

CY 2027 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> <p>Only RxCUIs with the same RxNorm ingredient can be included within the same Prior_Authorization_Group_Desc.</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 indications for which the PA will be approved that are not otherwise excluded from Part D coverage.</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., contraindications) that would result in the exclusion of coverage for an enrollee.
Required_Medical_Information	CHAR If applicable	2000	Enter medical information required for initiation or continuation of therapy (e.g., diagnosis, prerequisite requirements).
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.
Part_B_Prerequisite	CHAR If applicable	1	If the PA criteria requires a Part B drug before a Part D drug, then please enter "1" in this field", otherwise enter "0". This field only applies to MAPD plans that are associated with this formulary ID.
Prerequisite_Therapy_Required	CHAR Always Required	1	If the PA criteria require other Part D drug(s) before access to this Part D drug, please enter "1" in this field. Otherwise, enter "0".

Please Note: Certain characters are restricted from HPMS. The submitted file will be rejected if it contains restricted characters in any field, such as: 1) greater than sign (>), 2) less than sign (<), 3) semi-colon (;), 4) ampersand and hash combination (&#), etc.