

## Introduction:

**MNHGCanaRx** 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 Minuteman Nashoba Health Group. 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>MNHGCanaRx</b>		<b>Vs. 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>\$25 (Tier 2)</b>	<b>x</b>	<b>12</b>	<b>=</b>	<b>\$300 / Script</b>
	<b>Vs.</b>	<b>\$50 (Tier 3)</b>	<b>x</b>	<b>12</b>	<b>=</b>	<b>\$600 / Script</b>
	<b>Vs.</b>	<b>\$50 (Tier 2)</b>	<b>x</b>	<b>4</b>	<b>=</b>	<b>\$200 / Script</b>
	<b>Vs.</b>	<b>\$110 (Tier 3)</b>	<b>x</b>	<b>4</b>	<b>=</b>	<b>\$440 / Script</b>

## 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](http://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 **MNHGCanaRx**.

**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: MNHGCanaRx**

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

P.O. Box 44650  
Detroit, MI 48244-0650  
(This P.O. Box is used for expediting all  
communications crossing the border.)

## More forms are available:

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

**WELCOME TO MNHGCanaRx**

**ABILIFY (G) 15MG**

ACIPHEX 20MG  
ADVAIR DISKUS 100MCG  
ADVAIR DISKUS 250MCG  
ADVAIR DISKUS 500MCG  
ADVAIR HFA 45/21MCG  
ADVAIR HFA 115/21MCG  
ADVAIR HFA 230/21MCG  
ALOCRIL 2%  
ALOMIDE 0.1%  
ALPHAGAN-P 0.15%  
ALREX 0.2%  
ALVESCO 80MCG 100MCG  
ALVESCO 160MCG 200MCG  
ANORO ELLIPTA 62.5/25MCG  
APTOM 200MG  
APTOM 400MG  
APTOM 600MG  
APTOM 800MG  
ARCAPTA NEOHALER 75MCG  
ARNUITY ELLIPTA 100MCG  
ARNUITY ELLIPTA 200MCG  
ASMANEX TWISTHALER 110MCG  
ASMANEX TWISTHALER 220MCG  
ATROVENT HFA 20UG  
AUBAGIO 14MG  
AVANDIA 2MG

**AVODART (G) 0.5MG**

AZELEX 20%  
AZOPT 1%  
BANZEL 200MG  
BANZEL 400MG  
BETIMOL 0.25%  
BETIMOL 0.5%  
BETOPTIC S 0.25%  
BINOSTO 70MG  
BREO ELLIPTA 100/25MCG  
BREO ELLIPTA 200/25MCG  
BRILINTA 60MG  
BRILINTA 90MG  
BYSTOLIC 2.5MG  
BYSTOLIC 5MG  
BYSTOLIC 10MG  
BYSTOLIC 20MG  
CARDURA XL 4MG  
CARDURA XL 8MG  
COMBIGAN 0.2-0.5%  
COMBIVENT RESPIMAT  
20MCG/100MCG

**CRESTOR (G) 5MG****CRESTOR (G) 10MG****CRESTOR (G) 20MG****CRESTOR (G) 40MG**

CRINONE GEL 8%  
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**

DIPENTUM 250MG  
DIVIGEL 0.25MG

DIVIGEL 0.5MG  
DIVIGEL 1MG

DUAVEE 0.45-20MG  
DULERA 100MCG/5MCG

DULERA 200MCG/5MCG  
DYMISTA 137/50MCG

EDARBI 40MG  
EDARBI 80MG

EFFEXOR XR (G) 75MG  
ELIDEL 1%

ELIQUIS 2.5MG  
ELIQUIS 5MG

ELMIRON 100MG  
ENTRESTO 24MG-26MG

ENTRESTO 49MG-51MG  
ENTRESTO 97MG-103MG

EPIPEN 0.3MG  
EPIPEN JR 0.15MG

ESTROGEL 0.06%  
EUCRISA 2%

FARXIGA 5MG  
FARXIGA 10MG

FETZIMA 20MG  
FETZIMA 40MG

FETZIMA 80MG  
FETZIMA 120MG

FINACEA GEL 15%  
FLAREX 0.1%

FLOVENT 44MCG 50MCG  
FLOVENT 110MCG 125MCG

FLOVENT 220MCG 250MCG  
FLOVENT DISKUS 100MCG

FLOVENT DISKUS 250MCG  
FOSRENOL POWDER 750MG

FOSRENOL POWDER 1000MG  
GENVOYA 150-150-200-10MG

GILENYA 0.5MG  
GLUCAGEN HYPOKIT 1MG

GLYXAMBI 10MG/5MG  
GLYXAMBI 25MG/5MG

INCRUSE ELLIPTA 62.5MCG  
INVOKAMET 50MG-500MG

INVOKAMET 50MG-1000MG  
INVOKAMET 150MG-500MG

INVOKAMET 150MG-1000MG  
INVOKANA 100MG

INVOKANA 300MG  
IRESSA 250MG

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  
KEPPRA (G) 250MG

KEPPRA (G) 500MG  
KEPPRA (G) 750MG

KEPPRA (G) 1000MG  
LAMICTAL (G) 25MG

LAMICTAL (G) 100MG  
LATUDA 20MG

LATUDA 40MG  
LATUDA 60MG

LATUDA 80MG  
LATUDA 120MG

LEXAPRO (G) 10MG  
LEXAPRO (G) 20MG

LIALDA 1.2GM  
LINZESS 72MCG

LINZESS 145MCG  
LINZESS 290MCG

LIPITOR (G) 10MG  
LIPITOR (G) 20MG

LIPITOR (G) 40MG  
LIPITOR (G) 80MG

LOTEMAX GEL 0.5%  
LOTEMAX SUSP 0.5%

LUMIGAN 0.01%  
MESNEX 400MG

MIRVASO 0.33%  
MOTEGRITY 1MG

MOTEGRITY 2MG  
MULTAQ 400MG

MYRBETRIQ 25MG  
MYRBETRIQ 50MG

NEUPRO 1MG  
NEUPRO 2MG

NEUPRO 3MG  
NEUPRO 4MG

NEUPRO 6MG  
NEUPRO 8MG

NEXIUM 20MG  
NEXIUM 40MG

NEXIUM DR 10MG  
ONGLYZA 2.5MG

ONGLYZA 5MG  
ORILISSA 150MG

ORILISSA 200MG  
OTEZLA 30MG

PAZEO 0.7%  
PENTASA 500MG

PRADAXA 75MG  
PRADAXA 150MG

PREMARIN 0.3MG  
PREMARIN 0.625MG

PREMARIN 1.25MG  
PREMARIN CREAM 0.625MG/GM

PREMPRO 0.3MG/1.5MG  
PREVACID SOLUTAB 15MG

PREVACID SOLUTAB 30MG  
PREZISTA 800MG

PROGRAF (G) 1MG  
QTERN 10-5MG

QVAR REDHALER 40MCG  
QVAR REDHALER 80MCG

RANEXA 500MG  
RESTASIS MULTIDOSE 0.05%

RESTASIS VIALS 0.05%  
REXULTI 0.25MG

REXULTI 0.5MG  
REXULTI 1MG

REXULTI 2MG  
REXULTI 3MG

REXULTI 4MG  
SAPHRIS 5MG

SAPHRIS 10MG  
SENSIPAR 30MG

SENSIPAR 60MG  
SEREVENT DISKUS 50MCG

SIMBRINZA 1%/0.2%  
SOOLANTRA 1%

SPIRIVA 18MCG  
SPIRIVA RESPIMAT 2.5MCG

STEGLATRO 5MG  
STEGLATRO 15MG

STIOLTO RESPIMAT 2.5/2.5MCG  
STRATTERA 100MG

STRIBILD  
SYNAREL NASAL

SYNJARDY 5MG/500MG  
SYNJARDY 5MG/1000MG

SYNJARDY 12.5MG/500MG  
SYNJARDY 12.5MG/1000MG

TAZORAC CREAM 0.05%  
TAZORAC CREAM 0.1%

TAZORAC GEL 0.05%  
TAZORAC GEL 0.1%

TECFIDERA 120MG  
TECFIDERA 240MG

TEKTURN 150MG  
TEKTURN 300MG

TEKTURN HCT 150-25MG  
TEKTURN HCT 300-12.5MG

TEKTURN HCT 300-25MG  
TIVICAY 50MG

TOBREX OINT 0.3%  
TOVIAZ 4MG

TOVIAZ 8MG  
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

VAGIFEM 10MCG  
VALTREX (G) 500MG

VALTREX (G) 1000MG  
VENTOLIN HFA 90MCG

VESICARE 5MG  
VESICARE 10MG

VIIBRYD 10MG  
VIIBRYD 20MG

VIIBRYD 40MG  
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 XR 11MG  
XIGDUO XR 5/1000MG

XIGDUO XR 10/500MG  
XIGDUO XR 10/1000MG

XIIDRA 5%  
ZOLOFT (G) 50MG

ZOMIG NASAL SPRAY 5MG  
ZYCLARA PACKET 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.

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: MNHGCanaRx, 235 EUGENIE ST. WEST, SUITE 105D, WINDSOR, ON, CANADA, N8X 2X7 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

-CONTACT US ABOUT EXPEDITING COMMUNICATIONS CROSSING THE BORDER

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 Services Inc. at Windsor, Ontario, Canada, and CanaRx Group Inc. at Christ Church, Barbados (collectively 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 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. 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, 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 contracted physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
7. CanaRx contracted 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 CanaRx contracted pharmacies for dispensing medicine in accordance with my prescriptions and to CanaRx contracted 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 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 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 contracted 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 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 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, 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.
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](http://www.CanaRx.com) 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.