WSHGCanaRx

Tufts

Introduction:

WSHGCanaRx is a voluntary international prescription drug program that is available to eligible Employees, Non-Medicare eligible Retirees and their Dependents enrolled in the **HMOs** or the **PPO plan** with the West Suburban Health Group. 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**.

WSHGCanaRx	**Vs.**	**Current local purchase plan**				
Annual Cost ***No Copays!***		**Current Mail Order Copays**		**Refills**		**Annual Savings**
	Vs.	**$50** *(Tier 2)* *Rate Saver*	**x**	**4**	**=**	**$200 / Script**
$0	**Vs.**	**$90** *(Tier 3)* *Rate Saver*	**x**	**4**	**=**	**$360 / Script**
	Vs.	**$75** *(Tier 2)* *Benchmark*	**x**	**4**	**=**	**$300 / Script**
	Vs.	**$165** *(Tier 3)* *Benchmark*	**x**	**4**	**=**	**$660 / 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 ***WSHGCanaRx*.**

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: **WSHGCanaRx**

P.O. Box 44650

DETROIT, MI. 48244-0650

More forms are available:

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

WELCOME TO WSHGCanaRx

September 2017

Tufts WSHGCanaRx

For More Information: Call 1-866-893-MEDS (6337)

ABILIFY 2MG
ABILIFY 5MG
ABILIFY 10MG
ABILIFY 15MG
ABILIFY 20MG
ABILIFY 30MG
ABILIFY DISCMELT 10MG
ABILIFY DISCMELT 15MG
ACCOLATE (G) 20MG
ACTOPLUS (G) 15MG-850MG
ADCIRCA 20MG
ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/2 MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
AFINITOR 2.5MG
AFINITOR 5MG
AFINITOR 10MG
AGGRENOX 200/25MG
ALDARA CREAM (G) 5%-250MG
ALPHAGAN-P OPHTH SOL (G) 0.15%
ALREX 0.2%
AMITIZA 24MCG
ANORO ELLIPTA 62.5/25MCG
ANZEMET 100MG
ARNUITY ELLIPTA 100MCG
ARNUITY ELLIPTA 200MCG
AROMASIN (G) 25MG
ARTHROTEC (G) 50MG
ARTHROTEC (G) 75MG
ATRIPLA 600-200-300MG
ATROVENT HFA 20UG
AUBAGIO 14MG
AVODART 0.5MG
AXERT 6.25MG
AXERT 12.5MG
AZILECT 0.5MG
AZILECT 1MG
AZOPT OPHTH DROPS 1%
AZOR 20/5MG
AZOR 40/5MG
AZOR 40/10MG
BANZEL 200MG
BANZEL 400MG
BARACLUDE 0.5MG
BARACLUDE 1MG
BENICAR 20MG
BENICAR 40MG
BENICAR HCT 20MG/12.5MG
BENICAR HCT 40MG/12.5MG
BENICAR HCT 40MG/25MG
BENZACLIN PUMP
BETIMOL 0.25%
BETIMOL 0.5%
BETOPTIC S OPHTH 0.25%
BREO ELLIPTA 100/25MCG
BRILINTA 60MG
BRILINTA 90MG
BYSTOLIC 5MG
CADUET (G) 5/10MG
CADUET (G) 5/20MG
CADUET (G) 5/40MG
CADUET (G) 10/10MG
CADUET (G) 10/20MG
CAMBIA 50MG
CARDIZEM CD (G) 240MG
CARDURA XL 4MG
CARDURA XL 8MG
CELEBREX 100MG
CELEBREX 200MG
CELEXA (G) 20MG
CELEXA (G) 40MG
CLIMARA PATCH (G) 25MCG
CLIMARA PATCH (G) 50MCG
CLIMARA PATCH (G) 75MCG
CLIMARA PRO 0.045/0.015MG
COMBIGAN 0.2-0.5%
COMBIVENT RESPIMAT 20MCG/100MCG
COMPLERA 200/25/300MG
COMTAN (G) 200MG
CRESTOR 5MG
CRESTOR 10MG
CRESTOR 20MG
CRESTOR 40MG
CUTIVATE OINT (G) 0.005%
CYMBALTA (G) 30MG
CYMBALTA (G) 60MG
DALIRESP 500MCG
DDAVP (G) 0.2MG
DERMOTIC OIL 0.01%
DETROL (G) 1MG
DETROL (G) 2MG
DETROL LA 2MG
DETROL LA 4MG
DEXILANT DR 30MG
DEXILANT DR 60MG
DIFFERIN CREAM (G) 0.1%
DIFFERIN GEL (G) 0.1%
DIFFERIN GEL 0.3%
DIOVAN (G) 40MG
DIOVAN (G) 80MG
DIOVAN (G) 160MG
DIOVAN (G) 320MG
DIOVAN HCT (G) 320/25MG
DIPENTUM 250MG
DIPROLENE LOTION (G) 0.05%
DIPROLENE OINT (G) 0.05%
DIVIGEL 0.5MG
DIVIGEL 1MG
DOVONEX CREAM (G) 50MCG
DUAVEE 0.45-20MG
DYMISTA NASAL SPRAY 137/50MCG
EDECRIN 25MG
EDURANT 25MG
EFFEXOR XR (G) 75MG
EFFEXOR XR (G) 150MG
EFFIENT 5MG
EFFIENT 10MG
ELIDEL 1%
ELIQUIS 2.5MG
ELIQUIS 5MG
ELMIRON 100MG
ENABLEX 7.5MG
ENABLEX 15MG
ENTOCORT (G) 3MG
ENTRESTO 24MG-26MG
ENTRESTO 49MG-51MG
ENTRESTO 97MG-103MG
EPIVIR / HBV (G) 100MG
EPZICOM
ESTROGEL 0.06%
EVISTA 60MG
EXELON 3MG
EXELON 6MG
EXELON 4.6MG/24HR
EXELON 9.5MG/24HR
EXELON 13.3MG/24HR
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
EXJADE 125MG
EXJADE 250MG
EXJADE 500MG
FARESTON 60MG
FELDENE 10MG
FELDENE 20MG
FINACEA GEL 15%
FLOVENT 44MCG 50MCG
FLOVENT 110MCG 125MCG
FLOVENT 220MCG 250MCG
FLOVENT DISKUS 100MCG
FLOVENT DISKUS 250MCG
FORADIL + AEROLIZER 12MCG
FOSRENOL CHEW 500MG
FOSRENOL CHEW 750MG
FOSRENOL CHEW 1000MG
FOSRENOL POWDER 750MG
FOSRENOL POWDER 1000MG
FROVA 2.5MG
GELNIQUE 10%
GENVOYA 150-150-200-10MG
GILENYA 0.5MG
GILOTRIF 20MG
GILOTRIF 30MG
GILOTRIF 40MG
GLEEVEC 100MG
GLEEVEC 400MG
GLUCAGEN HYPOKIT 1MG
IMITREX AUTOINJECTOR STATDOSE (G) 6MG/0.5ML
IMITREX NASAL SPRAY (G) 5MG-2DOSE
IMITREX NASAL SPRAY (G) 20MG-2DOSE
INLYTA 1MG
INLYTA 5MG
INTELENCE 200MG
INVIRASE 500MG
INVOKAMET 50MG-500MG
INVOKAMET 50MG-1000MG
INVOKAMET 150MG-500MG
INVOKAMET 150MG-1000MG
INVOKANA 100MG
INVOKANA 300MG
ISENTRESS 400MG
JADENU 90MG
JADENU 180MG
JADENU 360MG
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
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LEXAPRO (G) 10MG
LEXAPRO (G) 20MG
LEXIVA 700MG
LIALDA 1.2GM
LINZESS 145MCG
LINZESS 290MCG
LIPITOR (G) 10MG
LIPITOR (G) 20MG
LIPITOR (G) 40MG
LIPITOR (G) 80MG
LOCOID LIPOCREAM 0.1%
LOTEMAX GEL 0.5%
LOTEMAX SUSPENSION 0.5%
LOVENOX (G) 40MG
LOVENOX (G) 60MG
LOVENOX (G) 80MG
LOVENOX (G) 100MG
LUMIGAN OPHTH 0.01%
MESNEX 400MG
MESTINON TS 180MG
METRO CREAM (G) 0.75%
METROGEL PUMP 1%
MIGRANAL NASAL SPRAY 4MG/ML
MIRAPEX ER 0.375MG
MIRAPEX ER 0.75MG
MIRAPEX ER 1.5MG
MIRAPEX ER 2.25MG
MIRAPEX ER 3MG
MIRAPEX ER 3.75MG
MIRAPEX ER 4.5MG
MULTAQ 400MG
MYRBETRIQ 25MG
MYRBETRIQ 50MG
NASONEX 50MCG
NEUPRO 1MG
NEUPRO 2MG
NEUPRO 3MG
NEUPRO 4MG
NEUPRO 6MG
NEUPRO 8MG
NEXAVAR 200MG
NEXIUM 20MG
NEXIUM 40MG
NEXIUM DR 10MG
NIASPAN 500MG
NIASPAN 1000MG
NORITATE CREAM 1%
NORVIR TABLET 100MG
ORTHO-TRI-CYCLEN LO
OTEZLA 30MG
PATANOL OPHTH SOL 0.1%
PENTASA 500MG
PLAVIX (G) 75MG
PRADAXA 75MG
PRADAXA 150MG
PRED FORTE (G) 1%
PREMARIN 0.3MG
PREMARIN 0.625MG
PREMARIN 1.25MG
PREMARIN VAG 0.625MG/GM
PREMPRO 0.3MG/1.5MG
PREMPRO 0.625MG/2.5MG
PREMPRO 0.625MG/5MG
PREVACID (G) 30MG
PREVACID SOLUTAB 15MG
PREVACID SOLUTAB 30MG
PREZCOBIX 800MG/150MG
PREZISTA 800MG
PRISTIQ 50MG
PRISTIQ 100MG
PROMETRIUM (G) 100MG
PROTOPIC OINT 0.03%
PROTOPIC OINT 0.1%
PROZAC (G) 10MG
PROZAC (G) 20MG
QVAR 40MCG 50MCG
QVAR 80MCG 100MCG
RANEXA 500MG
RAPAFLO 4MG
RAPAFLO 8MG
RAPAMUNE (G) 0.5MG
RAPAMUNE (G) 1MG
RAPAMUNE (G) 2MG
RELPAX 20MG
RELPAX 40MG
RENAGEL 800MG
RENVELA 800MG
RESTASIS VIALS 0.05%
RETIN A CREAM (G) 0.05%
RETIN A MICRO GEL PUMP (G) 0.04%
RETIN-A MICRO GEL PUMP (G) 0.1%
REYATAZ 150MG
REYATAZ 200MG
REYATAZ 300MG
SEASONIQUE (G) 0.15/0.03/0.01MG
SENSIPAR 30MG
SENSIPAR 60MG
SENSIPAR 90MG
SEREVENT DISKUS 50MCG
SEROQUEL XR 50MG
SEROQUEL XR 150MG
SEROQUEL XR 200MG
SEROQUEL XR 300MG
SEROQUEL XR 400MG
SIMBRINZA 1%/0.2%
SINGULAIR (G) 5MG
SINGULAIR (G) 10MG
SINGULAIR GRANULES (G) 4MG
SOLARAZE (G) 3%
SOOLANTRA 1%
SORIATANE (G) 10MG
SORIATANE (G) 25MG
SPIRIVA 18MCG
SPIRIVA RESPIMAT 2.5MCG
SPRYCEL 20MG
SPRYCEL 50MG
SPRYCEL 70MG
SPRYCEL 100MG
STARLIX (G) 60MG
STARLIX (G) 120MG
STIVARGA 40MG
STRATTERA 10MG
STRATTERA 18MG
STRATTERA 25MG
STRATTERA 40MG
STRATTERA 60MG
STRATTERA 80MG
STRATTERA 100MG
STRIBILD
SUSTIVA 50MG
SUSTIVA 200MG
SUSTIVA 600MG
SUTENT 12.5MG
SUTENT 25MG
SUTENT 50MG
SYNAREL NASAL
SYNJARDY 5MG/500MG
SYNJARDY 5MG/1000MG
SYNJARDY 12.5MG/500MG
SYNJARDY 12.5MG/1000MG
TABLOID 40MG
TARKA 2/180MG
TARKA 4/240MG
TASIGNA 150MG
TASIGNA 200MG
TASMAR 100MG
TAZORAC CREAM 0.05%
TAZORAC CREAM 0.1%
TAZORAC GEL 0.05%
TAZORAC GEL 0.1%
TECFIDERA 120MG
TECFIDERA 240MG
TEGRETOL (G) 200MG
TEGRETOL XR (G) 200MG
TEGRETOL XR (G) 400MG
TEKTURNA 150MG
TEKTURNA 300MG
TEKTURNA HCT 150-12.5MG
TEKTURNA HCT 150-25MG
TEKTURNA HCT 300-12.5MG
TEKTURNA HCT 300-25MG
TIVICAY 50MG
TOBREX OINT 0.3%
TOPAMAX (G) 25MG
TOPAMAX (G) 100MG
TRACLEER 62.5MG
TRACLEER 125MG
TRADJENTA 5MG
TRAVATAN Z OPHTH SOL 0.004%
TRINTELLIX 5MG
TRINTELLIX 10MG
TRINTELLIX 20MG
TRIUMEQ TABLET
TRUVADA 200-300MG
TYZEKA 600MG
ULORIC 80MG
URSO (G) 250MG
VAGIFEM 10MCG
VALCYTE 450MG
VESICARE 5MG
VESICARE 10MG
VIRAMUNE XR 400MG
VIREAD 300MG
VIVELLE-DOT 25MCG
VIVELLE-DOT 37.5MCG
VIVELLE-DOT 50MCG
VIVELLE-DOT 75MCG
VIVELLE-DOT 100MCG
VYTORIN 10/10MG
VYTORIN 10/20MG
VYTORIN 10/40MG
VYTORIN 10/80MG
WELCHOL 625MG
WELLBUTRIN XL (G) 150MG
WELLBUTRIN XL (G) 300MG
XALKORI 200MG
XALKORI 250MG
XARELTO 10MG
XARELTO 15MG
XARELTO 20MG
XELJANZ 5MG
XELODA (G) 150MG
XELODA (G) 500MG
XENICAL 120MG
XTANDI 40MG
YAZ (G) 3/0.02MG
ZANAFLEX (G) 2MG
ZANTAC (G) 150MG
ZESTRIL (G) 20MG
ZESTRIL (G) 5MG
ZESTRIL (G) 10MG
ZETIA 10MG
ZOCOR (G) 10MG
ZOCOR (G) 20MG
ZOCOR (G) 40MG
ZOLOFT (G) 50MG
ZOLOFT (G) 100MG
ZOMIG (G) 2.5MG
ZOMIG NASAL SPRAY 5MG
ZOMIG ZMT (G) 2.5MG (1X6)
ZORTRESS 0.25MG
ZORTRESS 0.5MG
ZORTRESS 0.75MG
ZOVIRAX CREAM 5%
ZYCLARA 3.75%
ZYTIGA 250MG

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. *September 2017*

WSHGCanaRx

CanaRx Enrollment Form

TUFTS MEMBER ID #:

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

PATIENT INFORMATION: Birthdate _____ (MM/DD/YYYY) ☐ SUBSCRIBER ☐ 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. *(THIS IS NOT A PRESCRIPTION.)*

Name of Medicine	Dosage	Time(s) to Take	Date Started	Reason for Taking
Ex. Januvia	*Ex. 50mg*	*Ex. Twice Daily*	*Ex. 8/20/2017*	*Ex. Diabetes*

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:** *(MM/DD/YY)*

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 Signature: **Date:** *(MM/DD/YY)*

TERMS OF AGREEMENT

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.