

# ROMEMeds

Employee Program

**Introduction:**

**ROMEMeds** is an international mail order option for eligible Employees, Retirees and Dependents of the City of Rome, New York. Your list of qualified maintenance medications is on the reverse.

**Copays:**

All member copayments have been **waived** for this program **only**.

<b>ROMEMeds</b>		<b>Vs.</b>	<b>Current local purchase plan</b>			
<b>Annual Cost No Copays!</b>			<b>Current 90 Day Copays</b>	<b>Refills</b>		<b>Annual Savings</b>
<b>\$0</b>	<b>Vs.</b>		<b>\$50 (Tier 2)</b>	<b>x</b>	<b>4</b>	<b>= \$200 / Script</b>
	<b>Vs.</b>		<b>\$80 (Tier 3)</b>	<b>x</b>	<b>4</b>	<b>= \$320 / Script</b>

**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 taken for 30 days before ordering through **ROMEMeds**.

**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: ROMEMeds**

**P.O. Box 44650**

**Detroit, Michigan**

**48244-0650**

**More forms are available:**

Additional forms may be obtained at the Personnel Office, by printing them from the website at [www.ROMEMeds.com](http://www.ROMEMeds.com) or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

**Welcome to ROMEMeds**

ABILIFY 2MG  
 ABILIFY DISCMELT 10MG  
 ABILIFY DISCMELT 15MG  
**ACCOLATE (G) 20MG**  
**ACIPHEX (G) 20MG**  
 ACTONEL 5MG  
 ACTONEL 30MG  
 ACTONEL 150MG  
**ACULAR LS SOL (G) 0.4%**  
 ACZONE 5%  
 ADCIRCA 20MG  
 ADVAIR DISKUS 100MCG  
 ADVAIR DISKUS 250MCG  
 ADVAIR DISKUS 500MCG  
 ADVAIR HFA 45/21MCG  
 ADVAIR HFA 115/21MCG  
 ADVAIR HFA 230/21MCG  
 AFINITOR 2.5MG  
 AFINITOR 5MG  
 AFINITOR 10MG  
 AGGRENOX 200/25MG  
 ALOCRILOPHTH 2%  
 ALOMIDE 0.1%  
**ALPHAGAN-P OPHTH SOL (G) 0.15%**  
 ALREX 0.2%  
 ALVESCO 80MCG 100MCG  
 ALVESCO 160MCG 200MCG  
 AMITIZA 24MCG  
**ANAPROX D.S. (G) 550MG**  
 ANORO ELLIPTA 62.5/25MCG  
 ANZEMET 100MG  
**ARAVA (G) 10MG**  
**ARAVA (G) 20MG**  
 ARCAPTA NEOHALER 75MCG  
 ARNUITY ELLIPTA 100MCG  
 ARNUITY ELLIPTA 200MCG  
**ARTHROTEC (G) 50MG**  
**ARTHROTEC (G) 75MG**  
 ASACOL HD 800MG  
 ASMANEX TWISTHALER 110MCG  
 ASMANEX TWISTHALER 220MCG  
**ATACAND (G) 4MG**  
**ATACAND (G) 8MG**  
**ATACAND (G) 16MG**  
**ATACAND (G) 32MG**  
**ATACAND HCT (G) 16MG/12.5MG**  
**ATACAND HCT (G) 32MG/12.5MG**  
 ATELVIA DR 35MG  
 ATRIPLA 600-200-300MG  
 ATROVENT HFA 20UG  
 AUBAGIO 14MG  
 AVANDAMET 2MG/500MG  
 AVANDAMET 2MG/1000MG  
 AVANDAMET 4MG/500MG  
 AVANDAMET 4MG/1000MG  
 AVANDIA 2MG  
 AVANDIA 4MG  
 AVANDIA 8MG  
 AXERT 6.25MG  
 AXERT 12.5MG  
 AZILECT 0.5MG  
 AZILECT 1MG  
 AZOPT OPHTH DROPS 1%  
 AZOR 20/5MG  
 AZOR 40/5MG  
 AZOR 40/10MG  
 BACTROBAN NASAL OINT 2%  
 BANZEL 200MG  
 BANZEL 400MG  
 BARACLUDE 0.5MG  
 BARACLUDE 1MG  
 BECONASE AQ 42MCG  
 BENICAR 20MG  
 BENICAR 40MG  
 BENICAR HCT 20MG/12.5MG  
 BENICAR HCT 40MG/12.5MG  
 BENICAR HCT 40MG/25MG  
 BENZACLIN PUMP  
 BETIMOL 0.25%  
 BETIMOL 0.5%  
 BETOPTIC S OPHTH 0.25%  
 BREO ELLIPTA 100/25MCG  
 BREO ELLIPTA 200/25MCG  
 BRILINTA 60MG  
 BRILINTA 90MG  
 BYSTOLIC 2.5MG  
 BYSTOLIC 5MG  
 BYSTOLIC 10MG  
 BYSTOLIC 20MG  
**CADUET (G) 5/10MG**  
**CADUET (G) 5/20MG**  
**CADUET (G) 5/40MG**  
**CADUET (G) 10/10MG**  
**CADUET (G) 10/20MG**  
 CAMBIA 50MG  
**CARDIZEM CD (G) 360MG**  
**CARDIZEM LA (G) 180MG**  
**CARDIZEM LA (G) 240MG**  
**CARDIZEM LA (G) 360MG**  
 CARDURA XL 4MG  
 CARDURA XL 8MG  
**CLIMARA PATCH (G) 25MCG**

**CLIMARA PATCH (G) 50MCG**  
**CLIMARA PATCH (G) 75MCG**  
 CLIMARA PRO 0.045/0.015MG  
**COLAZAL (G) 750MG**  
 COMBIGAN 0.2-0.5%  
 COMBIVENT RESPIMAT 20MCG/100MCG  
 COMPLERA 200/25/300MG  
**CORGARD (G) 80MG**  
 COSOPT PF DROPS 2%/0.5%  
 CRINONE GEL 8%  
 CRIVIVAN 200MG  
 CRIVIVAN 400MG  
**CUTIVATE OINT (G) 0.005%**  
**CYTOTEC (G) 200MCG**  
 DALIRESP 500MCG  
 DERMOTIC OIL 0.01%  
 DESCOVY 200MG/25MG  
 DETROL LA 2MG  
 DETROL LA 4MG  
 DEXILANT DR 30MG  
 DEXILANT DR 60MG  
**DIFFERIN CREAM (G) 0.1%**  
**DIFFERIN GEL (G) 0.1%**  
 DIFFERIN GEL 0.3%  
 DIPENTUM 250MG  
**DIPROLENE LOTION (G) 0.05%**  
**DIPROLENE OINT (G) 0.05%**  
 DIVIGEL 0.5MG  
 DIVIGEL 1MG  
**DOVONEX CREAM (G) 50MCG**  
 DUAVEE 0.45-20MG  
 DULERA 100MCG/5MCG  
 DULERA 200MCG/5MCG  
 DYMISTA NASAL SPRAY 137/50MCG  
 EDARBI 40MG  
 EDARBI 80MG  
 EDARBYCLOR 40MG/25MG  
 EDECRIN 25MG  
 EDURANT 25MG  
 EFFIENT 5MG  
 EFFIENT 10MG  
 ELIDEL 1%  
 ELIQUIS 2.5MG  
 ELIQUIS 5MG  
 ELMIRON 100MG  
 EMADINE 0.05%  
 EMTRIVA 200MG  
 ENABLEX 7.5MG  
 ENABLEX 15MG  
**ENTOCORT (G) 3MG**  
 ENTRESTO 24MG-26MG  
 ENTRESTO 49MG-51MG  
 ENTRESTO 97MG-103MG  
 EPIDUO GEL PUMP 0.1%/2.5%  
 EPIPEN 0.3MG  
 EPIPEN JR 0.15MG  
 EPZICOM  
 ESTROGEL 0.06%  
 EXELON 9.5MG/24HR  
 EXELON 13.3MG/24HR  
 EXJADE 125MG  
 EXJADE 250MG  
 EXJADE 500MG  
 FARESTON 60MG  
 FARXIGA 5MG  
 FARXIGA 10MG  
 FELDENE 10MG  
 FELDENE 20MG  
 FINACEA 15%  
 FLAREX 0.1%  
 FLOVENT 44MCG 50MCG  
 FLOVENT 110MCG 125MCG  
 FLOVENT 220MCG 250MCG  
 FLOVENT DISKUS 100MCG  
 FLOVENT DISKUS 250MCG  
 FORADIL + AEROLIZER 12MCG  
 FOSRENOL CHEW 500MG  
 FOSRENOL CHEW 750MG  
 FOSRENOL CHEW 1000MG  
 FOSRENOL POWDER 750MG  
 FOSRENOL POWDER 1000MG  
 FROVA 2.5MG  
 GELNIQUE 10%  
 GILENYA 0.5MG  
 GILOTTRIF 20MG  
 GILOTTRIF 30MG  
 GILOTTRIF 40MG  
 GLEEVEC 100MG  
 GLEEVEC 400MG  
 GLUCAGEN HYPOKIT 1MG  
 GLUMETZA ER 1000MG  
**HEPSERA (G) 10MG**  
**IMITREX AUTOINJECTOR STATDOSE (G) 6MG/0.5ML**  
**IMITREX NASAL SPRAY (G) 5MG-2DOSE**  
**IMITREX NASAL SPRAY (G) 20MG-2DOSE**  
**IMURAN (G) 50MG**  
 INCRUSE ELLIPTA 62.5MCG  
 INLYTA 1MG

INLYTA 5MG  
**INSPIRA (G) 25MG**  
**INSPIRA (G) 50MG**  
 INTELENCE 100MG  
 INTELENCE 200MG  
 INVEGA 3MG  
 INVEGA 6MG  
 INVEGA 9MG  
 INVIRASE 500MG  
 INVOKANA 100MG  
 INVOKANA 300MG  
 ISENTRESS 400MG  
 ISOPTO CARPINE 1%  
 ISOPTO CARPINE 2%  
 ISOPTO CARPINE 4%  
 JADENU 90MG  
 JADENU 180MG  
 JADENU 360MG  
 JAKAFI 5MG  
 JAKAFI 10MG  
 JAKAFI 15MG  
 JAKAFI 20MG  
 JALYN 0.5MG/0.4MG  
 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/850MG  
 JENTADUETO 2.5MG/1000MG  
 JUBLIA 10%  
 KALETRA 200MG/50MG  
 KAZANO 12.5/1000MG  
 KOMBIGLYZE XR 2.5MG/1000MG  
 KOMBIGLYZE XR 5MG/500MG  
 KOMBIGLYZE XR 5MG/1000MG  
 LATUDA 20MG  
 LATUDA 40MG  
 LATUDA 60MG  
 LATUDA 80MG  
 LATUDA 120MG  
**LESCOL (G) 20MG**  
**LESCOL (G) 40MG**  
 LESCOL XL 80MG  
 LEXIVA 700MG  
 LIALDA 1.2GM  
 LINZESS 145MCG  
 LINZESS 290MCG  
 LOCID LIPOCREAM 0.1%  
**LOCID OINT (G) 0.1%**  
 LOTEMAX SUSPENSION 0.5%  
**LOVENOX (G) 40MG**  
**LOVENOX (G) 60MG**  
**LOVENOX (G) 80MG**  
**LOVENOX (G) 100MG**  
**LOVENOX (G) 120MG**  
**LOVENOX (G) 150MG**  
 LUMIGAN OPHTH 0.01%  
 MESNEX 400MG  
 MESTINON TS 180MG  
**METRO CREAM (G) 0.75%**  
 METROGEL PUMP 1%  
**MICARDIS HCT (G) 40/12.5MG**  
**MICARDIS HCT (G) 80/12.5MG**  
**MICARDIS HCT (G) 80/25MG**  
 MIGRANAL NASAL SPRAY 4MG/ML  
**MINIPRESS (G) 1MG**  
**MINIPRESS (G) 2MG**  
**MINIPRESS (G) 5MG**  
 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  
 MIRVASO 0.33%  
 MULTAQ 400MG  
 MYFORTIC 360MG  
 MYRBETRIQ 25MG  
 MYRBETRIQ 50MG  
 NASONEX 50MCG  
 NESINA 6.25MG  
 NESINA 12.5MG  
 NESINA 25MG  
 NEUPRO 1MG  
 NEUPRO 2MG  
 NEUPRO 3MG  
 NEUPRO 4MG  
 NEUPRO 6MG  
 NEUPRO 8MG  
 NEXAVAR 200MG  
 NEXIUM DR 10MG  
 NORITATE CREAM 1%  
 NORVIR TABLET 100MG  
 OLYSIO 150MG  
 OMNARIS NASAL SPRAY 50MCG

ONGLYZA 2.5MG  
 ONGLYZA 5MG  
 ORACEA 40MG  
 OTEZLA 30MG  
 PATADAY 0.2%  
 PATANOL OPHTH SOL 0.1%  
**PAXIL CR (G) 12.5MG**  
**PAXIL CR (G) 25MG**  
 PENNSAID 1.5%  
 PENTASA 500MG  
**PLAQUENIL (G) 200MG**  
 PRADAXA 75MG  
 PRADAXA 150MG  
**PRED FORTE (G) 1%**  
 PREMARIN 0.3MG  
 PREMARIN 0.625MG  
 PREMARIN 1.25MG  
 PREMARIN VAG 0.625MG/GM  
 PREMPRO 0.3MG/1.5MG  
 PREMPRO 0.625MG/2.5MG  
 PREMPRO 0.625MG/5MG  
 PREVACID SOLUTAB 15MG  
 PREVACID SOLUTAB 30MG  
 PREZCOBIX 800MG/150MG  
 PREZISTA 600MG  
 PREZISTA 800MG  
 PRISTIQ 50MG  
 PRISTIQ 100MG  
**PROMETRIUM (G) 100MG**  
 PROTOPIC OINT 0.03%  
 PROTOPIC OINT 0.1%  
 QVAR 40MCG 50MCG  
 QVAR 80MCG 100MCG  
 RANEXA 500MG  
 RAPAFLO 4MG  
 RAPAFLO 8MG  
**RAPAMUNE (G) 0.5MG**  
**RAPAMUNE (G) 1MG**  
**RAPAMUNE (G) 2MG**  
 RELPAX 20MG  
 RELPAX 40MG  
 RENAGEL 800MG  
 RENVELA 800MG  
 RESTASIS 0.05%  
**RETIN A CREAM (G) 0.05%**  
**RETIN A MICRO GEL (G) 0.04%**  
**RETIN-A MICRO GEL PUMP (G) 0.1%**  
 REYATAZ 150MG  
 REYATAZ 200MG  
 REYATAZ 300MG  
**SANCTURA XR (G) 60MG**  
 SAPHRIS 5MG  
 SAPHRIS 10MG  
 SELZENTRY 150MG  
 SELZENTRY 300MG  
 SENSIPAR 30MG  
 SENSIPAR 60MG  
 SENSIPAR 90MG  
 SEREVENT DISKUS 50MCG  
 SEROQUEL XR 50MG  
 SEROQUEL XR 150MG  
 SEROQUEL XR 200MG  
 SEROQUEL XR 300MG  
 SEROQUEL XR 400MG  
 SIMBRINZA 1%/0.2%  
**SOLARAZE (G) 3%**  
 SOOLANTRA 1%  
**SORIATANE (G) 10MG**  
**SORIATANE (G) 25MG**  
 SPIRIVA 18MCG  
 SPIRIVA RESPIMAT 2.5MCG  
 SPRYCEL 20MG  
 SPRYCEL 50MG  
 SPRYCEL 70MG  
 SPRYCEL 100MG  
 STIOLTO RESPIMAT 2.5/2.5MCG  
 STIVARGA 40MG  
 STRATTERA 10MG  
 STRATTERA 18MG  
 STRATTERA 25MG  
 STRATTERA 40MG  
 STRATTERA 60MG  
 STRATTERA 80MG  
 STRATTERA 100MG  
 STRIBILD  
 SUSTIVA 50MG  
 SUSTIVA 200MG  
 SUSTIVA 600MG  
 SUTENT 12.5MG  
 SUTENT 25MG  
 SUTENT 50MG  
 SYNAREL NASAL  
 SYNJARDY 5MG/500MG  
 SYNJARDY 5MG/1000MG  
 SYNJARDY 12.5MG/500MG  
 SYNJARDY 12.5MG/1000MG  
 TABLOID 40MG  
 TARKA 2/180MG  
 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%  
 TECFIDERA 120MG  
 TECFIDERA 240MG  
**TEGRETOL (G) 200MG**  
**TEGRETOL XR (G) 200MG**  
**TEGRETOL XR (G) 400MG**  
 TEKTURNA 150MG  
 TEKTURNA 300MG  
 TEKTURNA HCT 150-12.5MG  
 TEKTURNA HCT 300-12.5MG  
 TEKTURNA HCT 300-25MG  
 TEVETEN HCT 600/12.5MG  
 TIVICAY 50MG  
 TOBEX OINT 0.3%  
 TOVIAZ 4MG  
 TOVIAZ 8MG  
 TRACLEER 62.5MG  
 TRACLEER 125MG  
 TRADJENTA 5MG  
 TRAVATAN Z OPHTH SOL 0.004%  
 TRIBENZOR 20/5/12.5MG  
 TRIBENZOR 40/5/12.5MG  
 TRIBENZOR 40/10/12.5MG  
 TRIBENZOR 40/10/25MG  
 TRINTELLIX 5MG  
 TRINTELLIX 10MG  
 TRINTELLIX 20MG  
 TRIUMEQ TABLET  
**TRIZIVIR (G)**  
 TRUVADA 200-300MG  
 TUDORZA PRESSAIR 400MCG  
 TWYNSTA 40/5MG  
 TWYNSTA 40/10MG  
 TWYNSTA 80/5MG  
 TWYNSTA 80/10MG  
 TYKERB 250MG  
 TYZEKA 600MG  
 ULORIC 80MG  
**UROCI-K (G) 10MEQ**  
 VAGIFEM 10MCG  
 VALCYTE 450MG  
**VECTICAL (G) 3MCG/GM**  
 VENTOLIN HFA 90MCG  
 VERAMYST 27.5MCG  
 VESICARE 5MG  
 VESICARE 10MG  
 VIMOVO 375/20MG  
 VIMOVO 500/20MG  
 VIRAMUNE XR 400MG  
 VIREAD 300MG  
 VIVELLE-DOT 25MCG  
 VIVELLE-DOT 37.5MCG  
 VIVELLE-DOT 50MCG  
 VIVELLE-DOT 75MCG  
 VIVELLE-DOT 100MCG  
 VOLTAREN GEL  
 VYTORIN 10/10MG  
 VYTORIN 10/20MG  
 VYTORIN 10/40MG  
 VYTORIN 10/80MG  
 WELCHOL 625MG  
 XALKORI 200MG  
 XALKORI 250MG  
 XARELTO 10MG  
 XARELTO 15MG  
 XARELTO 20MG  
 XELJANZ 5MG  
**XELODA (G) 150MG**  
**XELODA (G) 500MG**  
 XENICAL 120MG  
 XIGDUO XR 5/1000MG  
 XIGDUO XR 10/500MG  
 XIGDUO XR 10/1000MG  
 XTANDI 40MG  
**ZANAFLEX (G) 2MG**  
 ZELAPAR 1.25MG  
 ZELBORAF 240MG  
 ZETIA 10MG  
 ZIAGEN 300MG  
 ZOMIG NASAL SPRAY 5MG  
 ZORTRESS 0.25MG  
 ZORTRESS 0.5MG  
 ZORTRESS 0.75MG  
 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.

March 2017



Employee Program

CanaRx  
Member/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: RomeMeds, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

PATIENT INFORMATION: Birthdate \_\_\_\_\_  MEMBER  
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. <i>Ex. Januvia (This is NOT a prescription.)</i>	Strength <i>Ex. 50 mg</i>	Reason for Taking <i>Ex. Diabetes</i>	Daily Use <i>Ex. Once Daily</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 MEMBER, 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.