

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.

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. 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	EDARBI 40MG	LIPITOR (G) 40MG	STEGLATRO 15MG
ABILIFY (G) 5MG	EDARBI 80MG	LIPITOR (G) 80MG	STEGLUJAN 5MG-100MG
ACIPHEX 20MG	EDARBYCLOR 40MG/12.5MG	LOTEMAX GEL 0.5%	STEGLUJAN 15MG-100MG
ACTONEL 35MG	EDARBYCLOR 40MG/25MG	LOTEMAX OINT 0.5%	STIOLTO RESPIMAT 2.5/2.5MCG
ACTOPLUS 15MG-850MG	EDURANT 25MG	LOTEMAX SUSP 0.5%	STRATTERA 10MG
ACZONE 5%	EFFEXOR XR (G) 75MG	LUMIGAN 0.01%	STRATTERA 18MG
ADDICRA (G) 20MG	EFFEXOR XR (G) 150MG	METRO CREAM 0.75%	STRATTERA 25MG
ADVAIR DISKUS 100MCG	ELIDEL 1%	METROGEL PUMP 1%	STRATTERA 40MG
ADVAIR DISKUS 250MCG	ELIQUIS 2.5MG	MIRVASO 0.33%	STRATTERA 60MG
ADVAIR DISKUS 500MCG	ELIQUIS 5MG	MOTEGRITY 1MG	STRATTERA 80MG
ADVAIR HFA 45/21MCG	ELMIRON 100MG	MOTEGRITY 2MG	STRATTERA 100MG
ADVAIR HFA 115/21MCG	ENTOCORT 3MG	MULTAQ 400MG	SYNJARDY 5MG/500MG
ADVAIR HFA 230/21MCG	ENTRESTO 24MG-26MG	MYRBETRIQ 25MG	SYNJARDY 5MG/1000MG
AKLIEF 50MCG/G	ENTRESTO 49MG-51MG	MYRBETRIQ 50MG	SYNJARDY 12.5MG/500MG
ALOMIDE 0.1%	ENTRESTO 97MG-103MG	NASONEX 50MCG	SYNJARDY 12.5MG/1000MG
ALPHAGAN-P 0.15%	EPIDUO FORTE 0.3%/2.5%	NATAZIA 3/2-2-3/1MG	TAZORAC CREAM 0.05%
ALREX 0.2%	EPIDUO GEL PUMP 0.1%/2.5%	NESINA 6.25MG	TAZORAC CREAM 0.1%
ALVESCO 80MCG 100MCG	EPIPEN 0.3MG	NESINA 12.5MG	TAZORAC GEL 0.05%
ALVESCO 160MCG 200MCG	EPIPEN JR 0.15MG	NESINA 25MG	TAZORAC GEL 0.1%
ANORO ELLIPTA 62.5/25MCG	ESTROGEL 0.06%	NEUPRO 1MG	TECFIDERA 120MG
APTIOM 200MG	EUCRISA 2%	NEUPRO 2MG	TECFIDERA 240MG
APTIOM 400MG	EVISTA 60MG	NEUPRO 3MG	TEKTURN 150MG
APTIOM 600MG	EXFORGE HCT 160/12.5/5MG	NEUPRO 4MG	TEKTURN 300MG
APTIOM 800MG	EXFORGE HCT 160/12.5/10MG	NEUPRO 6MG	TIVICAY 50MG
ARNUITY ELLIPTA 100MCG	EXFORGE HCT 160/25/5MG	NEUPRO 8MG	TOBI PODHALER 28MG
ARNUITY ELLIPTA 200MCG	EXFORGE HCT 160/25/10MG	NEXIUM (G) 20MG	TOVIAZ 4MG
AROMASIN 25MG	EXFORGE HCT 320/25/10MG	NEXIUM (G) 40MG	TOVIAZ 8MG
ARTHROTEC 50MG	FARXIGA 5MG	NEXIUM DR (G) 10MG	TRADJENTA 5MG
ARTHROTEC 75MG	FARXIGA 10MG	NEXLETOL 180MG	TRAVATAN Z 0.004%
ASACOL HD 800MG	FETZIMA 20MG	NEXLIZET 180MG-10MG	TRELEGY ELLIPTA 100-62.5-25MCG
ASMANEX TWISTHALER 110MCG	FETZIMA 40MG	NORITATE CREAM 1%	TRIBENZOR 20/5/12.5MG
ASMANEX TWISTHALER 220MCG	FETZIMA 80MG	NORVASC (G) 10MG	TRIBENZOR 40/5/12.5MG
ATACAND 4MG	FETZIMA 120MG	OMNARIS 50MCG	TRIBENZOR 40/5/25MG
ATACAND 8MG	FINACEA GEL 15%	ONGLYZA 2.5MG	TRIBENZOR 40/10/12.5MG
ATACAND 16MG	FLOVENT 44MCG 50MCG	ONGLYZA 5MG	TRIBENZOR 40/10/25MG
ATACAND 32MG	FLOVENT 110MCG 125MCG	ORILISSA 150MG	TRINTELLIX 5MG
ATACAND HCT 16MG/12.5MG	FLOVENT 220MCG 250MCG	ORILISSA 200MG	TRINTELLIX 10MG
ATACAND HCT 32MG/12.5MG	FLOVENT DISKUS 100MCG	OSPHENA 60MG	TRINTELLIX 20MG
ATROVENT HFA 20UG	FLOVENT DISKUS 250MCG	OTEZLA 30MG	TRIUMEQ 600-50-300MG
AVODART (G) 0.5MG	FOSAMAX PLUS D 70MG-2800IU	PENTASA 500MG	TUDORZA PRESSAIR 400MCG
AZELEX 20%	FOSAMAX PLUS D 70MG-5600IU	PLAVIX (G) 75MG	TWYNSTA 40/5MG
AZILECT 0.5MG	FROVA 2.5MG	PRADAXA 75MG	TWYNSTA 40/10MG
AZILECT 1MG	GENVOYA 150-150-200-10MG	PRADAXA 150MG	TWYNSTA 80/5MG
AZOPT 1%	GILENYA 0.5MG	PRED FORTE 1%	TWYNSTA 80/10MG
AZOR 20/5MG	GLUCAGEN HYPOKIT 1MG	PREMARIN 0.3MG	UCERIS 9MG
AZOR 40/5MG	GLUMETZA ER 1000MG	PREMARIN 0.625MG	ULORIC 80MG
AZOR 40/10MG	GLYXAMBI 10MG/5MG	PREMARIN 1.25MG	URSO 250MG
BANZEL 200MG	GLYXAMBI 25MG/5MG	PREMARIN CREAM 0.625MG/GM	VAGIFEM 10MCG
BANZEL 400MG	IBRANCE 75MG	PREMPRO 0.3MG/1.5MG	VALTRES (G) 500MG
BECONASE AQ 42MCG	IBRANCE 100MG	PRESTALIA 3.5MG/2.5MG	VALTRES (G) 1000MG
BENICAR HCT 20MG/12.5MG	IBRANCE 125MG	PRESTALIA 7MG/5MG	VECTICAL 3MCG/GM
BENICAR HCT 40MG/12.5MG	ILEVRO 0.3%	PRESTALIA 14MG/10MG	VELPHORO 500MG
BENICAR HCT 40MG/25MG	IMITREX NASAL SPRAY 5MG	PREVACID (GR) 30MG	VENTOLIN HFA 90MCG
BENZACLIN GEL	IMITREX NASAL SPRAY 20MG	PREVACID SOLUTAB 15MG	VESICARE (G) 5MG
BEPREVE 1.5%	IMITREX STATDOSE 6MG/0.5ML	PREVACID SOLUTAB 30MG	VESICARE (G) 10MG
BETIMOL 0.25%	INCRUSE ELLIPTA 62.5MCG	PRISTIQ 50MG	VIIBRYD 10MG
BETIMOL 0.5%	INVOKAMET 50MG-500MG	PRISTIQ 100MG	VIIBRYD 20MG
BETOPTIC S 0.25%	INVOKAMET 50MG-1000MG	PROMETRIUM 100MG	VIIBRYD 40MG
BEYAZ	INVOKAMET 150MG-500MG	PROZAC (G) 20MG	VIMOVO 375/20MG
BIKTARVY 50MG-200MG-25MG	INVOKAMET 150MG-1000MG	QTERN 10-5MG	VIMOVO 500/20MG
BINOSTO 70MG	INVOKANA 100MG	QVAR REDHALER 40MCG	VIVELLE-DOT 25MCG
BREO ELLIPTA 100/25MCG	INVOKANA 300MG	QVAR REDHALER 80MCG	VIVELLE-DOT 37.5MCG
BREO ELLIPTA 200/25MCG	JAKAFI 5MG	RANEXA 500MG	VIVELLE-DOT 50MCG
BRILINTA 60MG	JAKAFI 10MG	RAPAFLO 4MG	VIVELLE-DOT 75MCG
BRILINTA 90MG	JAKAFI 15MG	RAPAFLO 8MG	VIVELLE-DOT 100MCG
BYSTOLIC 2.5MG	JAKAFI 20MG	RELPAZ 20MG	VRAYLAR 1.5MG
BYSTOLIC 5MG	JALYN 0.5MG/0.4MG	RELPAZ 40MG	VRAYLAR 3MG
BYSTOLIC 10MG	JANUMET 50/500MG	RENAGEL 800MG	VRAYLAR 4.5MG
BYSTOLIC 20MG	JANUMET 50/1000MG	RENVELA (G) 800MG	VRAYLAR 6MG
CELEBREX 100MG	JANUMET XR 50MG/500MG	RESTASIS MULTIDOSE 0.05%	VYTORIN 10/10MG
CELEBREX 200MG	JANUMET XR 50MG/1000MG	RESTASIS VIALS 0.05%	VYTORIN 10/20MG
COMBIGAN 0.2-0.5%	JANUMET XR 100MG/1000MG	RETIN-A MICRO GEL PUMP 0.04%	VYTORIN 10/40MG
COMBIVENT RESPIMAT 20MCG/100MCG	JANUVIA 25MG	RETIN-A MICRO GEL PUMP 0.1%	VYTORIN 10/80MG
COSOPT PF 2%/0.5%	JANUVIA 50MG	REXULTI 0.25MG	WELCHOL 625MG
CRESTOR (G) 5MG	JANUVIA 100MG	REXULTI 0.5MG	WELCHOL PACKET 3.75G
CRESTOR (G) 10MG	JARDIANCE 10MG	REXULTI 1MG	WELLBUTRIN XL (G) 150MG
CRESTOR (G) 20MG	JARDIANCE 25MG	REXULTI 2MG	WELLBUTRIN XL (G) 300MG
CRESTOR (G) 40MG	JENTADUETO 2.5MG-500MG	REXULTI 3MG	XARELTO 2.5MG
CYMBALTA (G) 30MG	JENTADUETO 2.5MG-850MG	REXULTI 4MG	XARELTO 10MG
CYMBALTA (G) 60MG	JENTADUETO 2.5MG-1000MG	RYBELSUS 3MG	XARELTO 15MG
CYTOTEC (G) 200MCG	JUBLIA 10%	RYBELSUS 7MG	XARELTO 20MG
DALIRESP 500MCG	JULUCA 50MG-25MG	RYBELSUS 14MG	XELJANZ 5MG
DETROL 1MG	KAZANO 12.5/500MG	SAPHRIS 5MG	XELJANZ 10MG
DETROL 2MG	KAZANO 12.5/1000MG	SAPHRIS 10MG	XELJANZ XR 11MG
DETROL LA 2MG	KEPPRA (G) 500MG	SEGLUROMET 2.5MG-500MG	XIGDUO XR 5/1000MG
DETROL LA 4MG	KEPPRA (G) 750MG	SEGLUROMET 2.5MG-1000MG	XIGDUO XR 10/500MG
DEXILANT DR 30MG	KOMBIGLYZE XR 2.5MG/1000MG	SEGLUROMET 7.5MG-500MG	XIGDUO XR 10/1000MG
DEXILANT DR 60MG	KOMBIGLYZE XR 5MG/500MG	SEGLUROMET 7.5MG-1000MG	XIIDRA 5%
DIFFERIN GEL 0.3%	KOMBIGLYZE XR 5MG/1000MG	SENSIPAR (G) 30MG	YAZ 3/0.02MG
DIOVAN (G) 40MG	LATUDA 20MG	SENSIPAR (G) 60MG	ZETIA (G) 10MG
DIOVAN (G) 80MG	LATUDA 40MG	SEREVENT DISKUS 50MCG	ZIANA 1.2%-0.025%
DIOVAN (G) 160MG	LATUDA 60MG	SEROQUEL XR (G) 50MG	ZOCOR (G) 80MG
DIOVAN (G) 320MG	LATUDA 80MG	SEROQUEL XR (G) 150MG	ZOCOR (G) 40MG
DIPENTUM 250MG	LATUDA 120MG	SEROQUEL XR (G) 200MG	ZOCOR (G) 10MG
DIVIGEL 0.25MG	LEXAPRO (G) 10MG	SEROQUEL XR (G) 300MG	ZOCOR (G) 20MG
DIVIGEL 0.5MG	LEXAPRO (G) 20MG	SEROQUEL XR (G) 400MG	ZOLOFT (G) 50MG
DIVIGEL 1MG	LIALDA 1.2GM	SIMBRINZA 1%/0.2%	ZOLOFT (G) 100MG
DUAVEE 0.45-20MG	LINZESS 72MCG	SINGULAIR (G) 10MG	ZOMIG NASAL SPRAY 5MG
DULERA 100MCG/5MCG	LINZESS 145MCG	SOOLANTRA 1%	ZOMIG ZMT 2.5MG
DULERA 200MCG/5MCG	LINZESS 290MCG	SPIRIVA 18MCG	ZOVIRAX CREAM 5%
DYMISTA 137/50MCG	LIPITOR (G) 10MG	SPIRIVA RESPIMAT 2.5MCG	ZYCLARA PACKET 3.75%
	LIPITOR (G) 20MG	STEGLATRO 5MG	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

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

PATIENT INFORMATION (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/ 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.