

BrattleboroRetreatCanaRx

Introduction:

BrattleboroRetreatCanaRx is a voluntary prescription drug program that is available to eligible Employees and their Dependents of Brattleboro Retreat enrolled in the Bronze plan. An expanded list of preventive medications is available to you through this program only. 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.

BrattleboroRetreatCanaRx		Vs.	Current Purchase Plan			
Annual Cost No Copays		Current Copays		Refills		Annual Savings
\$0	Vs.	\$30 (Preferred)	x	12	=	\$360 / Script
\$0	Vs.	\$50 (Non-Preferred)	x	12	=	\$600 / Script

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 **BrattleboroRetreatCanaRx**.

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: BrattleboroRetreatCanaRx



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

OR

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 your Human Resource office, by visiting www.BrattleboroRetreatCanaRx.com or by contacting our Customer Service Representatives toll free at 1-866-893-6337.

WELCOME TO BrattleboroRetreatCanaRx

ABILIFY (G) 2MG ABILIFY (G) 5MG ABILIFY (G) 10MG ABILIFY (G) 15MG ABILIFY (G) 20MG ABILIFY (G) 30MG ACIPHEX 20MG ACTONEL 5MG ACTONEL 30MG ACTONEL 35MG ACTONEL 150MG ACTOPLUS 15MG-850MG ADVAIR DISKUS 100MCG ADVAIR DISKUS 250MCG ADVAIR DISKUS 500MCG ADVAIR HFA 45/21MCG ADVAIR HFA 115/21MCG ADVAIR HFA 230/21MCG AGGRENOX 200/25MG ALOCRIL 2% ALOMIDE 0.1% ALPHAGAN-P 0.15% ALREX 0.2% ALVESCO 80MCG 100MCG ALVESCO 160MCG 200MCG ANORO ELLIPTA 62.5/25MCG ARCAPTA NEOHALER 75MCG ARNUITY ELLIPTA 100MCG ARNUITY ELLIPTA 200MCG AROMASIN 25MG ASACOL HD 800MG ASMANEX TWISTHALER 110MCG ASMANEX TWISTHALER 220MCG 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 AVANDIA 2MG AVANDIA 4MG AVODART (G) 0.5MG AZOPT 1% AZOR 20/5MG AZOR 40/5MG AZOR 40/10MG BECONASE AQ 42MCG BENICAR (G) 20MG BENICAR (G) 40MG BENICAR HCT (G) 20MG/12.5MG BENICAR HCT (G) 40MG/12.5MG BENICAR HCT (G) 40MG/25MG BETIMOL 0.25% BETIMOL 0.5% BETOPTIC S 0.25% BONIVA (G) 150MG 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 CARDURA XL 4MG CARDURA XL 8MG COMBIGAN 0.2-0.5% COMBIVENT RESPIMAT 20MCG/100MCG COMTAN 200MG CRESTOR (G) 5MG CRESTOR (G) 10MG CRESTOR (G) 20MG CRESTOR (G) 40MG	CYMBALTA (G) 20MG CYMBALTA (G) 30MG CYMBALTA (G) 60MG DALIRESP 500MCG DEXILANT DR 30MG DEXILANT DR 60MG DIOVAN (G) 40MG DIOVAN (G) 80MG DIOVAN (G) 160MG DIOVAN (G) 320MG 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 EFFIENT (G) 5MG EFFIENT (G) 10MG ELIQUIS 2.5MG ELIQUIS 5MG ENTRESTO 24MG-26MG ENTRESTO 49MG-51MG ENTRESTO 97MG-103MG EPIVIR / HBV 100MG EUCRISA 2% EVISTA 60MG 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 INCRUSE ELLIPTA 62.5MCG INDERAL LA 60MG INDERAL LA 80MG INDERAL LA 120MG INDERAL LA 160MG INVEGA 3MG INVEGA 6MG INVEGA 9MG 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 JUBLIA 10%	KAZANO 12.5/1000MG KEPPRA (G) 250MG KEPPRA (G) 500MG KEPPRA (G) 750MG KEPPRA (G) 1000MG KOMBIGLYZE XR 2.5MG/1000MG KOMBIGLYZE XR 5MG/500MG KOMBIGLYZE XR 5MG/1000MG LATUDA 20MG LATUDA 40MG LATUDA 60MG LATUDA 80MG LATUDA 120MG LESCOL XL 80MG LEXIVA 700MG LIPITOR (G) 10MG LIPITOR (G) 20MG LIPITOR (G) 40MG LIPITOR (G) 80MG LUMIGAN 0.01% MESNEX 400MG MESTINON TS 180MG METROGEL (G) 0.75% MICARDIS HCT 40/12.5MG MICARDIS HCT 80/12.5MG MICARDIS HCT 80/25MG 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% MULTAQ 400MG NESINA 6.25MG NESINA 12.5MG NESINA 25MG NEUPRO 1MG NEUPRO 2MG NEUPRO 3MG NEUPRO 4MG NEUPRO 6MG NEUPRO 8MG NEXIUM 20MG NEXIUM 40MG NEXIUM DR 10MG ONGLYZA 2.5MG ONGLYZA 5MG OTEZLA 30MG PRADAXA 75MG PRADAXA 150MG PREVACID SOLUTAB 15MG PREVACID SOLUTAB 30MG PREZISTA 800MG PRISTIQ 50MG PRISTIQ 100MG PROGRAF (G) 1MG QTERN 10-5MG QVAR REDIHALER 40MCG QVAR REDIHALER 80MCG RANEXA 500MG RAPAMUNE 0.5MG 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 SAPHRIS 5MG SAPHRIS 10MG SEASONIQUE 0.15/0.03/0.01MG SENSIPAR 30MG SENSIPAR 60MG SEREVENT DISKUS 50MCG SEROQUEL XR 50MG SEROQUEL XR 150MG SEROQUEL XR 200MG SEROQUEL XR 300MG SEROQUEL XR 400MG	SIMBRINZA 1%/0.2% SOOLANTRA 1% SPIRIVA 18MCG SPIRIVA RESPIMAT 2.5MCG STARLIX 60MG STARLIX 120MG STEGLATRO 5MG STEGLATRO 15MG STIOLTO RESPIMAT 2.5/2.5MCG STRATTERA 10MG STRATTERA 18MG STRATTERA 25MG STRATTERA 40MG STRATTERA 60MG STRATTERA 80MG STRATTERA 100MG 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 TEKTURNA HCT 150-25MG TEKTURNA HCT 300-12.5MG TEKTURNA HCT 300-25MG TOBREX OINT 0.3% 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 TABLET 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 WELLBUTRIN XL (G) 150MG WELLBUTRIN XL (G) 300MG XARELTO 10MG XARELTO 15MG XARELTO 20MG XELJANZ 5MG 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 ZETIA (G) 10MG ZYCLARA 3.75%
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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.



BrattleboroRetreatCanaRx

CanaRx 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: *BrattleboroRetreatCanaRx*, 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 _____
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
<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 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.