

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 be limited to updates.

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>
Prior_Authorization_Group_Indication	CHAR Always Required	500	<p>Enter the indication code for which the prior authorization applies. If the prior authorization applies to more than one indication, the subsequent fields should be repeated for each indication, and the information entered should correspond only to that specific indication.</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 2026, 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>
Exclusion_Criteria	CHAR If applicable	2000	<p>Describe any criteria (e.g. comorbid diseases, laboratory data, etc.) that would result in the exclusion of coverage for an enrollee.</p>
Required_Medical_Information	CHAR If applicable	1000	<p>Enter laboratory, diagnostic, or other medical information required for initiation or continuation of the drug(s).</p>
Age_Restriction_Modifier	CHAR If applicable	1	<p>Enter the age for which the prior authorization will be approved.</p> <p>1 = greater than or equal to 2 = less than or equal to 3 = between two ages</p>

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Field Name	Field Type	Maximum Field Length	Field Description
Age_Restrictions	CHAR If applicable	7	Enter age, in years, required for prior authorization approval. If 3 is selected in the previous field, enter as a comma delimited field to indicate an age range. Required only if Age_Restriction_Modifier is entered.
Prescriber_Restrictions	CHAR If applicable	500	Enter the required prescriber type code(s) for prior authorization approval. If multiple prescriber codes, enter as a comma delimited field.
Coverage_Duration	CHAR Always Required	5	Enter the duration for which the prior authorization will be approved. <ul style="list-style-type: none"> a. Lifetime b. 1-year c. Plan Year d. Months, (number of months) e. Days, (number of days) Other (enter information in the Other criteria box)
Other_Criteria	CHAR If applicable	1000	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 requires use of a prerequisite Part D drug then 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.