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	Defines the type of change that is being made to the Prior Authorization File. During the initial formulary submission period, all rows must be "ADD." ADD = Add Group Description to file UPD = Change fields for an existing Group Description
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	Enter both the FDA-approved and off-label indications for which the drug(s) will be covered. At a minimum, you must enter the following in this field: "All FDA-approved indications not otherwise excluded from Part D." 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. 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.
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 (;).