



How to submit your Medical Information and Prescription Drug Order for Immediate Processing

1. Find your Employee Number

Print your employee name and your dependents' names on document 1 and your employee number on each page that you fax to us.

2. Prepare your Documents

Please prepare the following information in order to receive your prescription drug order. You must fully complete the attached forms. If they are not completed in full, they will be returned to you. The medical questionnaire form is designed to provide the pharmacy with a summary of your drug history for your safety.

Prescriptions from your specialists are acceptable.

Make sure you have all the pages together and ready to fax at once.

The following summary will help you:

Document #	Form Name
1	Patient Health and Medication Background
2	US Customs Statement for international drug purchases/Patient Authorization and Release
3	Rx form or <u>Doctor's own prescriptions</u>

3. Fax your documents to: 1-866-436-2876

IMPORTANT: The fax MUST be sent only from your physician's office.

It is against the law for us to accept prescriptions by fax from any other location.

**If you prefer, you can mail your forms and ORIGINAL prescription to us at:
Canusa Health Inc., 14 William St. N., Chatham, ON N7M 4L1**

Call customer service if needed: 1-866-448-1726 (9am to 5pm Mon-Fri EST)

Once your documents have been received by our Prescription Processing Department, your order will be immediately prepared for delivery. Under normal circumstances, your initial (first) order will arrive within 3 to 4 weeks of the time that we receive your order.

If you do not want your prescription drugs shipped immediately, you must indicate this and state clearly when you would like them delivered.



Document 2
COMPLETED BY EACH PATIENT
ORDERING PRESCRIPTIONS

U.S. Customs Statement - International Drugs

U.S. Physician Name: _____

State License Number: _____

(from prescription)

Physician Address: _____

His or her original prescription is attached.

The undersigned hereby acknowledges, confirms and certifies that the enclosed medication(s) is (are) imported to the U.S.A. solely for personal use for a period not exceeding three (3) months.

Patient Name: _____

Address: _____

PATIENT Signature: X _____

Group 6000 **Dept #** **Employee#**

Patients must provide a separate, signed statement for each prescribing physician.

U.S. Physician State License Number can be found on your original prescription.

Canusa Authorization and Release

Group Name: Broome County, New York

Employee ID# _____

Patient Name: _____

No prescriptions will be filled without a signed and dated copy of this form.

1. The Patient hereby authorizes (a) any of his or her primary physician, Canusa to release any and all information regarding the Patient's 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 any other physician (the "referred physician") who may be required to review the Patient's health record for the purposes of being in a position to evaluate the medical necessity and indications for prescription medication; (b) the referred physician to prescribe, if he or she deems it advisable and appropriate, a prescription medication; (c) the referred physician to release any and all information he or she may possess to any pharmacy outside of the United States for the purpose of having the Patient's prescription filled; (d) Canusa, the primary physician, the referred physician and any such pharmacy to release any such information concerning the Patient to any person undertaking the adjudication and/or payment of any such prescription, and/or payment of any such prescription, and for any such person to provide reports in respect thereof containing any such information to any of Canusa and any such pharmacy; and (e) the Patient further authorizes Canusa Health Inc., the primary physician, the referred physician, and any such Canadian/International pharmacy to release any such personal information concerning the Patient to any person undertaking the adjudication and/or payment of any such prescription, and for any such person to provide reports in respect thereof containing any such personal information to Canusa Health Inc., and/or such Canadian/International pharmacy. It is agreed that Canusa Health Inc. may act as the Patient's agent for the purpose of assigning or transferring the Patient's prescription(s) to any licensed pharmacy it deems to be in the interest of the Patient.
2. The Patient acknowledges that he or she wishes to obtain a prescription from a referred physician outside of the United States and accepts all of the risks inherent with the fact that such referred physician has not personally examined the Patient. The Patient understands and accepts that the referred physician will rely on the accuracy of the history, functional inquiry, and examination performed and provided by the Patient's primary physician in the United States. The Patient hereby authorizes the referred physician to contact the primary physician if necessary for clarification or confirmation of any details concerning the Patient's medical history or condition or the prescription issued by the Patient's primary physician.
3. The Patient acknowledges having read and agreed to Canusa's security policy re: transmission of information over the Internet. Canusa uses a secure server with 128-bit encryption and SSL (Secure Socket Layers) to ensure all Patient information is secure and private. Patient data is stored on secure media which is not stored online.
4. The Patient acknowledges that prescription medication, once shipped, may not be returned for a refund or an exchange.

By signing this document the Patient confirms that he or she has read and understood these terms and that they are true and correct and the Patient agrees that the terms herein are binding on the Patient and the heirs, assigns, successors and personal representatives of the Patient and further understands that the released information will no longer be protected by federal privacy regulations.

I understand this authorization will start on the dated signed below and expire in one (1) year.

Signed and dated this _____ day of _____, 200__ at (city) _____, in the State of _____, U.S.A.

PATIENT Signature: X _____ *Signing Parent or Guardian* (please print your name): _____

IMPORTANT!

Please photocopy this form if you need additional pages, or call Canusa Health (1-866-448-1726)

PLEASE FAX ALL FORMS ONLY FROM YOUR DOCTOR'S OFFICE TO 1-866-436-2876



Document 3 - *Optional*
COMPLETED BY PHYSICIAN

Prescription (*Optional*)



Group 6000

Dept #

Employee #

Patient name: _____

Shipping address: Same as member, or: _____

PHYSICIAN: Please complete the prescription below or attach your legible, printed and faxable prescription pad original.

	Drug name	Strength	Frequency	Quantity	# of Refills
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____

All prescriptions will be shipped immediately unless requested otherwise.

All prescriptions are issued for a period of 90 days plus 3 refills.

The patient has been on these medications for at least 90 days.

In order to avoid delays, please type or print legibly in black ink.

Patient savings are increased through generic substitution where available. No generic substitution.

X

Prescribing Physician's Signature _____ Date: _____

Physician's name: _____

DEA #: _____ State License # _____

Physician's Phone: _____ Physician's Fax _____

PLEASE FAX ALL FORMS FROM YOUR DOCTOR'S OFFICE TO 1-866-436-2876