CANARX

CANARX is a voluntary international mail order option. To be eligible for the CANARX program, you must be an existing member of a health insurance plan that currently has CANARX implemented as an additional option for prescription medication coverage.

FREE Brand-Name Medications

No Shipping and Handling Charges to You!

ZERO COPAYS

SIMPLE.

SAFE.

SMART.

Who is CANARX?

We're the easy way for you to get prescription medications. CANARX offers hundreds of brand-name maintenance medications that you can get — **copay-free** — in just a few easy steps.

Medications are shipped direct to you from licensed and regulated pharmacies located in Canada, the United Kingdom and Australia. All medications are backed by a Quality Assurance Team of doctors and pharmacists, as well as 20-plus years of experience in the industry.

With our program, you pay **$0** in copays and your medications are shipped right to your door for **FREE**. How? Your health plan pays less for the medication and shares these savings with you.

Ready to Start Saving?

ENROLL ONLINE TODAY!



Let's Get Started

JOINING IS EASY!

Visit our website today to enroll and view:

- Frequently Asked Questions (FAQs)
- Video Overview
- List of Available Medications

Call 1-866-893-6337 for your plan's WebID.

canarx.com/enroll

Scan to go to the website

Before ordering through CANARX, you or your doctor must attest that you have been taking your prescribed medication for at least 30 days – this is to ensure you have not experienced any complications with the medication.

STEP 1

Check medication availability.

STEP 2

Enroll online by completing the online form and uploading a copy of your photo ID, or complete the enclosed enrollment form and mail it to us.

STEP 3

Submit the original prescription via mail or arrange to have it sent directly from your prescriber. We can help with this step if required.

STEP 4

A licensed pharmacy will ship your medications directly to you.

STEP 5

CANARX will call you prior to each refill to ensure you have a continuous supply.

ENROLL ONLINE TODAY!



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: **CANARXDOCS.COM**
FAX: **1-866-715-6337** (NOTE: Faxed ***prescriptions*** 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**

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

SEX: ☐ **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 Services Inc. at Windsor, Ontario, Canada, and CANARX Group Inc. at Christ Church, Barbados, (collectively referred to as "CANARX") so that I may obtain access to medically-necessary and lawfully-prescribed drugs at low costs. I ask CANARX to assist me in exercising any and all of my rights of personal importation into the United States of medicine for my personal use (or, if applicable, for the personal use of a person of whom I am the lawful parent or guardian).

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. If I am not the patient for whom the medicine was prescribed, I am the parent or lawful guardian of the person ("the dependent") for whom the medicine was prescribed and I have lawful authority to order and obtain prescription medicine on behalf of such person.
4. I certify that I am a resident of the United States and not a resident of any other country.
5. I am (or, if applicable, the dependent is) 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 (or for the dependent) by my U.S. physician.
6. My U.S. physician has examined me (or the dependent) within the last 12 months and will examine me (or the dependent) at least once every 12 months while I am (or the dependent is) taking medicine.
7. Any medicine that I ask CANARX to assist me in obtaining is medicine that I have (or the dependent has) 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.
8. My care (or that of the dependent) 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-contacted physician.
9. 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.
10. The prescription issued by my U.S. physician has not been altered in any way nor has it been filled previously.
11. I will use any medications obtained for me through CANARX strictly in accordance with the instructions provided by my U.S. physician.
12. The medicine dispensed in accordance with my prescription will not be used in any way whatsoever except as directed by my U.S. physician;
13. I will not permit anyone else to use the prescription or any medications which I receive.
14. In the event that I suffer (or the dependent suffers) any side effects from any medication obtained for me by CANARX, I will immediately contact my U.S. physician.
15. I represent and warrant that all medicine I purchase and obtain with the assistance of CANARX is for my personal use or that of the dependent; that I do not seek to import medicine into the United States for any commercial purpose; and that I will not re-sell or otherwise exchange or distribute for gain any medicine that I purchase or obtain with the assistance of CANARX.
16. I have enrolled in a CANARX program and have engaged CANARX as my agent of my own free will. Neither my employer nor anyone connected with my health benefits or health insurance plan has required me to engage the services of CANARX or to import medicine. I understand that I have the right to decline to participate in the CANARX program and to obtain medicine in some other way, including from a local pharmacy.
17. If I have enrolled in or registered for a CANARX program, or given information to CANARX, via a website or a computerized platform of any kind, I have read, understood, and consented to all of the terms and conditions stated on the website or computerized platform. In particular, I acknowledge that if I have given my consent to these or any other terms on a CANARX website I have done so not merely by visiting the website (a "browsewrap agreement") but by specifically clicking on buttons or otherwise electronically indicating my assent after I have had a full opportunity to read and understand every such term.
18. 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, contractors, and agents (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 contact and communicate with me and arrange for me to contact and communicate with CANARX by all reasonable means, including in writing, by mail, by courier service, and by all electronic means (such telephone, e-mail, telecopiers, faxing, websites, texting, short message services ("SMS"), multi-media services ("MMS"), and applications ("apps" for use on personal devices)).
5. I authorize and instruct my U.S. physician to release to CANARX (and any CANARX-contacted physician, pharmacist, and pharmacy technician) any and all personal medical information pertaining to me or, if applicable, the dependent ("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 the physicians, pharmacists, pharmacy technicians, nurses, and other personnel it selects may contact my U.S. physician to discuss my prescription if necessary.
8. CANARX-contacted 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-contacted pharmacies for dispensing medicine in accordance with my prescriptions, to CANARX-contacted physicians for services rendered on my behalf, and to CANARX itself for its services rendered to me.
10. CANARX may make any use of any and all information, including but not limited to Personal Medical History, pertaining to me and/or, if applicable, the dependent, that it reasonably deems necessary to provide services to me.
11. In accordance with my rights and privileges under any all health benefits or health insurance plans applicable to me or the dependent, I hereby request and authorize my employer or plan holder, to pay for all products and services relating to the prescription medicine that I obtain through CANARX in such amounts as are billed by CANARX and found appropriate by my employer or plan holder in accordance with the benefits plan. I authorize CANARX to act as my agent in presenting my claim for benefits to my employer or plan holder or to anyone else.
12. In the event my employer or plan holder fails or refuses to honor my claim for benefits when presented, I promise to reimburse CANARX on demand for the costs of the medicine and of the professional services that I have received through the CANARX program.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments and releases to and of CANARX and all its employees, delegates, agents, and contractors, including physicians, pharmacists, pharmacy technicians, nurses, clerical personnel, and staff:

1. My U.S. physician is my primary physician (or, if applicable, is the primary physician of the dependent). Any CANARX-contacted 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 or the dependent by my U.S. physician to be dispensed to me by a CANARX-contacted 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-contacted physician and have enlisted the services of CANARX to facilitate it. I understand that the CANARX-contacted 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 for personal use and understand that my medications may be subject to U.S. border inspection and seizure.
6. I specifically confirm, acknowledge and agree that title to my medications passes to me when my medications are shipped from the CANARX-contacted contracted pharmacy.
7. 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 ACKNOWLEDGMENT

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 and, if applicable, about the dependent and the health of the dependent, including but not limited to full name, address, telephone number, e-mail address, Social Security Number, personal medical information, and payment information; may maintain such information on file as necessary to verify and process future orders and to obtain payment and reimbursement for them; and may transmit and store such information in writing, electronically, or by any practicable means. CANARX and CANARX-contacted physicians and pharmacists may share any and all information received from or about me or the dependent with my U.S. physician, CANARX-contacted 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 a website or otherwise via the internet) to its agents, contractors, and other personnel and 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, contractors, agents, and 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.
4. If and to the extent that the Health Insurance Portability and Accountability Act of 1986 ("HIPAA"); the Health Information Technology for Economic and Clinical Health Act ("HITECH"), enacted as part of the American Recovery and Reinvestment Act of 2009; and of amendments thereto and of rules and regulations promulgated thereunder, including the "Interim Final Rule" promulgated by the United States Department of Health and Human Services at 77 Fed. Reg. 1556 (Jan. 10, 2012), the "Omnibus Final Rule" promulgated by the United States Department of Health and Human Services at 78 Fed. Reg. 5566 (Jan. 25, 2013) and the rules codified at 45 C.F.R. Parts 160, 162, and 164; and similar statutes and regulations; all as amended from time to time; may apply to my relationship with CANARX or to any transaction undertaken in connection with this agreement, then I waive my rights under those acts and rules as necessary to achieve the purposes of this agreement.

ANTI-STEERING ACKNOWLEDGMENT

I have voluntarily elected to enroll in the CANARX program.

1. I understand that I am free to take my business to pharmacies other than a pharmacy that might be selected for me in the CANARX program.
2. No one has told me that I am required to enroll in the CANARX program or that I will be penalized in any way if I do not enroll in the CANARX program.
3. I understand that CANARX promises me that it is completely independent of my employer, my health plan sponsor, my health insurer, and any and all benefits managers and plan administrators who work for my employer, the plan sponsor, and/or the insurer.
4. I understand that CANARX promises me that it pays no fees or money of any kind to my employer, my health plan sponsor, my health insurer, or any benefits manager or plan administrator who works for my employer, the plan sponsor, or the insurer; and I understand that, to the contrary, CANARX is paid by my health plan for the services that CANARX renders to me.
5. I understand that the option to elect the CANARX program is made available to me because it allows me to decide whether or not I am satisfied with the quality of medicine and service I receive and with the cost savings that my plan and I realize by using the CANARX plan.
6. I understand that I have the option to enroll in the CANARX program to acquire some of my prescription medicine while I may at the same time choose to acquire some of my medicine elsewhere. I acknowledge that CANARX advises me to seek to have any prescription for medicine needed on an acute basis (the same day as prescribed, or for an emergency or on a short-term basis) or for administration under a pharmacist's immediate supervision or with the pharmacist's participation, to be filled at a local pharmacy near me.
7. I understand that I have the right to leave the CANARX program at any time and to take my pharmacy business elsewhere for any reason I choose.

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.