INTRODUCTION:	CanaRxMeds is an optional mail order program for employees, retirees, and their covered dependents who are insured through the following West Suburban Health Group plans: Network Blue New England, Medex with OBRA 90, Tufts Health Plan EPO or POS, or Harvard Pilgrim EPO (HMO), PPO, or Medicare Enhanced. When ordering your new medications, please allow 20 business days for delivery.
CO-PAYMENTS:	All member co-payments have been waived for this program only.
ORDERING INSTRUCTIONS:	To place your first order, we require a completed Medication Record Form, as well as a prescription for each medication. Please ask your doctor to specify a **3-month supply** with **3 refills** on each prescription. This will allow our Pharmacies to ***automatically ship*** your medications after confirming your continued need.
	COMPLETED MEDICATION RECORD FORMS MAY BE SUBMITTED BY: A. FAXING TOLL FREE TO: 1-866-715-6337 B. MAILING TO: CanaRx Services P.O. Box 44650 Detroit, MI 48244-0650 **NOTE**: Ideally, the Medication Record and the prescriptions should arrive together. If you need to order new medications later in the year, you will not need to send another Medication Record; you can simply have your doctor fax the prescription directly, with your health plan number (from your card) written on the prescription.
	PRESCRIPTIONS MAY BE SUBMITTED BY: A. FAXING TOLL FREE TO: 1-866-715-6337 **DIRECTLY FROM YOUR DOCTOR'S OFFICE ONLY** B. MAILING TO: CanaRx Services P.O. Box 44650 Detroit, MI 48244-0650
SERVICE INFORMATION:	Additional forms may be obtained from your employer, online at www.myMedicationAdvisor.com, or by calling the ***myMedicationAdvisor***® HelpLine at (800) 643-8028.

Thank you for participating in this program. Our goal is your total satisfaction.
Please do not hesitate to bring any questions or concerns to our attention.
Call CanaRxMeds at 1-866-893-6337.

CONFIRMATION & REPRESENTATIONS

I, the undersigned, am entering into this agreement with *CanaRx Services Inc.* 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 medication(s) that I have requested that CanaRx Services Inc. 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. The prescription has not been altered in any way nor has it been filled previously. I agree to mail the original copy of the prescription to CanaRx Services Inc.;
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 Services Inc. or any Canadian 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 medication(s) which I receive;
9. I will use any medication(s) obtained for me by CanaRx Services Inc. strictly in accordance with the instructions provided by the Physician who prescribed the medication(s); and
10. In the event that I suffer any side effects from any medication(s) I receive through the services of CanaRx Services Inc., I will immediately contact my U.S. Physician.

AUTHORIZATION & CONSENT

I further provide my authorization and consent to the following:

1. I hereby appoint CanaRx Services Inc. and its delegates or contractors as my agent and attorney for the purposes of obtaining a prescription from Canada, which corresponds to the prescription provided by my U.S. Physician.
2. I authorize CanaRx Services Inc. and its delegates or contractors to arrange delivery of the medication(s) prescribed to me on the term outlined in this Agreement and to the same extent as if I personally took such steps.
3. I consent and authorize CanaRx Services Inc. 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 Services Inc. 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 Canadian 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 Canadian Physician to contact my U.S. Physician to discuss my prescription if necessary.
6. I further authorize the Canadian Physician to issue a prescription for medication(s) I have ordered only if he/she deems it advisable and appropriate.
7. I further authorize the Canadian Physician to release any and all information they may require to any Canadian Pharmacy for the purpose of having my prescription(s) filled.

ACKNOWLEDGEMENT & RELEASE

I hereby make the following acknowledgments and releases to *CanaRx Services Inc.*, 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 Canadian Physician is being asked only to review the information contained in the Personal Medical History for the purpose of authorizing any properly prescribed medication(s) for fulfillment from a Canadian pharmacy.
2. I acknowledge that CanaRx Services Inc. 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 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).
3. I acknowledge that I wish to obtain a prescription from a Canadian Physician and have enlisted the services of CanaRx Services Inc. to facilitate this matter. I understand and appreciate that the Canadian Physician will rely on the accuracy of the examination and prescription provided by my U.S. Physician.
4. I acknowledge that child protective packaging may not be used by the Pharmacies filling my prescription and I release CanaRx Services Inc. 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.
5. I acknowledge that CanaRx Services Inc. requires payment in full prior to shipment and that my order may not be returned for a refund or an exchange. All member co-payments have been waived for this program *only*.

MY MEDICATION ADVISOR®

Medication Record Form

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S).
OR MAIL TO: CanaRx Services, P.O. Box 44650, Detroit, MI 48244-0650

FAX: TOLL FREE 1-866-715-6337
TEL: TOLL FREE 1-866-893-6337

PERSONAL INFORMATION

Full Name *(please print)*: _____

This person *is* *(select one)*: ☐ subscriber ☐ spouse ☐ dependent **Date of Birth:** ____ ____ - ____ ____ - ____ ____

Gender: ☐ Male ☐ Female **Height:** _____' _____" **Weight:** _____ pounds

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Telephone:** _____

E-Mail: _____ **Employer:** West Suburban Health Group

PATIENT HEALTH INFORMATION

Note: Each prescription should request a **3-month** supply of medications with **3 refills** indicated. **New-to-you** medications should be tried for a period of **30-days** before ordering through CanaRx Services Inc. You may be contacted by one of our representatives or the pharmacy filling the prescription to discuss or confirm your order.

Health Plan Identification Number: _____ **Health Plan Name:** _____

Operations: (e.g., Hysterectomy, Gall Bladder, Heart Operations, etc.) _____

Hospitalizations: (stays in hospital past 5 years) _____

Current Medical Conditions: _____

OVER-THE-COUNTER MEDICATIONS/HERBAL REMEDIES
☐ **NO** ☐ **YES If yes, please specify:**

MEDICATION/FOOD ALLERGIES
☐ **NO** ☐ **YES If yes, please specify:**

PRESCRIPTION MEDICATION LIST

Please be sure that all fields below are entered completely.

Name of Medicine	Reason for Taking	Dosage	Date Started	Time(s) to Take	What to Avoid	Doctor Name
ex:Lipitor	*ex*:Cholesterol	*ex*:25mg	*ex*:1/1/2000	*ex:*Twice daily	*ex*:grapefruit	*ex*: Dr.Smith

If you have additional medications to enter, please use an additional Medication Record Form and check here ☐

AUTHORIZATION: I certify this to be a true and accurate statement of the above Patient's Medical History. I confirm that he/she has been and will continue to be regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I certify that I have read and understand the terms of agreements for both CanaRx and myMedicationAdvisor.com and that the information provided by me is accurate and true.

I request and authorize my Employer to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service. A Guardian/Parent ***must sign*** for an Underage Dependent.

Patient Name (please print): _____ Signature _____ Date _____

Subscriber/Guardian, if applicable (please print): _____ Signature _____ Date _____

THIS FORM *MUST BE* ACCOMPANIED WITH THE WRITTEN PRESCRIPTIONS OF YOUR U.S. PHYSICIAN.