



CRX International is a voluntary international mail order option. To be eligible for the CRX International program, you must be an existing member of a health insurance plan that currently has CRX International implemented as an additional option for prescription medication coverage.



FREE Brand-Name Medications



No Shipping and Handling Charges to You!



SAVINGS.

Who is CRX International?

With our program, you pay **\$0** in copays and your medications are shipped right to your door for **FREE**. How? Your health plan pays less for the medication and shares these savings with you.

SIMPLE.

We're the easy way for you to get prescription medications. CRX International offers hundreds of brand-name maintenance medications that you can get — **copay-free** — in just a few easy steps.

SAFE.

Medications are shipped direct to you from licensed and regulated pharmacies located in Canada, the United Kingdom and Australia. All medications are backed by a Quality Assurance Team of doctors and pharmacists, as well as 20-plus years of experience in the industry.

Ready to Start Saving?

ENROLL TODAY!

1-866-488-7874 | crxintl.com



Let's Get Started

JOINING IS EASY!

Visit our website today, for more information including:

- Additional Forms
- Frequently Asked Questions (FAQs)
- Video Overview
- List of Medications

Call 1-866-488-7874 for your plan's WebID.

crxintl.com

Scan to go to the website ▶



Before ordering through CRX International, you or your doctor must attest that you have been taking your prescribed medication for at least 30 days – this is to ensure you have not experienced any complications with the medication.



STEP 1

Ask your doctor for a prescription for a **3-month** supply of your maintenance medication with **3 refills**.



STEP 2

Fill out the attached enrollment form or download one from your group website.



STEP 3

Send us your prescription, enrollment form and a copy of your state driver's license or other approved government ID.



STEP 4

CRX International will call you to welcome you to the program and review your order.



STEP 5

A licensed and regulated pharmacy will ship your medication to you in the original manufacturer's sealed packaging.



STEP 6

Refills are worry-free. CRX International will call you prior to each renewal of your prescription to ensure you have a continuous supply.

Submit Your Completed and Signed Enrollment Form, Original Prescription and ID:

By Mail to:

CRX International
PO Box 3009
Windsor, ON Canada
N8N 2M3

Enrollment Form
and ID can also
be sent by secure
upload to:
crxdocs.com

By Fax to:

1-866-215-7874

Note: Prescriptions must be faxed directly from the physician's office.

CRX
INTERNATIONAL



MEMBER ENROLLMENT FORM

For more information, please call:
TOLL-FREE PHONE: 1-866-488-7874

Please return completed enrollment form by one of the following methods:
MAIL: CRX International, PO BOX 3009, WINDSOR, ONTARIO CANADA N8N 2M3
SECURE UPLOAD: CRXDOCS.COM
FAX: 1-866-215-7874 (NOTE: Faxed prescriptions must be sent directly from the physician's office.)

WEBID (CALL IF UNSURE)
NAME OF EMPLOYER

PATIENT INFORMATION (PLEASE PRINT)		DATE OF BIRTH (MM/DD/YYYY)		MEMBER ID # (IF AVAILABLE)	
HOME PHONE	MOBILE PHONE	WORK PHONE	EXT.	EMAIL ADDRESS	
FIRST NAME		INITIAL	LAST NAME		
STREET ADDRESS					
CITY		STATE	ZIP CODE	<input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> DEPENDENT	

CURRENT MEDICATIONS / VITAMINS THIS IS NOT A PRESCRIPTION.
LIST ALL: PRESCRIPTION, NON-PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS; HERBAL, NUTRITIONAL AND VITAMIN SUPPLEMENTS.

NAME OF MEDICATION <i>Ex. JANUVIA</i>	DOSAGE <i>Ex. 50MG</i>	TIME(S) TO TAKE <i>Ex. TWICE DAILY</i>	DATE STARTED <i>Ex. 08/20/2019</i>	REASON FOR TAKING <i>Ex. DIABETES</i>

NEW-TO-YOU MEDICATIONS MUST BE DOMESTICALLY PRESCRIBED, FILLED AND TAKEN FOR A PERIOD OF **NO LESS THAN 30 DAYS** BEFORE ORDERING THROUGH THIS PROGRAM. **PLEASE ASK YOUR PHYSICIAN TO ISSUE A PRESCRIPTION FOR A 3-MONTH SUPPLY OF MEDICATION WITH 3 REFILLS.**

PRESCRIPTION IS ATTACHED PRESCRIPTION WILL FOLLOW BY MAIL PRESCRIPTION WILL BE FAXED FROM PHYSICIAN'S OFFICE

MEDICAL HISTORY (If you require more space, please attach a separate piece of paper.) **MALE** **FEMALE**

1. OPERATIONS (EX. HYSTERECTOMY, GALL BLADDER, HEART OPERATIONS, ETC.):

2. HOSPITALIZATIONS (STAYS IN HOSPITAL DURING THE PAST 5 YEARS):

3. MEDICAL CONDITIONS (ONGOING – EX. TYPE 1 DIABETES MELLITUS, VASCULITIS, OSTEOPOROSIS, ETC.) – **NOTE:** Please refrain from using generic terms such as **“heart disease”** as this could indicate any number of conditions such as valvular heart disease, heart failure, a bradyarrhythmia, a tachyarrhythmia, a ventricular conduction delay, etc.

4. DRUG ALLERGIES: **YES** **NO** 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/YYYY)

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's Signature: _____ **Date:** _____ (MM/DD/YYYY)

CONFIRMATION AND REPRESENTATIONS

I enter into this agreement with CRX International Inc. at Christ Church, Barbados (referred to as "CRX") 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 CRX 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 CRX 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 CRX.
7. My care by my U.S. physician is ongoing and I do not seek and will not rely on any medical information from CRX or any CRX selected 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 CRX 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 CRX, I will immediately contact my U.S. physician.
14. All information that I give to CRX is true.

AUTHORIZATION AND CONSENT

I consent to, and authorize, the following:

1. I hereby appoint CRX and its delegates and contractors (collectively referred to as "CRX") 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; selecting physicians, pharmacies, and other professionals as necessary to serve me outside the U.S.; and of arranging for pharmacies to dispense to me medications as prescribed.
2. CRX 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 by mail.
3. CRX 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 CRX (and any CRX selected 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 CRX from my U.S. physician's office the original signed copy of the prescription.
6. CRX and its selected physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
7. CRX selected physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
8. CRX may make payments on my behalf to pharmacies for dispensing medicine in accordance with my prescriptions and to 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 CRX 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 CRX 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 CRX selected 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 CRX selected pharmacy.
2. CRX 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 CRX selected physician and have enlisted the services of CRX to facilitate it. I understand that the physician will rely on the accuracy of the examination performed, and the prescription provided, by my U.S. physician.
4. I release CRX 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 CRX selected pharmacy.
6. I acknowledge that CRX, 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 CRX Privacy Policy in detail as provided below:

1. CRX 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. CRX and CRX selected physicians and pharmacists may share any and all information received from or about me with my U.S. physician, CRX selected 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 CRX may transmit my personal information by electronic means (for example fax, or via the internet) to its agents, selected 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 CRX, 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 CRX's transmission of my personal information by electronic means to its delegates, employees, selected physicians and pharmacies.
3. I acknowledge that CRX will obtain health information about me, and is obligated in accordance with the CRX Privacy Policy to protect such information. I can visit www.CRXIntl.com/privacy-policy/ at any time to view the most updated version of the CRX 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 CRX 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 CRX 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.