Introducing...

DELAMeds

Employee Program

No Co-Pays on Brand Name Medications

Delaware County Employees, Retirees and Dependents can lower the high cost of prescription maintenance medications through the 'DELAMeds' program. This program will allow Employees and their families access to safe affordable prescription medications from International sources. CanaRx Services Inc. will be administering the plan on your behalf.

Mail or have your Doctor fax your prescriptions and enrollment form. It's that easy!

DELAMeds

P.O. Box 44650
Detroit MI 48244-0650

Phone: (toll free)
1-866-893-MEDS (6337)
Fax: (toll free)
1-866-715-MEDS (6337)
www.DELAMeds.com

CanaRx Services Inc. is dedicated to providing all U.S. residents with the opportunity to acquire the highest quality prescription medications at the lowest possible cost.

'DELAMeds' is an optional International Mail-Order program that will provide a large number of brand name, approved medications identical to what you already take. The cost of these medications is substantially less and, therefore, the co-pay is $0 for all drugs offered through this program.

We welcome the opportunity to assist Delaware County Employees, Retirees and Dependents in this cost saving measure.

G. Anthony Howard
President & CEO
CanaRx Services Inc.

DELAMeds
Employee Program

Introduction:

DELAMeds is an international mail order option for eligible Employees, Retirees and Dependents of the County of Delaware, Indiana. Your list of qualified maintenance medications is on the reverse.

Co-Payments:

All member co-payments have been waived for this program only.

DELAMeds vs. Current local purchase plan

Annual Cost *No co-pays*		Monthly Co-pays	x	Refills	=	Annual Cost
$0	vs.	$20	x	12	=	$240 / script
	vs.	$30	x	12	=	$360 / script

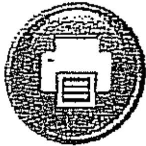
Ordering Instructions:

To place your first order simply complete the enrollment form and include a new prescription for each medication. Please allow 20 days 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 **DELAMeds**.

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

WELCOME TO DELAMeds

DELAMeds

Employee Program

For Information: Call 1-866-893-MEDS (6337) International

ABILIFY
ACCOLATE
ACCUPRIL (G) 5 & 10MG
ACCURETIC (G)
 10/12.5 & 20/12.5MG
ACIPHEX 20MG
ACTONEL
ACTONEL/CALCIUM
ACTOS
ACULAR LS OPHTH
ADALAT CC (G) 30 & 60MG
ADVAIR DISKUS
ADVICOR
AGGRENOX
ALDACTAZIDE (G) 25MG
ALDACTONE (G)
ALDARA CR
ALLEGRA (G) 60 & 180MG
ALOCRIL OPHTH
ALPHAGAN-P OPHTH 0.15%
ALTACE CAPS (G)
ALTACE TABS
AMARYL (G) 4MG
AMERGE
ANAPROX DS (G) 550MG
ARAVA (G)
ARIMIDEX
AROMASIN 25MG
ARTHROTEC
ASACOL 400MG
ASMANEX TWISTHALER
ATACAND (EXCEPT 16MG)
ATACAND HCT 16MG/12.5MG
ATROVENT HFA INH 20UG
ATROVENT NASAL (G) 0.06%
AVALIDE (EXCEPT 300/25MG)
AVANDAMET
 (EXCEPT 1/500 & 1/1000MG)
AVANDIA
AVAPRO
AVODART
AXERT
AXID (G)
AZOPT OPHTH DROPS
BACTROBAN CR
BACTROBAN OINT (G)
BENICAR 20 & 40MG
BENICAR HCT 20/12.5MG
BENTYL (G) 20MG
BENZACLIN PUMP
BENZAMYCIN (G)
BETAGAN OPHTH (G)
BETOPTIC-S OPHTH
BONIVA
BUSPAR (G)
CADUET
(EXCEPT 5/80MG & 10/80MG)
CAPOTEN (G)
CARDIZEM CD (G)
 (EXCEPT 120 & 300MG)
CARDIZEM LA
 (EXCEPT 240MG)
CASODEX
CATAPRES TABS (G)
CELEBREX 100 & 200MG
CELEXA (G) 20 & 40MG
CELLCEPT
CLARINEX 5MG
COLESTID TABS (G)
COMBIVENT INH 20UG
COMTAN
CORDARONE (G) 200MG
COREG (G) (NOT CR)
CORGARD (G) 80MG
COSOPT OPHTH
COVERA-HS 180 & 240MG
COZAAR 50 & 100MG
CREON 10 & 20MG
CRESTOR (EXCEPT 40MG)
CYMBALTA
CYTOXAN (G) 50MG
DAYPRO (G) 600MG
DDAVP SOL (G)
DEPAKOTE (G) (NOT ER)
DESYREL (G) 150MG
DETROL
DETROL LA
DIABETA (G) 5MG
DIFFERIN
DIOVAN
DIOVAN HCT
DIPENTUM
DIPROLENE (G)
DITROPAN XL (G) 5 & 10MG
DOVONEX CR
DOVONEX SOL (G)
EFFEXOR (G) 37.5 & 75MG
EFFEXOR XR
EFUDEX (G)
ELIDEL
ELMIRON
ELOCON CR (G)
ELOCON LOT (G)
ENABLEX
ENTOCORT
EPIVIR/HBV
ESTRACE TABS (G)
ESTRADERM PATCH
EVISTA
EXELON 3 & 4.5MG
FAMVIR (G)
FEMARA
FLOMAX TABS 0.4MG
FLONASE (G)
FLOVENT HFA INH
FLOVENT DISKUS 50MCG
FORADIL + AEROLIZER
FOSAMAX (G) 5 & 70MG
FOSAMAX-D 70/2800MG
FOSAMAX SOL
FROVA
GLUCOPHAGE (G) 500 & 850MG
GLUCOPHAGE XR (G) 500MG
GLUCOVANCE (G) 500/5MG
HYTRIN (G) 1MG
HYZAAR
IMDUR (G) 60 & 120MG
IMITREX INJ 6MG/0.5ML
IMITREX NASAL SPRAY
IMITREX TABS (G)
IMURAN (G) 50MG
ISOPTIN SR (G) 120 & 240MG
JANUMET
JANUVIA 100MG
KEPPRA (G)
KYTRIL (G) 1MG
LAMICTAL (G)
LAMISIL TABS (G)
LAMISIL CR
LESCOL
LESCOL XL 80MG
LEXAPRO 10 & 20MG
LIPITOR
LOESTRIN 28 (G)
LOPID (G) 600MG
LOPRESSOR (G) 50 & 100MG
LOTRISONE CR (G)
LUMIGAN OPHTH
MAVIK (G) 2MG
MAXALT
MAXALT MELT 10MG
METROCREAM (G) 0.75%
METROGEL TOPICAL 0.75%
METRO GEL 1%
MICARDIS
MICARDIS HCT
MICRONOR (G)
MINITRAN (G)
MINOCIN (G)
MOBIC (G)
MONOPRIL (G) 20MG
NASACORT AQ
NASONEX
NEORAL (G) 100MG
NEURONTIN (G)
NEXIUM 20 & 40MG
NIASPAN
NITRO-DUR PATCH (G)
NORVASC (G)
NUVARING MIS
OGEN (G) 1.5 & 2.5MG
ORTHO-EVRA
ORTHO-TRI-CYCLEN LO
OXSORALEN-ULTRA
OXYTROL PATCH 3.9MG
PATANOL OPHTH SOL
PAXIL (G) 20 & 30MG
PENTASA 500MG
PEPCID (G)
PLAQUENIL (G)
PLAVIX
PRANDIN
PRAVACHOL (G)
PRECOSE 50MG
PREMARIN TABS
 (EXCEPT 0.45 & 0.9MG)
PREVACID CAPS
PREVACID SOLUTAB
PROGRAF
PROSCAR (G)
PROTONIX (G)
PROTOPIC OINT 0.10%
PROVERA (G) 5 & 10MG
PROZAC (G) 10 & 20MG
PULMICORT TURBU
PURINETHOL (G) 50MG
QVAR INH
RAPAMUNE
RELAFEN (G) 500MG
RELPAX
REMERON (G) 30MG
REMERON SOL (G)
REQUIP (G) (EXCEPT 5MG)
RETIN-A CR (G)
RETIN-A GEL (G)
RETIN-A MICRO
REYATAZ
RHINOCORT AQ
RIDAURA 3MG
RISPERDAL (G)
ROCALTROL (G) 0.5MCG
RYTHMOL (G)
SANCTURA 20MG
SEASONALE (G)
SEREVENT DISKUS
SEROQUEL (NOT XR)
SINEMET (G)
SINEMET CR (G) 200/50MG
SINEQUAN (G) 50 & 75MG
SINGULAIR
SORIATANE
SPIRIVA
STALEVO 150MG
STARLIX
STRATTERA
 (EXCEPT 40 & 60MG)
TAMBOCOR (G)
TARCEVA
TARKA 2/180MG
TAZORAC
TEGRETOL (G)
TEGRETOL XR (G)
TEMOVATE CR (G)
TENORETIC (G) 100/25MG
TENORMIN (G)
TEVETEN
TEVETEN HCT 600/12.5MG
TIAZAC (G) 240 & 300MG
TOPAMAX
TOPAMAX SPRINKLE
TOPROL XL (G)100 & 200MG
 (LOPRESOR SR SUPPLIED)
TRAVATAN OPHTH (NOT Z)
TRICOR
TRILEPTAL TABS (G)
TRUSOPT OPHTH SOL (G)
ULTRASE MT20
UNIPHYL (G) 400 & 600MG
UNIVASC (G)
UROXATRAL
URSO
VAGIFEM
VALTREX 500 & 1000MG
VASOTEC (G) 5, 10 & 20MG
VESICARE
VIVELLE-DOT (G)
 50 & 100MCG
VIVELLE-DOT
 25, 37.5 & 75MCG
VOLTAREN (G) 50MG
VOLTAREN XR (G)
WELLBUTRIN XL (G)
 150 & 300MG
XENICAL
YASMIN 28 (G)
YAZ
ZADITOR OPHTH (G)
ZANAFLEX (G) 4MG
ZANTAC (G)
ZAROXOLYN (G)
ZEBETA (G) 5 & 10MG
ZERIT (EXCEPT 40MG)
ZETIA
ZOCOR (G)
ZOFRAN (G)
ZOFRAN ODT (G)
ZOLOFT (G)
ZOMIG
ZOMIG ZMT
ZOVIRAX TABS (G)
ZOVIRAX CR
ZOVIRAX OINT
ZYLOPRIM (G) 300MG
ZYPREXA
ZYPREXA ZYDIS

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.

DELAMeds
Employee Program

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

PATIENT INFORMATION: Birthdate ______ DD/MM/YYYY

Phone (Home) Phone (Work)

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 taken for 30 days before ordering through this program.

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. *Ex. Lipitor* *(This is NOT a prescription.)*	Strength *Ex. 10 mg*	Reason for Taking *Ex. Cholesterol*	Daily Use *Ex. Twice Daily*

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) Hospitalization: (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: ______

Physician's Name: Signature: *(optional)* Date: *(DD/MM/YY)*

AUTHORIZATION
I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medications for a period of more than 30 days. I certify that I have read and understand the Terms of Agreement on the reverse and that the information provided by me is accurate and true.
I request and authorize the County of Delaware, IN, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Subscriber Signature: Date: *(DD/MM/YY)*

CONFIRMATION AND REPRESENTATIONS

I, the undersigned, am entering into this agreement with *CanaRx Group Inc. ("CanaRx")* in order that I may obtain access to medically necessary prescription drugs at low costs.

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. The medications that I have requested that CanaRx facilitate my obtaining were prescribed by a duly qualified and licensed medical practitioner in the United States;
4. I have not violated any laws in the jurisdiction in which I ordinarily reside, in obtaining the prescription for the ordered product;
5. This prescription has not been altered in any way nor has it been filled previously. I agree to mail or fax from my doctor's office the original copy of the prescription to CanaRx;
6. I am under the ongoing care of a physician in my residing jurisdiction (my "U.S. physician"), and therefore, I am not seeking or relying on any medical information from CanaRx or any CanaRx contracted physician;
7. My prescription will not be used in any way whatsoever except as prescribed by my medical practitioner who originally issued the prescription;
8. I will not permit anyone else to use the prescription or any medications which I receive;
9. I will use any medications obtained for me by CanaRx strictly in accordance with the instructions provided by the physician who prescribed the medications; and
10. In the event that I suffer any side effects from any medications I receive through the services of CanaRx, I will immediately contact my U.S. physician.
11. I certify that I am a resident of the United States and not a resident of any other country.

AUTHORIZATION AND CONSENT

I further provide my authorization and consent to the following:

1. I hereby appoint CanaRx and its delegates or contractors as my paid agent and attorney for the purposes of obtaining prescriptions which correspond to the prescriptions provided by my U.S. physician.
2. I authorize CanaRx and its delegates or contractors to arrange the purchase and delivery of the medications prescribed to me on the terms outlined in this agreement and to the same extent as if I personally took such steps.
3. I consent and authorize CanaRx to collect my personal medical information and to maintain on file the information necessary to verify and process future orders, including but not limited to my full name, address, phone number, complete medical history and payment information.
4. I authorize my U.S. physician and CanaRx to release any and all information required in connection with my physical condition, including but not limited to all X-rays, medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions and/or any other knowledge or information which they may possess to a CanaRx contracted physician who may be required to review my health record for the purposes of being in a position to evaluate the medical necessity and indications for prescription medication.
5. I authorize the CanaRx contracted physician to contact my U.S. physician to discuss my prescription if necessary.
6. I further authorize the CanaRx contracted physician to issue prescriptions for medications I have ordered only if he/she deems it advisable and appropriate.
7. I further authorize the CanaRx contracted physician to release any and all information that may be required by any CanaRx contracted pharmacy for the purpose of having my prescriptions filled.
8. I further authorize CanaRx to make payments on my behalf to the CanaRx contracted pharmacy for the filling of my prescriptions and to the CanaRx contracted physician for services rendered on my behalf.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments and releases to *CanaRx*, including all of its employees, its contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. I acknowledge that my U.S. physician is my primary physician and the CanaRx contacted physician is being asked only to review the information contained in the Personal Medical History for the purpose of authorizing any properly prescribed medications for fulfillment from a CanaRx contracted pharmacy.
2. I acknowledge that 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 acknowledge that I wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx to facilitate this matter. I understand and appreciate that the CanaRx contracted physician will rely on the accuracy of the examination and prescription provided by my U.S. physician.
4. I hereby specifically acknowledge that I am aware that CanaRx may transmit my personal information by electronic means (for example fax, or secure 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 agents, contracted physicians and pharmacies.
5. I acknowledge that child protective packaging may not be used by the CanaRx contracted pharmacy filling my prescription and I release CanaRx and all of their officers and directors, agents, employees and contractors from any and all 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 understand that my medications may be subject to U.S. border seizure. I specifically confirm, acknowledge and agree that title to my medication passes to me when my medications are shipped from the CanaRx contracted pharmacy.
7. 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.

DELAMeds

Employee Program

CanaRx

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

PATIENT INFORMATION: Birthdate ____________ (DD/MM/YYYY) ☐ SPOUSE ☐ DEPENDENT

Phone (Home) Phone (Work)

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 taken for 30 days before ordering through this program.

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. *Ex. Lipitor* *(This is NOT a prescription.)*	Strength *Ex. 10 mg*	Reason for Taking *Ex. Cholesterol*	Daily Use *Ex. Twice Daily*

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) Hospitalization: (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:

Physician's Name: Signature: *(optional)* Date: *(DD/MM/YY)*

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 and understand the Terms of Agreement on the reverse and that the information provided above is accurate and true. I request and authorize the County of Delaware, IN, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Parent's/Guardian's Signature: Date: *(DD/MM/YY)*

AUTHORIZATION IF THE PATIENT IS THE SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER

I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medication for a period of more than 30 days. I certify that I have read and understand the Terms of Agreement on the reverse and that the information provided by me is accurate and true. I request and authorize the County of Delaware, IN, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Patient Signature: Date: *(DD/MM/YY)*

CONFIRMATION AND REPRESENTATIONS

I, the undersigned, am entering into this agreement with *CanaRx Group Inc. ("CanaRx")* in order that I may obtain access to medically necessary prescription drugs at low costs.

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. The medications that I have requested that CanaRx facilitate my obtaining were prescribed by a duly qualified and licensed medical practitioner in the United States;
4. I have not violated any laws in the jurisdiction in which I ordinarily reside, in obtaining the prescription for the ordered product;
5. This prescription has not been altered in any way nor has it been filled previously. I agree to mail or fax from my doctor's office the original copy of the prescription to CanaRx;
6. I am under the ongoing care of a physician in my residing jurisdiction (my "U.S. physician"), and therefore, I am not seeking or relying on any medical information from CanaRx or any CanaRx contracted physician;
7. My prescription will not be used in any way whatsoever except as prescribed by my medical practitioner who originally issued the prescription;
8. I will not permit anyone else to use the prescription or any medications which I receive;
9. I will use any medications obtained for me by CanaRx strictly in accordance with the instructions provided by the physician who prescribed the medications; and
10. In the event that I suffer any side effects from any medications I receive through the services of CanaRx, I will immediately contact my U.S. physician.
11. I certify that I am a resident of the United States and not a resident of any other country.

AUTHORIZATION AND CONSENT

I further provide my authorization and consent to the following:

1. I hereby appoint CanaRx and its delegates or contractors as my paid agent and attorney for the purposes of obtaining prescriptions which correspond to the prescriptions provided by my U.S. physician.
2. I authorize CanaRx and its delegates or contractors to arrange the purchase and delivery of the medications prescribed to me on the terms outlined in this agreement and to the same extent as if I personally took such steps.
3. I consent and authorize CanaRx to collect my personal medical information and to maintain on file the information necessary to verify and process future orders, including but not limited to my full name, address, phone number, complete medical history and payment information.
4. I authorize my U.S. physician and CanaRx to release any and all information required in connection with my physical condition, including but not limited to all X-rays, medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions and/or any other knowledge or information which they may possess to a CanaRx contracted physician who may be required to review my health record for the purposes of being in a position to evaluate the medical necessity and indications for prescription medication.
5. I authorize the CanaRx contracted physician to contact my U.S. physician to discuss my prescription if necessary.
6. I further authorize the CanaRx contracted physician to issue prescriptions for medications I have ordered only if he/she deems it advisable and appropriate.
7. I further authorize the CanaRx contracted physician to release any and all information that may be required by any CanaRx contracted pharmacy for the purpose of having my prescriptions filled.
8. I further authorize CanaRx to make payments on my behalf to the CanaRx contracted pharmacy for the filling of my prescriptions and to the CanaRx contracted physician for services rendered on my behalf.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments and releases to *CanaRx*, including all of its employees, its contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. I acknowledge that my U.S. physician is my primary physician and the CanaRx contacted physician is being asked only to review the information contained in the Personal Medical History for the purpose of authorizing any properly prescribed medications for fulfillment from a CanaRx contracted pharmacy.
2. I acknowledge that 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 acknowledge that I wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx to facilitate this matter. I understand and appreciate that the CanaRx contracted physician will rely on the accuracy of the examination and prescription provided by my U.S. physician.
4. I hereby specifically acknowledge that I am aware that CanaRx may transmit my personal information by electronic means (for example fax, or secure 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 agents, contracted physicians and pharmacies.
5. I acknowledge that child protective packaging may not be used by the CanaRx contracted pharmacy filling my prescription and I release CanaRx and all of their officers and directors, agents, employees and contractors from any and all 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 understand that my medications may be subject to U.S. border seizure. I specifically confirm, acknowledge and agree that title to my medication passes to me when my medications are shipped from the CanaRx contracted pharmacy.
7. 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.