ControlRxInternational

Introduction:

ControlRxInternational is an international mail order option for eligible Members and their Dependents enrolled in a medical plan with MedOne. 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.

- ✔ **FREE Brand Name Medications - ZERO Copays!**
- ✔ **No Shipping and Handling Charges to You!**

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. 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 ***ControlRxInternational.***

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: ***ControlRxInternational***

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 by printing them from the website at **www.ControlRxInternational.com** or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

WELCOME TO ControlRxInternational

ControlRxInternational

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

ACTONEL 30MG
ACTONEL 35MG
ACTONEL 150MG
ACTOS (G) 15MG
ACTOS (G) 30MG
ACTOS (G) 45MG
ACULAR (G) 0.5%
ACULAR LS (G) 0.4%
ACZONE 5%
ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/21MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
AGGRENOX 200/25MG
ALDACTONE (G) 25MG
ALPHAGAN-P 0.15%
ALREX 0.2%
ALTACE (G) 1.25MG
ALTACE (G) 2.5MG
ALTACE (G) 5MG
ALTACE (G) 10MG
AMERGE (G) 2.5MG
ANAPROX DS 550MG
ARCAPTA NEOHALER 75MCG
ARTHROTEC 50MG
ARTHROTEC 75MG
ASMANEX TWISTHALER 220MCG
ATELVIA DR 35MG
ATROVENT HFA 20UG
AXERT 12.5MG
AZILECT 0.5MG
AZILECT 1MG
AZOPT 1%
BANZEL 400MG
BETOPTIC S 0.25%
BRILINTA 60MG
BRILINTA 90MG
CADUET 5/10MG
CADUET 5/20MG
CADUET 5/40MG
CADUET 5/80MG
CADUET 10/10MG
CADUET 10/20MG
CADUET 10/40MG
CADUET 10/80MG
CARDURA XL 4MG
CARDURA XL 8MG
CATAPRES (G) 0.1MG
CLARINEX 5MG
COLAZAL (G) 750MG
COMBIGAN 0.2-0.5%
COMTAN 200MG
CORGARD (G) 80MG
CYTOTEC (G) 200MCG
DALIRESP 500MCG
DDAVP (G) 0.1MG/ML
DEPAKOTE (G) 250MG
DEPAKOTE (G) 500MG
DEXILANT DR 30MG
DEXILANT DR 60MG
DIFFERIN CREAM 0.1%
DIFFERIN GEL 0.1%
DIFFERIN GEL 0.3%
DIOVAN HCT (G) 160/12.5MG
DIOVAN HCT (G) 160/25MG
DIPENTUM 250MG
DIPROLENE OINT 0.05%
DITROPAN XL (G) 5MG
DITROPAN XL (G) 10MG
DUAVEE 0.45-20MG
DYMISTA 137/50MCG
EDARBI 40MG
EDECRIN 25MG
EFFIENT (G) 5MG
EFFIENT (G) 10MG
ELIQUIS 2.5MG
ELIQUIS 5MG
ELMIRON 100MG
ENABLEX 15MG
ENTOCORT 3MG
ENTRESTO 24MG-26MG
ENTRESTO 49MG-51MG
ENTRESTO 97MG-103MG
EPIPEN 0.3MG
EPIPEN JR 0.15MG
EUCRISA 2%
EVISTA 60MG
EXELON 6MG
EXELON 4.6MG/24HR
EXELON 9.5MG/24HR
EXELON 13.3MG/24HR
FELDENE 10MG
FELDENE 20MG
FETZIMA 120MG
FINACEA GEL 15%
FLOVENT 44MCG 50MCG
FLOVENT 110MCG 125MCG
FLOVENT 220MCG 250MCG
FLOVENT DISKUS 100MCG
FLOVENT DISKUS 250MCG
FROVA 2.5MG
GEODON (G) 20MG
GEODON (G) 40MG
GLUCAGEN HYPOKIT 1MG
IMURAN (G) 50MG
INSPRA (G) 25MG
INSPRA (G) 50MG
LESCOL XL 80MG
LIALDA 1.2GM
LOCOID LIPOCREAM 0.1%
LOPID (G) 600MG
LOPRESSOR (G) 50MG
LOPRESSOR (G) 100MG
LOTEMAX SUSP 0.5%
MESTINON TS 180MG
METRO CREAM 0.75%
METROGEL (G) 0.75%
METROGEL PUMP 1%
MINIPRESS (G) 5MG
MIRAPEX (G) 0.125MG
MIRAPEX (G) 0.25MG
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%
MOBIC (G) 7.5MG
MOBIC (G) 15MG
MOTEGRITY 1MG
MOTEGRITY 2MG
MULTAQ 400MG
MYRBETRIQ 25MG
MYRBETRIQ 50MG
NAMENDA 10MG
NEUPRO 1MG
NEUPRO 2MG
NEUPRO 3MG
NEUPRO 4MG
NEUPRO 6MG
NEUPRO 8MG
NEXIUM 20MG
NEXIUM 40MG
NEXIUM DR 10MG
NORITATE CREAM 1%
PATANOL 0.1%
PAXIL (G) 20MG
PAXIL (G) 30MG
PAZEO 0.7%
PRANDIN (G) 0.5MG
PRANDIN (G) 1MG
PRANDIN (G) 2MG
PRED FORTE 1%
PREMARIN 0.3MG
PREMARIN 0.625MG
PREMARIN 1.25MG
PREMARIN CREAM 0.625MG/GM
PREMPRO 0.3MG/1.5MG
PROTOPIC OINT 0.03%
PROTOPIC OINT 0.1%
QVAR REDIHALER 80MCG
RANEXA 500MG
RELPAX 20MG
RELPAX 40MG
RENVELA 800MG
REQUIP (G) 0.25MG
REQUIP (G) 1MG
REQUIP (G) 2MG
RESTASIS MULTIDOSE 0.05%
RESTASIS VIALS 0.05%
RISPERDAL (G) 0.25MG
RISPERDAL (G) 0.5MG
RISPERDAL (G) 1MG
RISPERDAL (G) 2MG
RISPERDAL (G) 4MG
SAPHRIS 5MG
SAPHRIS 10MG
SEREVENT DISKUS 50MCG
SIMBRINZA 1%/0.2%
SINEMET (G) 100/25MG
SINEMET CR (G) 200/50MG
SOLARAZE (G) 3%
SOOLANTRA 1%
SPIRIVA 18MCG
STALEVO (G) 50MG
STALEVO (G) 100MG
STALEVO (G) 125MG
STARLIX 60MG
STARLIX 120MG
TARKA 2/180MG
TARKA 4/240MG
TAZORAC CREAM 0.05%
TAZORAC CREAM 0.1%
TAZORAC GEL 0.05%
TAZORAC GEL 0.1%
TEKTURNA 300MG
TEKTURNA HCT 300-12.5MG
TEKTURNA HCT 300-25MG
TENORMIN (G) 50MG
TENORMIN (G) 100MG
TOBREX OINT 0.3%
TOPICORT CREAM (G) 0.25%
TOVIAZ 4MG
TOVIAZ 8MG
TRAVATAN Z 0.004%
TRELEGY ELLIPTA 100-62.5-25MCG
TUDORZA PRESSAIR 400MCG
UROXATRAL (G) 10MG
URSO 250MG
VECTICAL 3MCG/GM
VESICARE 5MG
VESICARE 10MG
WELCHOL PACKET 3.75G
XARELTO 2.5MG
XARELTO 10MG
XARELTO 15MG
XARELTO 20MG
ZESTRIL (G) 20MG
ZOMIG NASAL SPRAY 5MG
ZYPREXA (G) 2.5MG
ZYPREXA (G) 5MG
ZYPREXA (G) 7.5MG
ZYPREXA (G) 10MG
ZYPREXA (G) 15MG

The following medications are covered if Prior Authorization requirements have been met and approved.

APTIOM 200MG
APTIOM 400MG
APTIOM 600MG
APTIOM 800MG
ARAVA (G) 10MG
ARAVA (G) 20MG
AROMASIN 25MG
BENZACLIN PUMP
BINOSTO 70MG
CARDIZEM CD (G) 180MG
CARDIZEM CD (G) 240MG
CARDIZEM CD (G) 360MG
DDAVP (G) 0.2MG
EPIDUO GEL PUMP 0.1%/2.5%
FARESTON 60MG
FARXIGA 5MG
FARXIGA 10MG
FEMARA (G) 2.5MG
FETZIMA 20MG
FETZIMA 40MG
FETZIMA 80MG
GEODON (G) 80MG
GILENYA 0.5MG
GLYXAMBI 10MG/5MG
GLYXAMBI 25MG/5MG
HEPSERA (G) 10MG
INVEGA 3MG
INVEGA 6MG
INVEGA 9MG
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
KOMBIGLYZE XR 5MG/500MG
KOMBIGLYZE XR 5MG/1000MG
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LINZESS 72MCG
LINZESS 145MCG
LINZESS 290MCG
MESNEX 400MG
MIGRANAL 4MG/ML
MINOCIN (G) 50MG
ONGLYZA 2.5MG
ORILISSA 150MG
ORILISSA 200MG
PENTASA 500MG
PROGRAF (G) 1MG
QTERN 10-5MG
RAPAMUNE 2MG
RETIN A GEL (G) 0.025%
RETIN A MICRO GEL PUMP 0.04%
RETIN-A MICRO GEL PUMP 0.1%
REVATIO (G) 20MG
REXULTI 0.25MG
REXULTI 0.5MG
REXULTI 1MG
REXULTI 2MG
REXULTI 3MG
REXULTI 4MG
RILUTEK (G) 50MG
RISPERDAL (G) 3MG
SYNAREL NASAL
SYNJARDY 5MG/500MG
SYNJARDY 5MG/1000MG
SYNJARDY 12.5MG/500MG
SYNJARDY 12.5MG/1000MG
TASMAR 100MG
TECFIDERA 120MG
TECFIDERA 240MG
TRINTELLIX 5MG
TRINTELLIX 10MG
TRINTELLIX 20MG
TRIUMEQ 600-50-300MG
TWYNSTA 40/5MG
TWYNSTA 40/10MG
TWYNSTA 80/5MG
TWYNSTA 80/10MG
UCERIS 9MG
ULORIC 80MG
VIIBRYD 10MG
VIIBRYD 20MG
VRAYLAR 1.5MG
VRAYLAR 3MG
VRAYLAR 4.5MG
VRAYLAR 6MG
WELLBUTRIN XL (G) 150MG
WELLBUTRIN XL (G) 300MG
XELJANZ 5MG
XELJANZ XR 11MG
XELODA 500MG
XIGDUO XR 10/500MG
XIGDUO XR 10/1000MG
ZELAPAR 1.25MG
ZOVIRAX CREAM 5%
ZYPREXA (G) 20MG

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.

June 2020

ControlRxInternational

CanaRx Enrollment Form

COMPANY NAME: **MEMBER ID #:**

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337
OR ~ MAIL TO: *ControlRxInternational*, P.O. BOX 3009, WINDSOR, ON, CANADA, N8N 2M3 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

PATIENT INFORMATION: **Birthdate** _____ MM/DD/YYYY ☐ SUBSCRIBER ☐ 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
Ex. Januvia	*Ex. 50mg*	*Ex. Twice Daily*	*Ex. 8/20/2017*	*Ex. Diabetes*

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)*

TERMS OF AGREEMENT

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 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.