MTADACRX

About us:

MTADACRX is an international mail order option for eligible Participants and their Dependents of Montana Automobile Dealers Association Group Benefits Trust enrolled in an HSA plan. An expanded list of preventive medications is available to you through this program only. Your list of qualified maintenance medications is on the reverse.

Program Savings:

All member copayments have been **waived** for this program **only**. In addition, by enrolling in this program you will save your health plan substantially on the cost of these medications. It is truly a WIN/WIN for both you and the health plan.

MTADACRX		Vs.		Current Purchase Plan		
Annual Cost ***No Copays!***		**Current Copays**		**Refills**		**Annual Savings**
$0	**Vs.**	**$40** *(Preferred Brand)* **Dexilant 60MG - $138.75** *(Non-Preferred Brand - 50%)*	**x**	**12**	**=**	**$480 / Script** **$1665 / Script**
	Vs.	**$80** *(Preferred Brand)* **Janumet 50/500MG - $625.80** *(Non-Preferred Brand - 50%)*	**x**	**4**	**=**	**$320 / Script** **$2503 / Script**

Getting Started:

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 CRX 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.CRXDocs.com. If not included, a CRX 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 ***MTADACRX.***

RETURN YOUR COMPLETED AND SIGNED ENROLLMENT FORM AND ORIGINAL PRESCRIPTIONS:

BY FAXING TO: 1-866-215-7874 (TOLL FREE)

Faxed prescriptions are ONLY accepted if sent directly from the physician's office.

OR

BY MAILING TO: *MTADACRX*

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

OR

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

More forms are available:

Additional forms may be obtained at the Human Resources Office, by printing them from the website at www.MTADACRX.com or by contacting our Customer Service Representatives toll free at **1-866-488-7874**.

Welcome to MTADACRX

HSA **MTADACRX** *For More Information: Call 1-866-488-7874 Toll Free*

ACIPHEX 20MG
ACTONEL 5MG
ACTONEL 30MG
ACTONEL 35MG
ACTONEL 150MG
ACTOPLUS 15MG-850MG
ACULAR (G) 0.5%
ACULAR LS (G) 0.4%
ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/21MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
ALDACTAZIDE (G) 50MG
ALOCRIL 2%
ALOMIDE 0.1%
ALPHAGAN-P 0.15%
ALREX 0.2%
ALVESCO 80MCG 100MCG
ALVESCO 160MCG 200MCG
ANAPROX DS 550MG
ANORO ELLIPTA 62.5/25MCG
ANZEMET 100MG
APTIOM 200MG
APTIOM 400MG
APTIOM 600MG
APTIOM 800MG
ARAVA (G) 10MG
ARAVA (G) 20MG
ARCAPTA NEOHALER 75MCG
ARNUITY ELLIPTA 100MCG
ARNUITY ELLIPTA 200MCG
AROMASIN 25MG
ASACOL HD 800MG
ASMANEX TWISTHALER 110MCG
ASMANEX TWISTHALER 220MCG
ASTAGRAF XL 0.5MG
ASTAGRAF XL 1MG
ASTAGRAF XL 5MG
ATACAND 4MG
ATACAND 8MG
ATACAND 16MG
ATACAND 32MG
ATACAND HCT 16MG/12.5MG
ATACAND HCT 32MG/12.5MG
ATELVIA DR 35MG
ATROVENT HFA 20UG
AUBAGIO 14MG
AVALIDE (G) 150MG/12.5MG
AVALIDE (G) 300MG/12.5MG
AVAPRO (G) 75MG
AVAPRO (G) 150MG
AVAPRO (G) 300MG
AZOPT 1%
AZOR 20/5MG
AZOR 40/5MG
AZOR 40/10MG
BECONASE AQ 42MCG
BETAGAN 0.5%
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
CADUET 5/10MG
CADUET 5/20MG
CADUET 5/40MG
CADUET 5/80MG
CADUET 10/10MG
CADUET 10/20MG
CADUET 10/40MG
CADUET 10/80MG
CARDIZEM CD (G) 180MG
CARDIZEM CD (G) 240MG
CARDIZEM CD (G) 360MG
CARDURA XL 4MG
CARDURA XL 8MG
COLAZAL (G) 750MG
COMBIGAN 0.2-0.5%
COMBIVENT RESPIMAT 20MCG/100MCG
COMTAN 200MG
CORGARD (G) 80MG
COSOPT PF DROPS 2%/0.5%
CYTOTEC (G) 200MCG
DALIRESP 500MCG
DDAVP (G) 0.1MG/ML
DEXILANT DR 30MG
DEXILANT DR 60MG
DIOVAN (G) 40MG
DIOVAN (G) 80MG
DIOVAN (G) 320MG
DIOVAN HCT (G) 320/12.5MG
DIVIGEL 0.25MG
DIVIGEL 0.5MG
DIVIGEL 1MG
DUAVEE 0.45-20MG
DULERA 100MCG/5MCG
DULERA 200MCG/5MCG
EDARBI 40MG
EDARBI 80MG
EDARBYCLOR 40MG/12.5MG
EDARBYCLOR 40MG/25MG
EDECRIN 25MG
EFFEXOR XR (G) 37.5MG
ELIQUIS 2.5MG
ELIQUIS 5MG
ENTRESTO 24MG-26MG
ENTRESTO 49MG-51MG
ENTRESTO 97MG-103MG
EPIVIR / HBV 100MG
EUCRISA 2%
EVISTA 60MG
EXELON 4.6MG/24HR
EXELON 9.5MG/24HR
EXELON 13.3MG/24HR
EXFORGE (G) 5/160MG
EXFORGE (G) 5/320MG
EXFORGE (G) 10/160MG
EXFORGE (G) 10/320MG
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
GLUMETZA ER 1000MG
GLYXAMBI 10MG/5MG
GLYXAMBI 25MG/5MG
HEPSERA (G) 10MG
IMURAN (G) 50MG
INCRUSE ELLIPTA 62.5MCG
INDERAL LA 60MG
INDERAL LA 80MG
INDERAL LA 120MG
INDERAL LA 160MG
INSPRA (G) 25MG
INSPRA (G) 50MG
INVEGA 3MG
INVEGA 6MG
INVEGA 9MG
INVOKAMET 50MG-500MG
INVOKAMET 50MG-1000MG
INVOKAMET 150MG-500MG
INVOKAMET 150MG-1000MG
INVOKANA 100MG
INVOKANA 300MG
IRESSA 250MG
ISOPTO CARPINE 1%
ISOPTO CARPINE 2%
ISOPTO CARPINE 4%
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-500MG
JENTADUETO 2.5MG-850MG
JENTADUETO 2.5MG-1000MG
JUBLIA 10%
KAZANO 12.5/1000MG
KOMBIGLYZE XR 2.5MG/1000MG
KOMBIGLYZE XR 5MG/500MG
KOMBIGLYZE XR 5MG/1000MG
LAMICTAL (G) 5MG
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LESCOL XL 80MG
LEXIVA 700MG
LUMIGAN 0.01%
MESNEX 400MG
MESTINON TS 180MG
METROGEL (G) 0.75%
MICARDIS (G) 20MG
MICARDIS (G) 40MG
MICARDIS (G) 80MG
MICARDIS HCT 40/12.5MG
MICARDIS HCT 80/12.5MG
MICARDIS HCT 80/25MG
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%
MOTEGRITY 1MG
MOTEGRITY 2MG
MULTAQ 400MG
NESINA 6.25MG
NESINA 12.5MG
NESINA 25MG
NEUPRO 1MG
NEUPRO 2MG
NEUPRO 3MG
NEUPRO 4MG
NEUPRO 6MG
NEUPRO 8MG
NEXIUM DR 10MG
NIZORAL SHAMPOO (G) 2%
OLUMIANT 2MG
ONGLYZA 2.5MG
ONGLYZA 5MG
OTEZLA 30MG
PAXIL CR (G) 12.5MG
PAXIL CR (G) 25MG
PLAQUENIL (G) 200MG
PRADAXA 75MG
PRADAXA 150MG
PRANDIN (G) 0.5MG
PRANDIN (G) 1MG
PRANDIN (G) 2MG
PREVACID SOLUTAB 15MG
PREVACID SOLUTAB 30MG
PREZISTA 800MG
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
RHINOCORT AQ 32MCG
RYBELSUS 3MG
RYBELSUS 7MG
RYBELSUS 14MG
SAPHRIS 5MG
SAPHRIS 10MG
SEASONIQUE 0.15/0.03/0.01MG
SENSIPAR 30MG
SENSIPAR 60MG
SEREVENT DISKUS 50MCG
SIMBRINZA 1%/0.2%
SINEMET (G) 250/25MG
SINEMET CR (G) 100/25MG
SINEMET CR (G) 200/50MG
SINGULAIR GRANULES (G) 4MG
SOLARAZE (G) 3%
SOOLANTRA 1%
SPIRIVA 18MCG
SPIRIVA RESPIMAT 2.5MCG
STALEVO (G) 50MG
STALEVO (G) 100MG
STALEVO (G) 125MG
STIOLTO RESPIMAT 2.5/2.5MCG
STRATTERA 10MG
STRATTERA 18MG
STRATTERA 25MG
STRATTERA 40MG
STRATTERA 60MG
STRATTERA 80MG
STRATTERA 100MG
SUSTIVA 50MG
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
TEKTURNA 150MG
TEKTURNA 300MG
TIVICAY 50MG
TOBREX OINT 0.3%
TOPICORT CREAM (G) 0.25%
TRADJENTA 5MG
TRAVATAN Z 0.004%
TRELEGY ELLIPTA 100-62.5-25MCG
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 600-50-300MG
TUDORZA PRESSAIR 400MCG
TWYNSTA 40/5MG
TWYNSTA 40/10MG
TWYNSTA 80/5MG
TWYNSTA 80/10MG
ULORIC 80MG
UROCIT-K 10MEQ
URSO 250MG
VENTOLIN HFA 90MCG
VIIBRYD 10MG
VIIBRYD 20MG
VIIBRYD 40MG
VRAYLAR 1.5MG
VRAYLAR 3MG
VRAYLAR 4.5MG
VRAYLAR 6MG
VYTORIN 10/10MG
VYTORIN 10/20MG
VYTORIN 10/40MG
VYTORIN 10/80MG
WELCHOL 625MG
WELCHOL PACKET 3.75G
XADAGO 50MG
XADAGO 100MG
XARELTO 2.5MG
XARELTO 10MG
XARELTO 15MG
XARELTO 20MG
XELJANZ 5MG
XELJANZ 10MG
XELJANZ XR 11MG
XENICAL 120MG
XIGDUO XR 5/1000MG
XIGDUO XR 10/500MG
XIGDUO XR 10/1000MG
YASMIN 28
YAZ 3/0.02MG
ZELAPAR 1.25MG
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 1-866-488-7874 toll free to verify the availability of your medication through this program.

February 2021

MTADACRX

CRX INTERNATIONAL **ENROLLMENT FORM**

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

MAIL TO: **MTADACRX** ADDRESS: **PO Box 3009, Windsor, Ontario Canada N8N 2M3**

UPLOAD TO: **www.CRXDocs.com** (Secure upload site.)

FAX TO: **1-866-215-7874** (NOTE: Faxed ***prescriptions*** must be sent **directly** from the **physician's** office.)

For more information, please call:

TOLL-FREE PHONE: **1-866-488-7874**

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 CRX International Inc. at Christ Church, Barbados (referred to as "CRX") 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 CRX 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 CRX 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 CRX.
7. My care by my U.S. physician is ongoing and I do not seek and will not rely on any medical information from CRX or any CRX 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 CRX 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 CRX, I will immediately contact my U.S. physician.
14. All information that I give to CRX is true.

AUTHORIZATION AND CONSENT

I consent to, and authorize, the following:

1. I hereby appoint CRX and its delegates and contractors (collectively referred to as "CRX") 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. CRX 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. CRX 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 CRX (and any CRX 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 CRX from my U.S. physician's office the original signed copy of the prescription.
6. CRX and its selected physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
7. CRX selected physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
8. CRX 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 CRX 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 CRX 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 CRX 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 CRX selected pharmacy.
2. CRX 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 CRX selected physician and have enlisted the services of CRX 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 CRX 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 CRX selected pharmacy.
6. I acknowledge that CRX, 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 CRX Privacy Policy in detail as provided below:

1. CRX 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. CRX and CRX selected physicians and pharmacists may share any and all information received from or about me with my U.S. physician, CRX 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 CRX 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 CRX, 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 CRX's transmission of my personal information by electronic means to its delegates, employees, selected physicians and pharmacies.
3. I acknowledge that CRX will obtain health information about me, and is obligated in accordance with the CRX Privacy Policy to protect such information. I can visit www.CRXIntl.com/privacy-policy/ at any time to view the most updated version of the CRX 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 CRX 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 CRX 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.