

## CY 2020 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	<p>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.</p>
PA_Criteria_Change_Indicator	CHAR Always Required	1	<p>If the PA criteria content did not change for this group description compared to CY 2019, 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”.</p>
PA_Indication_Indicator	CHAR Always Required	1	<p>This field must be populated with one of the values below. This field is used to describe the indications for which the PA will be approved.</p> <p>1 = All FDA-approved Indications. This value cannot be used if the drug that requires PA is subject to Indication-Based Coverage (IBC).</p> <p>2 = Some FDA-approved Indications Only. This value is to be submitted for drugs that are subject to IBC.</p> <p>3 = All Medically-accepted Indications. Drugs for which the PA will be approved for all Part D medically-accepted indications (FDA-approved and compendia-supported) should be submitted with a 3.</p> <p>4 = All FDA-approved Indications, Some Medically-accepted Indications. If the PA will only be approved for specific off-label uses, a 4 should be submitted. The additional off-label uses should be submitted in the subsequent Off-Label Uses field.</p>

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Field Name	Field Type	Maximum Field Length	Field Description
Off-label_Uses	CHAR Required only if a 4 is entered for PA_Indication_Indicator	3000	Enter the specific off-label uses for which the PA will be approved. This field must not contain any FDA-approved indications.
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.
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 (;).