CCMHGCanarx

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 HSA qualified High Deductible Health Plans (HSAQs) with the Cape Cod Municipal Health Group (CCMHG). Only preventive medications are available to you through this program. 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**.

CCMHGCanarx		**Vs.**	**Current Purchase Plan**				
Annual Cost ***No Copays!***			**Current Copays**	**Refills**			**Annual Savings**
$0	**Vs.**	**Retail**	**$30** *(Tier 2)*	**x**	**12**	**=**	**$360 / Script**
			$65 *(Tier 3)*	**x**	**12**	**=**	**$780 / Script**
	Vs.	**Mail**	**$75** *(Tier 2)*	**x**	**4**	**=**	**$300 / Script**
			$165 *(Tier 3)*	**x**	**4**	**=**	**$660 / Script**

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. 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 ***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***

235 Eugenie St. West
Suite 105D
Windsor, ON, Canada
N8X 2X7

OR

P.O. Box 3009
Windsor, ON, Canada
N8N 2M3

Receive a one-time **$25 Gift Card** for enrolling in the **CCMHGCanarx** program with a qualifying prescription for a 90 day supply with 3 refills!
**Offer available to new program members only.*

More forms are available:

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

WELCOME TO CCMHGCanarx

ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/21MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
ALOMIDE 0.1%
ALPHAGAN-P 0.15%
ALREX 0.2%
ALVESCO 80MCG 100MCG
ALVESCO 160MCG 200MCG
ANAPROX DS 550MG
ANORO ELLIPTA 62.5/25MCG
APTIOM 200MG
APTIOM 400MG
APTIOM 600MG
APTIOM 800MG
ARNUITY ELLIPTA 100MCG
ARNUITY ELLIPTA 200MCG
ASTAGRAF XL 5MG
ATROVENT HFA 20UG
AUBAGIO 14MG
AVODART (G) 0.5MG
AZOPT 1%
BEPREVE 1.5%
BETIMOL 0.25%
BETIMOL 0.5%
BETOPTIC S 0.25%
BEYAZ
BIKTARVY 50MG-200MG-25MG
BINOSTO 70MG
BREO ELLIPTA 100/25MCG
BREO ELLIPTA 200/25MCG
BRILINTA 60MG
BRILINTA 90MG
BYSTOLIC 2.5MG
BYSTOLIC 5MG
BYSTOLIC 10MG
BYSTOLIC 20MG
COMBIGAN 0.2-0.5%
COMBIVENT RESPIMAT 20MCG/100MCG
COMTAN 200MG
CRESTOR (G) 5MG
CRESTOR (G) 10MG
CRESTOR (G) 20MG
CRESTOR (G) 40MG
DALIRESP 500MCG
DEPAKOTE (G) 250MG
DEPAKOTE (G) 500MG
DEXILANT DR 30MG
DEXILANT DR 60MG
DIOVAN (G) 40MG
DIOVAN (G) 80MG
DIOVAN (G) 160MG
DIOVAN (G) 320MG
DULERA 100MCG/5MCG
DULERA 200MCG/5MCG
EDARBI 40MG
EDARBI 80MG
EDARBYCLOR 40MG/12.5MG
EDARBYCLOR 40MG/25MG
EDECRIN 25MG
EDURANT 25MG
ELIQUIS 2.5MG
ELIQUIS 5MG
ENTRESTO 24MG-26MG
ENTRESTO 49MG-51MG
ENTRESTO 97MG-103MG
EUCRISA 2%
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
FARESTON 60MG
FARXIGA 5MG
FARXIGA 10MG
FETZIMA 20MG
FETZIMA 40MG
FETZIMA 80MG
FETZIMA 120MG
FLOVENT 44MCG 50MCG
FLOVENT 110MCG 125MCG
FLOVENT 220MCG 250MCG
FLOVENT DISKUS 100MCG
FLOVENT DISKUS 250MCG
FOSRENOL CHEW 500MG
FOSRENOL CHEW 750MG
FOSRENOL CHEW 1000MG
FOSRENOL POWDER 750MG
FOSRENOL POWDER 1000MG
GENVOYA 150-150-200-10MG
GILENYA 0.5MG
GLYXAMBI 10MG/5MG
GLYXAMBI 25MG/5MG
ILEVRO 0.3%
INCRUSE ELLIPTA 62.5MCG
INVOKAMET 50MG-500MG
INVOKAMET 50MG-1000MG
INVOKAMET 150MG-500MG
INVOKAMET 150MG-1000MG
INVOKANA 100MG
INVOKANA 300MG
JAKAFI 5MG
JAKAFI 10MG
JAKAFI 15MG
JAKAFI 20MG
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
JULUCA 50MG-25MG
KAZANO 12.5/500MG
KAZANO 12.5/1000MG
KEPPRA (G) 250MG
KEPPRA (G) 500MG
KEPPRA (G) 750MG
KEPPRA (G) 1000MG
KOMBIGLYZE XR 2.5MG/1000MG
KOMBIGLYZE XR 5MG/500MG
KOMBIGLYZE XR 5MG/1000MG
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LEXIVA 700MG
LUMIGAN 0.01%
MESTINON TS 180MG
MIRVASO 0.33%
MOTEGRITY 1MG
MOTEGRITY 2MG
MULTAQ 400MG
NATAZIA 3/2-2/2-3/1MG
NESINA 6.25MG
NESINA 12.5MG
NESINA 25MG
NEUPRO 1MG
NEUPRO 2MG
NEUPRO 3MG
NEUPRO 4MG
NEUPRO 6MG
NEUPRO 8MG
NEXIUM (G) 20MG
NEXIUM (G) 40MG
NEXLETOL 180MG
NEXLIZET 180MG-10MG
ONGLYZA 2.5MG
ONGLYZA 5MG
OSPHENA 60MG
OTEZLA 30MG
PRADAXA 75MG
PRADAXA 150MG
PRESTALIA 3.5MG/2.5MG
PRESTALIA 7MG/5MG
PRESTALIA 14MG/10MG
PRISTIQ 50MG
PRISTIQ 100MG
QTERN 10-5MG
QVAR REDIHALER 40MCG
QVAR REDIHALER 80MCG
RANEXA 500MG
RAPAMUNE 0.5MG
RAPAMUNE 1MG
RAPAMUNE 2MG
RENAGEL 800MG
RENVELA 800MG
RESTASIS MULTIDOSE 0.05%
RESTASIS VIALS 0.05%
REXULTI 0.25MG
REXULTI 0.5MG
REXULTI 1MG
REXULTI 2MG
REXULTI 3MG
REXULTI 4MG
RYBELSUS 3MG
RYBELSUS 7MG
RYBELSUS 14MG
SAPHRIS 5MG
SAPHRIS 10MG
SEGLUROMET 2.5MG-500MG
SEGLUROMET 2.5MG-1000MG
SEGLUROMET 7.5MG-500MG
SEGLUROMET 7.5MG-1000MG
SENSIPAR 30MG
SENSIPAR 60MG
SEREVENT DISKUS 50MCG
SIMBRINZA 1%/0.2%
SOOLANTRA 1%
SPIRIVA 18MCG
SPIRIVA RESPIMAT 2.5MCG
STEGLATRO 5MG
STEGLATRO 15MG
STEGLUJAN 5MG-100MG
STEGLUJAN 15MG-100MG
STIOLTO RESPIMAT 2.5/2.5MCG
STRATTERA 10MG
STRATTERA 18MG
STRATTERA 25MG
STRATTERA 40MG
STRATTERA 60MG
STRATTERA 80MG
STRATTERA 100MG
SYNJARDY 5MG/500MG
SYNJARDY 5MG/1000MG
SYNJARDY 12.5MG/500MG
SYNJARDY 12.5MG/1000MG
TARKA 2/180MG
TARKA 4/240MG
TASMAR 100MG
TECFIDERA 120MG
TECFIDERA 240MG
TIVICAY 50MG
TOBREX OINT 0.3%
TRADJENTA 5MG
TRAVATAN Z 0.004%
TRELEGY ELLIPTA 100-62.5-25MCG
TRILEPTAL (G) 150MG
TRILEPTAL (G) 300MG
TRILEPTAL (G) 600MG
TRINTELLIX 5MG
TRINTELLIX 10MG
TRINTELLIX 20MG
TRIUMEQ 600-50-300MG
TUDORZA PRESSAIR 400MCG
ULORIC 80MG
UROCIT-K 10MEQ
VELPHORO 500MG
VENTOLIN HFA 90MCG
VIIBRYD 10MG
VIIBRYD 20MG
VIIBRYD 40MG
VIREAD (G) 300MG
VRAYLAR 1.5MG
VRAYLAR 3MG
VRAYLAR 4.5MG
VRAYLAR 6MG
WELCHOL 625MG
WELCHOL PACKET 3.75G
WELLBUTRIN XL (G) 150MG
WELLBUTRIN XL (G) 300MG
XARELTO 2.5MG
XARELTO 10MG
XARELTO 15MG
XARELTO 20MG
XELJANZ 5MG
XELJANZ 10MG
XELJANZ XR 11MG
XIGDUO XR 5/1000MG
XIGDUO XR 10/500MG
XIGDUO XR 10/1000MG
YAZ 3/0.02MG
ZIANA 1.2%-0.025%
ZYCLARA PACKET 3.75%
ZYCLARA PUMP 3.75%

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.

October 2021

CCMHGCanarx

CANARX ENROLLMENT FORM

Please return completed enrollment form by one of the following methods:

MAIL TO: **CCMHGCanarx** 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

PATIENT INFORMATION *(PLEASE PRINT)*

DATE OF BIRTH *(MM/DD/YYYY)*				**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 *Ex. JANUVIA*	DOSAGE *Ex. 50MG*	TIME(S) TO TAKE *Ex. TWICE DAILY*	DATE STARTED *Ex. 08/20/2019*	REASON FOR TAKING *Ex. DIABETES*

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)*

TERMS OF AGREEMENT

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/ 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.