

Prior Authorization File Record Layout

Required File Format = ASCII File - Tab Delimited

Do not include a header record

Filename extension should be “.TXT”

During the initial formulary submission period the file must include all Prior Authorization Group Descriptions. All records must have ADD for the Change_Type.

After the initial formulary submission period the file must include only changes.

Field Name	Field Type	Maximum Field Length	Field Description
PA_Change_Type	CHAR Always Required	3	<p>Defines the type of change that is being made to the Prior Authorization File.</p> <p>During the initial formulary submission period, all rows must be “ADD.”</p> <p>ADD = Add Group Description to file UPD = Change fields for an existing Group Description</p>
Prior_Authorization_Group_Desc	CHAR Always Required	100	Description of the prior authorization group as it appears on the submitted formulary file. This field must exactly match the value entered in the Prior_Authorization_Group_Desc field on the Formulary File.
PA_Criteria_Change_Indicator	CHAR Always Required	1	If the PA criteria content did not change for this group description compared to CY 2015, please place a “0” in this field. If this group description is new, or the criteria content changed in any way (e.g. additional restrictions), please place a “1” in this field”.
Covered_Uses	CHAR Always Required	3000	<p>Enter <u>both the FDA-approved and off-label indications</u> for which the drug(s) will be covered.</p> <p>At a minimum, you must enter the following in this field: “All FDA-approved indications not otherwise excluded from Part D.”</p> <p>You may enter the statement “All medically accepted indications not otherwise excluded from Part D” if the PA will be approved for all non-excluded off-label uses in addition to the labeled indications.</p> <p>If only certain off-label uses will be approved by prior authorization, you should list the specific uses following the “All FDA-approved indications not otherwise excluded from Part D” statement.</p>
Exclusion_Criteria	CHAR If applicable	2000	Describe any criteria (e.g. comorbid diseases, laboratory data, etc.) that would result in the exclusion of coverage for an enrollee.

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Field Name	Field Type	Maximum Field Length	Field Description
Required_Medical_Information	CHAR If applicable	2000	Enter laboratory, diagnostic, or other medical information required for initiation or continuation of the drug(s).
Age_Restrictions	CHAR If applicable	500	Enter age limitations or restrictions required for prior authorization approval.
Prescriber_Restrictions	CHAR If applicable	500	Description of prescriber attribute necessary for PA to be considered, e.g. specialist in a field or registered under a certain program.
Coverage_Duration	CHAR Always Required	100	Enter the duration for which the prior authorization will be approved.
Other_Criteria	CHAR If applicable	3000	Enter any other relevant criteria.

Please Note: Certain characters are restricted from HPMS. The submitted file will be rejected if any of the following characters are included in any field: 1) greater than sign (>), 2) less than sign (<), and 3) semi-colon (;).