

**Introduction:**

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

<i>SVRHTCanarx</i>		Vs.	Current Purchase Plan			
Annual Cost <i>No Copays!</i>			Current Copays		Refills	Annual Savings
<b>\$0</b>	Vs.		<b>\$25</b> (Tier 2) <i>Retail</i>	x	<b>12</b>	= <b>\$300 / Script</b>
	Vs.		<b>\$50</b> (Tier 3) <i>Retail</i>	x	<b>12</b>	= <b>\$600 / Script</b>
	Vs.		<b>\$50</b> (Tier 2) <i>Mail Order</i>	x	<b>4</b>	= <b>\$200 / Script</b>
	Vs.		<b>\$110</b> (Tier 3) <i>Mail Order</i>	x	<b>4</b>	= <b>\$440 / Script</b>

**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**.

ACTONEL 5MG	DEXILANT DR 30MG	KEPPRA (G) 500MG	SIMBRINZA 1%/0.2%
ACTONEL 30MG	DEXILANT DR 60MG	KEPPRA (G) 750MG	<b>SINGULAIR (G) 10MG</b>
ACTONEL 35MG	DIFFERIN GEL 0.3%	KEPPRA (G) 1000MG	SOOLANTRA 1%
ACTONEL 150MG	<b>DIOVAN (G) 40MG</b>	KOMBIGLYZE XR 2.5MG/1000MG	SPIRIVA 18MCG
ACTOPLUS 15MG-850MG	<b>DIOVAN (G) 80MG</b>	KOMBIGLYZE XR 5MG/500MG	SPIRIVA RESPIMAT 2.5MCG
<b>ACTOS (G) 30MG</b>	<b>DIOVAN (G) 160MG</b>	KOMBIGLYZE XR 5MG/1000MG	STIOLTO RESPIMAT 2.5/2.5MCG
<b>ACTOS (G) 45MG</b>	<b>DIOVAN (G) 320MG</b>	<b>LAMICTAL (G) 100MG</b>	STRATTERA 10MG
ADCIRCA 20MG	DIPROLENE OINT 0.05%	<b>LAMICTAL (G) 150MG</b>	STRATTERA 18MG
ADVAIR DISKUS 100MCG	DIVIGEL 0.25MG	<b>LAMICTAL (G) 200MG</b>	STRATTERA 25MG
ADVAIR DISKUS 250MCG	DIVIGEL 0.5MG	LESCOL XL 80MG	STRATTERA 40MG
ADVAIR DISKUS 500MCG	DIVIGEL 1MG	LEXIVA 700MG	STRATTERA 60MG
ADVAIR HFA 45/21MCG	DULERA 100MCG/5MCG	LIALDA 1.2GM	STRATTERA 80MG
ADVAIR HFA 115/21MCG	DULERA 200MCG/5MCG	LINZESS 72MCG	STRATTERA 100MG
ADVAIR HFA 230/21MCG	EDARBI 40MG	LINZESS 145MCG	SYNAREL NASAL
ALOMIDE 0.1%	EDARBI 80MG	LINZESS 290MCG	SYNJARDY 5MG/500MG
ALPHAGAN-P 0.15%	EDARBYCLOR 40MG/12.5MG	<b>LIPITOR (G) 10MG</b>	SYNJARDY 5MG/1000MG
ALREX 0.2%	EDARBYCLOR 40MG/25MG	<b>LIPITOR (G) 20MG</b>	SYNJARDY 12.5MG/500MG
<b>ALTACE (G) 5MG</b>	EDECIN 25MG	<b>LIPITOR (G) 40MG</b>	SYNJARDY 12.5MG/1000MG
ALVESCO 80MCG 100MCG	<b>EFFIENT (G) 5MG</b>	<b>LIPITOR (G) 80MG</b>	TARKA 2/180MG
ALVESCO 160MCG 200MCG	<b>EFFIENT (G) 10MG</b>	LOCOD LIPOCREAM 0.1%	TARKA 4/240MG
ANAPROX DS 550MG	ELIDEL 1%	LOTEMAS GEL 0.5%	TASMAR 100MG
ANORO ELLIPTA 62.5/25MCG	ELIQUIS 2.5MG	LOTEMAS OINT 0.5%	TAZORAC CREAM 0.05%
APTIOM 200MG	ELIQUIS 5MG	LOTEMAS SUSP 0.1%	TAZORAC CREAM 0.1%
APTIOM 400MG	ELMIRON 100MG	LUMIGAN 0.01%	TAZORAC GEL 0.05%
APTIOM 600MG	ENTOCORT 3MG	<b>MAXALT (G) 10MG</b>	TAZORAC GEL 0.1%
APTIOM 800MG	ENTRESTO 24MG-26MG	MESNEX 400MG	TECFIDERA 120MG
ARNUITY ELLIPTA 100MCG	ENTRESTO 49MG-51MG	MESTINON TS 180MG	TECFIDERA 240MG
ARNUITY ELLIPTA 200MCG	ENTRESTO 97MG-103MG	METRO CREAM 0.75%	TIVICAY 50MG
AROMASIN 25MG	EPIPEN 0.3MG	<b>METROGEL (G) 0.75%</b>	TOBREX OINT 0.3%
ARTHROTEC 50MG	EPIPEN JR 0.15MG	METROGEL PUMP 1%	<b>TOPICORT CREAM (G) 0.25%</b>
ARTHROTEC 75MG	EPIVIR / HBV 100MG	MIGRANAL 4MG/ML	TOVIAZ 4MG
ASACOL HD 800MG	EUCRISA 2%	MOTEGRITY 1MG	TOVIAZ 8MG
ASTAGRAF XL 1MG	EVISTA 60MG	MOTEGRITY 2MG	TRADJENTA 5MG
ASTAGRAF XL 5MG	EXELON 3MG	MULTAQ 400MG	TRAVATAN Z 0.004%
ASTELIN 137MCG	EXELON 6MG	MYRBETRIQ 25MG	TRELEGY ELLIPTA 100-62.5-25MCG
ATROVENT HFA 20UG	EXELON 4.6MG/24HR	MYRBETRIQ 50MG	<b>TRILEPTAL (G) 150MG</b>
AUBAGIO 14MG	EXELON 9.5MG/24HR	NAMENDA 10MG	<b>TRILEPTAL (G) 300MG</b>
AVANDIA 2MG	EXELON 13.3MG/24HR	NEUPRO 1MG	<b>TRILEPTAL (G) 600MG</b>
<b>AVODART (G) 0.5MG</b>	EXFORGE HCT 160/12.5/5MG	NEUPRO 2MG	TRINTELLIX 5MG
AZELEX 20%	EXFORGE HCT 160/12.5/10MG	NEUPRO 3MG	TRINTELLIX 10MG
AZILECT 0.5MG	EXFORGE HCT 160/25/5MG	NEUPRO 4MG	TRINTELLIX 20MG
AZILECT 1MG	EXFORGE HCT 160/25/10MG	NEUPRO 6MG	TRIUMEQ 600-50-300MG
AZOPT 1%	EXFORGE HCT 320/25/10MG	NEUPRO 8MG	TUDORZA PRESSAIR 400MCG
BANZEL 200MG	FARESTON 60MG	NORITATE CREAM 1%	UCERIS 9MG
BANZEL 400MG	FARXIGA 5MG	<b>NORVASC (G) 5MG</b>	ULORIC 80MG
BECONASE AQ 42MCG	FARXIGA 10MG	<b>NORVASC (G) 10MG</b>	UROCIT-K 10MEQ
<b>BENICAR (G) 20MG</b>	FELDENE 10MG	ONGLYZA 2.5MG	URSO 250MG
<b>BENICAR (G) 40MG</b>	FELDENE 20MG	ONGLYZA 5MG	VAGIFEM 10MCG
<b>BENICAR HCT (G) 20MG/12.5MG</b>	FINACEA GEL 15%	ORILISSA 150MG	<b>VALTREX (G) 500MG</b>
<b>BENICAR HCT (G) 40MG/12.5MG</b>	FLOVENT 44MCG 50MCG	ORILISSA 200MG	<b>VALTRELX (G) 1000MG</b>
<b>BENICAR HCT (G) 40MG/25MG</b>	FLOVENT 110MCG 125MCG	OTEZLA 30MG	VENTOLIN HFA 90MCG
BETIMOL 0.25%	FLOVENT 220MCG 250MCG	PENTASA 500MG	VESICARE 5MG
BETIMOL 0.5%	FLOVENT DISKUS 100MCG	<b>PLAVIX (G) 75MG</b>	VESICARE 10MG
BETOPTIC S 0.25%	FLOVENT DISKUS 250MCG	PRADAXA 75MG	VIIBRYD 10MG
BREO ELLIPTA 100/25MCG	FOSRENOL CHEW 500MG	PRADAXA 150MG	VIIBRYD 20MG
BREO ELLIPTA 200/25MCG	FOSRENOL CHEW 750MG	<b>PRANDIN (G) 0.5MG</b>	VIIBRYD 40MG
BRILINTA 60MG	FOSRENOL CHEW 1000MG	<b>PRANDIN (G) 1MG</b>	VIREAD 300MG
BRILINTA 90MG	FOSRENOL POWDER 750MG	<b>PRANDIN (G) 2MG</b>	VIVELLE-DOT 25MCG
BYSTOLIC 2.5MG	FOSRENOL POWDER 1000MG	PRED FORTE 1%	VIVELLE-DOT 37.5MCG
BYSTOLIC 5MG	GENVOYA 150-150-200-10MG	PREMARIN 0.3MG	VIVELLE-DOT 50MCG
BYSTOLIC 10MG	GILENYA 0.5MG	PREMARIN 0.625MG	VIVELLE-DOT 75MCG
BYSTOLIC 20MG	GLUCAGEN HYPOKIT 1MG	PREMARIN 1.25MG	VIVELLE-DOT 100MCG
CADUET 5/10MG	GLUMETZA ER 1000MG	PREMARIN CREAM 0.625MG/GM	VYTORIN 10/10MG
CADUET 5/20MG	GLYXAMBI 10MG/5MG	PREMPRO 0.3MG/1.5MG	VYTORIN 10/20MG
CADUET 5/40MG	GLYXAMBI 25MG/5MG	PRISTIQ 50MG	VYTORIN 10/40MG
CADUET 5/80MG	<b>HEPSERA (G) 10MG</b>	PRISTIQ 100MG	VYTORIN 10/80MG
CADUET 10/10MG	IMITREX AUTOINJECTOR STATDOSE	<b>PROGRAF (G) 1MG</b>	WELCHOL 625MG
CADUET 10/20MG	6MG/0.5ML	PROMETRIUM 100MG	WELCHOL PACKET 3.75G
CADUET 10/40MG	IMITREX NASAL SPRAY 5MG-2DOSE	PROTOPIC OINT 0.03%	<b>WELLBUTRIN XL (G) 150MG</b>
CADUET 10/80MG	IMITREX NASAL SPRAY 20MG-2DOSE	PROTOPIC OINT 0.1%	<b>WELLBUTRIN XL (G) 300MG</b>
CELEBREX 100MG	<b>IMURAN (G) 50MG</b>	QTERN 10-5MG	XARELTO 2.5MG
CELEBREX 200MG	INCRUSE ELLIPTA 62.5MCG	QVAR REDHALER 40MCG	XARELTO 10MG
CLIMARA PATCH 25MCG	INVOKAMET 50MG-500MG	QVAR REDHALER 80MCG	XARELTO 15MG
CLIMARA PATCH 50MCG	INVOKAMET 50MG-1000MG	RANEXA 500MG	XARELTO 20MG
CLIMARA PATCH 75MCG	INVOKAMET 150MG-500MG	RAPAMUNE 0.5MG	XELJANZ 5MG
CLIMARA PATCH 100MCG	INVOKAMET 150MG-1000MG	RAPAMUNE 2MG	XELJANZ 10MG
COMBIGAN 0.2-0.5%	INVOKANA 100MG	RELPAZ 20MG	XELJANZ XR 11MG
COMBIVENT RESPIMAT	INVOKANA 300MG	RELPAZ 40MG	XIIDRA 5%
20MCG/100MCG	IRESSA 250MG	RENAGEL 800MG	YASMIN 28
COMTAN 200MG	JALYN 0.5MG/0.4MG	RENVELA 800MG	YAZ 3/0.02 MG
<b>CRESTOR (G) 5MG</b>	JANUMET 50/500MG	RESTASIS VIALS 0.05%	<b>ZETIA (G) 10MG</b>
<b>CRESTOR (G) 10MG</b>	JANUMET 50/1000MG	<b>RETIN A GEL (G) 0.025%</b>	<b>ZOMIG (G) 2.5MG</b>
<b>CRESTOR (G) 20MG</b>	JANUMET XR 50MG/500MG	RETIN A MICRO GEL PUMP 0.04%	ZOMIG NASAL SPRAY 5MG
<b>CRESTOR (G) 40MG</b>	JANUMET XR 50MG/1000MG	RETIN-A MICRO GEL PUMP 0.1%	ZOMIG ZMT 2.5MG
CRINONE GEL 8%	JANUMET XR 100MG/1000MG	REXULTI 1MG	ZOVIRAX CREAM 5%
<b>CYMBALTA (G) 20MG</b>	JANUVIA 25MG	REXULTI 3MG	ZYCLARA PACKET 3.75%
<b>CYMBALTA (G) 30MG</b>	JANUVIA 50MG	RYBELSUS 3MG	
<b>CYMBALTA (G) 60MG</b>	JANUVIA 100MG	RYBELSUS 7MG	
<b>DEPAKOTE (G) 250MG</b>	JARDIANCE 10MG	RYBELSUS 14MG	
<b>DEPAKOTE (G) 500MG</b>	JARDIANCE 25MG	SENSIPAR 30MG	
DETROL LA 2MG	KAZANO 12.5/1000MG	SENSIPAR 60MG	
DETROL LA 4MG	<b>KEPPRA (G) 250MG</b>	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: **SVRHTCANARX** 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

<b>PATIENT INFORMATION</b> (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 <i>Ex. JANUVIA</i>	DOSAGE <i>Ex. 50MG</i>	TIME(S) TO TAKE <i>Ex. TWICE DAILY</i>	DATE STARTED <i>Ex. 08/20/2019</i>	REASON FOR TAKING <i>Ex. DIABETES</i>

**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/](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.