

Introduction:

MMIAScripts is a voluntary prescription drug program that is available to eligible members, retirees and their dependents of Montana Municipal Interlocal Authority’s Employee Benefits Program. For those enrolled in the **Standard** plans a comprehensive formulary is included which lists all medications offered through MMIAScripts. For **HDHP** members, only preventive medications are available through this program. Please see the limited HDHP list included.

Copayments:

All member copayments have been waived for this program only.

<i>MMIAScripts</i>		Vs.	Current Purchase Plan				
Annual Cost <i>No Copays!</i>			Monthly Copays		Refills	Annual Savings	
\$0	Vs.		\$20	x	12	=	\$240 / Script
	Vs.		\$50	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 CRX 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.CRXDocs.com. If not included, a CRX 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 *MMIAScripts*.

RETURN YOUR COMPLETED AND SIGNED ENROLLMENT FORM AND ORIGINAL PRESCRIPTIONS:



BY FAXING TO: 1-866-215-7874 (TOLL FREE)

Faxed prescriptions are ONLY accepted if sent directly from the physician’s office.

OR



BY MAILING TO: *MMIAScripts*

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

OR

P.O. Box 3009
Windsor, ON, Canada
N8N 2M3

More forms are available:

Additional forms may be obtained by printing them from the website at www.MMIAScripts.com or by contacting our Customer Service Representatives toll free at **1-866-488-7874**.

WELCOME TO MMIAScripts

ENROLLING IN A CRX PROGRAM

Welcome to CRX International! You may have received an enrollment package in the mail or heard about our international prescription program through an employee communication or seminar. If you are ready to join, or need more information, the best option is to **CALL US FIRST!** We will answer all of your questions, confirm program eligibility and medication availability - and then all you need to do is submit your enrollment form and prescription(s), along with a copy of your photo ID.



PROGRAM ENROLLMENT

Enrollment forms and prescriptions can be submitted via fax or mail. As a safety measure, we only accept prescriptions that are **faxed directly from your doctor's office**. In order to have a continuous supply of medication on hand, we request that you submit a prescription for a **3-month quantity, with three refills**. If your prescription does not cover a full year, we can still accept it - but it must be written for a **minimum 3-month supply**.

If you did not contact us prior to enrolling, we will call you once we receive your paperwork and welcome you to the program! We will confirm the following: (a) your personal information; (b) medication availability; (c) shipping time; (d) refill schedule; and, (e) answer any questions you may have.

Enroll only once - and at any time! There is no need to enroll now, unless you are ready to order through the program.

PACK SIZES

Our program ONLY supplies **Brand Name medications**, dispensed in the **manufacturer's original sealed container**. Pack sizes vary from country to country. For example, a standard container quantity might be 84. We factor this in when scheduling your refill call.

SHIPPING

Your medication will be shipped directly from an international pharmacy to your home, via regular mail. Please allow **20 business days** (1 month) for your package to arrive.



CALL US -

Monday to Friday - 8:30am - 6:30pm Eastern Time

Saturday - 9:00am - 5:30pm Eastern Time

Toll Free 1-866-488-7874

REFILLS

Refills are not automatic, but they're easy - we call you! As an added safety measure before processing a refill, we need to confirm how much medication you have on hand and whether you've had any health or medication changes. We contact you **one month prior** to ensure you always have a sufficient supply of medication on-hand.

GENERIC MEDICATIONS

Generic medications may provide the greatest savings to your health care plan. Therefore, if you are currently using a Generic medication, you are not eligible to order the Brand Name medication through this program.

ACIPHEX 20MG	CLARINEX 5MG	IMITREX AUTOINJECTOR	NESINA 6.25MG	SYNAREL NASAL
ACTIVELLA (G) 1MG/0.5MG	CLIMARA PATCH 25MCG	STATDOSE 6MG/0.5ML	NESINA 12.5MG	SYNJARDY 5MG/500MG
ACTONEL 5MG	CLIMARA PATCH 50MCG	CLIMARA PATCH SPRAY	NESINA 25MG	SYNJARDY 5MG/1000MG
ACTONEL 30MG	CLIMARA PATCH 75MCG	5MG-2DOSE	NEUPRO 1MG	SYNJARDY 12.5MG/500MG
ACTONEL 35MG	CLIMARA PATCH 100MCG	IMITREX NASAL SPRAY	NEUPRO 2MG	SYNJARDY 12.5MG/1000MG
ACTONEL 150MG	COLAZAL (G) 750MG	20MG-2DOSE	NEUPRO 3MG	TARKA 2/180MG
ACULAR (G) 0.5%	COMBIGAN 0.2-0.5%	IMURAN (G) 50MG	NEUPRO 4MG	TARKA 4/240MG
ACTOPLUS 15MG-850MG	COMBIVENT RESPIMAT	INCRUSE ELLIPTA 62.5MCG	NEUPRO 6MG	TASMAR 100MG
ACULAR LS (G) 0.4%	20MCG/100MCG	INDERAL LA 60MG	NEUPRO 8MG	TAZORAC CREAM 0.05%
ACZONE 5%	COMTAN 200MG	INDERAL LA 80MG	NEUXIUM DR 10MG	TAZORAC CREAM 0.1%
ADVAIR DISKUS 100MCG	CORGARD (G) 80MG	INDERAL LA 120MG	NIZORAL SHAMPOO (G) 2%	TAZORAC GEL 0.05%
ADVAIR DISKUS 250MCG	COSOPT PF DROPS 2%/0.5%	INDERAL LA 160MG	NORITATE CREAM 1%	TAZORAC GEL 0.1%
ADVAIR DISKUS 500MCG	CRINONE GEL 8%	INSPIRA (G) 25MG	OLUMIANT 2MG	TECFIDERA 120MG
ADVAIR HFA 45/21MCG	CYTOTEC (G) 200MCG	INSPIRA (G) 50MG	OMNARIS 50MCG	TECFIDERA 240MG
ADVAIR HFA 115/21MCG	DALIRESP 500MCG	INVEGA 3MG	ONGLYZA 2.5MG	TEKTURNA 150MG
ADVAIR HFA 230/21MCG	DERMOTIC OIL 0.01%	INVEGA 6MG	ONGLYZA 5MG	TEKTURNA 300MG
ALDACTAZIDE (G) 50MG	DETROL 1MG	INVEGA 9MG	ORLISSA 150MG	TEKTURNA HCT 150-25MG
ALOCRI 2%	DETROL 2MG	INVOKAMET 50MG-500MG	ORLISSA 200MG	TEKTURNA HCT 300-12.5MG
ALOMIDE 0.1%	DETROL LA 2MG	INVOKAMET 50MG-1000MG	OTEZLA 30MG	TEKTURNA HCT 300-25MG
ALPHAGAN-P 0.15%	DETROL LA 4MG	INVOKAMET 150MG-500MG	PAXIL CR (G) 12.5MG	TIVICAY 50MG
ALREX 0.2%	DEXILANT DR 30MG	INVOKAMET 150MG-1000MG	PAXIL CR (G) 25MG	TOBEX OINT 0.3%
ALVESCO 80MCG 100MCG	DEXILANT DR 60MG	INVOKANA 100MG	PAZEO 0.7%	TOPICORT CREAM (G) 0.25%
ALVESCO 160MCG 200MCG	DIFFERIN CREAM 0.1%	INVOKANA 300MG	PENTASA 500MG	TOVIAZ 4MG
ANAPROX DS 550MG	DIFFERIN GEL 0.1%	IRESSA 250MG	PRADAXA 75MG	TOVIAZ 8MG
ANORO ELLIPTA 62.5/25MCG	DIFFERIN GEL 0.3%	ISOPTO CARPINE 1%	PRADAXA 150MG	TRADJENTA 5MG
APTIOM 200MG	DIPENTUM 250MG	ISOPTO CARPINE 2%	PRANDIN (G) 0.5MG	TRAVATAN Z 0.004%
APTIOM 400MG	DIPROLENE OINT 0.05%	ISOPTO CARPINE 4%	PRANDIN (G) 1MG	TRELEGY ELLIPTA 100-62.5-25MCG
APTIOM 600MG	DIVIGEL 0.25MG	JALYN 0.5MG/0.4MG	PRANDIN (G) 2MG	TRIBENZOR 20/5/12.5MG
APTIOM 800MG	DIVIGEL 0.5MG	JANUMET 50/500MG	PRED FORTE 1%	TRIBENZOR 40/5/12.5MG
ARAVA (G) 10MG	DIVIGEL 1MG	JANUMET 50/1000MG	PREMARIN 0.3MG	TRIBENZOR 40/5/25MG
ARAVA (G) 20MG	DUAVEE 0.45-20MG	JANUMET XR 50MG/500MG	PREMARIN 0.625MG	TRIBENZOR 40/10/12.5MG
ARCAPTA NEOHALER 75MCG	DULERA 100MCG/5MCG	JANUMET XR 50MG/1000MG	PREMARIN 1.25MG	TRIBENZOR 40/10/25MG
ARNUIITY ELLIPTA 100MCG	DULERA 200MCG/5MCG	JANUMET XR 100MG/1000MG	PREMARIN CREAM	TRICOR (G) 48MG
ARNUIITY ELLIPTA 200MCG	DYMISTA 137/50MCG	JANUVIA 25MG	0.625MG/GM	TRINTELLIX 5MG
AROMASIN 25MG	EDARBI 40MG	JANUVIA 50MG	PREMPRO 0.3MG/1.5MG	TRINTELLIX 10MG
ARTHROTEC 50MG	EDARBI 80MG	JANUVIA 100MG	PREVACID SOLUTAB 15MG	TRINTELLIX 20MG
ARTHROTEC 75MG	EDARBYCLOR 40MG/12.5MG	JARDIANCE 10MG	PREVACID SOLUTAB 30MG	TRIUMEQ 600-50-300MG
ASACOL HD 800MG	EDARBYCLOR 40MG/25MG	JARDIANCE 25MG	PREZISTA 800MG	TRUSOPT (G) 2%
ASMANEX TWISTHALER 110MCG	EDECIN 25MG	JENTADUETO 2.5MG-500MG	PRISTIQ 50MG	TUDORZA PRESSAIR 400MCG
ASMANEX TWISTHALER	EFFEXOR XR (G) 37.5MG	JENTADUETO 2.5MG-1000MG	PRISTIQ 100MG	TWYNSTA 40/5MG
220MCG	ELIDEL 1%	JUBLIA 10%	PROMETRIUM 100MG	TWYNSTA 40/10MG
ASTAGRAF XL 0.5MG	ELIQUIS 2.5MG	KAZANO 12.5/1000MG	PROTOPIC OINT 0.03%	TWYNSTA 80/5MG
ASTAGRAF XL 1MG	ELIQUIS 5MG	KOMBIGLYZE XR 2.5MG/1000MG	PROTOPIC OINT 0.1%	TWYNSTA 80/10MG
ASTAGRAF XL 5MG	ELMIRON 100MG	KOMBIGLYZE XR 5MG/500MG	QTERN 10-5MG	UCERIS 9MG
ATACAND 4MG	ENABLEX 7.5MG	KOMBIGLYZE XR 5MG/1000MG	QVAR REDHALER 40MCG	ULORIC 80MG
ATACAND 8MG	ENABLEX 15MG	LAMICTAL (G) 5MG	QVAR REDHALER 80MCG	UROKIT-K 10MEQ
ATACAND 16MG	ENTOCORT 3MG	LATUDA 20MG	RANEXA 500MG	URSO 250MG
ATACAND 32MG	ENTRESTO 24MG-26MG	LATUDA 40MG	RAPAFLO 4MG	VAGIFEM 10MCG
ATACAND HCT 16MG/12.5MG	ENTRESTO 49MG-51MG	LATUDA 60MG	RAPAFLO 8MG	VENTICAL 3MCG/GM
ATACAND HCT 32MG/12.5MG	ENTRESTO 97MG-103MG	LATUDA 80MG	RAPAMUNE 0.5MG	VENTOLIN HFA 90MCG
ATELVIA DR 35MG	EPIDUO GEL PUMP 0.1%/2.5%	LATUDA 120MG	RAPAMUNE 2MG	VESICARE 5MG
ATROVENT HFA 20UG	EPIPEN 0.3MG	LESCOL XL 80MG	RELPAZ 20MG	VESICARE 10MG
AUBAGIO 14MG	EPIPEN JR 0.15MG	LEXIVA 700MG	RELPAZ 40MG	VIIBRYD 10MG
AVALIDE (G) 150MG/12.5MG	EPIVIR / HBV 100MG	LIALDA 1.2GM	RENAGEL 800MG	VIIBRYD 20MG
AVALIDE (G) 300MG/12.5MG	ESTROGEL 0.06%	LINZESS 72MCG	RENVELA 800MG	VIIBRYD 40MG
AVANDIA 2MG	EUCRISA 2%	LINZESS 145MCG	RESTASIS VIALS 0.05%	VIMOVO 375/20MG
AVANDIA 4MG	EVISTA 60MG	LINZESS 290MCG	RETIN A CREAM 0.05%	VIMOVO 500/20MG
AVAPRO (G) 75MG	EXELON 4.6MG/24HR	LOCOID LIPOCREAM 0.1%	RETIN A GEL (G) 0.025%	VIVELLE-DOT 25MCG
AXERT 12.5MG	EXELON 9.5MG/24HR	LOCOID LIPOCREAM 0.1%	RETIN A MICRO GEL PUMP	VIVELLE-DOT 37.5MCG
AZELEX 20%	EXELON 13.3MG/24HR	LOTEMAX GEL 0.5%	0.04%	VIVELLE-DOT 50MCG
AZILECT 0.5MG	EXFORGE (G) 5/160MG	LOTEMAX OINT 0.5%	RETIN-A MICRO GEL PUMP 0.1%	VIVELLE-DOT 75MCG
AZILECT 1MG	EXFORGE (G) 5/320MG	LOTEMAX SUSP 0.5%	REXULTI 0.25MG	VIVELLE-DOT 100MCG
AZOPT 1%	EXFORGE (G) 10/160MG	LOTRISONE CREAM (G)	REXULTI 0.5MG	VRAYLAR 1.5MG
AZOR 20/5MG	EXFORGE (G) 10/320MG	1%/0.05%	REXULTI 1MG	VRAYLAR 3MG
AZOR 40/5MG	EXFORGE HCT 160/12.5/5MG	LOVENOX 40MG	REXULTI 2MG	VRAYLAR 4.5MG
AZOR 40/10MG	EXFORGE HCT 160/12.5/10MG	LOVENOX 60MG	REXULTI 3MG	VRAYLAR 6MG
BANZEL 200MG	EXFORGE HCT 160/25/5MG	LOVENOX 80MG	REXULTI 4MG	VYTORIN 10/10MG
BANZEL 400MG	EXFORGE HCT 160/25/10MG	LOVENOX 100MG	SAPHRIS 5MG	VYTORIN 10/20MG
BECONASE AQ 42MCG	EXFORGE HCT 320/25/10MG	LUMIGAN 0.01%	SAPHRIS 10MG	VYTORIN 10/40MG
BENZACLIN PUMP	FARESTON 60MG	MESNEX 400MG	SEASONIQUE	VYTORIN 10/80MG
BETIMOL 0.25%	FARXIGA 5MG	MESTINON TS 180MG	0.15/0.03/0.01MG	WELCHOL 625MG
BETIMOL 0.5%	FARXIGA 10MG	METRO CREAM 0.75%	SENSIPAR 30MG	WELCHOL PACKET 3.75G
BETOPTIC S 0.25%	FELDENE 10MG	METROGEL (G) 0.75%	SENSIPAR 60MG	XADAGO 50MG
BINOSTO 70MG	FELDENE 20MG	METROGEL PUMP 1%	SEREVENT DISKUS 50MCG	XADAGO 100MG
BREO ELLIPTA 100/25MCG	FETZIMA 20MG	MICARDIS (G) 20MG	SIMBRINZA 1%/0.2%	XARELTO 2.5MG
BREO ELLIPTA 200/25MCG	FETZIMA 40MG	MICARDIS (G) 40MG	SINEMET (G) 250/25MG	XARELTO 10MG
BRILINTA 60MG	FETZIMA 80MG	MICARDIS (G) 80MG	SINEMET CR (G) 100/25MG	XARELTO 15MG
BRILINTA 90MG	FETZIMA 120MG	MICARDIS HCT 40/12.5MG	SINEMET CR (G) 200/50MG	XARELTO 20MG
BYSTOLIC 2.5MG	FINACEA GEL 15%	MICARDIS HCT 80/12.5MG	SINGULAIR GRANULES (G) 4MG	XELJANZ 5MG
BYSTOLIC 5MG	FLAREX 0.1%	MICARDIS HCT 80/25MG	SOLARAZE (G) 3%	XELJANZ XR 11MG
BYSTOLIC 10MG	FLOVENT 44MCG 50MCG	MIGRANAL 4MG/ML	SOOLANTRA 1%	XELODA 500MG
BYSTOLIC 20MG	FLOVENT 110MCG 125MCG	MINIPRESS (G) 1MG	SPIRIVA 18MCG	XENICAL 120MG
CADUET 5/10MG	FLOVENT 220MCG 250MCG	MINIPRESS (G) 2MG	SPIRIVA RESPIMAT 2.5MCG	XIGDUO XR 5/1000MG
CADUET 5/20MG	FLOVENT DISKUS 100MCG	MINIPRESS (G) 5MG	STALEVO (G) 50MG	XIGDUO XR 10/500MG
CADUET 5/40MG	FLOVENT DISKUS 250MCG	MIRAPEX ER 0.375MG	STALEVO (G) 100MG	XIGDUO XR 10/1000MG
CADUET 5/80MG	FOSRENOL CHEW 500MG	MIRAPEX ER 0.75MG	STALEVO (G) 125MG	XIIDRA 5%
CADUET 10/10MG	FOSRENOL CHEW 750MG	MIRAPEX ER 1.5MG	STARLIX 60MG	YASMIN 28
CADUET 10/20MG	FOSRENOL CHEW 1000MG	MIRAPEX ER 2.25MG	STARLIX 120MG	YAZ 3/0.02MG
CADUET 10/40MG	FOSRENOL POWDER 750MG	MIRAPEX ER 3MG	STIOLTO RESPIMAT 2.5/2.5MCG	ZELAPAR 1.25MG
CADUET 10/80MG	FOSRENOL POWDER 1000MG	MIRAPEX ER 3.75MG	STRATTERA 10MG	ZERIT (G) 40MG
CAMBIA 50MG	FROVA 2.5MG	MIRAPEX ER 4.5MG	STRATTERA 18MG	ZOMIG (G) 2.5MG
CARDIZEM CD (G) 180MG	GENVOYA 150-150-200-10MG	MIRVASO 0.33%	STRATTERA 25MG	ZOMIG NASAL SPRAY 5MG
CARDIZEM CD (G) 240MG	GILENYA 0.5MG	MOTTEGRITY 1MG	STRATTERA 40MG	ZOMIG ZMT 2.5MG
CARDIZEM CD (G) 360MG	GLUCAGEN HYPOKIT 1MG	MOTTEGRITY 2MG	STRATTERA 60MG	ZOVIRAX CREAM 5%
CARDURA XL 4MG	GLUMETZA ER 1000MG	MULTAQ 400MG	STRATTERA 80MG	ZYCLARA PACKET 3.75%
CARDURA XL 8MG	GLYXAMBI 10MG/5MG	MYRBETRIQ 25MG	STRATTERA 100MG	
CELEBREX 100MG	GLYXAMBI 25MG/5MG	MYRBETRIQ 50MG	STRIBILD	
CELEBREX 200MG	HEPSERA (G) 10MG	NASONEX 50MCG	SUSTIVA 50MG	

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 1-866-488-7874 toll free to verify the availability of your medication through this program.

ACIPHEX 20MG	DEXILANT DR 30MG	JUBLIA 10%	SPIRIVA 18MCG
ACTONEL 5MG	DEXILANT DR 60MG	KAZANO 12.5/1000MG	SPIRIVA RESPIMAT 2.5MCG
ACTONEL 30MG	DIVIGEL 0.25MG	LAMICTAL (G) 5MG	STALEVO (G) 50MG
ACTONEL 35MG	DIVIGEL 0.5MG	LATUDA 20MG	STALEVO (G) 100MG
ACTONEL 150MG	DIVIGEL 1MG	LATUDA 40MG	STALEVO (G) 125MG
ACTOPLUS 15MG-850MG	DUAVEE 0.45-20MG	LATUDA 60MG	STARLIX 60MG
ACULAR (G) 0.5%	DULERA 100MCG/5MCG	LATUDA 80MG	STARLIX 120MG
ACULAR LS (G) 0.4%	DULERA 200MCG/5MCG	LATUDA 120MG	STEGLATRO 5MG
ADVAIR DISKUS 100MCG	EDARBI 40MG	LESCOL XL 80MG	STEGLATRO 15MG
ADVAIR DISKUS 250MCG	EDARBI 80MG	LEXIVA 700MG	STIOLTO RESPIMAT 2.5/2.5MCG
ADVAIR DISKUS 500MCG	EDARBYCLOL 40MG/12.5MG	LUMIGAN 0.01%	STRATTERA 10MG
ADVAIR HFA 45/21MCG	EDARBYCLOL 40MG/25MG	MESNEX 400MG	STRATTERA 18MG
ADVAIR HFA 115/21MCG	EDECRIIN 25MG	MESTINON TS 180MG	STRATTERA 25MG
ADVAIR HFA 230/21MCG	EFFEXOR XR (G) 37.5MG	METROGEL (G) 0.75%	STRATTERA 40MG
AGGRENOX 200/25MG	ELIQUIS 2.5MG	MICARDIS (G) 20MG	STRATTERA 60MG
ALDACTAZIDE (G) 50MG	ELIQUIS 5MG	MICARDIS (G) 40MG	STRATTERA 80MG
ALOCRI 2%	ENTRESTO 24MG-26MG	MICARDIS (G) 80MG	STRATTERA 100MG
ALOMIDE 0.1%	ENTRESTO 49MG-51MG	MICARDIS HCT 40/12.5MG	STRIBILD
ALPHAGAN-P 0.15%	ENTRESTO 97MG-103MG	MICARDIS HCT 80/12.5MG	SUSTIVA 50MG
ALREX 0.2%	EPIVIR / HBV 100MG	MICARDIS HCT 80/25MG	SYNJARDY 5MG/500MG
ALVESCO 80MCG	EUCRISA 2%	MINIPRESS (G) 1MG	SYNJARDY 5MG/1000MG
ALVESCO 160MCG 200MCG	EVISTA 60MG	MINIPRESS (G) 2MG	SYNJARDY 12.5MG/500MG
ANAPROX DS 550MG	EXELON 4.6MG/24HR	MINIPRESS (G) 5MG	SYNJARDY 12.5MG/1000MG
ANORO ELLIPTA 62.5/25MCG	EXELON 9.5MG/24HR	MINOCIN (G) 50MG	TARKA 2/180MG
APTIOM 200MG	EXELON 13.3MG/24HR	MIRAPEX ER 0.375MG	TARKA 4/240MG
APTIOM 400MG	EXFORGE (G) 5/160MG	MIRAPEX ER 0.75MG	TASMAR 100MG
APTIOM 600MG	EXFORGE (G) 5/320MG	MIRAPEX ER 1.5MG	TECFIDERA 120MG
APTIOM 800MG	EXFORGE (G) 10/160MG	MIRAPEX ER 2.25MG	TECFIDERA 240MG
ARAVA (G) 10MG	EXFORGE (G) 10/320MG	MIRAPEX ER 3MG	TEKTURNA 150MG
ARAVA (G) 20MG	EXFORGE HCT 160/12.5/5MG	MIRAPEX ER 3.75MG	TEKTURNA 300MG
ARCAPTA NEOHALER 75MCG	EXFORGE HCT 160/12.5/10MG	MIRAPEX ER 4.5MG	TEKTURNA HCT 150-25MG
ARNUITY ELLIPTA 100MCG	EXFORGE HCT 160/25/5MG	MIRVASO 0.33%	TEKTURNA HCT 300-12.5MG
ARNUITY ELLIPTA 200MCG	EXFORGE HCT 160/25/10MG	MOTTEGRITY 1MG	TEKTURNA HCT 300-25MG
AROMASIN 25MG	EXFORGE HCT 320/25/10MG	MOTTEGRITY 2MG	TIVICAY 50MG
ASACOL HD 800MG	FARESTON 60MG	MULTAQ 400MG	TOBREX OINT 0.3%
ASMANEX TWISTHALER 110MCG	FARXIGA 5MG	NESINA 6.25MG	TOPICORT CREAM (G) 0.25%
ASMANEX TWISTHALER 220MCG	FARXIGA 10MG	NESINA 12.5MG	TRADJENTA 5MG
ASTAGRAF XL 0.5MG	FETZIMA 20MG	NESINA 25MG	TRAVATAN Z 0.004%
ASTAGRAF XL 1MG	FETZIMA 40MG	NEUPRO 1MG	TRELEGY ELLIPTA 100-62.5-25MCG
ASTAGRAF XL 5MG	FETZIMA 80MG	NEUPRO 2MG	TRIBENZOR 20/5/12.5MG
ATACAND 4MG	FETZIMA 120MG	NEUPRO 3MG	TRIBENZOR 40/5/12.5MG
ATACAND 8MG	FLOVENT 44MCG 50MCG	NEUPRO 4MG	TRIBENZOR 40/5/25MG
ATACAND 16MG	FLOVENT 110MCG 125MCG	NEUPRO 6MG	TRIBENZOR 40/10/12.5MG
ATACAND 32MG	FLOVENT 220MCG 250MCG	NEUPRO 8MG	TRIBENZOR 40/10/25MG
ATACAND HCT 16MG/12.5MG	FLOVENT DISKUS 100MCG	NEXIUM DR 10MG	TRICOR (G) 48MG
ATACAND HCT 32MG/12.5MG	FLOVENT DISKUS 250MCG	NIZORAL SHAMPOO (G) 2%	TRINTELLIX 5MG
ATELVIA DR 35MG	FOSRENOL CHEW 500MG	ONGLYZA 2.5MG	TRINTELLIX 10MG
ATROVENT HFA 20UG	FOSRENOL CHEW 750MG	ONGLYZA 5MG	TRINTELLIX 20MG
AUBAGIO 14MG	FOSRENOL CHEW 1000MG	OTEZLA 30MG	TRIUQUE 600-50-300MG
AVALIDE (G) 150MG/12.5MG	FOSRENOL POWDER 750MG	PAXIL CR (G) 12.5MG	TRUSOPT (G) 2%
AVALIDE (G) 300MG/12.5MG	FOSRENOL POWDER 1000MG	PAXIL CR (G) 25MG	TUDORZA PRESSAIR 400MCG
AVANDIA 2MG	GENVOYA 150-150-200-10MG	PLAQUENIL (G) 200MG	TWYNSTA 40/5MG
AVANDIA 4MG	GILENYA 0.5MG	PRADAXA 75MG	TWYNSTA 40/10MG
AVAPRO (G) 75MG	GLUMETZA ER 1000MG	PRADAXA 150MG	TWYNSTA 80/5MG
AZOPT 1%	GLYXAMBI 10MG/5MG	PRANDIN (G) 0.5MG	TWYNSTA 80/10MG
AZOR 20/5MG	GLYXAMBI 25MG/5MG	PRANDIN (G) 1MG	ULORIC 80MG
AZOR 40/5MG	HEPSERA (G) 10MG	PRANDIN (G) 2MG	UROCIT-K 10MEQ
AZOR 40/10MG	IMURAN (G) 50MG	PREVACID SOLUTAB 15MG	URSO 250MG
BECONASE AQ 42MCG	INCRUSE ELLIPTA 62.5MCG	PREVACID SOLUTAB 30MG	VENTOLIN HFA 90MCG
BETIMOL 0.25%	INDERAL LA 60MG	PREZISTA 800MG	VIIBRYD 10MG
BETIMOL 0.5%	INDERAL LA 80MG	PRISTIQ 50MG	VIIBRYD 20MG
BETOPTIC S 0.25%	INDERAL LA 120MG	PRISTIQ 100MG	VIIBRYD 40MG
BINOSTO 70MG	INDERAL LA 160MG	QTERN 10-5MG	VRAYLAR 1.5MG
BREO ELLIPTA 100/25MCG	INSPIRA (G) 25MG	QVAR REDHALER 40MCG	VRAYLAR 3MG
BREO ELLIPTA 200/25MCG	INSPIRA (G) 50MG	QVAR REDHALER 80MCG	VRAYLAR 4.5MG
BRILINTA 60MG	INVEGA 3MG	RANEXA 500MG	VRAYLAR 6MG
BRILINTA 90MG	INVEGA 6MG	RAPAMUNE 0.5MG	VYTORIN 10/10MG
BYSTOLIC 2.5MG	INVEGA 9MG	RAPAMUNE 2MG	VYTORIN 10/20MG
BYSTOLIC 5MG	INVOKAMET 50MG-500MG	RENAGEL 800MG	VYTORIN 10/40MG
BYSTOLIC 10MG	INVOKAMET 50MG-1000MG	REVELA 800MG	VYTORIN 10/80MG
BYSTOLIC 20MG	INVOKAMET 150MG-500MG	RESTASIS MULTIDOSE 0.05%	WELCHOL 625MG
CADUET 5/10MG	INVOKAMET 150MG-1000MG	RESTASIS VIALS 0.05%	WELCHOL PACKET 3.75G
CADUET 5/20MG	INVOKANA 100MG	REXULTI 0.25MG	XADAGO 50MG
CADUET 5/40MG	INVOKANA 300MG	REXULTI 0.5MG	XADAGO 100MG
CADUET 5/80MG	IRESSA 250MG	REXULTI 1MG	XARELTO 2.5MG
CADUET 10/10MG	ISOPTO CARPINE 1%	REXULTI 2MG	XARELTO 10MG
CADUET 10/20MG	ISOPTO CARPINE 2%	REXULTI 3MG	XARELTO 15MG
CADUET 10/40MG	ISOPTO CARPINE 4%	REXULTI 4MG	XARELTO 20MG
CADUET 10/80MG	JALYN 0.5MG/0.4MG	RHINOCORT AQ 32MCG	XELJANZ 5MG
CARDIZEM CD (G) 180MG	JANUMET 50/500MG	SAPHRIS 5MG	XELJANZ XR 11MG
CARDIZEM CD (G) 240MG	JANUMET 50/1000MG	SAPHRIS 10MG	XENICAL 120MG
CARDIZEM CD (G) 360MG	JANUMET XR 50MG/500MG	SEASONIQUE 0.15/0.03/0.01MG	XIGDUO XR 5/1000MG
CARDURA XL 4MG	JANUMET XR 50MG/1000MG	SENSIPAR 30MG	XIGDUO XR 10/500MG
CARDURA XL 8MG	JANUMET XR 100MG/1000MG	SENSIPAR 60MG	XIGDUO XR 10/1000MG
COLAZAL (G) 750MG	JANUVIA 25MG	SEREVENT DISKUS 50MCG	XYZAL (G) 5MG
COMBIGAN 0.2-0.5%	JANUVIA 50MG	SIMBRINZA 1%/0.2%	YASMIN 28
COMBIVENT RESPIMAT 20MCG/100MCG	JANUVIA 100MG	SINEMET (G) 250/25MG	YAZ 3/0.02MG
COMTAN 200MG	JARDIANCE 10MG	SINEMET CR (G) 100/25MG	ZELAPAR 1.25MG
CORGARD (G) 80MG	JARDIANCE 25MG	SINEMET CR (G) 200/50MG	ZYCLAR PACKET 3.75%
COSOPT PF DROPS 2%/0.5%	JENTADUETO 2.5MG-500MG	SINGULAIR GRANULES (G) 4MG	
CYTOTEC (G) 200MCG	JENTADUETO 2.5MG-850MG	SOLARAZE (G) 3%	
DALIRESP 500MCG	JENTADUETO 2.5MG-1000MG	SOOLANTRA 1%	

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 1-866-488-7874 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: 1-866-215-7874
 Or MAIL TO: MMIA Scripts, P.O. BOX 3009, WINDSOR, ON, CANADA, N8N 2M3 PHONE TOLL-FREE: 1-866-488-7874

PATIENT INFORMATION:		Birthdate _____ <small>MM/DD/YYYY</small>
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 MEMBER, 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 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 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 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.