

## Antivirals: HIV – rilpivirine (Edurant®)

Please provide the information below, please print your answers, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.

**Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082, Options 0,1,2,3.**

Date of request:			
Patient		Date of birth	Molina ID
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength		Directions for use	Qty/Days supply

  

1. Is this request for a continuation of therapy? ☐ Yes ☐ No  
 If yes, does the patient have a previous history of medication use with Edurant (rilpivirine) within the last 6 months? ☐ Yes ☐ No
  
2. Indicate patient's diagnosis:  
☐ HIV-1 Treatment.  
 Which other ART medication will be used in combination with rilpivirine (Edurant)?  
  
☐ Other. Specify: \_\_\_\_\_
  
3. Will the patient be using rilpivirine (Edurant) in combination with cabotegravir? ☐ Yes ☐ No
  
4. Is patient ART experienced? ☐ Yes ☐ No  
 If yes, has patient had virologic suppression for at least 6 months (HIV-1 RNA < 50 copies/mL)?  
☐ Yes ☐ No
  
5. HIV-1 RNA \_\_\_\_\_ copies/mL
  
6. Is the patient's body weight greater than or equal to 35 kg? ☐ Yes ☐ No
  
7. Will the patient be using any of the following medications? (check all that apply)  

<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Dexamethasone (more than a single dose treatment)
<input type="checkbox"/> Oxcarbazepine	<input type="checkbox"/> Phenobarbital
<input type="checkbox"/> Rifampin	<input type="checkbox"/> Phenytoin
<input type="checkbox"/> Proton pump inhibitors	<input type="checkbox"/> Rifapentine
	<input type="checkbox"/> St John's Wort

 (i.e. esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole)

<b>CHART NOTES, LABS and TESTS ARE REQUIRED WITH THIS REQUEST</b>		
Prescriber signature	Prescriber specialty	Date