

MNHGCanarx

Tufts

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 **HMO** or **PPO** with the Minuteman Nashoba Health Group. A list of eligible medications is located on the back of this page.

Copayments:

All member copayments have been waived for this prescription drug program only.

<i>MNHGCanarx</i>		Vs.	Current Purchase Plan			
Annual Cost <i>No Copays!</i>			Current Copays	Refills	=	Annual Savings
<h1>\$0</h1>	Vs.	Retail	\$25 (Tier 2)	x 12	=	\$300 / Script
			\$50 (Tier 3)	x 12	=	\$600 / Script
	Vs.	Mail	\$50 (Tier 2)	x 4	=	\$200 / Script
			\$110 (Tier 3)	x 4	=	\$440 / Script

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. 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 or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

WELCOME TO MNHGCanarx

ABILIFY (G) 2MG	DIVIGEL 0.25MG	LIALDA 1.2GM	SEROQUEL XR 300MG
ABILIFY (G) 5MG	DIVIGEL 0.5MG	LINZESS 72MCG	SEROQUEL XR 400MG
ABILIFY (G) 10MG	DIVIGEL 1MG	LINZESS 145MCG	SIMBRINZA 1%/0.2%
ABILIFY (G) 15MG	DUAVEE 0.45-20MG	LINZESS 290MCG	SINGULAIR (G) 10MG
ABILIFY (G) 20MG	DYMISTA 137/50MCG	LIPITOR (G) 10MG	SOOLANTRA 1%
ABILIFY (G) 30MG	EDECIN 25MG	LIPITOR (G) 20MG	SPIRIVA 18MCG
ACTONEL 35MG	EFFEXOR XR (G) 75MG	LIPITOR (G) 40MG	SPIRIVA RESPIMAT 2.5MCG
ADVAIR DISKUS 100MCG	EFFEXOR XR (G) 150MG	LIPITOR (G) 80MG	STIOLTO RESPIMAT 2.5/2.5MCG
ADVAIR DISKUS 250MCG	ELIQUIS 2.5MG	LOTEMAX GEL 0.5%	STRIBILD
ADVAIR DISKUS 500MCG	ELIQUIS 5MG	LOTEMAX SUSP 0.5%	SYNAREL NASAL
ADVAIR HFA 45/21MCG	ELMIRON 100MG	LUMIGAN 0.01%	SYNJARDY 5MG/500MG
ADVAIR HFA 115/21MCG	ENTRESTO 24MG-26MG	MESNEX 400MG	SYNJARDY 5MG/1000MG
ADVAIR HFA 230/21MCG	ENTRESTO 49MG-51MG	METRO CREAM 0.75%	SYNJARDY 12.5MG/500MG
ALOCRIIL 2%	ENTRESTO 97MG-103MG	METROGEL PUMP 1%	SYNJARDY 12.5MG/1000MG
ALOMIDE 0.1%	EPIPEN 0.3MG	MIGRANAL 4MG/ML	TAZORAC CREAM 0.05%
ALPHAGAN-P 0.15%	EPIPEN JR 0.15MG	MULTAQ 400MG	TAZORAC CREAM 0.1%
ALREX 0.2%	ESTROGEL 0.06%	MYRBETRIQ 25MG	TAZORAC GEL 0.05%
ALVESCO 80MCG 100MCG	EUCRISA 2%	MYRBETRIQ 50MG	TAZORAC GEL 0.1%
ALVESCO 160MCG 200MCG	EVISTA 60MG	NASONEX 50MCG	TECFIDERA 120MG
ANORO ELLIPTA 62.5/25MCG	EXFORGE HCT 160/12.5/5MG	NEUPRO 1MG	TECFIDERA 240MG
APTIOM 200MG	EXFORGE HCT 160/12.5/10MG	NEUPRO 2MG	TEKURNA HCT 150-25MG
APTIOM 400MG	EXFORGE HCT 160/25/5MG	NEUPRO 3MG	TEKURNA HCT 300-12.5MG
APTIOM 600MG	EXFORGE HCT 160/25/10MG	NEUPRO 4MG	TEKURNA HCT 300-25MG
APTIOM 800MG	EXFORGE HCT 320/25/10MG	NEUPRO 6MG	TIVICAY 50MG
ARCAPTA NEOHALER 75MCG	FARXIGA 5MG	NEUPRO 8MG	TOVIAZ 4MG
ARNUITY ELLIPTA 100MCG	FARXIGA 10MG	NEXIUM 20MG	TOVIAZ 8MG
ARNUITY ELLIPTA 200MCG	FETZIMA 20MG	NEXIUM 40MG	TRADJENTA 5MG
ASMANEX TWISTHALER 110MCG	FETZIMA 40MG	NEXIUM DR 10MG	TRAVATAN Z 0.004%
ASMANEX TWISTHALER 220MCG	FETZIMA 80MG	NORITATE CREAM 1%	TRELEGY ELLIPTA 100-62.5-25MCG
ASTAGRAF XL 1MG	FETZIMA 120MG	NORVASC (G) 10MG	TRINTELLIX 5MG
ASTAGRAF XL 5MG	FINACEA 15%	ORILISSA 150MG	TRINTELLIX 10MG
AUTOVENT HFA 20UG	FLAREX 0.1%	ORILISSA 200MG	TRINTELLIX 20MG
AUBAGIO 14MG	FLOVENT 44MCG 50MCG	OTEZLA 30MG	TRIUMEQ 600-50-300MG
AVODART (G) 0.5MG	FLOVENT 110MCG 125MCG	PAZEO 0.7%	ULORIC 80MG
AZELEX 20%	FLOVENT 220MCG 250MCG	PENTASA 500MG	UROCIT-K 10MEQ
AZOPT 1%	FLOVENT DISKUS 100MCG	PLAVIX (G) 75MG	VAGIFEM 10MCG
BANZEL 200MG	FLOVENT DISKUS 250MCG	PRADAXA 75MG	VALTRES (G) 500MG
BANZEL 400MG	FOSRENOL CHEW 500MG	PRADAXA 150MG	VALTRES (G) 1000MG
BENICAR HCT (G) 20MG/12.5MG	FOSRENOL CHEW 750MG	PRAVACHOL (G) 20MG	VESICARE 5MG
BENICAR HCT (G) 40MG/12.5MG	FOSRENOL CHEW 1000MG	PREMARIN 0.3MG	VESICARE 10MG
BENICAR HCT (G) 40MG/25MG	FOSRENOL POWDER 750MG	PREMARIN 0.625MG	VIIBRYD 10MG
BETIMOL 0.25%	FOSRENOL POWDER 1000MG	PREMARIN 1.25MG	VIIBRYD 20MG
BETIMOL 0.5%	GENVOYA 150-150-200-10MG	PREMARIN CREAM 0.625MG/GM	VIIBRYD 40MG
BETOPTIC S 0.25%	GILENYA 0.5MG	PREMPRO 0.3MG/1.5MG	VIVELLE-DOT 25MCG
BREO ELLIPTA 100/25MCG	GLUCAGEN HYPOKIT 1MG	PREVACID (G) 15MG	VIVELLE-DOT 37.5MCG
BREO ELLIPTA 200/25MCG	GLYXAMBI 10MG/5MG	PREVACID (G) 30MG	VIVELLE-DOT 50MCG
BRILINTA 60MG	GLYXAMBI 25MG/5MG	PREVACID SOLUTAB 15MG	VIVELLE-DOT 75MCG
BRILINTA 90MG	IMITREX AUTOINJECTOR	PREVACID SOLUTAB 30MG	VIVELLE-DOT 100MCG
BYSTOLIC 2.5MG	STATDOSE 6MG/0.5ML	PRISTIQ 50MG	VRAYLAR 1.5MG
BYSTOLIC 5MG	IMITREX NASAL SPRAY	PRISTIQ 100MG	VRAYLAR 3MG
BYSTOLIC 10MG	5MG-2DOSE	PROTOPIC OINT 0.03%	VRAYLAR 4.5MG
BYSTOLIC 20MG	IMITREX NASAL SPRAY	PROTOPIC OINT 0.1%	VRAYLAR 6MG
CARDURA XL 4MG	20MG-2DOSE	PROZAC (G) 10MG	WELCHOL 625MG
CARDURA XL 8MG	INCRUSE ELLIPTA 62.5MCG	PROZAC (G) 20MG	WELCHOL PACKET 3.75G
CELEBREX 100MG	INVOKAMET 50MG-500MG	QVAR REDHALER 40MCG	WELLBUTRIN XL (G) 150MG
CELEBREX 200MG	INVOKAMET 50MG-1000MG	QVAR REDHALER 80MCG	WELLBUTRIN XL (G) 300MG
COMBIGAN 0.2-0.5%	INVOKAMET 150MG-500MG	RANEXA 500MG	XARELTO 2.5MG
COMBIVENT RESPIMAT	INVOKAMET 150MG-1000MG	RAPAFLO 4MG	XARELTO 10MG
20MCG/100MCG	INVOKANA 100MG	RAPAFLO 8MG	XARELTO 15MG
CRESTOR (G) 5MG	INVOKANA 300MG	RELPAK 20MG	XARELTO 20MG
CRESTOR (G) 10MG	IRESSA 250MG	RELPAK 40MG	XELJANZ 5MG
CRESTOR (G) 20MG	JANUMET 50/500MG	RENAGEL 800MG	XELJANZ XR 11MG
CRESTOR (G) 40MG	JANUMET 50/1000MG	REVELA 800MG	XIGDUO XR 5/1000MG
CYMBALTA (G) 20MG	JANUMET XR 50MG/500MG	RESTASIS VIALS 0.05%	XIGDUO XR 10/500MG
CYMBALTA (G) 30MG	JANUMET XR 50MG/1000MG	RETIN A GEL (G) 0.025%	XIGDUO XR 10/1000MG
CYMBALTA (G) 60MG	JANUMET XR 100MG/1000MG	RETIN A MICRO GEL PUMP 0.04%	XIIDRA 5%
DALIRESP 500MCG	JANUVIA 25MG	RETIN-A MICRO GEL PUMP 0.1%	ZETIA (G) 10MG
DEPAKOTE (G) 250MG	JANUVIA 50MG	REXULTI 0.25MG	ZOCOR (G) 10MG
DETROL 1MG	JANUVIA 100MG	REXULTI 0.5MG	ZOCOR (G) 20MG
DETROL 2MG	JARDIANCE 10MG	REXULTI 1MG	ZOCOR (G) 40MG
DETROL LA 2MG	JARDIANCE 25MG	REXULTI 2MG	ZOLOFT (G) 50MG
DETROL LA 4MG	JENTADUETO 2.5MG-500MG	REXULTI 3MG	ZOLOFT (G) 100MG
DEXILANT DR 30MG	JENTADUETO 2.5MG-850MG	REXULTI 4MG	ZOVIRAX CREAM 5%
DEXILANT DR 60MG	JENTADUETO 2.5MG-1000MG	SAPHRIS 5MG	
DIFFERIN GEL 0.1%	KEPPRA (G) 500MG	SAPHRIS 10MG	
DIFFERIN GEL 0.3%	LATUDA 20MG	SENSIPAR 30MG	
DIOVAN (G) 40MG	LATUDA 40MG	SENSIPAR 60MG	
DIOVAN (G) 80MG	LATUDA 60MG	SEREVENT DISKUS 50MCG	
DIOVAN (G) 160MG	LATUDA 80MG	SEROQUEL XR 50MG	
DIOVAN (G) 320MG	LATUDA 120MG	SEROQUEL XR 150MG	
DIPENTUM 250MG	LEXAPRO (G) 20MG	SEROQUEL XR 200MG	

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.

MNHGCanarx

Canarx Enrollment Form

TUFTS MEMBER ID #:

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337
OR ~ MAIL TO: MNHGCANARX, P.O. BOX 3009, WINDSOR, ON, CANADA, N8N 2M3 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

PATIENT INFORMATION: Birthdate _____ SUBSCRIBER
MM/DD/YYYY SPOUSE
 DEPENDENT

NOTE:
Please request a **3-month** supply of medication with **3 refills**.

Phone (Home) _____ Phone (Work or Cell) _____

New-to-you medications must be domestically prescribed, filled and taken for a period of no less than 30 days.

First Name (please print) _____ Initial _____ Last Name _____

Street Address _____

City/State _____ Zip Code _____

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. (THIS IS NOT A PRESCRIPTION.)

Name of Medicine	Dosage	Time(s) to Take	Date Started	Reason for Taking
<i>Ex. Januvia</i>	<i>Ex. 50mg</i>	<i>Ex. Twice Daily</i>	<i>Ex. 8/20/2017</i>	<i>Ex. Diabetes</i>

MEDICAL HISTORY (If you require more space, please attach a separate piece of paper.) Male Female

(i) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. _____

(ii) Hospitalizations: (stays in hospital during the past 5 years) _____

(iii) Present illness: (ongoing) e.g., Diabetes, Heart disease, Osteoporosis, etc. _____

(iv) Drug allergies: NO YES 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/YY)

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 Signature: _____ Date: (MM/DD/YY)

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/ 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.