MMIAScripts

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.

MMIAScripts	Vs.	Current local purchase plan				
Annual Cost ***No Copays!***		**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 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 **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
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.MMIAScripts.com or by contacting our Customer Service Representatives toll free at **1-866-488-7874**.

WELCOME TO MMIAScripts

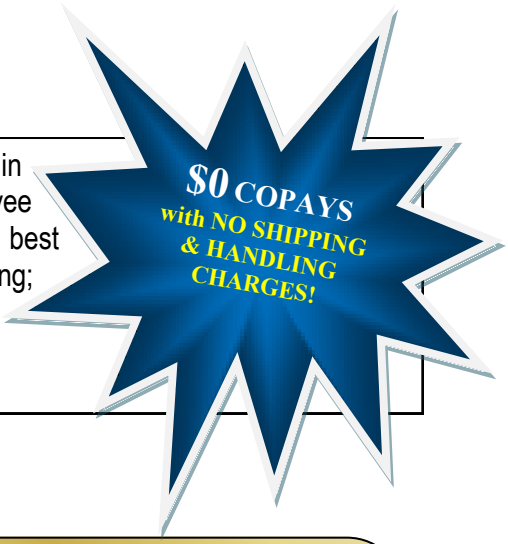
November 2017

MMIA Scripts

CRX INTERNATIONAL

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 including; program eligibility and medication availability, and then all you need to do is submit your enrollment form and prescription(s).



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.

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.

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.

Generic Medications

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

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.

MMIAScripts

CRX INTERNATIONAL

CRX Enrollment Form

Member ID#:

FAX DIRECTLY **FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION (S) TOLL-FREE TO: 1-866-215-7874**
***Or MAIL* TO: *MMIAScripts*, P.O. BOX 44650, DETROIT, MI 48244-0650 PHONE TOLL-FREE: 1-866-488-7874**

PATIENT INFORMATION: **Birthdate** _____ MM/DD/YYYY

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
Ex. Januvia	*Ex. 50mg*	*Ex. Twice Daily*	*Ex. 8/20/2017*	*Ex. Diabetes*

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)*

TERMS OF AGREEMENT

CONFIRMATION AND REPRESENTATIONS

I enter into this agreement with CRX International Inc. ("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 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 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 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.
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. 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, 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 contracted physicians and pharmacists may share any and all information received from or about me with my U.S. physician, CRX 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 CRX (and any CRX 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 CRX from my U.S. physician's office the original signed copy of the prescription.
7. CRX and its contracted physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
8. CRX contracted physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
9. CRX may make payments on my behalf to CRX contracted pharmacies for dispensing medicine in accordance with my prescriptions and to CRX 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 CRX 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 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 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 CRX contracted 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 contracted physician and have enlisted the services of CRX to facilitate it. I understand that the CRX 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 CRX 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 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, contracted physicians and pharmacies.
5. 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.
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 CRX 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 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.