

# CCMHGCanaRx

Harvard Pilgrim

## Introduction:

**CCMHGCanaRx** 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 **PPO** with the Cape Cod Municipal Health Group (CCMHG). 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.

<b>CCMHGCanaRx</b>		<b>Vs.</b>	<b>Current Purchase Plan</b>			
<b>Annual Cost No Copays!</b>			<b>Current Copays</b>		<b>Refills</b>	<b>Annual Savings</b>
<b>\$0</b>	<b>Vs.</b>		<b>\$30</b> (Tier 2)	<b>x</b>	<b>12</b>	<b>= \$360 / Script</b>
	<b>Vs.</b>		<b>\$65</b> (Tier 3)	<b>x</b>	<b>12</b>	<b>= \$780 / Script</b>
	<b>Vs.</b>		<b>\$75</b> (Tier 2)	<b>x</b>	<b>4</b>	<b>= \$300 / Script</b>
	<b>Vs.</b>		<b>\$165</b> (Tier 3)	<b>x</b>	<b>4</b>	<b>= \$660 / Script</b>

## 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 **CCMHGCanaRx**.

**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: CCMHGCanaRx**

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.CCMHGCanaRx.com](http://www.CCMHGCanaRx.com) or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

**WELCOME TO CCMHGCanaRx**

ACZONE 5%	FARXIGA 10MG	NEUPRO 8MG	<b>TEGRETOL XR (G) 400MG</b>
ADCIRCA 20MG	FETZIMA 20MG	NEXAVAR 200MG	TEKTURNA 150MG
ADVAIR DISKUS 100MCG	FETZIMA 40MG	NEXIUM DR 10MG	TEKTURNA 300MG
ADVAIR DISKUS 250MCG	FETZIMA 80MG	NORITATE CREAM 1%	TEKTURNA HCT 150-12.5MG
ADVAIR DISKUS 500MCG	FETZIMA 120MG	NORVIR TABLET 100MG	TEKTURNA HCT 150-25MG
ADVAIR HFA 45/21MCG	FINACEA GEL 15%	OLYSIO 150MG	TEKTURNA HCT 300-12.5MG
ADVAIR HFA 115/21MCG	FLOVENT 44MCG 50MCG	OMNARIS NASAL SPRAY 50MCG	TEKTURNA HCT 300-25MG
ADVAIR HFA 230/21MCG	FLOVENT 110MCG 125MCG	ONGLYZA 2.5MG	TIVICAY 50MG
AFINITOR 2.5MG	FLOVENT 220MCG 250MCG	ONGLYZA 5MG	TOVIAZ 4MG
AFINITOR 5MG	FLOVENT DISKUS 100MCG	OTEZLA 30MG	TOVIAZ 8MG
AFINITOR 10MG	FLOVENT DISKUS 250MCG	PENTASA 500MG	TRACLEER 62.5MG
ALOCRIOL OPHTH 2%	FORADIL + AEROLIZER 12MCG	PRADAXA 75MG	TRACLEER 125MG
ALOMIDE 0.1%	FOSRENOL CHEW 500MG	PRADAXA 150MG	TRADJENTA 5MG
ALREX 0.2%	FOSRENOL CHEW 750MG	PREMARIN 0.3MG	TRAVATAN Z OPHTH SOL 0.004%
ALVESCO 80MCG 100MCG	FOSRENOL CHEW 1000MG	PREMARIN 0.625MG	TRINTELLIX 5MG
ALVESCO 160MCG 200MCG	FOSRENOL POWDER 750MG	PREMARIN 1.25MG	TRINTELLIX 10MG
AMITIZA 24MCG	FOSRENOL POWDER 1000MG	PREMARIN VAG 0.625MG/GM	TRINTELLIX 20MG
ANORO ELLIPTA 62.5/25MCG	GELNIQUE 10%	PREMPRO 0.3MG/1.5MG	TRIUMEQ TABLET
ANZEMET 100MG	GENVOYA 150-150-200-10MG	PREMPRO 0.625MG/2.5MG	TRUVADA 200-300MG
ARCAPTA NEOHALER 75MCG	GILENYA 0.5MG	PREMPRO 0.625MG/5MG	TUDORZA PRESSAIR 400MCG
ARNUITY ELLIPTA 100MCG	GILOTRIF 20MG	PREZCOBIX 800MG/150MG	TYZEKA 600MG
ARNUITY ELLIPTA 200MCG	GILOTRIF 30MG	PREZISTA 800MG	ULORIC 80MG
ASMANEX TWISTHALER 110MCG	GILOTRIF 40MG	QVAR 40MCG 50MCG	VENTOLIN HFA 90MCG
ASMANEX TWISTHALER 220MCG	GLUCAGEN HYPOKIT 1MG	QVAR 80MCG 100MCG	VESICARE 5MG
ATRIPLA 600-200-300MG	INCRUSE ELLIPTA 62.5MCG	RANEXA 500MG	VESICARE 10MG
AUBAGIO 14MG	INLYTA 1MG	RAPAFLO 4MG	VIMOVO 375/20MG
AVANDAMET 4MG/500MG	INLYTA 5MG	RAPAFLO 8MG	VIMOVO 500/20MG
AVANDIA 2MG	INVIRASE 500MG	<b>RAPAMUNE (G) 0.5MG</b>	VIREAD 300MG
AVANDIA 4MG	INVOKAMET 50MG-500MG	<b>RAPAMUNE (G) 1MG</b>	WELCHOL 625MG
AVANDIA 8MG	INVOKAMET 50MG-1000MG	<b>RAPAMUNE (G) 2MG</b>	XALKORI 200MG
AZOPT OPHTH DROPS 1%	INVOKAMET 150MG-500MG	RELPAZ 20MG	XALKORI 250MG
BANZEL 200MG	INVOKAMET 150MG-1000MG	RELPAZ 40MG	XARELTO 10MG
BANZEL 400MG	INVOKANA 100MG	RENAGEL 800MG	XARELTO 15MG
BECONASE AQ 42MCG	INVOKANA 300MG	REVELA 800MG	XARELTO 20MG
BETIMOL 0.25%	ISENTRESS 400MG	RESTASIS VIALS 0.05%	XELJANZ 5MG
BETIMOL 0.5%	JADENU 90MG	REXULTI 0.25MG	XIGDUO XR 5/1000MG
BETOPTIC S OPHTH 0.25%	JADENU 180MG	REXULTI 0.5MG	XIGDUO XR 10/500MG
BREO ELLIPTA 100/25MCG	JADENU 360MG	REXULTI 2MG	XIGDUO XR 10/1000MG
BREO ELLIPTA 200/25MCG	JAKAFI 5MG	REXULTI 4MG	XTANDI 40MG
BRILINTA 60MG	JAKAFI 10MG	REYATAZ 150MG	ZELAPAR 1.25MG
BRILINTA 90MG	JAKAFI 15MG	REYATAZ 200MG	ZORTRESS 0.25MG
BYSTOLIC 2.5MG	JAKAFI 20MG	REYATAZ 300MG	ZORTRESS 0.5MG
BYSTOLIC 5MG	JANUMET 50/500MG	SAPHRIS 5MG	ZORTRESS 0.75MG
BYSTOLIC 10MG	JANUMET 50/1000MG	SAPHRIS 10MG	ZYCLARA 3.75%
BYSTOLIC 20MG	JANUMET XR 50MG/500MG	SENSIPAR 30MG	ZYTIGA 250MG
CAMBIA 50MG	JANUMET XR 50MG/1000MG	SENSIPAR 60MG	
COMBIGAN 0.2-0.5%	JANUMET XR 100MG/1000MG	SENSIPAR 90MG	
COMBIVENT RESPIMAT 20MCG/100MCG	JANUVIA 25MG	SEREVENT DISKUS 50MCG	
COMPLERA 200/25/300MG	JANUVIA 50MG	SIMBRINZA 1%/0.2%	
DALIRESP 500MCG	JANUVIA 100MG	<b>SOLARAZE (G) 3%</b>	
DEXILANT DR 30MG	JARDIANCE 10MG	SOOLANTRA 1%	
DEXILANT DR 60MG	JARDIANCE 25MG	SPIRIVA 18MCG	
DIPENTUM 250MG	JENTADUETO 2.5MG-500MG	SPIRIVA RESPIMAT 2.5MCG	
DIVIGEL 1MG	JENTADUETO 2.5MG-850MG	SPRYCEL 20MG	
DUAVEE 0.45-20MG	JENTADUETO 2.5MG-1000MG	SPRYCEL 50MG	
DULERA 100MCG/5MCG	JUBLIA 10%	SPRYCEL 70MG	
DULERA 200MCG/5MCG	KOMBIGLYZE XR 2.5MG/1000MG	SPRYCEL 100MG	
DYMISTA NASAL SPRAY 137/50MCG	KOMBIGLYZE XR 5MG/500MG	STIOLTO RESPIMAT 2.5/2.5MCG	
EDARBI 40MG	KOMBIGLYZE XR 5MG/1000MG	STIVARGA 40MG	
EDARBI 80MG	LATUDA 20MG	STRIBILD	
EDARBYCLOR 40MG/25MG	LATUDA 40MG	SUSTIVA 50MG	
EDURANT 25MG	LATUDA 60MG	SUSTIVA 200MG	
EFFIENT 5MG	LATUDA 80MG	SUSTIVA 600MG	
EFFIENT 10MG	LATUDA 120MG	SUTENT 12.5MG	
ELIDEL 1%	LEXIVA 700MG	SUTENT 25MG	
ELIQUIS 2.5MG	LIALDA 1.2GM	SUTENT 50MG	
ELIQUIS 5MG	LINZESS 145MCG	SYNAREL NASAL	
ELMIRON 100MG	LINZESS 290MCG	SYNJARDY 5MG/500MG	
EMADINE 0.05%	LOTEMAX GEL 0.5%	SYNJARDY 5MG/1000MG	
ENTRESTO 24MG-26MG	LOTEMAX SUSP 0.5%	SYNJARDY 12.5MG/500MG	
ENTRESTO 49MG-51MG	LUMIGAN OPHTH 0.01%	SYNJARDY 12.5MG/1000MG	
ENTRESTO 97MG-103MG	MESNEX 400MG	TABLOID 40MG	
EPIDUO GEL PUMP 0.1%/2.5%	MIRVASO 0.33%	TASIGNA 150MG	
ESTROGEL 0.06%	MULTAQ 400MG	TASIGNA 200MG	
EXJADE 125MG	MYRBETRIQ 25MG	TASMAR 100MG	
EXJADE 250MG	MYRBETRIQ 50MG	TAZORAC GEL 0.05%	
EXJADE 500MG	NEUPRO 1MG	TAZORAC GEL 0.1%	
FARESTON 60MG	NEUPRO 2MG	TECFIDERA 120MG	
FARXIGA 5MG	NEUPRO 3MG	TECFIDERA 240MG	
	NEUPRO 4MG	<b>TEGRETOL (G) 200MG</b>	
	NEUPRO 6MG	<b>TEGRETOL XR (G) 200MG</b>	

**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.

HP MEMBER ID #:

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337  
OR

MAIL TO: CCMHGCanaRx, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

PATIENT INFORMATION: Birthdate \_\_\_\_\_  SUBSCRIBER  
MM/DD/YYYY  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
<i>Ex. Januvia</i>	<i>Ex. 50mg</i>	<i>Ex. Twice Daily</i>	<i>Ex. 8/20/2017</i>	<i>Ex. Diabetes</i>

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)

## 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.