

Mail Order Program Descriptions

AmeriPharm At-Home: A Pharmacy at Your Door!

AmeriPharm is proud to be the Preferred Provider for the Northwest Ohio Pharmacy Card Network. You can trust our experienced pharmaceutical experts and registered pharmacists to fill your prescriptions accurately, promptly and conveniently.

To Use AmeriPharm at Home:

- 1) Obtain a prescription from your doctor. Your doctor can authorize a year's supply by specifying 3 refills on a 90 day supply.
- 2) Complete the AmeriPharm enrollment form above. Please be sure to provide all the requested information.
- 3) Include your doctor's original, handwritten prescription(s).
- 4) Include appropriate payment information.
- 5) Mail the prescriptions along with this completed form to the address shown on the back-side of this enrollment brochure.

REMEMBER:

- Please allow "up to" 14 days from the time you mail your prescription to us until you receive the medication back in your mailbox. In most cases, it will take less time.
- Fastest shipping is available by requesting overnight or second-day delivery at an additional cost. Please call us Toll Free to specify faster shipping

FEES: The charges for AmeriPharm drugs include the following:

- The Cost of the Drugs
- A \$1.50 Dispensing Fee
- Shipping & Handling Fee of \$1.00 (regular mail)

GENERIC POLICY: AmeriPharm will substitute a generic drug if one is available. If you do not wish to have such a substitution, be sure to mark and sign the DO NOT box on the Enrollment Form.

Customer Service:

For Price Quotes and Questions:

Call Toll Free: **1-866-744-0621**

Mon-Fri 8:00 a.m. to 7:00 p.m. Eastern Time

Scriptsense Canada - Canadian Mail Program

Our goal is to provide low-cost pharmaceuticals adhering to the guidelines of the FDA. This means that some drugs are not available. Be sure to read the Patient Consent and Waiver section as this explains our process.

To Use Scriptsense Canada:

- 1) Obtain a prescription from your doctor. Your doctor can authorize a year's supply by specifying 3 refills on a 90 day supply.
- 2) Complete the Scriptsense Enrollment Form on Reverse Side of the Brochure. Please be sure to provide all the requested information.
- 3) Sign and Date the Consent and Waiver Form on the Reverse Side
- 4) Complete the Medical History Form (Required)
- 5) Include your doctor's original, handwritten prescription(s).
- 6) Mail the prescriptions along with this completed form to the address shown on the back-side of this enrollment brochure.

TIME:

- Please allow "up to" 14 days from the time you mail your prescription to us until you receive the medication back in your mailbox. In most cases, it will take less time.

FEES: The charges for Scriptsense drugs include the following:

All Fees except shipping are Included in the Cost of the Drugs

SHIPPING FEE: A shipping fee of \$15.00 is charged regardless of the number of drugs you purchase. All drugs are shipped Canada Express Post.

PRESCRIPTION REFILLS:

FOR FASTEST SERVICE VERIFY AVAILABLE REFILLS AND CALL US TOLL FREE AT **1-866-236-3784**. **Have your prescriptions handy so you can tell the pharmacist the refill number(s) as they appear on the package. Refill instructions are mailed along with your drug order.**

Customer Service:

For Price Quotes and Questions:

Call Toll Free: **1-888-493-8440**

Mon-Fri 8:30 a.m. to 5:00 p.m. Eastern Time

www.RxSave.org
Saving Everyone on their Rx Costs!

Medical History: (All Patients Required to Complete)

In order to process your drugs appropriately and offer a sound drug utilization Review Program.

Date of Birth: _____ Sex: ___ Male ___ Female

Height: _____ feet _____ Inches Weight: _____ lbs.

Allergies: _____

Medical
Conditions: _____

Other Health Issues:

The information on both sides of this form are considered protected health information according to U.S. HIPAA law. I authorize the use of my information as required to fulfill my prescriptions. Our privacy policy may be viewed at www.scriptsense.ca. (Canadian) & www.ameripharminc.com (US)

Signature: _____

Date: _____

ENROLLMENT FORM

(Must Be Completed for Either or Both of the Mail Order Programs.)

You may choose to use either US Mail or Canadian Mail or Both. Please advise us by marking the appropriate choice below (Please check one only):

US Mail Only Canadian Only Both

| | |
|-------------------|--|
| Name: | |
| Address | |
| City | |
| State | |
| Zip | |
| Home Phone | |
| Work Phone | |

Credit Card Information

Cardholder Name (Name as appears on the card):

Address: (Street) _____

Apt./Box: _____ City: _____ State: _____ Zip: _____

Credit Card Type: Check one: Master Card Visa Discover _____

Card Number [_____] [_____] [_____] [_____]

Expiration Date: _____

I understand that Scriptsense Canada or AmeriPharm will only use this credit card for required charges related to the purchase of my drugs. I hereby authorize use for this stated purpose and authorize them to keep my card information on file.

Signature: _____ Date: _____

GENERIC SUBSTITUTION : I DO DO NOT want generic substitution.

Signature: _____

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Saving Everyone on their Rx Costs!
This Section Must Be Signed in Order to Use Canada.

Patient Consent and Waiver of Liability:

I, the undersigned, on behalf of myself, my heirs, assigns and successors, hereby agree to all of the following terms and conditions, represent that I understand all of the following terms and conditions and that I have had adequate opportunity to consult any necessary medical, legal, or other advisors.

I hereby appoint Scriptsense Canada, Inc. and its representatives or contractors as my agent and attorney for purposes of obtaining a prescription from a Canadian Physician (medical doctor, M.D. or D.O.) which corresponds to my prescriptions provided by my personal U.S. physician whose care I am under. I understand and agree this may include directly contacting my U.S. prescribing physician. I further appoint and authorize Scriptsense Canada, Inc. and its representatives or contractors to purchase and arrange delivery of these same medications prescribed in the Canadian prescription pursuant to the terms set forth below, to the same extent I could, if I personally took such steps.

I hereby consent to Scriptsense, the Canadian Physician and the Scriptsense pharmacy supplying my order, the right to collect and maintain my medical (protected health information) and personal information, and to maintain the information necessary to evaluate and process future orders in an efficient and timely manner. I understand this may include retaining on file my personal, medical, medical history, payment, and other information and verifying future orders.

I hereby confirm that my personal, medical and payment information will be handled only by Scriptsense Canada's employees and contractors including physicians, nurses, pharmacists, pharmacy technicians, and order processing personnel. All this information (collectively protected health information) will be handled and maintained according to Scriptsense's Privacy and Confidentiality policies available on the Scriptsense website at: www.scriptsense.ca and which have been provided me upon enrollment in the Scriptsense program. I acknowledge that I understand the policy which may be updated from time to time.

I hereby confirm and represent that I have read, understand and consent to all the following:

- I am at least eighteen years of age and am capable of making my own medical decisions according to the laws of my state of residence.
- The prescription(s) I am seeking to obtain through the Scriptsense program were prescribed by a U.S. qualified and licensed physician whose care I am under.
- The medications sought through my prescriptions are solely for my personal use and will not be provided to any other person.
- I will use all medications obtained by Scriptsense on my behalf in strict accordance with the instructions provided by the prescribing physician.
- I will immediately contact my personal U.S. licensed physician whose care I am under should I suffer any adverse effects while taking the prescribed medications obtained by me through the Scriptsense program.
- I have not sought nor am I relying on any medical information provided by Scriptsense.
- I have consulted a licensed U.S. physician whose care I am under and who has provided me with my prescriptions within the last year.
- I understand that Scriptsense and its physicians will not prescribe new medications.
- I understand that Scriptsense does not and will not provide me any controlled medications, narcotics, tranquilizers, or other medications the Scriptsense physician decides are inappropriate.
- I understand that Scriptsense is in no manner a substitute for a healthcare provider.

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- I understand that this service is not intended for the diagnosis of a medical condition and that Scriptsense and its employees and contractors will not make any medical diagnoses and that the service should not be used as a substitute for professional medical advice.
- I agree that I will consult and direct my treatment questions to my personal licensed U.S. physician.
- I understand that my request may be denied at the sole discretion of Scriptsense Canada. My money will be refunded.
- I agree to provide updated medical history information as I become aware of changes in my physical or medical condition.

I acknowledge and understand that medical diagnoses, opinions and treatments differ even among well-trained and respected physicians and that there is no implied warranty to me that treatments I am receiving and the medications I am obtaining through Scriptsense on the prescribed order of my personal physician, will benefit me.

I hereby release and save Scriptsense, its physicians, nurses, pharmacists, pharmacy technicians, and other employees and contractors harmless from any and all suits, demands, liabilities, claims, actions, expenses, losses and damages of any kind or nature whatsoever, including, without limitation, general, direct, special, indirect and consequential damages and costs of litigation including reasonable attorney fees arising from:

- My use of the medication obtained for me by Scriptsense including, any and all side effects whether previously known or unknown;
- Scriptsense's or its contractors' manner or timeliness of completing any actions I have authorized above, including, without limitation, their manner or timeliness in prescribing the appropriate strength, dosage, or dispensing in non-child proof packaging; and,
- My breach of any terms, conditions or representations or warranties in the agreement.

This agreement, along with any disputes that may arise, will be governed by and construed in accordance with the laws of the Province of Ontario, Canada.

I have read and understand the above referenced "Patient Consent and Waiver of Liability,;" and hereby accept and authorize the proposed terms (**Signature Required**).

Signature: _____ Date: _____

Medical History Form Also Required!

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Mailing Instructions:

Mail Your Completed Form Along with Your Prescriptions to the Following Address:

Northwest Ohio Pharmacy Card Network
3349 Executive Parkway, Suite I
Toledo, Ohio 43606