

SLUMeds

EMPLOYEE PROGRAM

Introduction:

SLUMeds is an optional international mail order program designed and offered to Employees and their dependents of St. Lawrence University, New York. For your convenience, a list of eligible medications is located on the back of this page.

Co-Payments:

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

SLUMeds vs. Current local purchase plan

| Annual Cost No co-pays | | Monthly Co-pays | x | Refills | = | Annual Cost |
|---------------------------|-----|--------------------|---|---------|---|----------------|
| \$0 | vs. | \$25 (Tier 2) | x | 12 | = | \$300 / script |
| \$0 | vs. | \$50 (Tier 3) | x | 12 | = | \$600 / script |

Ordering Instructions:

To place your first order simply complete the enrollment form and include a new prescription for each medication. Please allow 4 weeks 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 tried for 30 days before ordering through **SLUMeds**.

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: SLUMeds

P.O. Box 44650

Detroit, MI 48244-0650

EMPLOYEE PROGRAM

MEMBER ID #.

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION (S) TOLL-FREE TO: 1-866-715-(MEDS) 6337
OR
MAIL TO: *SLUMeds*, 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 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. <i>Ex. Lipitor (This is NOT a prescription.)</i> | Strength <i>Ex. 10 mg</i> | Reason for Taking <i>Ex. Cholesterol</i> | Daily Use <i>Ex. Twice Daily</i> |
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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, understand and agree to the Terms of Agreement on the reverse and that the information provided by me is accurate and true.**

I request and authorize St. Lawrence University, New York, as my appointed agent, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service as determined appropriate by St. Lawrence University, New York in the administration of my employment or benefits.

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

TERMS OF AGREEMENT

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.

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 by the pharmacies filling my prescription.
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 Group Inc. in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use of any medications delivered through this program which are utilized for any purpose whatsoever.

EMPLOYEE PROGRAM

MEMBER ID #: _____

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337
OR
MAIL TO: *SLUMeds*, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

PATIENT INFORMATION: Birthdate _____ SPOUSE
DD/MM/YYYY DEPENDENT

NOTE:
Please request a **3-month** supply of medication with **3 refills**.

Phone (Home) _____ Phone (Work) _____

New-to-you medications must be domestically prescribed, filled and taken for a period of no less than 30 days.

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

Street Address _____

City/State _____ Zip Code _____

| List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. <i>Ex. Lipitor (This is NOT a prescription.)</i> | Strength <i>Ex. 10 mg</i> | Reason for Taking <i>Ex. Cholesterol</i> | Daily Use <i>Ex. Twice Daily</i> |
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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, understand and agree to the Terms of Agreement on the reverse and that the information provided above is accurate and true. I request and authorize St. Lawrence University, NY, as my authorized agent, 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, understand and agree to the Terms of Agreement on the reverse and that the information provided by me is accurate and true. I request and authorize St. Lawrence University, NY, as my authorized agent, 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)* _____

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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

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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.

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 by the pharmacies filling my prescription.
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 Group Inc. in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use of any medications delivered through this program which are utilized for any purpose whatsoever.



DOCTOR'S OFFICE FAXED MEDICATION ORDER

Toll free phone: 1-866-893-MEDS (6337) Toll free fax: 1-866-715-MEDS (6337)

PATIENT

First Name Initial Last Name Phone (Home)

Indicate any change in your health or existing medications below. Birthdate DD/MM/YYYY

PROVIDER

U.S. Physician Name Phone Fax

Street Address City, State, Zip Code

Please answer the following as it applies to this Patient:

- 1. Has this Patient been taking this medication (s) for at least 30 days? YES NO
2. If the answer to Question #1 was NO (ie. This is a new prescription (s)), has the Patient shown that they can tolerate this medication? YES NO

ALL PRESCRIPTIONS SHOULD ACCOMPANY THIS FORM

If FAXING: Make sure your Physician attaches all medication orders to one form
Your ORIGINAL prescription (s) is (are) to remain on file with your prescribing Physician.
Number of prescription (s) attached.

FAX TOLL FREE DIRECTLY FROM YOUR DOCTOR'S OFFICE 1-866-715-6337

If MAILING: Please forward your ORIGINAL prescription (s) with this form to:

SLUMeds
P.O. Box 44650
DETROIT, MI, 48244-0650

If you or your Physician have any questions, please contact our Customer Representatives toll free at 1-866-893-6337.

Patient Signature (Parent / Guardian if Patient is Under Age 18)

Date