I-SaveRx Program ENROLLMENT FORM

I-SaveRx

Safe and Affordable

Prescription Drugs

RETURN YOUR COMPLETED AND SIGNED ENROLLMENT FORM AND ORIGINAL PRESCRIPTIONS:

FAX TO: 1-866-715-6337 (toll-free)
(NOTE: Faxed prescriptions are ONLY accepted if sent directly from the physician's office.)

OR

MAIL TO: I-SaveRx
P. O. BOX 21086
c/o CanaRx Services Inc.
Tecumseh, Ontario Canada N8N 4S1
International postage rates apply.

CUSTOMER SERVICE INFORMATION:

We have customer service representatives and pharmacist assistance available to assist you 24 hours a day, 7 days a week at 1-866-I-SAVE33 (1-866-472-8333) toll-free.

1-866-I-SAVE33
(1-866-472-8333)
www.I-SaveRx.net

ROD BLAGOJEVICH
GOVERNOR, STATE OF ILLINOIS

WELCOME TO I-SaveRx

I-SaveRx is a program designed to save Illinois residents 25 to 50 percent on safe prescription medication refills. The State of Illinois is working with CanaRx Services Inc., a Pharmacy Benefits Manager for the I-SaveRx program and its international network of pharmacies.

ENROLLMENT INSTRUCTIONS

You can either fill out the attached Enrollment Form or call **1-866-I-SAVE33** to start the enrollment process. For either option, you are required to have your physician verify your medications and health history and sign your Enrollment Form.

- Phone: Call I-SaveRx toll-free 24 hours a day and 7 days a week at 1-866-I-SAVE33 (1-866-472-8333). You will be required to supply your name, mailing address and a list of all prescription and over-the-counter medications, herbal, nutritional and vitamin supplements currently taken. You will be advised as to which medications are available through the I-SaveRx Program. The completed Enrollment Form will be forwarded to you by mail, fax or email for your approval, your physician's signature and your signature.
- Web site: Enrollment forms may be completed on-line, downloaded and printed from **www.I-SaveRx.net**

ORDERING INSTRUCTIONS

To place your first order, we require a completed Enrollment Form as well as the original prescription for each medication. To find out if your medications are included in the program, please call **1-866-I-SAVE33** or visit our Web site at **www.I-SaveRx.net**. If acceptable to the prescribing physician, each prescription should be written for a **3-month supply** of medication with **3 refills**. This will allow our pharmacies to automatically ship your refill medications after confirming over the phone your continued need for a one year period. New-to-you medications must be tried for a period of 30 days before ordering through I-SaveRx. When ordering your medications, please allow approximately 20 days for delivery.

IMPORTANT WARNING AND INFORMATION REGARDING THE SAFETY AND LEGALITY OF PRESCRIPTION DRUGS PURCHASED FROM OTHER COUNTRIES

Purchasing prescription drugs by mail order from another country involves certain unavoidable risks. As with any prescription drug purchase, you should educate yourself about your needs and the product to be purchased to minimize your risks. You should always inspect your purchases carefully to ensure that you have received the correct quantity of the correct medication in the correct dosage. You should also check your shipping packages carefully to ensure that your purchases have not been damaged or tampered with during shipping. If you have any questions or doubts about any prescription drugs received through the mail, you should talk to a doctor or pharmacist before you begin taking the medication. Take medication only as instructed by your doctor. Do not take medication that has not been prescribed for you, that does not match your prescription, or that appears to have been damaged or tampered with. If you have symptoms after you begin taking a new medication, talk to a doctor or pharmacist right away. Failure to follow these warnings could result in serious injury or death.

The Canadian, Irish, or United Kingdom regulatory bodies have approved all medications available through this program to be safe for use within their own respective countries. Prescription drugs purchased from other countries fall outside of the regulatory system for prescription drugs purchased in the United States. Canada and United Kingdom have their own regulatory systems to protect the safety of prescription drugs, and those systems differ in certain respects from the system in the United States. Prescription drugs purchased from other countries, for example, may be labeled or packaged differently than prescription drugs purchased in the United States, or manufactured in different facilities. The State of Illinois has investigated the regulatory systems of Canada, Ireland, and the United Kingdom, and believes that they are safe and effective.

The United States Food and Drug Administration (the "FDA"), however, has taken the position that the purchase of prescription drugs from outside of the United States can be unsafe and illegal. To learn more about the FDA's position, please go to http://www.fda.gov/importeddrugs/. The State of Illinois, its officers, and its employees make no representation as to the legality of the importation or reimportation of pharmaceuticals from other countries.

The State of Illinois does not license pharmacies outside of Illinois, and the pharmacies in Canada and United Kingdom participating in this program are not licensed Illinois pharmacies. All pharmacies participating in this program are required to consent to regular inspections by Illinois pharmacy inspectors. The State of Illinois has inspected all of the participating pharmacies, and has concluded that they meet the same conditions required of licensed Illinois pharmacies. The State of Illinois will continue to inspect those pharmacies in the future, and to remove from this program any pharmacy that does not comply with Illinois standards. Nevertheless, the State of Illinois cannot guarantee the safety of any particular prescription drug purchase. The State of Illinois makes no representations or warranties as to the safety or efficacy of prescription drugs purchased from foreign sources.

The I-SaveRx program is not a licensed pharmacy and is not engaged in the practice of pharmacy.

I-SaveRx
Safe and Affordable
Prescription Drugs

FAX: DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTIONS
TOLL-FREE TO: **1-866-715-6337**

MAIL TO: **I-SaveRx**, P.O. BOX 21086, CanaRx Services Inc., TECUMSEH, ON, CANADA N8N 4S1

PHONE TOLL-FREE: **1-866-I-SAVE33 (1-866-472-8333)**

(If you require more space for any information in this enrollment form, please attach a separate piece of paper.)

PATIENT INFORMATION:

Phone (Home) ______ Phone (Work) ______

First Name (please print) ______ Initial ______ Last Name ______

Street Address ______

City/State ______ Zip Code ______ **ENGLISH/SPANISH** Language Preference ______

NOTE: If acceptable to the prescribing physician, each prescription should request a 3-month supply of medication with 3 refills. **New-to-you medications must be tried for a period of 30 days before ordering through the I-SaveRx Program.** You may be contacted by one of our representatives, physicians or the network pharmacy filling the prescription to discuss or confirm your order.

List of all prescription and over-the-counter medications, herbal, nutritional and vitamin supplements currently taken. (This is NOT a prescription.)	STRENGTH	DAILY USE	STARTED TAKING ON

MEDICAL HISTORY ○ **Male** ○ **Female** **Birthdate** DD / MM / YY

1) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. ______

2) Hospitalization: (stays in hospital during the past 5 years) ______

3) Present Illness: (ongoing) e.g., Diabetes, Heart disease, Osteoporosis, etc. ______

4) Drug Allergies: ○**NO** ○**YES** **If yes, please specify** ______

PHYSICIAN'S NAME: ______ **PHYSICIAN'S SIGNATURE:** Optional ______ **DATE:** DD / MM / YY

PAYMENT INFORMATION:

Cardholder Name ______ Credit Card Number ______ Expiry Date (MM / YY) ______

○ **VISA** ○ **MASTERCARD** ○ **CERTIFIED CHECK*** ○ **MONEY ORDER***

* Made payable and mailed directly to CanaRx Services Inc.

Signature of Cardholder ______ **DATE:** DD / MM / YY

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 certify that I have read and understood the CanaRx Terms of Agreement and the Warning Statement, and that the information provided by me is accurate and true.

SIGNATURE OF PATIENT: ______ **DATE:** DD / MM / YY

THIS FORM MUST BE ACCOMPANIED BY THE WRITTEN PRESCRIPTION(S) OF YOUR U.S. PHYSICIAN.

CanaRx TERMS OF AGREEMENT

CONFIRMATION AND REPRESENTATIONS

I, the undersigned, am entering into this agreement with *CanaRx Services Inc.* 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 medication(s) that I have requested that CanaRx Services Inc. 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. If the Rx has not been faxed from my US Physician's office, I agree to mail the original copy of the prescription to CanaRx Services Inc.;
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 Services Inc. 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 medication(s) which I receive;
9) I will use any medication(s) obtained for me by CanaRx Services Inc. strictly in accordance with the instructions provided by the physician who prescribed the medication(s); and
10) In the event that I suffer any side effects from any medication(s) I receive through the services of CanaRx Services Inc., I will immediately contact my U.S. physician.

AUTHORIZATION AND CONSENT

I further provide my authorization and consent to the following:

1) I hereby appoint CanaRx Services Inc. and its delegates or contractors as my agent and attorney for the purposes of obtaining a prescription from the CanaRx Network Pharmacy, which corresponds to the prescription provided by my U.S. physician.
2) I authorize CanaRx Services Inc. and its delegates or contractors to arrange delivery of the medication(s) 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 Services Inc. 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 Services Inc. 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 a prescription for medication(s) 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 they may require to any CanaRx Network Pharmacy for the purpose of having my prescription(s) filled.

ACKNOWLEDGMENT AND RELEASE

I hereby make the following acknowledgments and releases to *CanaRx Services Inc.,* 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 contracted physician is being asked only to review the information contained in the Personal Medical History for the purpose of authorizing any properly prescribed medication(s) for fulfillment from a CanaRx Network Pharmacy.
2) I acknowledge that CanaRx Services Inc. 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 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).
3) I acknowledge that I wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx Services Inc. 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 acknowledge that child protective packaging may not be used by the CanaRx Network Pharmacy filling my prescription and I release CanaRx Services Inc. 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.
5) I acknowledge that CanaRx Services Inc. requires payment in full prior to shipment and that my order may not be returned for a refund or an exchange.