



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

**Liraglutide (Victoza®) Initial
Prior Authorization Request Form**

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date Of Birth: ____/____/____

Pharmacy Name: _____

Pharmacy Medicaid ID#: _____ Pharmacy NPI#: _____

Phone number: (____) _____ Fax number: (____) _____

NDC Requesting: _____

Prescribing Physician's Name: _____

Physician Medicaid ID#: _____ Physician NPI#: _____

Phone number: (____) _____ Fax number: (____) _____

PLEASE ANSWER ALL FOLLOWING QUESTIONS:

Please indicate diagnosis for which Victoza® is being prescribed. _____

Please provide HbA1C _____ Date ____/____/____

Have therapeutic goals been achieved or maintained? Yes _____ No _____

Does the patient have a documented improvement of HbA1c from pretreatment levels? Yes _____ No _____

If fluctuation in HbA1c –please provide physician rational _____

Is the patient taking the maximum tolerated dose of metformin? Yes _____ No _____

Does the patient have a documented contraindication preventing them from taking the maximum doses of metformin? Yes _____ No _____

For renewal: 1)documented improvement of HbA1c from pretreatment levels 2) achievement or maintenance of therapeutic goals. If fluctuation in HbA1c –please provide rational _____

Signature of Physician or Designee: _____ Date: ____/____/____

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**