

Canada US Pharmacy Inc.

16-1313 Border Street
Winnipeg, Manitoba, R3H 0X4, Canada

Ordering Package

Toll Free Phone # 1-877-888-3323
Toll Free Fax # 1-866-888-3311
www.canadauspharmacy.com

Thank you for choosing us to service your healthcare needs. This ordering package provides all the necessary forms for you to complete so that we can fill your prescriptions.

Please sign and date ALL individual pages which have printed out from your printer. When all the forms are completed, fax them toll free along with your prescription(s) to **1-866-888-3311**.

You may also mail the forms and prescription(s) to us at:

Canada US Pharmacy Inc.
16-1313 Border Street
Winnipeg, Manitoba R3H 0X4
Canada

Prescription prices may be obtained by calling our toll free number at **1-877-888-3323** or by visiting our website. Please note that all prices are quoted in U.S. dollars and are subject to change. All sales are final.

Policies and Frequently Asked Questions

1. Do I require a prescription?

Yes! A prescription is required for all medications. Just like your local pharmacy, we require a valid prescription from a physician licensed in your area of residence. Our licensed Canadian physician on staff will review your medical history against your written prescription and once satisfied will issue a new prescription under his or her Canadian license so we can fill your order.

2. Is there a dispensing fee charged for each prescription?

All our dispensing fees are included in our prices.

3. What are my shipping charges?

Each order will have a \$10.95 U.S. shipping charge. You may include more than one prescription in each order. Prescriptions for your husband/wife may be included in the same shipment, provided they were ordered at the same time and we have their permission.

4. How long will it take to ship my order?

Once we have your fully completed patient profile and valid prescription, your order may take up to 2 to 3 weeks to process and 7 business days for delivery.

5. What can delay my shipment?

a. We have to contact your doctor to get a copy of the prescription or to verify the order. Sometimes the doctor may not get back to us right away, so this can delay the process.

b. Make sure that your order forms and credit card information is completely filled out. Failure to do so will delay shipping.

c. Shipping times are at the mercy of the postal service. Please order your medications early enough to ensure you do not run out of them.

6. How do I pay for my order?

We accept VISA, MASTERCARD, and AMERICAN EXPRESS. We also accept certified cheques or money orders (which must be verified before the order can be shipped). Personal cheques and postal money orders are NOT accepted.

7. Is there a limit on how much I can buy?

YES. You can purchase up to a maximum of 3 month supply on each of your medications for which we

have a valid prescription. If your physician writes a prescription for more than 3 months, we can refill your prescription at 3 month intervals as required.

8. Are all medications available in Canada?

NO. We do not have all medications that are available in other parts of the world. However, we do have the majority of them.

9. Can I buy Tylenol No.3, Valium or similar medications from your pharmacy?

NO. We cannot legally ship any narcotic, controlled substance, or habit forming drugs across the border.

10. Will you accept my insurance?

Unfortunately NO. We cannot accept any form of foreign insurance because we are located in Canada. We will provide you with a proper receipt which you may submit to your insurance company. Depending on your plan, your insurance company may or may not accept our receipts.

11. What is a generic drug?

A generic drug is the exact same medication and strength as the brand name drug. It is produced by a manufacturer other than the brand name manufacturer. This can be done when the original manufacturer has lost its patent protection on a particular drug. Canada has some of the strictest guidelines and standards in the world for the production of generic drugs. This is to ensure that they will be as potent and provide the same therapeutic effect as the brand name drug. However, generic drugs are available at a lower price, saving you money.

12. When do you supply generic medications?

We will substitute a brand name medication with the generic one if it is available. This will maximize your savings. Please note that not all name brand drugs have generic equivalents. If you or your doctor want you to have a brand name medication, you can indicate which medications you do not want substituted on your medication form, or your physician can indicate this by writing NO SUBSTITUTION on your prescription.

13. Why do some drugs have different names in Canada?

These are trade or brand names registered by the manufacturers. Often you will see different trade names in different countries. The medications have the same active ingredients, but may look different and have a different trade name.

14. What is your policy on privacy?

We do not sell, trade, or rent your personal information to others. We adhere to Provincial and Federal laws governing the protection of personal health information.

Feel free to copy and give this ordering package to your family, friends, or anyone else who may require our services. Please call us at **1-877-888-3323** or email us at info@canadauspharmacy.com if you have any questions or concerns.

Canada US Pharmacy Inc.

16-1313 Border Street, Winnipeg, Manitoba, R3H 0X4, Canada

Customer Agreement

Toll Free Fax: 1-866-888-3311

No prescription(s) will be filled until a signed and dated copy of this document and a completed Medical Questionnaire have been received by Canada US Pharmacy Inc.

I, as the undersigned, being over the age of 21, hereby:

Disclosure and Representations

Represent and confirm to Canada US Pharmacy Inc. their affiliates, related companies, subsidiaries and parent company (hereinafter collectively referred to as "CUSP") that:

1. The pharmaceutical(s) to be delivered to me were prescribed by a doctor licensed to practice medicine in the country, state or other applicable jurisdiction in which I reside or where I sought treatment.
2. The prescription(s) for the pharmaceutical(s) were lawfully obtained from that physician.
3. I will use any medication obtained for me by CUSP strictly according to the instructions provided by the physician who prescribed the medication.
4. The pharmaceutical(s) will only be used as directed and only by the person for whom the pharmaceutical(s) were prescribed.
5. I can make my own medical decisions according to the law of the place where I reside.
6. The prescription(s) I am requesting CUSP to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to CUSP. I agree to immediately destroy all copies of my prescription(s) once it has been filled.
7. I have consulted a qualified physician where I obtained the prescription within the last year upon whose advice I am relying.
8. I will immediately contact the physician who provided my prescription included with this order in the event I suffer any unexpected side effects from any medication obtained for me by CUSP.
9. I understand that it is my responsibility to have regular physical examinations by my primary US licensed physician that is responsible for my care including all suggested testing to ensure that I have no medical problems which would constitute a contradiction to me taking the medications being prescribed.
10. I acknowledge that CUSP's employees and agents have relied on the information and documentation that I am providing (including the Patient Profile) and I represent and confirm that I have fully disclosed all pertinent information and documentation to CUSP. I agree to notify CUSP of any changes to my physical or medical condition by providing an updated Patient Profile.

Authorization and Consent

11. I hereby authorize and appoint CUSP, as my agent and attorney for the limited purpose of taking all steps and signing all documents on my behalf necessary to obtain a prescription in Canada that is the equivalent of the prescription that I sent to CUSP, to the same extent as I could do personally if I were present taking those steps and signing those documents myself. This authorization shall include, but not be limited to: collecting personal health information about me; collecting similar information from my prescribing physician or pharmacist, and disclosing that personal health information to CUSP employees, agents and service providers including the Canadian physician being retained on my behalf, as required, for the limited purpose of obtaining the Canadian prescription.

12. I hereby specifically acknowledge that I am aware that CUSP will be transmitting my personal health information by electronic means (for example fax, secure internet) to its employees, agents, affiliates and service providers including the Canadian physician retained on my behalf. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that CUSP, as a custodian of my personal health information will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to CUSP's transmission of my personal health information by electronic means.

13. If I was directed to CUSP's services through an affiliate or intermediary (for example Pharmacy Benefit Manager, Health Management Organization, or other healthcare service provider), I hereby authorize CUSP to release the following data to such an intermediary:

- (a) a numerical identifier indicating that I was a patient referred from that source;
- (b) financial information that will permit the processing of any claims on my behalf;

It is my understanding that all such intermediaries will enter into Confidentiality Agreements where they agree to abide by the privacy policies of CUSP relating to the protection of my personal health information. I specifically consent to the transmission of the foregoing information by electronic means.

14. I authorize and appoint CUSP as my agent and attorney for the purpose of taking all steps and signing all documents on my behalf necessary to package or re-package the pharmaceutical(s) and to deliver them to me, to the same extent as I could do if I were personally present taking those steps and signing those documents myself.

15. I authorize and appoint CUSP as my agent and my attorney for the purpose of taking all steps and signing all documents on my behalf necessary for shipping my prescribed pharmaceutical(s) to me as if I had shipped the prescribed pharmaceutical(s) to my own address.

16. I acknowledge and agree that I initiated a consultation with CUSP and that CUSP is not located in the United States. I also acknowledge that the pharmacists working for CUSP and the physicians contracted by CUSP on my behalf are located and licensed to practice medicine or pharmacy in Canada and that all services that I receive from the Canadian physician and the pharmacist are being received in Canada.

17. I further agree that any and all agreements reached or contracts formed throughout the course of the relationship between me and CUSP shall be deemed to be made in the Province of Manitoba, Canada and accordingly shall be governed by the laws of the Province of Manitoba and the laws of Canada applicable to such contracts and agreements.

18. I agree that any dispute that arises between me and CUSP, its affiliates, related companies, subsidiaries, parent company, officers, directors, employees, agents and contractors shall be governed by the laws of the Province of Manitoba and the laws of Canada applicable to contracts formed in Manitoba, and I agree that the courts of the Province of Manitoba shall have sole and exclusive jurisdiction over any such dispute.

Purchase and Sale Terms

19. Canada US Pharmacy Inc. will charge my credit card the following amounts:

- (a) the medication price and shipping (in US dollars) as posted on the CUSP web site on the day CUSP receives my order; and
- (b) in the event my payment is not authorized, CUSP has the right to cancel my order and attempt to provide me with notice of such cancellation.

20. The pharmaceutical(s) will be packaged in child resistant closures unless I decline.

21. CUSP shall be entitled to substitute a brand name prescription drug with a generic prescription drug, where available in accordance with the Manitoba Drug Standards and Therapeutic Formulary, unless the physician has indicated that there be "no substitution". That once purchased and shipped, no pharmaceutical product may be returned or exchanged.

22. CUSP reserves the right to refuse to assist me in obtaining any order in its sole discretion, in which event I will be entitled to a refund for monies paid for such order.

23. CUSP does not provide its agency or attorney services as a substitute for the advice that the customer receives from his/her primary care physician.

24. CUSP will not exchange medication or return any monies paid once an order is filled, unless the medication provided to me by the supplying pharmacy does not correspond with my prescription.

I have read and understood the terms and conditions set out in this Agreement and agree, on behalf of myself, my heirs, successors, administrators and assigns to be bound by these terms and conditions.

Signed this _____ day of _____, 20_____.

(Signature)

(Print Name) (Please Print Clearly)

PLEASE FILL OUT ALL FIELDS COMPLETELY

Important! For optimal health and best results of any medication it is important to have had a physical examination in the past 12 months. Have you had one? Y___ N___ If not, we will require that you schedule an appointment with your physician.

PATIENT INFORMATION

| | | |
|--------------|--------------|--------------------------------|
| _____ | | _____ |
| Full Name | | Age |
| _____ | | _____ |
| Address | | Date of Birth (Month/Day/Year) |
| _____ | _____ | _____ |
| City | State | Sex |
| _____ | _____ | _____ |
| Zip | Email | Height |
| () _____ | () _____ | _____ |
| Phone (Home) | Phone (Work) | Weight |

ALTERNATE SHIPPING ADDRESS

| | | |
|----------------------------|-------|--------------|
| _____ | | _____ |
| Alternate Shipping Address | | Phone Number |
| _____ | _____ | _____ |
| City | State | Zip |

| |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>SHIP TO: Primary Address: <input type="checkbox"/> Alternate Address: <input type="checkbox"/></p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|

PHYSICIAN INFORMATION

| | | | |
|---------------------------------|-------|------------|-------|
| _____ | | _____ | |
| Primary Physician Name | | Phone | |
| _____ | | _____ | |
| Name of Clinic / Doctors Office | | Fax Number | |
| _____ | _____ | _____ | _____ |
| Address | City | State | Zip |

How did you learn about Canada US Pharmacy? _____

PATIENT COUNSELLING

As a member of the Manitoba Pharmaceutical Association we pledge to keep all of our clients well informed about the prescription medications we provide. We also ensure that these consultations will be conducted in an atmosphere of confidentiality and privacy. These consultations are designed to provide you, our clients, with important information regarding your prescription medications. This information includes:

- The drug name
- What the drug does
- How and at what time the drug should be taken
- The importance of taking the drug as directed, regularly or when needed
- What to do if a dose is missed
- Common side effects
- Food, drink other drugs or activities to avoid
- Special storage requirements
- Refill information

Manitoba law requires that we contact you to offer patient counselling. Please indicate the best time and the appropriate phone number to call to get a hold of you.

Best time: _____ am/pm **Phone number:** _____

We will package medications in child resistant closures unless you decline.

I decline child resistant packaging: Yes No

Sign here _____ **Date:** _____

Have you previously filled out a Medical Questionnaire? Yes _____ No _____ Not Sure _____

If YES are there any changes? Yes (please specify) _____

No _____

NOTE: It is only necessary to fill out the Questionnaire once a year, as long as there are no changes.

Please indicate if you / your family has a history of any of the following:

Patient Family Medical History

- 1) Hypertension (high blood pressure) Yes ____ No ____
- 2) Cardiovascular (heart or artery disease) Yes ____ No ____
- 3) Lipid or cholesterol disorder Yes ____ No ____
- 4) Diabetes, thyroid or other endocrine disorder Yes ____ No ____
- 5) Cancer Yes ____ No ____
- 6) Migraine headaches Yes ____ No ____
- 7) Other illness Yes ____ No ____

If you answered YES to any of these questions, please explain in more detail, if necessary

Patient Medical History

- 1) High blood pressure Yes ____ No ____
- 2) Heart or artery disease including atherosclerosis, angina, palpitation, heart failure or history of heart attack Yes ____ No ____
- 3) Liver disease Yes ____ No ____
- 4) Renal or kidney disease Yes ____ No ____
- 5) Cancer Yes ____ No ____
- 6) Immune disorders Yes ____ No ____
- 7) Blood disorders Yes ____ No ____
- 8) Diabetes, thyroid, or other endocrine disorder, including insulin resistance Yes ____ No ____
- 9) Lipid or cholesterol disorder Yes ____ No ____
- 10) Smoker Yes ____ No ____
- 11) Asthma or emphysema Yes ____ No ____
- 12) Neurological disorders Yes ____ No ____
- 13) Emotional disorders Yes ____ No ____
- 14) Poor wound healing Yes ____ No ____

- 15) Rheumatoid arthritis, lupus, or connective tissue diseases Yes ____ No ____
- 16) Any known nutrition deficiency including minerals and electrolytes Yes ____ No ____
- 17) Edema (fluid retention) Yes ____ No ____
- 18) Glaucoma Yes ____ No ____
- 19) Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome Yes ____ No ____
- 20) Surgery Yes ____ No ____
- 21) Chemical dependency Yes ____ No ____
- 22) Other illness not yet noted Yes ____ No ____

***Do you have any drug allergies? Yes ____ No ____**
 If yes, please list: _____

If you answered YES to any of the above questions please elaborate in the box below (i.e., duration of illness, any treatment or surgery received, amount smoked and for how long)

I hereby confirm that the above information is true and accurate as of the date hereof.

Patient's Full Legal Name (Print)

Patient's Signature

Date (Month/Day/Year)

CURRENT MEDICATIONS

Please list all medications (**including** non-prescription (over the counter) and herbal products) you are currently taking and the condition for which they are prescribed.

| Medication & Strength | Daily dosage (eg.1 tab daily) | How long? | Condition |
|-----------------------|-------------------------------|-----------|-----------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

MEDICATIONS BEING ORDERED TODAY

| Medication | Strength | Quantity | Generics | Unit Price | Subtotal |
|------------|----------|----------|----------|------------|----------|
| _____ | _____ | _____ | Yes No | _____ | _____ |
| _____ | _____ | _____ | Yes No | _____ | _____ |
| _____ | _____ | _____ | Yes No | _____ | _____ |
| _____ | _____ | _____ | Yes No | _____ | _____ |
| _____ | _____ | _____ | Yes No | _____ | _____ |
| _____ | _____ | _____ | Yes No | _____ | _____ |
| _____ | _____ | _____ | Yes No | _____ | _____ |

Please note that once purchased, medications may NOT be exchanged or returned. All sales are FINAL.

Add Shipping _____
 Total (US \$) \$ _____

PAYMENT INFORMATION (NOTE: PERSONAL CHEQUES AND POSTAL MONEY ORDERS ARE NOT ACCEPTED)

VISA MASTERCARD AMEX

Card Holder Name (on Card) _____

Card Holder Address _____

Card Holder City _____ Card Holder State _____

Credit Card Number _____ Card Holder Zip _____

Credit Card Expiry _____ Card Holder Country _____

Unless otherwise notified in writing, I hereby authorize the dispensing pharmacy to charge my credit card for the cost of all present and future medications ordered plus all associated shipping costs.

Signature _____ Date (Month/Day/Year) _____

Please check everything over carefully and remember to SIGN and DATE every page that you send to us.