

Introduction:

CRXMeds is a voluntary prescription drug program that is available to eligible Employees and their Dependents of Tompkins County, New York, who are covered under the County's health insurance plan. For your convenience, a list of eligible medications is located on the back of this page.

Copayments:

All member copayments have been waived for this program only.

CRXMeds		Vs.		Current local purchase plan			
Annual Cost <i>No Copays!</i>		Current Retail Copays		Refills		Annual Savings	
\$0		Vs.	\$20 (Tier 2)	x	12	=	\$240 / Script
		Vs.	\$35 (Tier 3)	x	12	=	\$420 / Script

Ordering Instructions:

To place your first order simply complete the enrollment form and include a new prescription for each medication. Please allow 4 weeks for delivery.

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.

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

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: CRXMeds

P.O. Box 44650

Detroit, MI 48244-0650

More forms are available:

Additional forms may be obtained from your Human Resources Department, by visiting www.CRXMeds.com or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

WELCOME TO CRXMeds

ABILIFY 2MG	CARBATROL (G) 200MG	FOSRENOL CHEW 750MG	NEXAVAR 200MG	SYNAREL NASAL
ABILIFY 5MG	CARDIZEM CD (G) 360MG	FOSRENOL CHEW 1000MG	NEXIUM 20MG	TABLOID 40MG
ABILIFY 10MG	CARDIZEM LA (G) 180MG	FROVA 2.5MG	NEXIUM 40MG	TARKA 2/180MG
ABILIFY 15MG	CARDIZEM LA (G) 240MG	GELNIQUE 10%	NEXIUM DR 10MG	TARKA 4/240MG
ABILIFY 20MG	CARDIZEM LA (G) 360MG	GILENYA 0.5MG	NIASPAN (G) 500MG	TASIGNA 150MG
ABILIFY 30MG	CARDURA XL 4MG	GLEEVEEC 100MG	NIASPAN (G) 750MG	TASIGNA 200MG
ABILIFY DISCMELT 10MG	CARDURA XL 8MG	GLEEVEEC 400MG	NIASPAN (G) 1000MG	TASMAR 100MG
ABILIFY DISCMELT 15MG	CELEBREX 100MG	GLUCAGEN HYPOKIT 1MG	NORITATE CREAM 1%	TAZORAC CREAM 0.05%
ABILIFY SOLUTION 1MG/ML	CELEBREX 200MG	GLUMETZA ER 1000MG	NORVIR TABLET 100MG	TAZORAC CREAM 0.1%
ACCOLATE (G) 20MG	CLIMARA PATCH (G) 25MCG	IMITREX AUTOINJECTOR STATDOSE (G) 6MG/0.5ML	OLYSIO 150MG	TAZORAC GEL 0.05%
ACTONEL 5MG	CLIMARA PATCH (G) 50MCG	IMITREX NASAL SPRAY (G) 5MG-2DOSE	OMNARIS NASAL SPRAY 50MCG	TAZORAC GEL 0.1%
ACTONEL 30MG	CLIMARA PATCH (G) 75MCG	IMITREX NASAL SPRAY (G) 20MG-2DOSE	ONGLYZA 2.5MG	TECFIDERA 120MG
ACTONEL 35MG	CLIMARA PRO 0.045/0.015MCG	IMURAN (G) 50MG	ONGLYZA 5MG	TECFIDERA 240MG
ACTONEL 150MG	COMBIGAN 0.2-0.5%	INDERAL LA (G) 60MG	ORACEA 40MG	TEGRETOL (G) 200MG
ACTOPLUS (G) 15MG-850MG	COMBIVENT RESPIMAT	INDERAL LA (G) 80MG	ORTHO-EVRA (G)	TEGRETOL XR (G) 400MG
ACULAR LS SOL (G) 0.4%	20MCG/100MCG	INDERAL LA (G) 120MG	ORTHO-TRI-CYCLLEN LO	TEKTURNAL 150MG
ACZONE 5%	COMPLERA 200/25/300MG	INDERAL LA (G) 160MG	PATADAY 0.2%	TEKTURNAL 300MG
ADALAT CC (G) 30MG	COMTAN (G) 200MG	INLYTA 1MG	PATANOL OPHTH SOL 0.1%	TEKTURNAL HCT 150-12.5MG
ADCIRCA 20MG	CORGARD (G) 80MG	INLYTA 5MG	PAXIL CR (G) 12.5MG	TEKTURNAL HCT 300-12.5MG
ADVAIR DISKUS 100MCG	COSOPT PF DROPS 2%/0.5%	INSPIRA (G) 25MG	PAXIL CR (G) 25MG	TEKTURNAL HCT 300-25MG
ADVAIR DISKUS 250MCG	COVERA-HS 240MG	INSPIRA (G) 50MG	PENNSAID 1.5%	TEMOVATE OINT (G) 0.05%
ADVAIR DISKUS 500MCG	CRESTOR 5MG	INTELENCE 200MG	PENTASA 500MG	TEVETEN HCT 600/12.5MG
ADVAIR HFA 45/21MCG	CRESTOR 10MG	INVEGA 3MG	PLAQUENIL (G) 200MG	TIVICAY 50MG
ADVAIR HFA 115/21 MCG	CRESTOR 20MG	INVEGA 6MG	PRADAXA 75MG	TOBREX OINT 0.3%
ADVAIR HFA 230/21MCG	CRESTOR 40MG	INVEGA 9MG	PRADAXA 150MG	TOPROL XL (G) 200MG
AFINITOR 2.5MG	CUTIVATE OINT (G) 0.005%	INVIRASE 500MG	PRANDIN (G) 1MG	TOVIAZ 4MG
AFINITOR 5MG	CYMBALTA (G) 30MG	INVOKANA 100MG	PRANDIN (G) 2MG	TOVIAZ 8MG
AFINITOR 10MG	CYMBALTA (G) 60MG	INVOKANA 300MG	PRED FORTE (G) 1%	TRACLEER 62.5MG
AGGRENOX 200/25MG	CYTOTEC (G) 200MCG	ISENTRESS 400MG	PREMARIN 0.3MG	TRACLEER 125MG
ALOCRIOL OPHTH 2%	DALIRESP 500MCG	ISOPTO CARPINE 1%	PREMARIN 0.625MG	TRADJENTA 5MG
ALOMIDE 0.1%	DERMOTIC OIL 0.01%	ISOPTO CARPINE 2%	PREMARIN 1.25MG	TRAVATAN Z OPHTH SOL 0.004%
ALPHAGAN-P OPHTH SOL (G) 0.15%	DETROL (G) 1MG	ISOPTO CARPINE 4%	PREMARIN VAG 0.625MG/GM	TRIBENZOR 40/5/12.5MG
ALREX 0.2%	DETROL (G) 2MG	JALYN 0.5MG/0.4MG	PREMPRO 0.3/1.5MG	TRIBENZOR 40/5/25MG
ALVESCO 80MCG 100MCG	DETROL LA (G) 2MG	JANUMET 50/500MG	PREMPRO 0.625MG/2.5MG	TRIBENZOR 40/10/12.5MG
ALVESCO 160MCG 200MCG	DETROL LA (G) 4MG	JANUMET 50/1000MG	PREMPRO 0.625MG/5MG	TRIBENZOR 40/10/25MG
AMITIZA 24MCG	DEXILANT DR 30MG	JANUMET XR 50MG/1000MG	PREVACID SOLUTAB 15MG	TRICOR (G) 48MG
ANAPROX D.S. (G) 550MG	DEXILANT DR 60MG	JANUVIA 25MG	PREVACID SOLUTAB 30MG	TRICOR (G) 145MG
ANORO ELLIPTA 62.5/25MCG	DIFFERIN CREAM (G) 0.1%	JANUVIA 50MG	PREZCOBIX 800MG/150MG	TRIUQUE TABLET
ANZEMET 100MG	DIFFERIN GEL 0.3%	JANUVIA 100MG	PREZISTA 800MG	TRUVADA 200-300MG
ARCAPTA NEOHALER 75MCG	DIFFERIN GEL (G) 0.1%	JARDIANCE 10MG	PRISTIQ 50MG	TUDORZA PRESSAIR 400MCG
AROMASIN (G) 25MG	DIPENTOL 250MG	JARDIANCE 25MG	PROMETRIUM (G) 100MG	TWYNSTA 40/5MG
ARTHROTEC (G) 50MG	DIPROLENE LOTION (G) 0.05%	JENTADUETO 2.5MG/850MG	PROTOPIC OINT 0.03%	TWYNSTA 40/10MG
ARTHROTEC (G) 75MG	DIPROLENE OINT (G) 0.05%	JENTADUETO 2.5MG/1000MG	PROTOPIC OINT 0.1%	TWYNSTA 80/5MG
ASACOL HD 800MG	DIVIGEL 0.5MG	JENTADUETO 12.5/1000MG	QVAR 40 MCG 50MCG	TWYNSTA 80/10MG
ASMANEX TWISTHALER 220MCG	DIVIGEL 1MG	LAMICTAL (G) 5MG	QVAR 80 MCG 100MCG	TYZEKA 600MG
ATACAND (G) 4MG	DOVONEX CREAM (G) 50MCG	LATUDA 20MG	RANEXA 500MG	ULORIC 80MG
ATACAND (G) 8MG	DULERA 100MCG/5MCG	LATUDA 40MG	RAPAFLO 4MG	UROCIT-K (G) 10MEQ
ATACAND (G) 16MG	DULERA 200MCG/5MCG	LATUDA 60MG	RAPAFLO 8MG	URSO (G) 250MG
ATACAND (G) 32MG	DYMISTA NASAL SPRAY 137/50MCG	LATUDA 80MG	RAPAMUNE (G) 1MG	VAGIFEM 10MCG
ATACAND HCT (G) 16MG/12.5MG	EDARBI 40MG	LATUDA 120MG	RAPAMUNE (G) 2MG	VALCYTE 450MG
ATACAND HCT (G) 32MG/12.5MG	EDARBI 80MG	LESCOL (G) 20MG	RELPAZ 20MG	VECTICAL (G) 3MCG/GM
ATELVIA DR 35MG	EDARBYCLOR 40MG/12.5MG	LESCOL (G) 40MG	RELPAZ 40MG	VENTOLIN HFA 90MCG
ATRIPLA 600-200-300MG	EDARBYCLOR 40MG/25MG	LESCOL XL 80MG	RENAGEL 800MG	VERAMYST 27.5MCG
ATROVENT HFA 20UG	EDECIN 25MG	LIXIVA 700MG	RENVELA 800MG	VESICARE 5MG
AUBAGIO 14MG	EDURANT 25MG	LIALDA 1.2GM	RESTASIS 0.05%	VESICARE 10MG
AVANDAMET 2MG/500MG	EFFIENT 5MG	LINZESS 145MCG	RETIN A CREAM (G) 0.05%	VIMOVO 375/20MG
AVANDAMET 2MG/1000MG	EFFIENT 10MG	LINZESS 290MCG	RETIN A MICRO GEL (G) 0.04%	VIMOVO 500/20MG
AVANDAMET 4MG/500MG	ELIDEL 1%	LOCOID LIPOCREAM 0.1%	RETIN A MICRO GEL (G) 0.1%	VIRAMUNE XR 400MG
AVANDAMET 4MG/1000MG	ELIQUIS 2.5MG	LOCOID OINTMENT (G) 0.1%	RETIN-A MICRO GEL PUMP (G) 0.1%	VIREAD 300MG
AVANDIA 2MG	ELIQUIS 5MG	LOTEMAX 0.5%	RHINOCORT AQ 32MCG	VIVELLE-DOT 25MCG
AVANDIA 4MG	ELMIRON 100MG	LOTURISONE CREAM (G)	SALAGEN 5MG	VIVELLE-DOT 37.5MCG
AVANDIA 8MG	EMADINE 0.05%	LOVENOX (G) 40MG	SANCTURA XR (G) 60MG	VIVELLE-DOT 50MCG
AVODART 0.5MG	EMTRIVA 200MG	LOVENOX (G) 60MG	SAPHRIS 5MG	VIVELLE-DOT 75MCG
AXERT 6.25MG	ENABLEX 7.5MG	LOVENOX (G) 80MG	SAPHRIS 10MG	VIVELLE-DOT 100MCG
AXERT 12.5MG	ENABLEX 15MG	LOVENOX (G) 100MG	SEASONIQUE (G) 0.15-0.03-0.01	VOLTAREN GEL
AZILECT 0.5MG	ENTOCORT (G) 3MG	LOVENOX (G) 120MG	SENSIPAR 30MG	VOSPIRE ER 4MG
AZILECT 1MG	EPIDUO GEL PUMP 0.1%/2.5%	LOVENOX (G) 150MG	SENSIPAR 60MG	VYTORIN 10/10MG
AZOPT OPHTH DROPS 1%	EPIPEN 0.3MG	LOVENOX (G) 150MG	SENSIPAR 90MG	VYTORIN 10/20MG
AZOR 20/5MG	EPIPEN JR 0.15MG	LOVENOX OPHTH 0.01%	SEREVENT DISKUS 50MCG	VYTORIN 10/40MG
AZOR 40/5MG	EPIVIR (G) 150MG	MESTINON TS 180MG	SEROQUEL XR 50MG	VYTORIN 10/80MG
AZOR 40/10MG	EPIVIR / HBV (G) 100MG	METRO CREAM (G) 0.75%	SEROQUEL XR 150MG	VYTORIN 10/160MG
BACTROBAN CREAM (G) 2%	EPZICOM	MICARDIS (G) 40MG	SEROQUEL XR 200MG	XALKORI 200MG
BACTROBAN NASAL OINT 2%	ESTROGEL GEL 0.06%	MICARDIS HCT (G) 40/12.5MG	SEROQUEL XR 300MG	XALKORI 250MG
BANZEL 200MG	EVISTA 60MG	MICARDIS HCT (G) 80/12.5MG	SEROQUEL XR 400MG	XARELTO 10MG
BANZEL 400MG	EXELON 3MG	MICARDIS HCT (G) 80/25MG	SINGULAIR GRANULES (G) 4MG	XARELTO 15MG
BARACLUDE 0.5MG	EXELON 6MG	MIGRANAL NASAL SPRAY 4MG/ML	SOLARAZE (G) 3%	XARELTO 20MG
BARACLUDE 1MG	EXELON 4.8 MG/24HR	MINIPRESS (G) 1MG	SORIATANE (G) 10MG	XELJANZ 5MG
BECONASE AQ 0.04%	EXELON 9.5MG/24HR	MINIPRESS (G) 2MG	SORIATANE (G) 25MG	XELODA (G) 150MG
BENICAR 20MG	EXELON 13.3MG/24HR	MINIPRESS (G) 5MG	SPIRIVA 18MCG	XELODA (G) 500MG
BENICAR 40MG	EXFORGE HCT 160/12.5/5MG	MIRAPEX ER 0.375MG	SPIRIVA RESPIMAT 2.5MCG 4ML	XENICAL 120MG
BENICAR HCT 20MG/12.5MG	EXFORGE HCT 160/12.5/10MG	MIRAPEX ER 0.75MG	SPRYCEL 20MG	XTANDI 40MG
BENICAR HCT 40MG/12.5MG	EXFORGE HCT 160/25/5MG	MIRAPEX ER 1.5MG	SPRYCEL 50MG	YASMIN 28 (G)
BENICAR HCT 40MG/25MG	EXFORGE HCT 160/25/10MG	MIRAPEX ER 2.25MG	SPRYCEL 70MG	YAZ (G) 3-0.02MG
BENZACLIN PUMP	EXFORGE HCT 320/25/10MG	MIRAPEX ER 3MG	SPRYCEL 100MG	ZANAFLEX (G) 2MG
BETIMOL 0.25%	EXJADE 125MG	MIRAPEX ER 3.75MG	STALEVO (G) 50MG	ZARONTIN SYRUP 250MG/5ML
BETIMOL 0.5%	EXJADE 250MG	MIRVASO 0.33%	STALEVO (G) 100MG	ZELAPAR 1.25MG
BETOPTIC S OPHTH 0.25%	EXJADE 500MG	MULTAQ 400MG	STALEVO (G) 125MG	ZETIA 10MG
BREO ELLIPTA 100/25MCG	FARESTON 60MG	MYRBETRIQ 25MG	STARLIX (G) 120MG	ZIAGEN 300MG
BRILINTA 90MG	FARXIGA 5MG	MYRBETRIQ 50MG	STIVARGA 40MG	ZOMIG (G) 2.5MG
BRINTELLIX 5MG	FARXIGA 10MG	NASONEX 50MCG	STRATTERA 10MG	ZOMIG NASAL SPRAY 5MG
BRINTELLIX 10MG	FELDENE 10MG	FLAREX 0.1%	STRATTERA 18MG	ZOMIG ZMT (G) 2.5MG (1X6)
BRINTELLIX 20MG	FELDENE 20MG	FLOVENT 44MCG 50MCG	STRATTERA 25MG	ZORTRESS 0.25MG
BYSTOLIC 2.5MG	FINACEA 15%	FLOVENT 110MCG 125MCG	STRATTERA 40MG	ZORTRESS 0.5MG
BYSTOLIC 5MG	FLAREX 0.1%	FLOVENT 220MCG 250MCG	STRATTERA 60MG	ZORTRESS 0.75MG
BYSTOLIC 10MG	FLOVENT DISKUS 100MCG	FLOVENT DISKUS 250MCG	STRATTERA 80MG	ZOVIRAX CREAM 5%
BYSTOLIC 20MG	FLOVENT DISKUS 250MCG	FORADIL + AEROLIZER 12MCG	STRATTERA 100MG	ZYCLARA 3.75%
CADUET (G) 5/10MG	FORADIL + AEROLIZER 12MCG	FOSAMAX-D 70/2800MG	STRIBILD	ZYTIGA 250MG
CADUET (G) 5/20MG	FOSAMAX-D 70/2800MG	FOSRENOL CHEW 500MG	SUSTIVA 50MG	
CADUET (G) 5/40MG	FOSRENOL CHEW 500MG		SUSTIVA 200MG	
CADUET (G) 10/10MG			SUSTIVA 600MG	
CADUET (G) 10/20MG				
CAMBIA 50MG				

NOTE: Medication names appearing with (G) are available in a Generic version from your local or U.S. mail order pharmacy. For a greater savings to your healthcare plan, ask your physician about taking a Generic equivalent of your medication.

This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.

October 2015

MEMBER ID #: _____

**FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337
OR
MAIL TO: CRXMeds, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337**

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

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

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

Street Address _____

City/State _____ Zip Code _____

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

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

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. <i>Ex. Crestor (This is NOT a prescription.)</i>	Strength <i>Ex. 10 mg</i>	Reason for Taking <i>Ex. Cholesterol</i>	Daily Use <i>Ex. Twice Daily</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:** (DD/MM/YY) _____

AUTHORIZATION IF THE PATIENT IS THE MEMBER, 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:** (DD/MM/YY) _____

CONFIRMATION AND REPRESENTATIONS

I enter into this agreement with CanaRx Group Inc. ("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 contracted 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 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.
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. 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, 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 contracted physicians and pharmacists may share any and all information received from or about me with my U.S. physician, CanaRx contracted physicians and pharmacists, and my 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.
5. I authorize and instruct my U.S. physician to release to CanaRx (and any CanaRx contracted 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, X-ray records, imaging records, laboratory reports, and/or any other knowledge or information which my U.S. physician may possess.
6. 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.
7. CanaRx and its contracted physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
8. CanaRx contracted physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
9. CanaRx may make payments on my behalf to CanaRx contracted pharmacies for dispensing medicine in accordance with my prescriptions and to CanaRx contracted physicians for services rendered on my behalf.
10. I request and authorize my plan payor, 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 plan payor in accordance with the benefits plan.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments 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 contracted 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 contracted 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 contracted physician and have enlisted the services of CanaRx to facilitate it. I understand that the CanaRx contracted physician will rely on the accuracy of the examination performed, and the prescription provided, by my U.S. physician.
4. I am aware that CanaRx may transmit my personal information by electronic means (for example fax, or via the internet) to its agents, contracted 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, contracted physicians and pharmacies.
5. 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.
6. I acknowledge that I have purchased my medications internationally for personal use and I specifically confirm, acknowledge and agree that title to my medications passes to me when my medications are shipped from the CanaRx contracted pharmacy.

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.