

IRCMeds

Introduction:

IRCMeds is a voluntary international prescription drug program that is available to eligible employees, retirees and their dependents of Indian River County, FL. 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.

IRCMeds		Vs.	Current local purchase plan			
Annual Cost No Copays!			Monthly Copays		Refills	Annual Savings
\$0	Vs.		\$35 (Tier 2)	x	12	= \$420 / Script
	Vs.		\$50 (Tier 3)	x	12	= \$600 / 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 **IRCMeds**.

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: IRCMeds

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.IRCMeds.com or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

WELCOME TO *IRCMeds*

<p>ACCOLATE (G) 20MG ACTONEL 5MG ACTONEL 30MG ACTONEL 35MG ACTONEL 150MG ACTOPLUS (G) 15MG-850MG 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 ALOCRIL OPHTH 2% ALOMIDE 0.1% ALPHAGAN-P OPHTH SOL (G) 0.15% ALREX 0.2% ALVESCO 80MCG 100MCG ALVESCO 160MCG 200MCG AMITIZA 24MCG ANORO ELLIPTA 62.5/25MCG ARCAPTA NEOHALER 75MCG ARNUITY ELLIPTA 100MCG ARNUITY ELLIPTA 200MCG AROMASIN (G) 25MG 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 ATELVA DR 35MG ATRIPLA 600-200-300MG ATROVENT HFA 20UG AUBAGIO 14MG AVANDIA 2MG AVANDIA 4MG AVANDIA 8MG AVODART 0.5MG 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 CREAM (G) 2% BANZEL 200MG BANZEL 400MG BARACLUDE 0.5MG BARACLUDE 1MG 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% BONIVA (G) 150MG 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 CARDURA XL 4MG CARDURA XL 8MG CELEBREX 100MG CELEBREX 200MG CLIMARA PATCH (G) 25MCG CLIMARA PATCH (G) 50MCG CLIMARA PATCH (G) 75MCG CLIMARA PRO 0.045/0.015MG COMBIGAN 0.2-0.5% COMBIVENT RESPIMAT 20MCG/100MCG COMPLERA 200/25/300MG</p>	<p>COMTAN (G) 200MG CRESTOR 5MG CRESTOR 10MG CRESTOR 20MG CRESTOR 40MG CUTIVATE OINT (G) 0.005% CYMBALTA (G) 30MG CYMBALTA (G) 60MG DALIRESP 500MCG DERMOTIC OIL 0.01% DEXILANT DR 30MG DEXILANT DR 60MG DIFFERIN CREAM (G) 0.1% DIFFERIN GEL (G) 0.1% DIFFERIN GEL 0.3% DIFFERIN GEL 0.2% DIOVAN (G) 40MG DIOVAN (G) 80MG DIOVAN (G) 160MG DIOVAN (G) 320MG DIPENTUM 250MG DIPHLENE 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/12.5MG EDARBYCLOR 40MG/25MG EDECIN 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 EPIVIR / HBV (G) 100MG EPZICOM ESTROGEL 0.06% EVISTA 60MG EXELON 3MG EXELON 6MG EXELON 4.6 MG/24HR EXELON 9.5MG/24HR EXELON 13.3MG/24HR 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 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 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 IMITREX AUTOINJECTOR STATDOSE (G) 6MG/0.5ML IMITREX NASAL SPRAY (G) 5MG-2DOSE</p>	<p>IMITREX NASAL SPRAY (G) 20MG-2DOSE INCRUSE ELLIPTA 62.5MCG INDERAL LA (G) 60MG INDERAL LA (G) 80MG INDERAL LA (G) 120MG INDERAL LA (G) 160MG INLYTA 1MG INLYTA 5MG 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 KALETRA 200MG/50MG KAZANO 12.5/1000MG LATUDA 20MG LATUDA 40MG LATUDA 60MG LATUDA 80MG LATUDA 120MG LESCOL (G) 20MG LESCOL (G) 40MG LESCOL XL 80MG LEXIVA 700MG LIALDA 1.2MG LINZESS 145MCG LINZESS 290MCG LOCOID LIPOCREAM 0.1% LOCOID OINTMENT (G) 0.1% LOTEMAX SUSPENSION 0.5% LOTIRISONE CREAM (G) 1%/0.05% 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 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 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 20MG NEXIUM 40MG NEXIUM DR 10MG</p>	<p>NIASPAN 500MG NIASPAN 750MG NIASPAN 1000MG NORVIR TABLET 100MG OLYSIO 150MG ONGLYZA 2.5MG ONGLYZA 5MG ORTHO-TRI-CYCLEN LO OTEZLA 30MG PATADAY 0.2% PATANOL OPHTH SOL 0.1% PENTASA 500MG 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 PREZCOBIX 800MG/150MG PREZISTA 600MG PREZISTA 800MG PRISTIQ 50MG PRISTIQ 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 (G) 0.1% RETIN-A MICRO GEL PUMP (G) 0.1% REYATAZ 300MG RHEUMATREX (G) 2.5MG RHINOCORT AQ 32MCG SAPHRIS 5MG SAPHRIS 10MG SEASONIQUE (G) 0.15/0.03/0.01 SENSIPAR 30MG SENSIPAR 60MG SENSIPAR 90MG SEREVEN DISKUS 50MCG SEROQUEL XR 50MG SEROQUEL XR 150MG SEROQUEL XR 200MG SEROQUEL XR 300MG SEROQUEL XR 400MG SIMBRINZA 1%/0.2% SINGLAIR GRANULES (G) 4MG 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 STARLIX (G) 60MG STARLIX (G) 120MG 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 TABLOID 40MG TARKA 2/180MG TARKA 4/240MG TASIGNA 150MG TASIGNA 200MG TASMAR 100MG TAZORAC CREAM 0.05% TAZORAC CREAM 0.1%</p>	<p>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 TEMOVATE OINT (G) 0.05% TIVICAY 50MG TOBREX OINT 0.3% TOPROL XL (G) 200MG TOVIAZ 4MG TOVIAZ 8MG TRACLEER 62.5MG TRACLEER 125MG TRADJENTA 5 MG TRAVATAN Z OPHTH SOL 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 TRINTELLIX 5MG TRINTELLIX 10MG TRINTELLIX 20MG TRIUMEQ TABLET TRUVADA 200-300MG TUDORZA PRESSAIR 400MCG TWYNSTA 40/5MG TWYNSTA 40/10MG TWYNSTA 80/5MG TWYNSTA 80/10MG TYZEKA 600MG ULORIC 80MG UROIC-K (G) 10MEQ URSO (G) 250MG VAGIFEM 10MCG VALCYTE 450MG VECTICAL (G) 3MCG/GM VENTOLIN HFA 90MCG VESICARE 5MG VESICARE 10MG 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 WELLBUTRIN XL (G) 150MG WELLBUTRIN XL (G) 300MG XALKORI 200MG XALKORI 250MG XARELTO 10MG XARELTO 15MG XARELTO 20MG XELJANZ 5MG XELODA (G) 150MG XELODA (G) 500MG XIGDUO XR 5/1000MG XIGDUO XR 10/500MG XIGDUO XR 10/1000MG XTANDI 40MG YASMIN 28 (G) YAZ (G) 3/0.02 MG ZANAFLEX (G) 2MG ZELBORAF 240MG ZETIA 10MG ZIAGEN 300MG ZOMIG (G) 2.5MG ZOMIG NASAL SPRAY 5MG ZOMIG ZMT (G) 2.5MG (1X6) ZORTRESS 0.25MG ZORTRESS 0.5MG ZORTRESS 0.75MG ZOVIRAX CREAM 5% ZYTIGA 250MG</p>
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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.

November 2016



MEMBER ID #:

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