

**Introduction:**

**SVRHTCanarx** is a voluntary international prescription drug program that is available to eligible Employees, non-Medicare eligible Retirees and their Dependents enrolled in a health plan with the Scantic Valley Regional Health Trust (SVRHT). 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 **SVRHTCanarx**.

**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: *SVRHTCanarx***

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

**OR**

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

**More forms are available:**

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

**WELCOME TO SVRHTCANARX**

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