Important!
If you wish to fill in these forms on your computer, please save them to your hard drive and then open them in Adobe Reader to complete and save them before printing. If you fill them in using your browser (e.g. Firefox), you can still print but will not be able to save them.

CanPharm Benefits
The Canadian Pharmacy Solution Company

CANUSA Rx

Three easy steps to Register your Medical Information and Prescription Drug Order for Immediate Processing

Step 1:

Call us **toll-free at 1-800-899-0835** or email us at info@canpb.com for pricing on your prescription drugs.

Step 2:

Complete these forms.

- Ensure your name is on each page of these forms. If these forms are not completed in full, your registration will NOT be accepted. 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.

Step 3:

Register on the phone (1-800-899-0835) with our customer service specialists and they will explain which forms to take to your doctor and what to do next *or* fax the completed forms **from your doctor's office** or mail them to us.

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

Have your doctor's office fax the above documents directly to 1-866-436-2876

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

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

or If you prefer not to fax, you can mail the completed forms along with your ORIGINAL prescriptions to us at:

CanUSA RX, 2488 McDougall Street, Suite 1, Windsor, Ontario (Canada) N8X 3N7

Once your documents have been received by our Prescription Processing Department, your order will be immediately prepared for delivery. Under normal circumstances, your order will arrive within 2 weeks of the time that we receive your order.

PLEASE FAX ALL FORMS TO 1-866-436-2876

*****Document 1*****
COMPLETED BY EACH PATIENT ORDERING PRESCRIPTIONS

CanPharm Benefits
The Canadian Pharmacy Solution Company

CANUSA Rx

Patient Health and Medication Background

Name: _____
First *Last* *Middle Initial*

Mailing address: Street _____

Apt / Unit# _____ City: _____ State: _____ Zip: _____

Home Phone # _____ Other Phone # _____

Date of Birth: _____ E-mail: _____

Occupation: _____ Employer: _____

Gender: ☐ Male ☐ Female Height _____ Weight _____ lbs

Has there been a change in weight of more than 10 pounds in the last year? ☐ Yes ☐ No

Explanation for weight change: _____

Current Medical Conditions: _____

Over-the-counter Medications/Herbal Remedies

IMPORTANT - DRUG ALLERGIES (or write NONE)

Prescription Medication List (*Please ensure that all fields below are entered completely)*

Drug Name	Strength	Reason for taking	HOW LONG USED?	# times/day	What to avoid	Doctor name
ex: Lipitor	*ex: 25mg*	*ex: Cholesterol*	*ex: 2 years*	*ex: twice daily*	*ex: grapefruit*	*ex:Dr. Smith*

If you have additional medications to enter, please use an additional Medication Record Form and check here ☐
I certify that the above information is complete and correct to the best of my knowledge and recollection.

Patient Signature: _____ Date: _____

PLEASE FAX ALL FORMS TO 1-866 436-2876

Document 2
COMPLETED BY EACH PATIENT
ORDERING PRESCRIPTIONS

CanPharm Benefits
The Canadian Pharmacy Solution Company

CANUSA Rx

CanUSA RX Authorization and Release

Name: _____

Address: _____

_____

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 RX 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 RX 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 RX and any such pharmacy; and (e) the Patient further authorizes CanUSA RX 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 RX and/or such Canadian/International pharmacy. It is agreed that CanUSA RX 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 grants AccuScreen Pharmacy, in Winnipeg, Manitoba, Canada, Power of Attorney to take all steps, sign all documents, and act on their behalf for the purpose of obtaining a prescription recognized and valid within Manitoba, and packaging and shipping the medications to the patient. The patient further agrees that the medication will be sold, dispensed, and shipped from a Manitoba pharmacy. The patient acknowledges that they take title and possession of their medications in Manitoba as if they had personally attended the pharmacy in Manitoba; and the patient agrees that the laws of Manitoba govern all transactions and the course of Manitoba are the sole and exclusive authority regarding any dispute arising between the member and the dispensing pharmacy.

4. The Patient acknowledges having read and agreed to CanUSA RX security policy re: transmission of information over the Internet. CanUSA RX 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.

5. 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

Signed and dated this _____ day of, _____ 20 _____.

at (city) _____, in the State of _____ U.S.A.

Print Name: ***X*** _____

PATIENT Signature: ***X*** _____

Please photocopy this form if you need additional pages, or call CanUSA RX Toll Free (1-800-899-0835)

PLEASE FAX ALL FORMS TO 1 866 436 2876

*****Document 3*****
COMPLETED BY PHYSICIAN

CanPharm Benefits
The Canadian Pharmacy Solution Company

CANUSA Rx

Patient name:

Shipping address:

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.					

All prescriptions will be shipped immediately unless requested otherwise.
All prescriptions are issued for a period of 90 days plus 3 refills.
In order to avoid delays, please type or print legibly in black ink.

The patient has been on these medications for at least 30 days.

X _____ _____

Prescribing Physician's Signature Date:

Physican's name: _____

Physican's address: _____

DEA #: _____ State License # _____

Physician's Phone: _____ Physician's Fax _____

mail to:
CanUSA RX,2488 McDougall St., Suite 1,Windsor, Ontario (Canada) ,N8X 3N7

or FAX ALL FORMS TO 1-866-436-2876

Payment Information

How would you like to pay for your medications ?

VISA ☐

MASTERCARD ☐

Name on Credit Card - _____

Credit Card Number # _____

Credit Card Verification Number ***(3 digit # on the back)*** _____

Card Expiry Date **(mm/yy)** _____

Cardholder's address _____

_____

Billing Authorization

I, the undersigned card/account holder, authorize CanPharm Benefits Ltd., a provider of prescription and billing services for CanUSA RX to apply all applicable charges to my credit card/account. These charges include the total cost of the drugs ordered, including refills on prescriptions submitted, and any applicable shipping and handling fees, which are applied to each package shipped to me.

I understand that a 90-day supply of each medication will be shipped, unless otherwise specified.

Cardholder Signature _____

Date (mm/dd/yy) _____

PLEASE FAX ALL FORMS TO 1-866-436-2876