. physician, CANARX selected physicians and pharmacists, and my employer or benefits plan administrator, and their respective assistants and agents, for the purposes of obtaining medicine as prescribed for me and of obtaining proper payments for the medicine and related services.
2. I am aware that CANARX may transmit my personal information by electronic means (for example fax, or via the internet) to its agents, selected physicians and pharmacies. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that CANARX, as a custodian of my personal information, will take all appropriate precautions to protect my personal information from improper disclosure or use. I hereby consent to CANARX’s transmission of my personal information by electronic means to its delegates, employees, selected physicians and pharmacies.
3. I acknowledge that CANARX will obtain health information about me, and is obligated in accordance with the CANARX Privacy Policy to protect such information. I can visit [www.CANARX.com/privacy-policy/](http://www.CANARX.com/privacy-policy/) at any time to view the most updated version of the CANARX Privacy Policy.

## FURTHER ACKNOWLEDGEMENT & RELEASE

*I hereby make the following further acknowledgement and release the plan holder, its employees, officers, agents, heirs and assigns:*

1. I acknowledge that the plan holder has made no representations or warranties to me, including without limitation, representations or warranties regarding the use for any particular purpose the medication(s) delivered, including without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease or its potential or actual side or adverse effects whether previously known or unknown.
2. I acknowledge that child protective packaging may not be used in filling my prescription. I promise that upon my receipt of the medicine I will take all steps necessary to prevent any child from having unauthorized access to the medicine. I hereby release CANARX and all its officers, directors, agents, delegates, employees, and contractors, including the pharmacy that fills my prescription, from any and all claims arising from or relating to the use of, or failure to use, child protective packaging.
3. I release the plan holder its officers, employees, agents, heirs and assigns from (i) any and all causes of actions with respect to errors or omissions by the company or agency responsible for transporting my order; (ii) any and all causes of actions with respect to errors or omissions by CANARX in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use for any purpose whatsoever of any medications delivered through this program.