

Introduction:

EverettMeds is a voluntary prescription drug program that is available to eligible Employees and their Dependents of the City of Everett, Massachusetts. 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.

EverettMeds		Vs.	Current Local Purchase Plan			
Annual Cost No Copays!			Current Copays	Refills		Annual Savings
\$0	Vs.		\$50 (Tier 2)	x 4	=	\$200 / Script
	Vs.		\$110 (Tier 3)	x 4	=	\$440 / 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 **EverettMeds**.

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: EverettMeds

P.O. Box 44650

Detroit, MI 48244-0650

More forms are available:

Additional forms may be obtained by printing them from the website at www.EverettMeds.com or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

WELCOME TO **EverettMeds**
Employee Program

ABILIFY 2MG ABILIFY 5MG ABILIFY 10MG ABILIFY 15MG ABILIFY 20MG ABILIFY 30MG ACIPHEX (G) 20MG ACTONEL 5MG ACTONEL 30MG ACTONEL 35MG ACTONEL 150MG ACTOPLUS (G) 15MG-850MG ACTOS (G) 30MG ACTOS (G) 45MG ACZONE 7.5% ADCIRCA 20MG ADVAIR DISKUS 100MCG ADVAIR DISKUS 250MCG ADVAIR DISKUS 500MCG ADVAIR HFA 45/21MCG ADVAIR HFA 115/21MCG ADVAIR HFA 230/21MCG AGGRENOX 200/25MG ALPHAGAN-P OPHTH SOL (G) 0.15% ALTACE (G) 5MG ALVESCO 80MCG 100MCG ALVESCO 160MCG 200MCG AMITIZA 24MCG ANORO ELLIPTA 62.5/25MCG ANZEMET 100MG ARAHA (G) 10MG ARAHA (G) 20MG ARCAPTA NEOHALER 75MCG ARNUITY ELLIPTA 100MCG ARNUITY ELLIPTA 200MCG AROMASIN (G) 25MG ARTHROTEC (G) 50MG ARTHROTEC (G) 75MG ASACOL HD 800MG ASMANEX TWISTHALER 110MCG ASMANEX TWISTHALER 220MCG ASTAGRAF XL 5MG ASTELIN (G) 137MCG ATACAND (G) 4MG ATACAND (G) 8MG ATACAND (G) 16MG ATACAND (G) 32MG ATELVIA DR 35MG ATROVENT HFA 20UG AUBAGIO 14MG AVANDIA 2MG AVANDIA 4MG AVANDIA 8MG AVODART 0.5MG AXERT 6.25MG AXERT 12.5MG AZILECT 0.5MG AZILECT 1MG AZOPT OPHTH DROPS 1% AZOR 20/5MG AZOR 40/5MG AZOR 40/10MG BANZEL 200MG BANZEL 400MG BARACLUDE 0.5MG BARACLUDE 1MG BECONASE AQ 42MCG BENICAR 20MG BENICAR 40MG BENICAR HCT 20MG/12.5MG BENICAR HCT 40MG/12.5MG BENICAR HCT 40MG/25MG BETIMOL 0.25% BETIMOL 0.5% BETOPTIC S OPHTH 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 (G) 5/10MG CADUET (G) 5/20MG CADUET (G) 5/40MG CADUET (G) 10/10MG	CADUET (G) 10/20MG CARDURA XL 4MG CARDURA XL 8MG CELEBREX 100MG CELEBREX 200MG CLIMARA PATCH (G) 25MCG CLIMARA PATCH (G) 50MCG CLIMARA PATCH (G) 75MCG COMBIGAN 0.2-0.5% COMBIVENT RESPIMAT 20MCG/100MCG COMTAN (G) 200MG CORGARD (G) 80MG COVERA-HS 240MG CRESTOR 5MG CRESTOR 10MG CRESTOR 20MG CRESTOR 40MG CYMBALTA (G) 20MG CYMBALTA (G) 30MG CYMBALTA (G) 60MG DALIRESP 500MCG DESCOVY 200MG/25MG DETROL (G) 1MG DETROL (G) 2MG DETROL LA 2MG DETROL LA 4MG DEXILANT DR 30MG DEXILANT DR 60MG DIFFERIN CREAM (G) 0.1% DIFFERIN GEL (G) 0.1% DIFFERIN GEL 0.3% DIOVAN (G) 40MG DIOVAN (G) 80MG DIOVAN (G) 160MG DIOVAN (G) 320MG DIPROLENE LOTION (G) 0.05% DIPROLENE OINT (G) 0.05% DOVONEX CREAM (G) 50MCG DULERA 100MCG/5MCG DULERA 200MCG/5MCG DYMISTA NASAL SPRAY 137/50MCG EDARBI 40MG EDARBI 80MG EDARBYCLOL 40MG/25MG EDECIN 25MG EDURANT 5MG EFFIENT 5MG EFFIENT 10MG ELIDEL 1% ELIQUIS 2.5MG ELIQUIS 5MG ELMIRON 100MG ENABLEX 7.5MG ENABLEX 15MG ENTOCORT (G) 3MG EPIPEN 0.3MG EPIPEN JR 0.15MG EPIVIR / HBV (G) 100MG EPZICOM ESTROGEL 0.06% EVISTA 60MG EXELON 3MG EXELON 6MG EXELON 4.6MG/24HR EXELON 9.5MG/24HR EXELON 13.3MG/24HR 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 EXJADE 500MG FARESTON 60MG FARXIGA 5MG FARXIGA 10MG FELDENE 10MG FELDENE 20MG FEMARA (G) 2.5MG FETZIMA 20MG FETZIMA 40MG FETZIMA 80MG FETZIMA 120MG FINACEA GEL 15% FLOVENT 44MCG 50MCG FLOVENT 110MCG 125MCG FLOVENT 220MCG 250MCG FLOVENT DISKUS 100MCG FLOVENT DISKUS 250MCG	FORADIL + AEROLIZER 12MCG FOSRENOL CHEW 500MG FOSRENOL CHEW 750MG FOSRENOL CHEW 1000MG FOSRENOL POWDER 750MG FOSRENOL POWDER 1000MG FROVA 2.5MG GELNIQUE 10% GENVOYA 150-150-200-10MG GILENYA 0.5MG GLEEVEC 100MG GLEEVEC 400MG GLUMETZA ER 1000MG IMITREX AUTOINJECTOR STATDOSE (G) 6MG/0.5ML IMITREX NASAL SPRAY (G) 5MG-2DOSE IMITREX NASAL SPRAY (G) 20MG-2DOSE IMURAN (G) 50MG INCRUSE ELLIPTA 62.5MCG INDERAL LA (G) 60MG INDERAL LA (G) 80MG INDERAL LA (G) 120MG INDERAL LA (G) 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 JADENU 90MG JADENU 180MG JADENU 360MG JALYN 0.5MG/0.4MG 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 LIALDA 1.2GM LINZESS 145MCG LINZESS 290MCG LIPITOR (G) 10MG LIPITOR (G) 20MG LIPITOR (G) 40MG LIPITOR (G) 80MG LOCOID LIPOCREAM 0.1% LOTEMAX GEL 0.5% LOTEMAX SUSP 0.5% LOVENOX (G) 40MG LOVENOX (G) 60MG LOVENOX (G) 80MG LOVENOX (G) 100MG LUMIGAN OPHTH 0.01% MESNEX 400MG MESTINON TS 180MG METRO CREAM (G) 0.75% METROGEL PUMP 1% MICARDIS HCT (G) 40/12.5MG MICARDIS HCT (G) 80/12.5MG	MICARDIS HCT (G) 80/25MG MIGRANAL NASAL SPRAY 4MG/ML MINOCIN (G) 50MG 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 MULTAQ 400MG MYRBETRIQ 25MG MYRBETRIQ 50MG NASONEX 50MCG 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 NORITATE CREAM 1% NORVIR TABLET 100MG OMNARIS NASAL SPRAY 50MCG ONGLYZA 2.5MG ONGLYZA 5MG ORTHO-TRI-CYCLEN LO OTEZLA 30MG PATANOL OPHTH SOL 0.1% PENTASA 500MG PLAVIX (G) 75MG PRADAXA 75MG PRADAXA 150MG PRED FORTE (G) 1% PREMARIN 0.3MG PREMARIN 0.625MG PREMARIN 1.25MG PREMARIN CREAM 0.625MG/GM PREMPRO 0.3MG/1.5MG PREMPRO 0.625MG/5MG PREVACID SOLUTAB 15MG PREVACID SOLUTAB 30MG PREZCOBIX 800MG/150MG PREZISTA 800MG PRISTIQ 50MG PRISTIQ 100MG PROGRAF (G) 1MG PROMETRIUM (G) 100MG PROTONIX (G) 40MG PROTOPIC OINT 0.03% PROTOPIC OINT 0.1% PROZAC (G) 20MG QVAR REDHALER 40MCG QVAR REDHALER 80MCG RANEXA 500MG RAPAFLO 4MG RAPAFLO 8MG RAPAMUNE (G) 0.5MG RAPAMUNE (G) 2MG RELPAZ 20MG RELPAZ 40MG RENAGEL 800MG RENVELA 800MG RESTASIS VIALS 0.05% RETIN A CREAM (G) 0.05% RETIN-A MICRO GEL PUMP (G) 0.1% REXULTI 0.25MG REXULTI 0.5MG REXULTI 2MG REXULTI 4MG REYATAZ 150MG REYATAZ 200MG REYATAZ 300MG RHINOCORT AQ 32MCG SENSIPAR 30MG SENSIPAR 60MG SEREVENT DISKUS 50MCG SOOLANTRA 1% SPIRIVA 18MCG SPIRIVA RESPIMAT 2.5MCG STARLIX (G) 60MG STARLIX (G) 120MG	STIOLTO RESPIMAT 2.5/2.5MCG STRATTERA 10MG STRATTERA 18MG STRATTERA 25MG STRATTERA 40MG STRATTERA 60MG STRATTERA 80MG STRATTERA 100MG SYNAREL NASAL SYNJARDY 5MG/500MG SYNJARDY 5MG/1000MG SYNJARDY 12.5MG/500MG SYNJARDY 12.5MG/1000MG TABLOID 40MG TARKA 2/180MG TARKA 4/240MG TASMAR 100MG TAZORAC CREAM 0.05% TAZORAC CREAM 0.1% TAZORAC GEL 0.05% TAZORAC GEL 0.1% TECFIDERA 120MG TECFIDERA 240MG TEGRETOL (G) 200MG TEGRETOL XR (G) 200MG TEGRETOL XR (G) 400MG TEKTURN 150MG TOBREX OINT 0.3% TOPAMAX (G) 25MG TOPAMAX (G) 100MG TOVIAZ 4MG TOVIAZ 8MG TRADJENTA 5MG TRAVATAN Z OPHTH SOL 0.004% TRELLEGY ELLIPTA 100-62.5-25MCG TRILEPTAL (G) 300MG TRINTELLIX 5MG TRINTELLIX 10MG TRINTELLIX 20MG TUDORZA PRESSAIR 400MCG ULORIC 80MG URCIT-K (G) 10MEQ URSO (G) 250MG VAGIFEM 10MCG VENTOLIN HFA 90MCG VESICARE 5MG VESICARE 10MG VIRAMUNE XR 400MG VIVELLE-DOT 25MCG VIVELLE-DOT 37.5MCG VIVELLE-DOT 50MCG VIVELLE-DOT 75MCG VIVELLE-DOT 100MCG VYTORIN 10/10MG VYTORIN 10/20MG VYTORIN 10/40MG VYTORIN 10/80MG WELCHOL 625MG WELLBUTRIN XL (G) 150MG WELLBUTRIN XL (G) 300MG XARELTO 10MG XARELTO 15MG XARELTO 20MG XELJANZ 5MG XELODA (G) 150MG XELODA (G) 500MG XIGDUO XR 5/1000MG XIGDUO XR 10/500MG XIGDUO XR 10/1000MG YAZ (G) 3/0.02MG ZANTAC (G) 300MG ZETIA 10MG ZOMIG (G) 2.5MG ZOMIG NASAL SPRAY 5MG ZOMIG ZMT (G) 2.5MG (1X6) ZORTRESS 0.25MG ZORTRESS 0.5MG ZORTRESS 0.75MG ZOVIRAX CREAM 5% ZYCLARA 3.75%
---	---	--	--	--

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.

MEMBER ID #:

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337
OR

MAIL TO: *EverettMeds*, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

PATIENT INFORMATION: Birthdate _____ SUBSCRIBER
MM/DD/YYYY 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 Group Inc. ("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. 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, 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 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.
5. 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, X-ray records, imaging records, laboratory reports, and/or any other knowledge or information which my U.S. physician may possess.
6. 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.
7. CanaRx and its contracted physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
8. CanaRx contracted physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
9. 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.
10. I request and authorize my plan payor, 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 plan payor in accordance with the benefits plan.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments 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 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.
5. 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.
6. I acknowledge that I have purchased my medications internationally for personal use and I specifically confirm, acknowledge and agree that title to my medications passes to me when my medications are shipped from the CanaRx contracted pharmacy.

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.