

Introduction:

CCMHGCanarx is a voluntary international prescription drug program that is available to eligible Employees, non-Medicare eligible Retirees and their Dependents enrolled in the Network Blue HMO, Blue Care Elect Preferred PPO or Master Health Plus with the Cape Cod Municipal Health Group (CCMHG). 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.

CCMHGCanarx		Vs. Current Purchase Plan				
Annual Cost		Current Copays		Refills		Annual Savings
\$0	Vs.	\$30 (Tier 2)	x	12	=	\$360 / Script
	Vs.	\$65 (Tier 3)	x	12	=	\$780 / Script
	Vs.	\$75 (Tier 2)	x	4	=	\$300 / Script
	Vs.	\$165 (Tier 3)	x	4	=	\$660 / 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 **CCMHGCanarx**.

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: CCMHGGCanarx

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

WELCOME TO CCMHGGCanarx

ACTONEL 35MG	DIVIGEL 0.25MG	KOMBIGLYZE XR 5MG/1000MG	SIMBRINZA 1%/0.2%
ACTONEL 150MG	DIVIGEL 0.5MG	LAMICTAL (G) 200MG	SOOLANTRA 1%
ACTOPLUS 15MG-850MG	DIVIGEL 1MG	LATUDA 20MG	SPIRIVA 18MCG
ADCIACA 20MG	DUAVER 0.45-20MG	LATUDA 40MG	SPIRIVA RESPIMAT 2.5MCG
ADVAIR DISKUS 100MCG	DULERA 100MCG/5MCG	LATUDA 60MG	STIOLTO RESPIMAT 2.5/2.5MCG
ADVAIR DISKUS 250MCG	DULERA 200MCG/5MCG	LATUDA 80MG	STRATTERA 10MG
ADVAIR DISKUS 500MCG	DYMISTA 137/50MCG	LATUDA 120MG	STRATTERA 18MG
ADVAIR HFA 45/21MCG	EDARBI 40MG	LESCOL XL 80MG	STRATTERA 25MG
ADVAIR HFA 115/21MCG	EDARBI 80MG	LEXIVA 700MG	STRATTERA 40MG
ADVAIR HFA 230/21MCG	EDARBYCLOR 40MG/12.5MG	LIALDA 1.2GM	STRATTERA 60MG
AKLIEF 50MCG/G	EDARBYCLOR 40MG/25MG	LINZESS 72MCG	STRATTERA 80MG
ALOMIDE 0.1%	EDECIN 25MG	LINZESS 145MCG	STRATTERA 100MG
ALPHAGAN-P 0.15%	EDURANT 25MG	LINZESS 290MCG	SYNAREL NASAL
ALREX 0.2%	EFFIENT (G) 5MG	LIPITOR (G) 10MG	SYNJARDY 5MG/500MG
ALVESCO 80MCG 100MCG	EFFIENT (G) 10MG	LIPITOR (G) 20MG	SYNJARDY 5MG/1000MG
ALVESCO 160MCG 200MCG	ELIDEL 1%	LIPITOR (G) 40MG	SYNJARDY 12.5MG/500MG
ANAPROX DS 550MG	ELIQUIS 2.5MG	LIPITOR (G) 80MG	SYNJARDY 12.5MG/1000MG
ANORO ELLIPTA 62.5/25MCG	ELIQUIS 5MG	LOTEMAX GEL 0.5%	TARKA 2/180MG
APTOM 200MG	ELMIRON 100MG	LOTEMAX OINT 0.5%	TARKA 4/240MG
APTOM 400MG	ENTOCORT 3MG	LOTEMAX SUSP 0.5%	TASMAR 100MG
APTOM 600MG	ENTRESTO 24MG-26MG	LUMIGAN 0.01%	TAZORAC CREAM 0.05%
APTOM 800MG	ENTRESTO 49MG-51MG	MESTINON TS 180MG	TAZORAC CREAM 0.1%
ARNUITY ELLIPTA 100MCG	ENTRESTO 97MG-103MG	METRO CREAM 0.75%	TAZORAC GEL 0.05%
ARNUITY ELLIPTA 200MCG	EPIDUO FORTE 0.3%/2.5%	METROGEL PUMP 1%	TAZORAC GEL 0.1%
ARTHROTEC 50MG	EPIDUO GEL PUMP 0.1%/2.5%	MIGRANAL 4MG/ML	TECFIDERA 120MG
ARTHROTEC 75MG	EPIPEN 0.3MG	MIRVASO 0.33%	TECFIDERA 240MG
ASACOL HD 800MG	EPIPEN JR 0.15MG	MOTEGRITY 1MG	TEKTURNA 150MG
ASTAGRAF XL 5MG	EPIVIR / HBV 100MG	MOTEGRITY 2MG	TEKTURNA 300MG
ASTELIN (G) 137MCG	ESTROGEL 0.06%	MULTAQ 400MG	TIVICAY 50MG
ATROVENT HFA 20UG	EUCRISA 2%	MYRBETRIQ 25MG	TOBREX OINT 0.3%
AUBAGIO 14MG	EUSTA 60MG	MYRBETRIQ 50MG	TOPICORT CREAM 0.25%
AVODART (G) 0.5MG	EXELON 13.3MG/24HR	NAMENDA (G) 10MG	TOVIAZ 4MG
AZELEX 20%	EXFORGE HCT 160/12.5/5MG	NESINA 6.25MG	TOVIAZ 8MG
AZILECT 0.5MG	EXFORGE HCT 160/12.5/10MG	NESINA 12.5MG	TRADJENTA 5MG
AZILECT 1MG	EXFORGE HCT 160/25/5MG	NESINA 25MG	TRAVATAN Z 0.004%
AZOPT 1%	EXFORGE HCT 160/25/10MG	NEUPRO 1MG	TRELEGY ELLIPTA
BANZEL 200MG	EXFORGE HCT 320/25/10MG	NEUPRO 2MG	100-62.5-25MCG
BANZEL 400MG	FARXIGA 5MG	NEUPRO 3MG	TRILEPTAL (G) 150MG
BECONASE AQ 42MCG	FARXIGA 10MG	NEUPRO 4MG	TRILEPTAL (G) 300MG
BENICAR (G) 20MG	FELDEN 10MG	NEUPRO 6MG	TRILEPTAL (G) 600MG
BENICAR (G) 40MG	FELDEN 20MG	NEUPRO 8MG	TRINTELLIX 5MG
BENICAR HCT (G) 20MG/12.5MG	FINACEA GEL 15%	NEXLIZET 180MG-10MG	TRINTELLIX 10MG
BENICAR HCT (G) 40MG/12.5MG	FLAREX 0.1%	NORITATE CREAM 1%	TRINTELLIX 20MG
BENICAR HCT (G) 40MG/25MG	FLOVENT 44MCG 50MCG	NORVASC (G) 5MG	TRIUMEQ 600-50-300MG
BEPREVE 1.5%	FLOVENT 110MCG 125MCG	NORVASC (G) 10MG	TUDORZA PRESSAIR 400MCG
BETIMOL 0.25%	FLOVENT 220MCG 250MCG	OMNARIS 50MCG	UCERIS 9MG
BETIMOL 0.5%	FLOVENT DISKUS 100MCG	ONGLYZA 2.5MG	ULORIC 80MG
BETOPTIC S 0.25%	FLOVENT DISKUS 250MCG	ONGLYZA 5MG	URSO 250MG
BIKTRAVY 50MG-200MG-25MG	FOSRENOL CHEW 500MG	ORILISSA 150MG	VAGIFEM 10MCG
BINOSTO 70MG	FOSRENOL CHEW 750MG	ORILISSA 200MG	VALTREM (G) 500MG
BREO ELLIPTA 100/25MCG	FOSRENOL CHEW 1000MG	OSPHENA 60MG	VALTREM (G) 1000MG
BREO ELLIPTA 200/25MCG	FOSRENOL POWDER 750MG	OTZLA 30MG	VELPHORO 500MG
BRILINTA 60MG	FOSRENOL POWDER 1000MG	PENTASA 500MG	VESICARE 5MG
BRILINTA 90MG	FROVA 2.5MG	PRADAXA 75MG	VESICARE 10MG
BYSTOLIC 2.5MG	GENVOYA 150-150-200-10MG	PRADAXA 150MG	VIIBRYD 10MG
BYSTOLIC 5MG	GILENYA 0.5MG	PRANDIN (G) 1MG	VIIBRYD 20MG
BYSTOLIC 10MG	GLUCAGEN HYPOKIT 1MG	PRANDIN (G) 2MG	VIIBRYD 40MG
BYSTOLIC 20MG	GLUMETZA ER 1000MG	PRED FORTE 1%	VIREAD (G) 300MG
CADUET 5/10MG	GLYXAMBI 10MG/5MG	PREMARIN 0.3MG	VIVELLE-DOT 25MCG
CADUET 5/20MG	GLYXAMBI 25MG/5MG	PREMARIN 0.625MG	VIVELLE-DOT 37.5MCG
CADUET 5/40MG	HEPSERA 10MG	PREMARIN 1.25MG	VIVELLE-DOT 50MCG
CADUET 5/80MG	IMITREX NASAL SPRAY 5MG	PREMARIN CREAM 0.625MG/GM	VIVELLE-DOT 75MCG
CADUET 10/10MG	IMITREX NASAL SPRAY 20MG	PREMPRO 0.3MG/1.5MG	VIVELLE-DOT 100MCG
CADUET 10/20MG	IMITREX STATDOSE 6MG/0.5ML	PRISTIQ 50MG	VRAYLAR 1.5MG
CADUET 10/40MG	IMURAN (G) 50MG	PRISTIQ 100MG	VRAYLAR 3MG
CADUET 10/80MG	INCRUSE ELLIPTA 62.5MCG	PROMETRIUM 100MG	VRAYLAR 4.5MG
CELEBREX 100MG	INDERAL LA 60MG	PROTOPIC OINT 0.03%	VRAYLAR 6MG
CELEBREX 200MG	INDERAL LA 80MG	PROTOPIC OINT 0.1%	VYTORIN 10/10MG
CLIMARA PATCH 25MCG	INDERAL LA 120MG	QTERN 10-5MG	VYTORIN 10/20MG
CLIMARA PATCH 50MCG	INDERAL LA 160MG	QVAR REDIHALER 40MCG	VYTORIN 10/40MG
CLIMARA PATCH 75MCG	INVOKAMET 50MG-500MG	QVAR REDIHALER 80MCG	VYTORIN 10/80MG
CLIMARA PATCH 100MCG	INVOKAMET 50MG-1000MG	RANEXA 500MG	WELCHOL 625MG
COMBIGAN 0.2-0.5%	INVOKAMET 150MG-500MG	RAPAMUNE 0.5MG	WELCHOL PACKET 3.75G
COMBIVENT RESPIMAT	INVOKAMET 150MG-1000MG	RAPAMUNE 1MG	WELLBUTRIN XL (G) 150MG
20MCG/100MCG	INVOKANA 100MG	RAPAMUNE 2MG	WELLBUTRIN XL (G) 300MG
COMTAN 200MG	INVOKANA 300MG	RELPAK 20MG	XADAGO 50MG
COSOPT PF 2%/0.5%	JALYN 0.5MG/0.4MG	RELPAK 40MG	XADAGO 100MG
CRESTOR (G) 5MG	JANUMET 50/500MG	RENAGEL 800MG	XARELTO 2.5MG
CRESTOR (G) 10MG	JANUMET 50/1000MG	RENVELA 800MG	XARELTO 10MG
CRESTOR (G) 20MG	JANUMET XR 50MG/500MG	RESTASIS MULTIDOSE 0.05%	XARELTO 15MG
CRESTOR (G) 40MG	JANUMET XR 50MG/1000MG	RESTASIS VIALS 0.05%	XARELTO 20MG
CRINONE GEL 8%	JANUMET XR 100MG/1000MG	RETIN A GEL (G) 0.025%	XELJANZ 5MG
CYMBALTA (G) 20MG	JANUVIA 25MG	RETIN A MICRO GEL PUMP 0.04%	XELJANZ 10MG
CYMBALTA (G) 30MG	JANUVIA 50MG	RETIN-A MICRO GEL PUMP 0.1%	XELJANZ XR 11MG
CYMBALTA (G) 60MG	JANUVIA 100MG	REXULTI 0.25MG	XIGDUO XR 5/1000MG
DALIRESP 500MCG	JARDIANCE 10MG	REXULTI 0.5MG	XIGDUO XR 10/500MG
DEPAKOTE (G) 250MG	JARDIANCE 25MG	REXULTI 1MG	XIGDUO XR 10/1000MG
DEPAKOTE (G) 500MG	JENTADUETO 2.5MG-500MG	REXULTI 2MG	XIIDRA 5%
DETROL LA 2MG	JENTADUETO 2.5MG-850MG	REXULTI 3MG	ZELAPAR 1.25MG
DETROL LA 4MG	JENTADUETO 2.5MG-1000MG	REXULTI 4MG	ZETIA (G) 10MG
DEXILANT DR 30MG	JUBLIA 10%	RYBELSUS 3MG	ZIANA 1.2%-0.025%
DEXILANT DR 60MG	KAZANO 12.5/1000MG	RYBELSUS 7MG	ZOMIG (G) 2.5MG
DIFFERIN GEL 0.3%	KEPPRA (G) 250MG	RYBELSUS 14MG	ZOMIG NASAL SPRAY 5MG
DIOVAN (G) 40MG	KEPPRA (G) 500MG	SAPHRIS 5MG	ZOMIG ZMT 2.5MG
DIOVAN (G) 80MG	KEPPRA (G) 750MG	SAPHRIS 10MG	ZOVIRAX CREAM 5%
DIOVAN (G) 160MG	KEPPRA (G) 1000MG	SENSIPAR 30MG	ZYCLARA PACKET 3.75%
DIOVAN (G) 320MG	KOMBIGLYZE XR 2.5MG/1000MG	SENSIPAR 60MG	
DIPROLENE OINT 0.05%	KOMBIGLYZE XR 5MG/500MG	SEREVENT DISKUS 50MCG	

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.

Please return completed enrollment form by one of the following methods:

MAIL TO: CCMHGCANARX ADDRESS: PO Box 3009, WINDSOR, ONTARIO CANADA N8N 2M3
UPLOAD TO: WWW.CANARXDOCS.COM (Secure upload site.)
FAX TO: 1-866-715-6337 (NOTE: Faxed prescriptions must be sent **directly** from the physician's office.)

For more information, please call:

TOLL-FREE PHONE: 1-866-893-6337

NAME OF EMPLOYER

PATIENT INFORMATION (PLEASE PRINT)

DATE OF BIRTH (MM/DD/YYYY)

BCBS MEMBER ID #

PHONE (HOME)

PHONE (CELL)

PHONE (WORK)

EXT.

EMAIL ADDRESS

FIRST NAME

INITIAL

LAST NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

SUBSCRIBER

SPOUSE

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

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



MALE



FEMALE

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)

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)

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.