HCGITMEDS

CanaRx Simple. Safe.

Introduction:

HCGITMeds is a voluntary prescription drug program that is available to eligible Employees, Retirees and their Dependents of Hampshire County Group Insurance Trust, MA. 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.

HCGITMeds	**Vs.**	**Current local purchase plan**				
Annual Cost ***No Copays!***		**Monthly Copays**		**Refills**		**Annual Savings**
$0	**vs.**	**$25** *(Tier 2)*	**x**	**12**	=	**$300 / Script**
	vs.	**$45** *(Tier 3)*	**x**	**12**	=	**$540 / 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 **HCGITMeds.**

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: **HCGITMeds**
P.O. Box 44650
Detroit, MI 48244-0650

More forms are available:

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

WELCOME TO HCGITMEDS

ABILIFY 2MG
ABILIFY 5MG
ABILIFY 10MG
ABILIFY 15MG
ABILIFY 20MG
ABILIFY 30MG
ABILIFY DISCMELT 10MG
ABILIFY DISCMELT 15MG
ABILIFY SOLUTION 1MG/ML
ACIPHEX 20MG
ACTONEL 5MG
ACTONEL 30MG
ACTONEL 35MG
ACTONEL 150MG
ACULAR LS SOLUTION (G) 0.4%
ACULAR OPHTH DROPS (G) 0.5%
ADCIRCA 20MG
ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/21MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
AGGRENOX 200/25MG
ALDARA CREAM (G) 5%-250MG
ALKERAN 2MG
ALPHAGAN-P OPHTH SOLUTION (G) 0.15%
ALREX 0.2%
ALVESCO 80MCG 100MCG
ALVESCO 160MCG 200MCG
ARAVA (G) 10MG
ARAVA (G) 20MG
ARTHROTEC 50MG
ARTHROTEC 75MG
ASACOL HD 800MG
ASMANEX TWISTHALER 220MCG
ASTELIN (G) 137MCG
ATACAND 4MG
ATACAND 8MG
ATACAND 16MG
ATACAND 32MG
ATRIPLA 600-200-300MG
ATROVENT HFA 20UG
AVANDIA 8MG
AVODART 0.5MG
AXERT 6.25MG
AXERT 12.5MG
AZILECT 1MG
AZOPT OPHTH DROPS 1%
AZOR 20/5MG
AZOR 40/5MG
AZOR 40/10MG
BACTROBAN CREAM 2%
BANZEL 200MG
BANZEL 400MG
BARACLUDE 0.5MG
BECONASE AQ 0.04%
BENICAR 20MG
BENICAR 40MG
BENICAR HCT 20MG/12.5MG
BENICAR HCT 40MG/12.5MG
BENICAR HCT 40MG/25MG
BENZACLIN PUMP
BETIMOL 0.5%
BETOPTIC S OPHTH 0.25%
BONIVA (G) 150MG
CARDURA XL 4MG
CEENU 40MG
CELEBREX 100MG
CELEBREX 200MG
CLIMARA PRO 0.045/0.015
COMPLERA 200/25/300MG
COSOPT OPHTH DROPS (G) 2%/0.5%
COVERA-HS 240MG
CRESTOR 5MG
CRESTOR 10MG
CRESTOR 20MG
CRESTOR 40MG
CUPRIMINE 250MG
CUTIVATE CREAM 0.05%
CUTIVATE OINTMENT 0.005%
CYMBALTA 20MG
CYMBALTA 30MG
CYMBALTA 60MG
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 0.3%
DIFFERIN GEL (G) 0.1%
DIOVAN 40MG
DIOVAN 80MG
DIOVAN 160MG
DIOVAN 320MG
DIOVAN HCT (G) 80/12.5MG
DIOVAN HCT (G) 160/12.5MG
DIOVAN HCT (G) 160/25MG
DIOVAN HCT (G) 320/12.5MG
DIOVAN HCT (G) 320/25MG
DOVONEX CREAM 50MCG
DOVONEX SOLUTION (G) 50MCG/ML
DULERA 100MCG/5MCG
DULERA 200MCG/5MCG
EDARBI 40MG
EDECRIN 25MG
EFFIENT 5MG
EFFIENT 10MG
ELIDEL 1%
ELIQUIS 5MG
ELMIRON 100MG
EMTRIVA 200MG
ENABLEX 7.5MG
ENABLEX 15MG
ENTOCORT (G) 3MG
EPIPEN 0.3MG
EPIPEN JR 0.15MG
EPIVIR 150MG
EPIVIR/HBV 100MG
EPZICOM
ESTROGEL GEL 0.06%
EVISTA 60MG
EXELON 3MG
EXELON 6MG
EXELON 4.6 MG/24HR
EXELON 9.5MG/24HR
EXFORGE 5/160MG
EXFORGE 10/160MG
EXFORGE 320/5MG
EXFORGE 320/10MG
EXFORGE HCT 160/12.5/5
EXFORGE HCT 160/12.5/10
EXFORGE HCT 160/25/5
EXFORGE HCT 160/25/10
EXFORGE HCT 320/25/10
EXJADE 125MG
EXJADE 250MG
EXJADE 500MG
FARESTON 60MG
FELDENE 10MG
FELDENE 20MG
FINACEA 15%
FLOMAX (G) 0.4MG
FLONASE (G) 50MCG
FLOVENT 44MCG 50MCG
FLOVENT 110MCG 125MCG
FLOVENT 220MCG 250MCG
FLOVENT DISKUS 50MCG
FLOVENT DISKUS 100MCG
FLOVENT DISKUS 250MCG
FORADIL + AEROLIZER 12MCG
FOSAMAX-D 70/2800MG
FOSRENOL CHEW 250MG
FOSRENOL CHEW 500MG
FOSRENOL CHEW 1000MG
FROVA 2.5MG
GELNIQUE 10%
GILENYA 0.5MG
GLEEVEC 100MG
GLEEVEC 400MG
GLUCAGEN HYPOKIT 1MG
HEPSERA 10MG
INCIVEK 375MG
INLYTA 1MG
INVEGA 3MG
INVEGA 6MG
INVEGA 9MG
INVIRASE 500MG
JALYN 0.5MG/0.4MG
JANUMET 50/500
JANUMET 50/1000
JANUVIA 25MG
JANUVIA 50MG
JANUVIA 100MG
JENTADUETO 2.5MG/850MG
JENTADUETO 2.5MG/1000MG
LAMICTAL DISPERSIBLE 25MG
LATUDA 40MG
LATUDA 80MG
LATUDA 120MG
LESCOL 20MG
LESCOL 40MG
LESCOL XL 80MG
LEUKERAN 2MG
LEXIVA 700MG
LIPITOR (G) 10MG
LIPITOR (G) 20MG
LIPITOR (G) 40MG
LIPITOR (G) 80MG
LOCOID LIPOCREAM 0.1%
LOCOID OINTMENT 0.1%
LOTEMAX 0.5%
LOTRISONE CREAM (G)
LUMIGAN OPHTH 0.01%
MAXALT (G) 5MG
MAXALT (G) 10MG
MAXALT MELT (G) 10MG
MESTINON TS 180MG
METRO CREAM (G) 0.75%
MICARDIS 20MG
MICARDIS 40MG
MICARDIS 80MG
MICARDIS HCT 40/12.5MG
MICARDIS HCT 80/12.5MG
MICARDIS HCT 80/25MG
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
NAMENDA 5MG
NASACORT AQ (G) 55MCG
NASONEX 50MCG
NEXIUM 20MG
NEXIUM 40MG
NEXIUM DR 10MG
NIASPAN 500MG
NIASPAN 750MG
NIASPAN 1000MG
NILANDRON 150MG
NORITATE CREAM 1%
NORVIR 100MG
OMNARIS NASAL SPRAY 50MCG
ONGLYZA 2.5MG
ONGLYZA 5MG
ORTHO-EVRA
ORTHO-TRI-CYCLEN LO
PENTASA 500MG
PLAVIX (G) 75MG
PRADAXA 75MG
PRADAXA 150MG
PRANDIN 0.5MG
PRANDIN 1MG
PRANDIN 2MG
PREMARIN 0.3MG
PREMARIN 0.625MG
PREMARIN 1.25MG
PREMPRO 0.3/1.5MG
PREMPRO 0.625MG/2.5MG
PREMPRO 0.625MG/5MG
PREVACID SOLUTAB 15MG
PREVACID SOLUTAB 30MG
PREZISTA 800MG
PRISTIQ 50MG
PRISTIQ 100MG
PROSCAR (G) 5MG
PROTOPIC OINTMENT 0.03%
PROTOPIC OINTMENT 0.1%
QVAR 40MCG 50MCG
QVAR 80MCG 100MCG
RANEXA 500MG
RAPAMUNE 1MG
RELPAX 20MG
RELPAX 40MG
RENAGEL 800MG
RENVELA 800MG
RETIN A CREAM (G) 0.05%
RETIN A MICRO GEL 0.04%
RETIN A MICRO GEL (G) 0.1%
RETIN-A MICRO GEL 0.1% PUMP
REVATIO 20MG
RHEUMATREX 2.5MG
RHINOCORT AQ 32MCG
RHINOCORT AQ 64MCG
RIDAURA 3MG
RILUTEK 50MG
SANCTURA (G) 20MG
SANCTURA XR 60MG
SAPHRIS 5MG
SAPHRIS 10MG
SEREVENT DISKUS 50MCG
SEROQUEL XR 50MG
SEROQUEL XR 150MG
SEROQUEL XR 200MG
SEROQUEL XR 300MG
SEROQUEL XR 400MG
SOLARAZE GEL 3%
SORIATANE 10MG
SORIATANE 25MG
SPIRIVA 18MCG
STRATTERA 40MG
STRATTERA 60MG
STRATTERA 80MG
STRATTERA 100MG
SURMONTIL 25MG
TARCEVA 100MG
TARKA 2/180MG
TARKA 2/240MG
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%
TEKTURNA HCT 300/25MG
TEKTURNA HCT 300-12.5
TEMOVATE OINTMENT (G) 0.05%
TEVETEN HCT 600/12.5MG
TOBREX 0.3%
TOBREX OINTMENT 0.3%
TOPICORT CREAM (G) 0.25%
TOVIAZ 4MG
TOVIAZ 8MG
TRACLEER 62.5MG
TRACLEER 125MG
TRADJENTA 5MG
TRAVATAN Z OPHTH SOLUTION 0.004%
TRIBENZOR 20/5/12.5MG
TRIBENZOR 40/5/12.5MG
TRIBENZOR 40/5/25MG
TRIBENZOR 40/10/12.5MG
TRIBENZOR 40/10/25MG
TRUVADA 200-300MG
TWYNSTA 40/5MG
TWYNSTA 40/10MG
TWYNSTA 80/5MG
TWYNSTA 80/10MG
ULORIC 80MG
VAGIFEM 10MCG
VALCYTE 450 MG
VERAMYST 27.5MCG
VESICARE 5MG
VESICARE 10MG
VIRAMUNE 200MG
VIRAMUNE XR 400MG
VIVELLE-DOT 25MCG
VIVELLE-DOT 37.5MCG
VIVELLE-DOT 50MCG
VIVELLE-DOT 75MCG
VIVELLE-DOT 100MCG
VOSPIRE ER 4MG
VYTORIN 10/10MG
VYTORIN 10/20MG
VYTORIN 10/40MG
VYTORIN 10/80MG
WELLBUTRIN XL (G) 150MG
WELLBUTRIN XL (G) 300MG
XARELTO 10MG
XARELTO 15MG
XARELTO 20MG
XELODA 150MG
XELODA 500MG
YAZ (G) 3-0.02MG
ZEMPLAR 1MCG
ZERIT 40MG
ZETIA 10MG
ZIAGEN 300MG
ZOMIG 2.5MG
ZOMIG NASAL SPRAY 5MG
ZOMIG ZMT 2.5MG (1X6)
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. *January 2014*

HCGITMEDS

CanaRx
Employee Enrollment Form

MEMBER ID #:

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

PATIENT INFORMATION: **Birthdate** _____
DD/MM/YYYY

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. *Ex. Crestor* *(This is NOT a prescription.)*	**Strength** *Ex. 10 mg*	**Reason for Taking** *Ex. Cholesterol*	**Daily Use** *Ex. Once Daily*

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
I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have 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 and that the information provided by me is accurate and true.
I request and authorize Hampshire County Group Insurance Trust, MA as my appointed agent, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service as determined appropriate by Hampshire County Group Insurance Trust, MA in the administration of my employment benefits.

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

TERMS OF AGREEMENT

CONFIRMATION AND REPRESENTATIONS

I, the undersigned, am entering into this agreement with *CanaRx Group Inc. ("CanaRx")* in order that I may obtain access to medically necessary prescription drugs at low costs.

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. The medications that I have requested that CanaRx facilitate my obtaining were prescribed by a duly qualified and licensed medical practitioner in the United States;
4. I have not violated any laws in the jurisdiction in which I ordinarily reside, in obtaining the prescription for the ordered product;
5. This prescription has not been altered in any way nor has it been filled previously. I agree to mail or fax from my doctor's office the original copy of the prescription to CanaRx;
6. I am under the ongoing care of a physician in my residing jurisdiction (my "U.S. physician"), and therefore, I am not seeking or relying on any medical information from CanaRx or any CanaRx contracted physician;
7. My prescription will not be used in any way whatsoever except as prescribed by my medical practitioner who originally issued the prescription;
8. I will not permit anyone else to use the prescription or any medications which I receive;
9. I will use any medications obtained for me by CanaRx strictly in accordance with the instructions provided by the physician who prescribed the medications; and
10. In the event that I suffer any side effects from any medications I receive through the services of CanaRx, I will immediately contact my U.S. physician.
11. I certify that I am a resident of the United States and not a resident of any other country.

AUTHORIZATION AND CONSENT

I further provide my authorization and consent to the following:

1. I hereby appoint CanaRx and its delegates or contractors as my paid agent and attorney for the purposes of obtaining prescriptions which correspond to the prescriptions provided by my U.S. physician.
2. I authorize CanaRx and its delegates or contractors to arrange the purchase and delivery of the medications prescribed to me on the terms outlined in this agreement and to the same extent as if I personally took such steps.
3. I consent and authorize CanaRx to collect my personal medical information and to maintain on file the information necessary to verify and process future orders, including but not limited to my full name, address, phone number, complete medical history and payment information.
4. I authorize my U.S. physician and CanaRx to release any and all information required in connection with my physical condition, including but not limited to all X-rays, medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions and/or any other knowledge or information which they may possess to a CanaRx contracted physician who may be required to review my health record for the purposes of being in a position to evaluate the medical necessity and indications for prescription medication.
5. I authorize the CanaRx contracted physician to contact my U.S. physician to discuss my prescription if necessary.
6. I further authorize the CanaRx contracted physician to issue prescriptions for medications I have ordered only if he/she deems it advisable and appropriate.
7. I further authorize the CanaRx contracted physician to release any and all information that may be required by any CanaRx contracted pharmacy for the purpose of having my prescriptions filled.
8. I further authorize CanaRx to make payments on my behalf to the CanaRx contracted pharmacy for the filling of my prescriptions and to the CanaRx contracted physician for services rendered on my behalf.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments and releases to *CanaRx*, including all of its employees, its contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. I acknowledge that my U.S. physician is my primary physician and the CanaRx contacted physician is being asked only to review the information contained in the Personal Medical History for the purpose of authorizing any properly prescribed medications for fulfillment from a CanaRx contracted pharmacy.
2. I acknowledge that 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 acknowledge that I wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx to facilitate this matter. I understand and appreciate that the CanaRx contracted physician will rely on the accuracy of the examination and prescription provided by my U.S. physician.
4. I hereby specifically acknowledge that I am aware that CanaRx may transmit my personal information by electronic means (for example fax, or secure 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 agents, contracted physicians and pharmacies.
5. I release CanaRx and all of their officers and directors, agents, employees and contractors from any and all 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 understand that my medications may be subject to U.S. border seizure. I specifically confirm, acknowledge and agree that title to my medication passes to me when my medications are shipped from the CanaRx 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**.**

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 herby release CanaRx Group and all its officer, directors, agents, 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 in filling my prescription .
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 Group Inc. in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use of any medications delivered through this program which are utilized for any purpose whatsoever.

HCGITMEDS

CanaRx
Spouse/Dependent Enrollment Form

MEMBER ID #:

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

PATIENT INFORMATION: **Birthdate** _____ ☐ **SPOUSE** ☐ **DEPENDENT**
DD/MM/YYYY

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. *Ex. Crestor* *(This is NOT a prescription.)*	**Strength** *Ex. 10 mg*	**Reason for Taking** *Ex. Cholesterol*	**Daily Use** *Ex. Once Daily*

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 and that the information provided above is accurate and true. I request and authorize Hampshire County Group Insurance Trust, MA as my authorized agent, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Parent's/Guardian's Signature **Date:** *(DD/MM/YY)*

AUTHORIZATION **IF THE PATIENT IS THE SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER**

I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medication 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 and that the information provided by me is accurate and true. I request and authorize Hampshire County Group Insurance Trust, MA as my authorized agent, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

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

TERMS OF AGREEMENT

CONFIRMATION AND REPRESENTATIONS

I, the undersigned, am entering into this agreement with *CanaRx Group Inc. ("CanaRx")* in order that I may obtain access to medically necessary prescription drugs at low costs.

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. The medications that I have requested that CanaRx facilitate my obtaining were prescribed by a duly qualified and licensed medical practitioner in the United States;
4. I have not violated any laws in the jurisdiction in which I ordinarily reside, in obtaining the prescription for the ordered product;
5. This prescription has not been altered in any way nor has it been filled previously. I agree to mail or fax from my doctor's office the original copy of the prescription to CanaRx;
6. I am under the ongoing care of a physician in my residing jurisdiction (my "U.S. physician"), and therefore, I am not seeking or relying on any medical information from CanaRx or any CanaRx contracted physician;
7. My prescription will not be used in any way whatsoever except as prescribed by my medical practitioner who originally issued the prescription;
8. I will not permit anyone else to use the prescription or any medications which I receive;
9. I will use any medications obtained for me by CanaRx strictly in accordance with the instructions provided by the physician who prescribed the medications; and
10. In the event that I suffer any side effects from any medications I receive through the services of CanaRx, I will immediately contact my U.S. physician.
11. I certify that I am a resident of the United States and not a resident of any other country.

AUTHORIZATION AND CONSENT

I further provide my authorization and consent to the following:

1. I hereby appoint CanaRx and its delegates or contractors as my paid agent and attorney for the purposes of obtaining prescriptions which correspond to the prescriptions provided by my U.S. physician.
2. I authorize CanaRx and its delegates or contractors to arrange the purchase and delivery of the medications prescribed to me on the terms outlined in this agreement and to the same extent as if I personally took such steps.
3. I consent and authorize CanaRx to collect my personal medical information and to maintain on file the information necessary to verify and process future orders, including but not limited to my full name, address, phone number, complete medical history and payment information.
4. I authorize my U.S. physician and CanaRx to release any and all information required in connection with my physical condition, including but not limited to all X-rays, medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions and/or any other knowledge or information which they may possess to a CanaRx contracted physician who may be required to review my health record for the purposes of being in a position to evaluate the medical necessity and indications for prescription medication.
5. I authorize the CanaRx contracted physician to contact my U.S. physician to discuss my prescription if necessary.
6. I further authorize the CanaRx contracted physician to issue prescriptions for medications I have ordered only if he/she deems it advisable and appropriate.
7. I further authorize the CanaRx contracted physician to release any and all information that may be required by any CanaRx contracted pharmacy for the purpose of having my prescriptions filled.
8. I further authorize CanaRx to make payments on my behalf to the CanaRx contracted pharmacy for the filling of my prescriptions and to the CanaRx contracted physician for services rendered on my behalf.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments and releases to *CanaRx*, including all of its employees, its contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. I acknowledge that my U.S. physician is my primary physician and the CanaRx contacted physician is being asked only to review the information contained in the Personal Medical History for the purpose of authorizing any properly prescribed medications for fulfillment from a CanaRx contracted pharmacy.
2. I acknowledge that 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 acknowledge that I wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx to facilitate this matter. I understand and appreciate that the CanaRx contracted physician will rely on the accuracy of the examination and prescription provided by my U.S. physician.
4. I hereby specifically acknowledge that I am aware that CanaRx may transmit my personal information by electronic means (for example fax, or secure 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 agents, contracted physicians and pharmacies.
5. I release CanaRx and all of their officers and directors, agents, employees and contractors from any and all 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 understand that my medications may be subject to U.S. border seizure. I specifically confirm, acknowledge and agree that title to my medication passes to me when my medications are shipped from the CanaRx 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**.**

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 herby release CanaRx Group and all its officer, directors, agents, 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 in filling my prescription .
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 Group Inc. in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use of any medications delivered through this program which are utilized for any purpose whatsoever.