surescripts

Electronic Prior Authorization Companion Guide

surescripts

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1. Electronic Prior Authorization Overview

About Electronic Prior Authorization

Electronic Prior Authorization (ePA) integrates directly with provider vendor and PBM/payer systems, enabling healthcare professionals to easily obtain prior authorizations at the point of care. The prior authorization messages are designed to support the exchange of information obtained from the electronic health record system. The messages allow for the use of coded references, increasing the opportunity for interoperability. It is important for both provider vendors and PBM/payers to implement ePA using the most automated system possible to ensure timely responses to each of the messages.

About This Guide

The Surescripts Electronic Prior Authorization Companion Guide was created to assist PBM/payers and provider vendors in developing and transferring ePA messages based on the NCPDP Script standard. Each message supports a particular step in the prior authorization process, which electronically supports the exchange of information necessary to facilitate the request for coverage of a specific medication under a patient's pharmacy benefit.

The audience for this document includes any customer responsible for developing a system interface for these electronic prior authorization messages.

Notes:

- The terms PBM/payer or processor, who acts on behalf of the PBM/payer, are referred to as PBM/payer throughout this guide.
- The term provider vendor in this document refers to both provider vendors and specialty pharmacies completing electronic prior authorizations on behalf of providers.
- The term third-party processor is used to describe the following:
  - A third-party that processes prior authorizations (PA) on behalf of the PBM/payer or health plan.
  - A health plan that processes their own PAs rather than delegating PA processing to their PBM/payer.

Document References

Please reference the following documents when reading this guide:

Surescripts provided materials
Connectivity and Authentication Implementation Guide
Surescripts Directory Implementation Guide
Eligibility 2.2 (or later) Companion Guide
Formulary 2.0 (or later) Companion Guide
E-Prescribing 6.2 (or later) Companion Guide
Real-Time Prescription Benefit for PBM/Payers Implementation Guide 1.3 (or later) Implementation Guide
Error Guidance Supplement - Provides common errors and specific recommendations related to SCRIPT TransactionErrorCodes(s), DescriptionCode(s), and other errors experienced on the network.
Electronic Prior Authorization Translation Matrix - Provides details on translation between different versions of the Surescripts implementation of the NCPDP SCRIPT standard.

External materials to be obtained by the customer (available at www.NCPDP.org)
NCPDP SCRIPT Standard 2023011 files (please note that the schema files version may change and will not be considered final until published in the Generally Available guide): • XML files (schemas) 20230114 • NCPDP SCRIPT Implementation Guide V2023011 (March 2024 republication) • XML Standard Guide V2022071 ◦ **Note:** The XML Standard only updates when the guide changes. The latest version is 2022071. NCPDP does not retroactively update XML versions with each new SCRIPT/Specialized Standard. This Standards Matrix shows the XML Guide version for each Standard. • V2023011 SCRIPT Standards Examples Guide V10
NCPDP SCRIPT Implementation Recommendations (latest version)
NCPDP External Code List 202301 (NCPDP online tool)

2. Integration & Production

Integration Process

When a customer begins integrating a Surescripts product into their application(s), they will be provided access to all the Surescripts documentation pertaining to the product being implemented. In addition, customers will be provided access to the staging environment to design, develop and test the product integration within their application.

> **Note:** The time frame of the project can vary depending on the customer's resource allocation for the project.

Meeting Requirements

During Integration, customers will ensure their system has met all product requirements. The Certification Testing will focus on message format, application workflow and display in accordance with Surescripts documentation and the associated Application Certification Requirements (ACRs). Upon successful completion of certification and, when applicable, other pre-production network requirements (e.g., Identity Proofing, Attestations, DEA audit), customers will be enabled in production.

For requirements, consider the following:

- Surescripts ACRs are required to be met to achieve production status on the Surescripts network and will be enforced as part of certification.
- To ensure high-quality transactions, Surescripts applies additional business rules above and beyond the NCPDP schema defined requirements that will cause a message to be successful or rejected.
- Surescripts test cases do not cover all possible scenarios in production. Customers are responsible for testing any other applicable scenarios specific to their production environment.
- In accordance with the customer's legal agreement with Surescripts, each customer is responsible for ensuring compliance with all applicable laws including, but not limited to, local and state laws/regulations where doing business.

Transition to Production

Once certification and the contract are complete and approved by the Surescripts Certification Review Board, the customer is ready to move into production. Surescripts will configure the production connection and validate successful operations with the customer. Prior to the transition to production, Surescripts Account Management will work with the customer and internal Surescripts teams to discuss the following:

- Production support contacts (Escalation Matrix)
- Support process and training
- Support hours

Surescripts Terminology Usage

For terminology usage throughout this guide, consider the following:

Term	Term Usage
must	Requirements that are enforced as part of the production code or by Surescripts business rules. **Note:** Some business rules reside in the element details section of the guide.
shall	The requirements customers are required to meet in order to be certified on the Surescripts network. These requirements will be enforced as part of certification, not through business rules.
should	Used for guidance and best practices to produce superior results and enhance electronic messaging. Best practices can also be found in the Best Practice sections. Customers are encouraged, but not required, to meet best practices in order to be certified on the Surescripts network.
PA.###	Designates a Surescripts Electronic Prior Authorization ACR.
S.###	Designates an ACR that is shared with other Surescripts products.

Communication Rules

Please refer to the Connectivity and Authentication Guide for details regarding communication and security protocol requirements as well as references to all links and IP addresses associated with Surescripts services. For the network to be reliable, there are communication rules to which all customers must adhere.

UTC Time Format

By using Coordinated Universal Time (UTC), the receiver of a message will know the time regardless of their time zone. For example: If a message was sent from Boston at 5:30PM EDT (Eastern Daylight Time), the time would be sent as 21:30 UTC time. If this message was received in Chicago CDT (Central Daylight Time), the 21:30 UTC could be converted to the local CDT time of 4:30PM. Refer to **http://en.wikipedia.org/wiki/Coordinated_Universal_Time**, or **http://www.w3.org/XML/** for more information. UTC time must be synchronized with NIST (National Institute of Standards and Technology) and the difference must be less than one minute. Drift of no more than one minute will be acceptable.

When sending only a Date (not Date and Time), it should be sent in your local time zone, and the receiver should interpret it in their local time. Neither party should attempt to convert the Date to UTC.

All standard programming languages should have a function for generating a date in the UTC time zone or displaying a date in the local time zone. The format of the date/time fields in the XML schema must use the xsd:dateTime format. Examples of that format are: CCYY-MM-DDTHH:MM:SS.FZ, where the UTC time zone may be specified as Z, + 00:00, or - 00:00. For example, 2013-01-01T16:09:04.5Z, or 2013-01-01T16:09:04.5-00:00, or 2013-01-01T16:09:04.5+00:00, where 16:09:04.5Z would be 16 hours, 09 minutes, 04 seconds, 5 fractional seconds. UTC time is denoted by either the “Z” in the first example or the “-00:00” in the second example, or the “+00:00” in the third example. The fractional seconds is not required. Refer to xsd:dateTime for more information.

For simple date fields that do not include the time portion, the format is: CCYY-MM-DD.

Character Set

The character set contains ASCII values 32 – 126, which includes:	
Symbols	! " # $ % & ' ( ) * + , - . / : ; < = > ? @ [\ ] ^ _ ` { | } ~
Numerals	Ø to 9
Letters, upper and lower case	A to Z, a to z

Unprintable characters, such as control characters, are not used within the field sets. Defined unprintable characters are used as delimiters.

UTF-8 is the required character encoding for XML. Other encoding formats are not supported by Surescripts.

> **Note:** It is recommended that customers declare their UTF-8 formatting in the message header.

XML Escape Character

Most symbols should be 'safe' within most alphanumeric fields; however, XML validation has issues with some characters, such as 'less than' (<) and 'ampersand' (&); therefore, these symbols must be properly escaped or unescaped. The quote and apostrophe only need to be escaped when used in an attribute. The most common escape encodings are:

ASCII Characters	XML Escape
quote (")	&quot;
apostrophe (')	&apos;
ampersand (&)	&amp;
less than (<)	&lt;
greater than (>)	&gt;

> **Note:** String lengths are calculated based on the un-escaped value. For example, ">98 degrees" should be encoded as ">98 degrees" but it would only be counted as a string length of 11, not 14. The quote and apostrophe only need to be escaped if they are used within an attribute.

Timeouts

For timeouts, consider the following:

- When sending a message to Surescripts, the initiator should set the HyperText Transport Protocol (HTTP) timeout to no less than 30 seconds.
  - A receiving system must reply with a valid response within 24 seconds.
    Valid responses include:
    - Status message (Code 010 – Synchronous Response Indicating Successful Receipt)
    - Error message
    - Status message (Code 000 – Synchronous Acknowledgement – Further Response to Follow)
- When a Status (Code 000) is sent as a reply, a receiving system must follow-up with a Verify or Error within 24 hours, as Surescripts may return a timeout error.

> **Note:** Refer to the **Acknowledgment Messages** section for more information on using Status, Error, and Verify messages.

Compliance

Surescripts goal is efficiency and consistency across the network so all customers can meet the highest measures of patient safety, end-to-end reliability, and quality. To ensure that customers comply with and adhere to the approved certification requirements, Surescripts:

- Monitors customers in production to ensure all network customers remain in compliance with certification requirements and contractual terms.
- Initiates a remediation process for identified compliance issues.

To ensure network and patient safety, customer agrees to notify Surescripts of any modifications through use of the Surescripts recertification form. Upon receipt of this form, changes will be reviewed, and a determination made as to what (if any) level of certification may be required before being placed into production.

When changes are made to a customer's implementation, the customer should advise their account manager. The customer will be given a recertification guide to provide details regarding the changes made. Upon receipt of the completed document, the details will be reviewed, and a determination will be made as to what (if any) level of recertification is necessary.

As a reminder, Surescripts conducts certification with customers to ensure the application adheres to network requirements. Surescripts will enforce mandatory fields as required by the Standards body and Surescripts guide requirements. To maximize interoperability, customers are recommended to support optional fields that have been created to address gaps in discrete data needs and the many solutions that are in place for the benefit of the receiver. Surescripts encourages, but does not guarantee, the use of optional discrete fields to support end user workflows.

This guide is intended for certification on our network only and is not intended to ensure compliance with state and federal law. In accordance with the customer's legal agreement with Surescripts, each customer is responsible for conducting its own due diligence to ensure compliance with all applicable laws and requirements, including, but not limited to, local and state laws and regulations in which the customer's application is deployed and used.

3. Messages Overview

The Messages Overview section describes the electronic message transactions supported by the Electronic Prior Authorization (ePA) Companion Guide and outlines their role within the prior authorization workflow. It provides a high-level summary of each message type, including its purpose, trigger events, and general processing expectations, to help implementers understand how requests, responses, and status updates are exchanged between trading partners.

This section is intended to orient readers to the message ecosystem before reviewing detailed transaction specifications and implementation requirements in subsequent sections.

Refer to the following topics for more details:

3.1. Message Descriptions

Prior authorizations have two possible message flows: solicited and unsolicited.

In the solicited model, the provider vendor notifies the PBM/payer that they wish to start the prior authorization process to determine if an authorization is needed for the patient and desired medication. In the unsolicited model, the provider vendor presumes that an authorization is needed and submits the information they anticipate the PBM/payer needs. Provider vendors and PBM/payers are required to support all message types outlined below.

PAInitiationRequest

In the solicited model, this message is used by the provider vendor to initiate the prior authorization process by notifying the PBM/payer of the patient and the medication for which prior authorization is being requested, along with the provider vendor's information and other related details. Provider vendors are encouraged to include any available relevant information when populating the PAInitiationRequest to receive the timeliest decision possible. The more detail provided up front, the less the PBM/payer must come back and ask for later.

PAInitiationResponse

In the solicited model, the PBM/payer returns a PAInitiationResponse after receiving the PAInitiationRequest. This message could contain either a set of questions established by the PBM/payer for the prior authorization or a request for information sent in lieu of the question set. If no PA is required, the PBM/payer sends a closed PAInitiationResponse without a question set. A PAInitiationResponse should be returned for each PAInitiationRequest.

> **Note:** For Prior Authorization Renewal Requests (Unsolicited PAInitiationResponse), the PBM/payer does not receive a PAInitiationRequest before sending the PAInitiationResponse. The PBM/payer sends the PAInitiationResponse to Electronic Prior Authorization Initiate (EPAINI) and Surescripts performs a provider lookup to identify the receiving Surescripts Provider Identification (SPI).

The PAInitiationResponse from the payer should identify all information required to complete the PA determination. This allows a determination to be made in one exchange of the PARequest and response messages.

The PAInitiationResponse is for the medication (name, strength, and dosage form) indicated in the PAInitiationRequest. When responding, the PBM/payer should not alter the values indicated in the PAInitiationRequest (e.g., replying with a generic product equivalent to brand product).

With the availability of the Prior Authorization Renewal Request (also known as the Unsolicited PAInitiationResponse), this allows PBM/payers to send a question set for an expiring PA case. If the EHR is not certified to receive this, Surescripts will attempt to deliver the question set to a PA Gateway Worklist. If this option is also not available, Surescripts will send a PDF notification of the renewal via Clinical Direct Message or Fax.

PARequest

The provider vendor presents questions for the provider to answer and/or extracts information from the patient's electronic medical record, then sends the information to the PBM/payer in the PARequest message.

PAResponse

The PBM/payer determines whether an authorization can be granted and provides the determination to the provider vendor in the PAResponse message. This message may indicate that the PBM/payer needs additional information to make a decision if needed. The payer will also indicate whether it supports electronic appeals for this case. Provider vendors implementing an ePA solution

should ensure that they have determined how they will support all possible response statuses (Approved, Denied, Partially Denied, In Process, Open, or Closed).

PAAppealRequest

The PAAppealRequest message enables the provider vendor to obtain the information required to submit an appeal. The PAAppealRequest message also enables the provider vendor to submit the appeal information for a prior authorization determination.

> **Note:** PAAppealRequest should only be sent when the IsEAppealSupported flag is set to "1" in the PAResponse.

PAAppealResponse

The PAAppealResponse message provides information from the PBM/payer to the provider vendor on what is needed for an appeal. The PAAppealResponse message is also used by the PBM/payer to indicate the outcome of an appeal. In some cases, the PAAppealResponse message may indicate that the PBM/payer needs additional information in order to make a decision.

PACancelRequest

The provider vendor sends the PACancelRequest to a PBM/payer to indicate that they are no longer pursuing their most recent request. This can be sent any time after the PAInitiationResponse with the PACaseID is received by the provider vendor. The provider vendor should ensure that, if changes are permitted to a prescription with an associated PA, the prescription and PA remain in sync. If a prescription changes, the original PA should be cancelled. A determination should be made as to whether a new PA is needed based on the new prescription details.

> **Note:** PACancelRequest messages should only be sent for PA cases that are still considered open and valid at the PBM/payer. If a closed PAInitiationResponse, PAResponse, or PAAppealResponse determination has been returned to the provider vendor, a PACancelRequest should not be sent to the PBM/payer.

PACancelResponse

The PBM/payer sends the PACancelResponse to a provider vendor to indicate whether the PARequest was canceled. This is only sent if a PACancelRequest is sent by the provider vendor to the PBM/payer.

PANotification

The PANotification message is used to notify the provider vendor or pharmacy vendor of the status of the prior authorization. PANotification is a one-way, information-only message that can be sent from the pharmacy to the provider or from the provider to the pharmacy. This message is required for customers using NCPDP SCRIPT messages.

PANotification messages close the communication gap at the pharmacy of the status of the prior authorization and reduce duplicate prior authorization workflows.

> **Note:** Notification of the prior authorization status also occurs via the NewRx or RxChange transaction.

3.2. Acknowledgment Messages

Note: The terms "free standing" and "asynchronous" are interchangeable.

Message Type	Code	Meaning(s)	As Sender	As Receiver
Status	000	The transmission has been accepted for processing but has not yet reached its final status. There should be a final Verify (010) or Error forthcoming.	Follow with an asynchronous (free standing) Verify or Error to complete the message flow.	While an asynchronous Verify or Error is expected to follow a Status 000, if it is not received, no assumption should be made as to whether the original message has been received successfully or not. The recommendation is to wait 24 hours before following a manual process or sending a duplicate message.
Status	010	Confirms successful delivery and acceptance of a message to itsfinal destination. The final acknowledgment message to close the transaction workflow. No further acknowledgment message should follow.	Synchronous response indicates that message processing is complete.	Subsequent acknowledgment message should not be expected.
Verify	010	Asynchronous message that confirms successful delivery and acceptance of a message to its final destination. The final acknowledgment message to close the transaction workflow. No further acknowledgment message should follow.	Send only if the original message was responded to with a Status 000.	Subsequent acknowledgment message should not be expected. Do not respond to a free-standing Error or Verify with a new free-standing Error or Verify.
Error	For a full list of NCPDP Error codes and their descriptions, see the NCPDP External Code List or schema.	Can be generated when there is a communication problem or when an error occurs during the processing of the message. Closes the transaction workflow. Subsequent acknowledgment messages should not be expected. Could be synchronous or asynchronous. A synchronous error is sent in response to a message.	Send to acknowledge that the transaction failed. Do not send if a transaction workflow has already been closed (Status/Verify Code 010). Send as soon as possible after a Status (Code 000) has been sent.	After receiving an Error, do not expect subsequent acknowledgment messages. Do not respond to a free-standing Error or Verify with a new free-standing Error or Verify.

Message Type	Code	Meaning(s)	As Sender	As Receiver
		An asynchronous error (also called Free-Standing Error) is initiated as a new message after the Status (Code 000) is sent.	Customers may create and return unique error descriptions which may further indicate why failure has occurred.	

3.3. Electronic Prior Authorization Message Flow

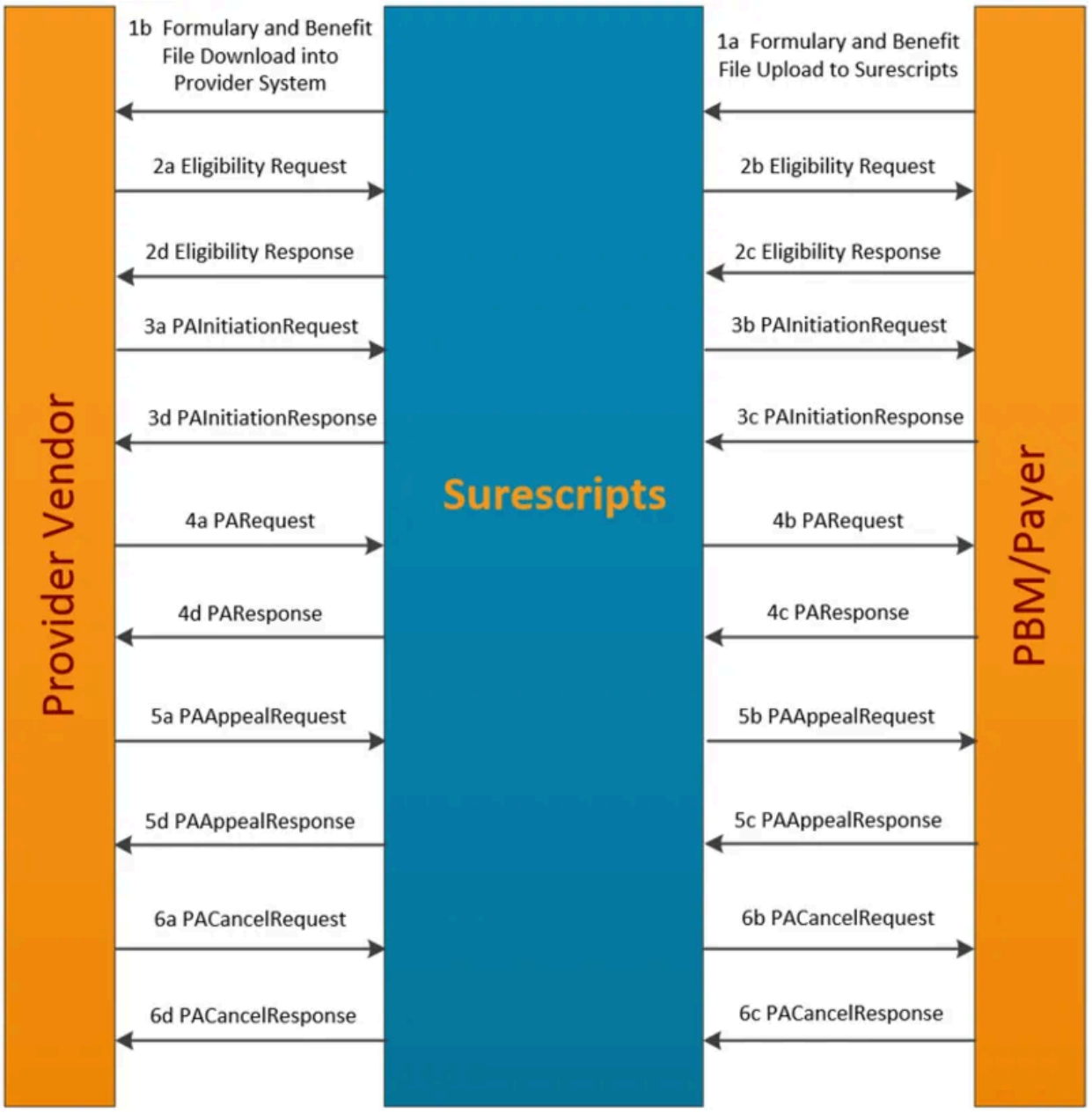
The NCPDP prior authorization messages support the electronic prescribing workflow by leveraging information through other electronic exchanges including the X12 eligibility messages and the NCPDP Formulary & Benefit Standard.

In an effort to increase the number of electronic prior authorizations available to providers, Surescripts will route prior authorizations to third-party prior authorization processors when available. While the PBM/payer is typically the prior authorization processor, there are scenarios where the health plan processes its own PAs or utilizes a third-party processor to process prior authorizations on its behalf. In these situations, messages may go directly to the health plan/third-party processor or may first be sent to the PBM/payer that provides the formulary and benefit information for the patient.

Provider vendors do not have to use the Surescripts Directory to determine if a PBM/payer is ePA enabled. However, before submitting an ePA request, the prescriber must ensure that this service level is active in their directory entry. All PAInitiationRequests are sent from the provider vendor to EPAINI. Surescripts finds the PBM/payer or third-party processor using the workflow detailed below.

While Surescripts cannot guarantee that the provider vendor will receive a PAInitiationResponse with a question set or determination of coverage, sending as many of the fields in the Benefits Coordination structure as possible will increase the provider vendor's chances that Surescripts will find a processor.

Surescripts Electronic Prior Authorization Message Flow



Step 1:

1a) PBM/payer uploads Formulary & Benefit file to Surescripts.

1b) Provider vendor retrieves formulary information from PBM/payer data (this is an ongoing process).

> **Note:** This is only applicable for native formulary implementations. For On-Demand Formulary (ODF), the provider vendor needs to send an eligibility request before sending a formulary request as the eligibility response populates the ODF.

Step 2:

2a) Provider vendor sends an eligibility request to Surescripts to determine patient benefit and formulary coverage. The provider can initiate a prior authorization at any time based on formulary details. If the ePA is sent after the transmission of the NewRx, use the original eligibility details. Do not submit a new eligibility request.

> **Note:** Please refer to the Eligibility Guide for additional eligibility information and requirements.

2b) If a patient match is found, Surescripts forwards the eligibility request on to the PBM/payer. Unmatchable patients may go into to a manual queue for the PBM/payer, or the PAInitiationRequest may be responded to with an automated “patient not found” response.

2c) PBM/payer returns benefit and formulary coverage to Surescripts.

2d) Surescripts returns benefit and formulary coverage to the provider vendor.

Step 3:

3a) The provider vendor sends a PAInitiationRequest to EPAINI, which is the Surescripts identifier for ePA. Surescripts uses the PayerID in the BenefitsCoordination element to determine the PBM/payer and whether or not they are enabled for ePA. In order to maximize the potential for a positive ePA response, the provider vendor should send all available fields referenced in **Sending Prior Authorization Initiation Requests**.

> **Note:** This process does not apply for Prior Authorization renewal requests.

3b) If enabled for ePA, Surescripts forwards the PAInitiationRequest message on to the PBM/payer. If the PBM/payer referenced in the PayerID of BenefitsCoordination is not enabled for ePA, Surescripts uses the IIN (previously BIN), PCN, and Group ID information to check if there is a direct ePA connection to the health plan/third-party processor and forwards the PAInitiationRequest directly to the health plan or third-party processor.

3c) The initial recipient (either the PBM/payer or the health plan/third-party processor) returns the PAInitiationResponse indicating one of the following:

- Open status (a question set).
- Closed status (see **Closed Reason Code** information in **Message Business Flow Response Summary**).
- Closed status indicating the initial recipient is not the PA processor (a reason code of CO or CP).

3c-1) (applies when the initial recipient indicates that they are not the PA processor):

In cases where the initial recipient indicates they are not the PA processor, Surescripts forwards the PAInitiationResponse to the provider vendor and initiates a secondary search to find a different PA processor. If Surescripts finds a secondary recipient, it routes a secondary PAInitiationRequest to that processor, who returns a PAInitiationResponse indicating one of the following:

- Open status (a question set).
- Closed status (see **Closed Reason Code** information in **Message Business Flow Response Summary**).
- Closed status indicating that recipient is not the PA processor (a reason code of CO or CP).

> **Note:** If a connected health plan/third-party processor responds to an initial PAInitiationRequest indicating they are not the PA processor (a reason code of CO or CP) and the PBM/payer does not have an ePA service level, Surescripts does not perform any additional searches.

3c-2) (applies if either a secondary recipient indicates that they are not the PA processor or no secondary recipient is found):

If either a response from a secondary recipient indicates that they are not the PA processor or no secondary recipient is found, Surescripts sends back a PAInitiationResponse indicating that ePA is not available and the prescriber should use the contact number, if provided, in the PANote field from the first PAInitiationResponse to continue with a manual PA process.

3c-3) (applies if the PA processor indicates that ePA is not supported or the patient cannot be found):

If either the PA processor indicates that ePA is not available for the requested health plan or product (a reason code of BX) or patient cannot be found (a reason code of CD), Surescripts does one of the following:

- Sends back a PAInitiationResponse indicating that ePA is not available and the prescriber should use the contact number, if provided, in the PANote field from the first PAInitiationResponse to continue with a manual PA process.
- Sends back a PAInitiationResponse with a question set based on the NDC using a forms vendor.

> **Note:** If the PBM/payer is enabled for ePA and the health plan/third party processor responds to the initial request indicating the patient either cannot be found (a reason code of CD) or is not eligible (a reason code of CE), Surescripts will route a secondary PAInitiationRequest to a forms vendor.

3c-4) (applies if neither the PBM/payer nor health plan/third-party processor are connected to Surescripts for ePA):

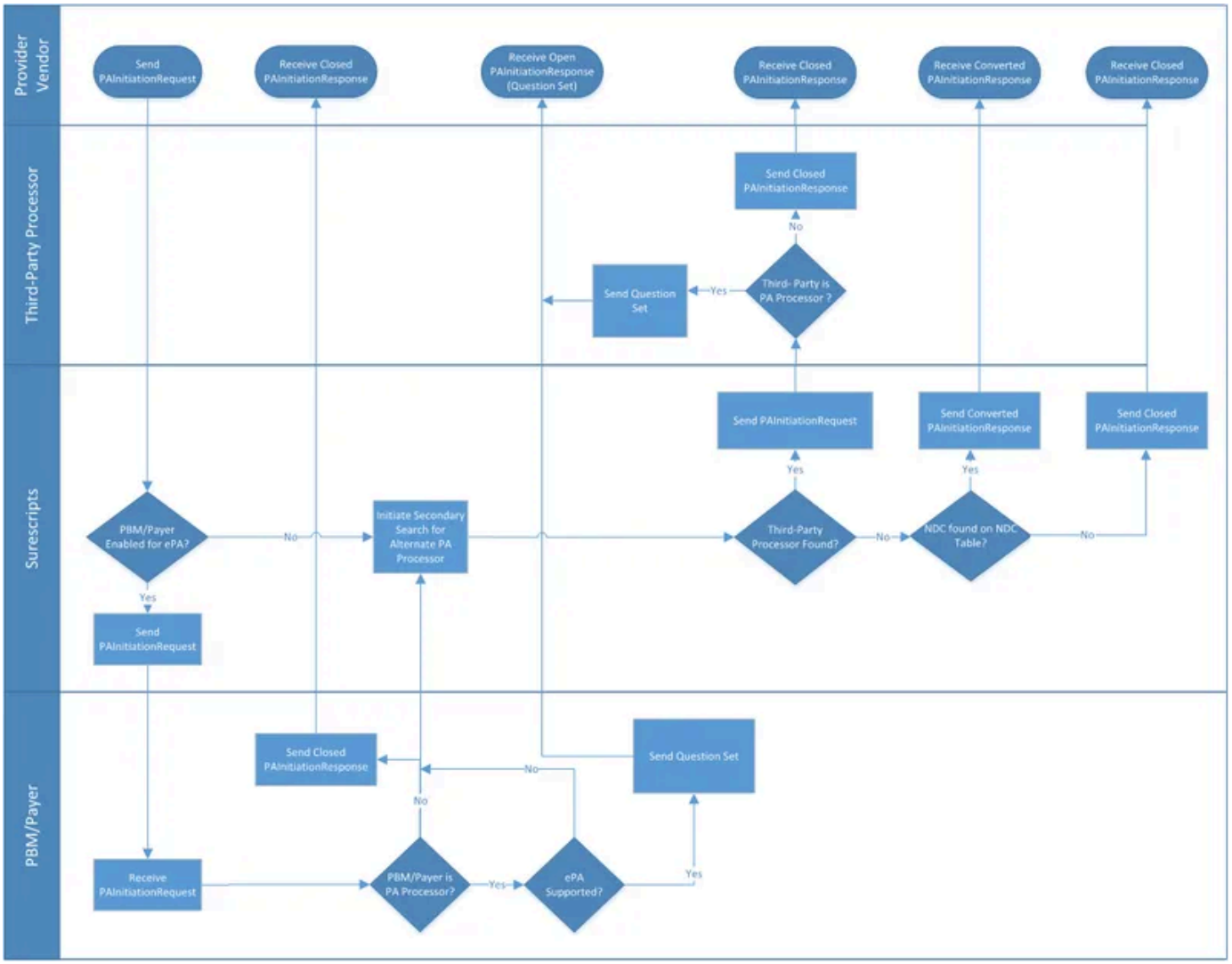
If no routable entity exists for a PAInitiationRequest sent by the provider vendor, Surescripts sends back a PAInitiationResponse indicating that ePA is not available and the prescriber should refer to the back of the patient's prescription benefit card to continue with a manual PA process.

See the message flow diagram at the bottom of this step for more details.

> **Notes:**
>
> - The provider vendor may receive up to three responses. These responses may include a Closed status from the PBM/payer, a Closed status from the third-party processor, and/or a Closed status from Surescripts. The Closed status from Surescripts (EPAINI) will contain a BY reason code, which indicates that no further PAInitiationResponse(s) will follow. Either the PBM/payer or the third-party processor may return an Open response with a question set if they are the processor.
> - If a reason code of CO, CP, or BX is returned in the PAInitiationResponse, the provider vendor is required to display the PANote field. The PANote field may include the communication number the provider should use to continue processing the prior authorization manually. If provided in the PAInitiationResponse, the PACaseID should also be displayed.

Third-Party Processor Provider Enabled Message Flow Diagram

> **Note:** The following diagram shows the high-level process and does not capture all scenarios. Some scenarios not listed may additionally trigger PA Forms provisioning processes.



3d) Surescripts forwards the message on to the provider vendor.

Step 4:

4a) The provider vendor sends a PARequest to Surescripts containing the answers to the question set.

4b) Surescripts forwards the message on to the PBM/payer.

4c) The PBM/payer returns the PAResponse indicating one of the following:

- Approval (Approved status)
- Denial (Denied status)
- Partial Denial (PartiallyDenied status)
- Notice that the request is in process, including the expected resolution date if known (InProcess status)
- A request for more information (Open status)
- That it cannot proceed (Closed status) (for example, a request was received after the deadline for reply)

4d) Surescripts forwards the message on to the provider vendor.

Step 5:

5a) The provider vendor can send a PAAppealRequest to Surescripts to:

- appeal a prior authorization determination, or
- obtain the information required to submit an appeal reconsideration.

> **Note:** PAAppealRequest should only be sent when the IsEAppealSupported flag is set to "Y" in the PAResponse.

5b) Surescripts forwards the message on to the PBM/payer.

5c) The PBM/payer:

- returns the PAAppealResponse indicating what information is required to submit an appeal reconsideration, or
- returns PAAppeal approval, denial, or a request for more information.

5d) Surescripts forwards the message on to the provider vendor.

Step 6:

6a) A PACancelRequest can be sent any time after the PBM/payer returns the PAInitiationResponse with a Case ID populated.

6b) Surescripts forwards the message on to the PBM/payer.

6c) The PBM/payer returns the PACancelResponse indicating if it was cancelled. A PAResponse is not sent after the PACancelResponse is sent.

6d) Surescripts forwards the message on to the provider vendor.

> **Note:** Provider vendors should ensure that PACancelRequests are sent to the entity that returned the question set and/or PACaseID. If the PACancelRequest is sent to the primary PBM/payer (that indicated they do not process the PA), there is no guarantee that the cancel will be processed.

3.4. Detailed Electronic Prior Authorization Message Scenarios

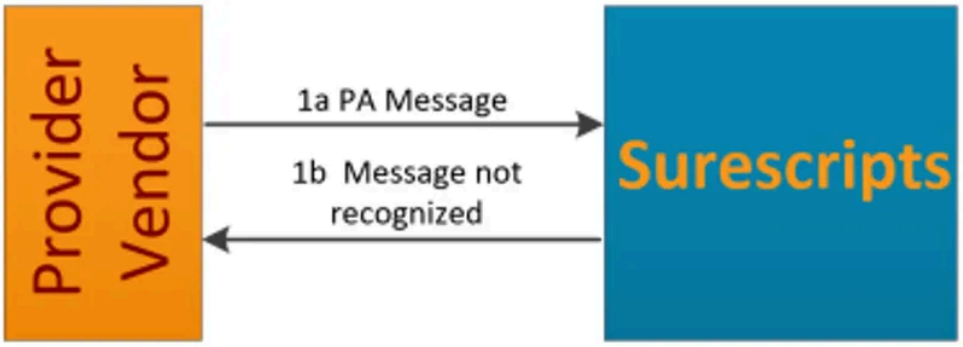
The following diagrams depict various scenarios where Verify, Error, and Status messages are sent in response to a Prior Authorization message.

> **Note:** This applies to any of the ePA messages for all of these scenarios.

Surescripts Detailed Electronic Prior Authorization Message Flow Scenarios

> **Note:** In the following scenarios, any messages sent from the provider vendor after the PAInititiationRequest should utilize the Sender ID of the received message to populate the Receiver ID of the response.

Scenario 1 - Surescripts Cannot Recognize Message:



1a) A PA message is sent to Surescripts.

1b) Surescripts cannot recognize the message and sends error text back to the provider vendor.

Scenario 2 - Surescripts Recognized Message Format but Errors Found:

2a) A PA message is sent to Surescripts.

2b) Surescripts recognizes the format as NCPDP but finds errors in the message. Surescripts returns an Error message.

Scenario 3 - PBM/Payer Cannot Recognize Message:

3a) A PA message is sent to Surescripts.

3b) Surescripts forwards the message on to the PBM/payer.

3c) The PBM/payer cannot recognize the message and sends error text to Surescripts.

3d) Surescripts creates an Error message and returns it to the provider vendor.

Scenario 4 - PBM/Payer Validates Message and Returns Status (Code 010):

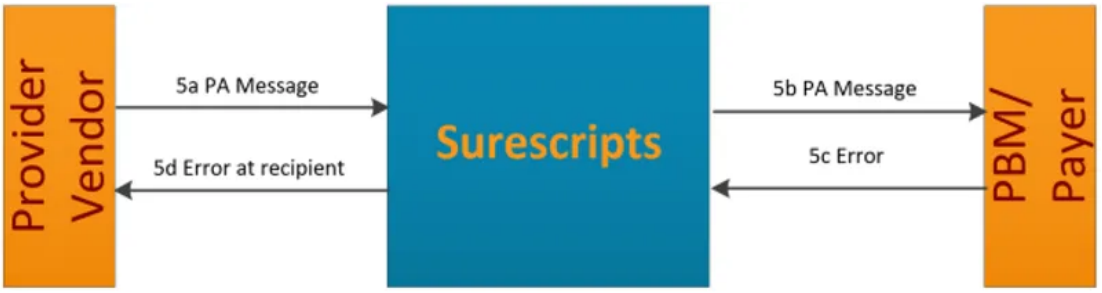
4a) A PA message is sent to Surescripts.

4b) Surescripts forwards the message on to the PBM/payer.

4c) The PBM/payer validates the message and returns a Status (Code 010) message to Surescripts. Status (Code 010) is a synchronous message and means the message was accepted by ultimate receiver.

4d) Surescripts forwards the Status (Code 010) message back to the provider vendor.

Scenario 5 - PBM/Payer Validates Message and Returns Error Message:



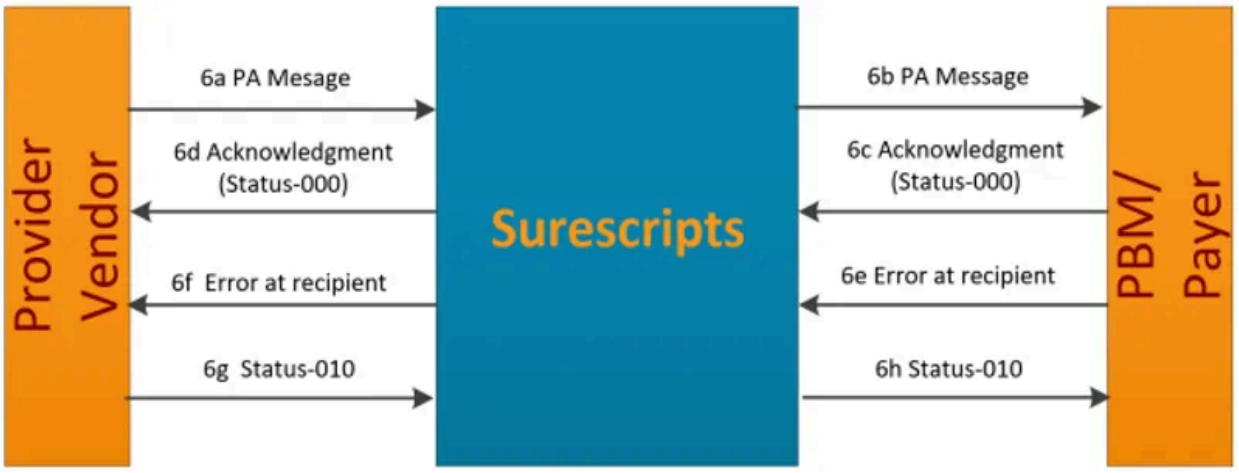
5a) A PA message is sent to Surescripts.

5b) Surescripts forwards the message on to the PBM/payer.

5c) The PBM/payer validates the message, finds errors in the message, and returns an Error message to Surescripts.

5d) Surescripts forwards the Error message back to the provider vendor.

Scenario 6 - PBM/Payer Returns Status (Code 000) and Message Results in Error:



6a) A PA message is sent to Surescripts.

6b) Surescripts forwards the message on to the PBM/payer.

6c) The PBM/payer validates the message and returns a pending Status (Code 000) message to Surescripts.

6d) Surescripts forwards the pending Status (Code 000) message back to the provider vendor.

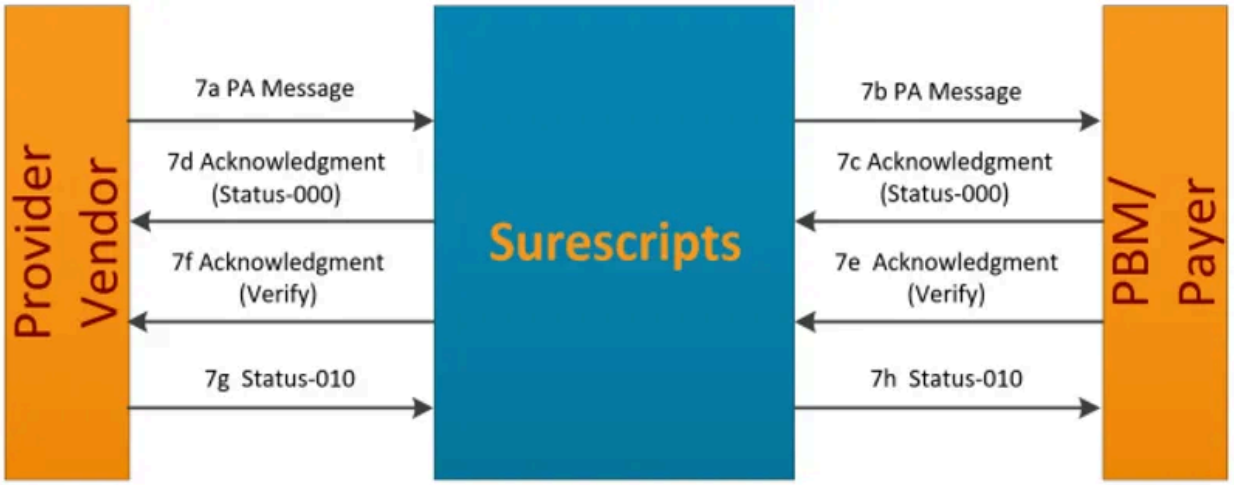
6e) The PBM/payer fails trying to process message and initiates a new Error message (sometimes referred to as a Free Standing Error) to Surescripts.

6f) Surescripts forwards the Error message to the provider vendor.

6g) The provider vendor acknowledges the error by returning a verified Status (Code 010) message to Surescripts.

6h) Surescripts forwards the verified Status (Code 010) message to the PBM/payer.

Scenario 7 - PBM/Payer Returns Status (Code 000) and Message is Accepted:



7a) A PA message is sent to Surescripts.

7b) Surescripts forwards the message on to the PBM/payer.

7c) The PBM/payer validates the message and returns a Status (Code 000) message to Surescripts. In this case the message has not reached its ultimate destination.

7d) Surescripts forwards the Status (Code 000) message back to the provider vendor.

7e) The PBM/payer delivers the PA message to the end point and returns a Verify message.

7f) Surescripts forwards the Verify message to the provider vendor.

7g) The provider vendor acknowledges the Verify message by returning Status (Code 010) to Surescripts. Status (Code 010) means it was accepted by the ultimate receiver.

7h) Surescripts forwards the Status (Code 010) message to the PBM/payer.

> **Note:** Where the Status message is used, the Status Code can be either 000 – Transmission successful or 010 – Successfully accepted by ultimate receiver. Status (Code 000) indicates that there could be an Error or Verify message forthcoming. If an Error or Verify message is not received following Status (Code 000), then no assumptions should be made as to whether the message has been received successfully or not. Status (Code 010) indicates that no further messages will follow.

3.5. PANotification Message Scenarios

Surescripts Recognizes PANotification Message Format but Errors Found

1a) Provider Vendor → Surescripts OR pharmacy software vendor→ Surescripts

1b) PANotification is sent to Surescripts.

1c) Surescripts recognizes the format as NCPDP PANotification but finds an error with the message. Surescripts returns an Error message.

- If the provider vendor sends PANotification to a pharmacy that is not enabled, an error is sent back to the provider vendor.
- If the pharmacy vendor sends PANotification to a provider vendors that is not enabled, an error is sent back to the pharmacy vendor.
- Missing required PACaseID returns a schema validation error.

Pharmacy Software Validates Message and Returns Status (Code 010):

2a) A PANotification message is sent to Surescripts from the provider vendor.

2b) Surescripts forwards the message on to the pharmacy software vendor.

2c) The pharmacy vendor validates the message and returns a Status (Code 010) message to Surescripts. Status (Code 010) is a synchronous message and means the message was accepted by ultimate receiver.

2d) Surescripts forwards the Status (Code 010) message back to the provider vendor

Provider Vendor Validates Message and Returns Status (Code 010):

3a) A PANotification message is sent to Surescripts from the pharmacy vendor.

3b) Surescripts forwards the message on to the provider vendor.

3c) The provider vendor validates the message and returns a Status (Code 010) message to Surescripts. Status (Code 010) is a synchronous message and means the message was accepted by ultimate receiver.

3d) Surescripts forwards the Status (Code 010) message back to the pharmacy vendor.

3.6. Validating PAInitiationRequest Data

Surescripts has implemented four different ways of validating the data within the PAInitiationRequest from the provider vendor. Each are enabled at the portal level.

Prescriber Details Data Validation

When the Prescriber Name and Prescriber Specialty are not matched by PBMs/health plans, electronic workflows could be disrupted. To decrease these errors, Surescripts checks the incoming PAInitiationRequest for these two fields and updates the outgoing message to match the information for the SPI from the Surescripts Directory, eliminating delays in the prior authorization process. This will decrease the number of closed PAInitiationResponses due to mismatched prescriber name and specialty details and will create efficiencies in the electronic workflow.

A new field has been added and labeled "Update Prescriber Details" in the portal configuration. When this feature is utilized in the processing of a PA, the PANote of the PAInitiationResponse will be appended with the verbiage "Prescriber details have been updated to match prescriber directory".

NDC Data Validation

Surescripts validates NDCs contained in PAInititiationRequests to ensure invalid and/or obsolete values are not used. An obsolete NDC will be replaced with a valid NDC before being sent on to the PBM/payer.

When this action is taken, a PANote will be appended to the PAInititiationResponse indicating "An obsolete NDC was found and replaced" or "An obsolete NDC was found but there was not a valid NDC to replace it with".

Days Supply

Surescripts reviews incoming PaInitiationRequests to determine if the DaysSupply field is missing and, when possible, populates the value rather than delay processing.

If the DaysSupply field is empty and the medication is for tablets or capsules; the SIG text, Quantity Value, and Drug Description details are captured for parsing by the Surescripts SIG parser. The SIG parser attempts to calculate the DaysSupply value based on the elements provided. If a DaysSupply value can be determined, it will be mapped to the PAInititiationRequest before being sent on to the PBM/payer.

If this service is used in the processing of the message, it will be indicated in the log codes in Workbench.

3.7. PAIntiationRequests After Real-Time Prescription Benefit (Real-Time Benefits Inquiry)

Real-Time Prescription Benefit (RTPB) provides patient-specific medication coverage information directly from the patient's PBM/payer. The type of information returned from this message (or other integrated real-time benefit check solutions) and the level of detail may vary from one PBM/payer to another and can affect whether or not a PAInitiationRequest should be sent. The need for a PA can vary between the group and patient-specific coverage details. For the most efficient workflow possible, it is recommended that RTPB is both included as part of the implementation and integrated into the prescription writing process. After determining formulary details, if the PBM/payer also supports RTPB, send a request and display the details returned from the RTPB response. If the PA determination varies between formulary and RTPB, send the PAInitiationRequest based upon the RTPB details.

If the real time benefit response indicates prior authorization is required for the target medication, provider vendors should send a PAInitiationRequest if the PBM/payer:

- Does not provide alternatives in their real-time response (and the prescriber wishes to continue prescribing the target medication)
- Provides alternatives, but the provider does not choose one
- Provides alternatives, but the provider chooses one that is flagged as needing a PA
- Lists coverage limitations within their real-time benefit response

Provider vendors should not send a PAInitiationRequest for a requested medication if the PBM/payer:

- Indicates that the target medication does not require a PA (and the prescriber wishes to continue prescribing the target medication)
- Provides alternatives AND the provider chooses one not flagged as needing a PA
- Has available alternatives that do not require a PA and substitutions are indicated to be allowed in the prescription

> **Note:** Coverage limitations do not necessarily have a PA flag. Considerations should be made for coverage limitations as well as if a PA flag is present.

Surescripts Electronic Prior Authorization/RTPB Message Flow

Step 1:

1a) Provider vendor sends an eligibility request to Surescripts to determine patient benefit and formulary coverage. The provider initiates a prior authorization based on formulary details. Use the original eligibility details and do not submit a new eligibility request.

> **Note:** Please refer to the Eligibility Guide for additional eligibility information and requirements.

1b) Surescripts forwards the eligibility request to any PBM/payer who indicates a match based on details found in the Master Patient Index (MPI).

1c) PBM/payer returns the eligibility response. If the response indicates patient is not eligible, the provider vendor can still send the PAInititationRequest when they are confident that the patient has pharmacy benefit coverage. This may require checking the Surescripts Directory to select the PBM and ensure the PayerID is included in the PAInitiationRequest. If sent to EPAINI, Surescripts will determine routing.

1d) Surescripts combines all eligibility responses into a single batch and returns it to the provider vendor.

Step 2:

Formulary and Benefit information is checked with either WebDAV or On-Demand Formulary.

Step 3:

3a) During the prescription writing process, the provider vendor sends a RTPB Request to Surescripts to determine real-time patient benefit information for the requested medication at the selected pharmacy.

3b) Surescripts forwards the RTPB Request message on to the PBM/payer.

3c) The PBM/payer sends a RTPB Response which may include the formulary, pricing, and coverage information that is known for multiple channels. The RTPB Response may contain alternative medication information.

3d) Surescripts forwards the RTPB Response message on to the provider vendor.

Step 4:

4a) Based on the information supplied in the RTPB Response message, the provider vendor determines if it is appropriate to continue with the ePA process. If the requested medication returned indicates needing a PA in the RTPB Response and:

- If the PBM/payer returned alternatives but the provider does not choose one, the ePA process continues with a PAInitiationRequest
- If the PBM/payer returned alternatives flagged as needing a PA and the provider chooses one, the ePA process continues for the newly selected medication with a PAInitiationRequest
- If the PBM/payer did not return alternatives and the provider wishes to continue prescribing the current medication, the ePA process continues with a PAInitiationRequest

4b) Surescripts forwards the PAInitiationRequest message on to the PBM/payer or the health plan/third-party processor. Please see **Electronic Prior Authorization Message Flow** for more details on third-party processing.

4c) The PBM/payer or health plan/third-party processor returns the PAInitiationResponse indicating:

- Open status (a question set), or
- Closed status (see **Closed Reason Code** information in **Message Business Flow Response Summary**), or
- Closed status indicating the initial recipient is not the PA processor (a reason code of CO or CP)

4d) Surescripts forwards the message on to the provider vendor.

4e) If PAInitiationResponse is open, the provider vendor responds with PARequest.

4f) Surescripts forwards the PARequest message on to the PBM/payer or health plan/third-party processor.

4g) The PBM/payer or health plan/third-party processor returns the PAResponse indicating:

- Approval (Approved status), or
- Denial (Denied status), or
- Partial Denial (PartiallyDenied), or
- Notice that the request is in process, including the expected resolution date if known (InProcess status), or
- A request for more information (Open status), or
- That it can’t proceed (Closed status) (e.g., a request was received after the deadline for reply)

4h) Surescripts forwards the message on to the provider vendor.

Step 5:

5a) The provider vendor can send a PAAppealRequest to Surescripts to:

- appeal a prior authorization determination, or
- obtain the information required to submit an appeal reconsideration.

> **Note:** PAAppealRequest should only be sent when the IsEAppealSupported flag is set to “Y” in the PAResponse.

5b) Surescripts forwards the message on to the PBM/payer.

5c) The PBM/payer returns the PAAppealResponse indicating:

- what information is required to submit an appeal reconsideration, or
- returns PAAppeal approval, denial, or a request for more information.

5d) Surescripts forwards the message on to the provider vendor.

3.8. Directories

This section explains how directories are used for electronic prior authorization (ePA) message routing. For more detailed information, refer to the *Surescripts Directory Implementation Guide*.

Provider Vendor Directory Usage

Provider vendors are **not required** to use the Surescripts Directory to identify PBM/payers that support ePA.

However, the Directory **may be used** when:

- An Eligibility Response (271) does not indicate active coverage, and
- The provider still wants to initiate a prior authorization with a specific PBM/payer

In these cases:

- ePA messages are still sent to **EPAINI**
- The **PayerID** in the PAInitiationRequest is populated using the value obtained from the directory

Provider vendors must also ensure that directory service levels are properly configured for prescribers who use ePA.

PBM/Payer Directory Usage

PBM/payers **do not use the Directory** for routing or message lookup in standard ePA workflows.

- ePA workflows begin with a **PAInitiationRequest sent to EPAINI**
- Responses are sent directly back to the initiating provider vendor
- No directory lookup is required for message routing

Exception:

- Unsolicited **PAInitiationResponse** workflows may differ, but standard ePA message exchange does not require PBM/payer directory access

3.9. Failure Mode/Response Approach

Surescripts has identified different levels of failure for NCPDP-based messages:

- In instances where Surescripts receives a message that is unrecognizable, Surescripts sends back an HTTP error.
- If an error occurs after the sender has been identified and validated and the message has been determined to be an NCPDP message, Surescripts returns an NCPDP Error message to the sender.
- If the recipient identifies an error, the recipient creates an NCPDP Error message and returns it through Surescripts to the sender.

4. Best Practices

The following best practices apply to all ePA message types.

4.1. Drug Description

Customers should work with their drug database vendors to obtain the preferred drug description. The description should align with industry best practice standards as well as Surescripts requirements. It should be noted that medications that are sent with the same drug name and form may appear slightly different among customers depending on the system's drug compendia.

Examples:

- Prevacid 30 MG Oral Delayed-Release Capsule
- Prevacid 30 MG DR Capsule

4.2. Handling PARequests When a Health Plan Changes ePA Processing Vendor

In instances where the PBM/payer sends the <DeadlineForReply> date, the PBM/payer is to normally process any ePA message received through that date. For example, if the PBM/payer sends a question set on 12/30/2019 with a <DeadlineForReply> date of 1/5/2020, the ePA messages are still to be normally processed by that PBM/payer through 1/5/2020.

4.3. Prescriber Order Number

If the Prescriber Order Number (PON) is available, it is strongly recommended to be sent.

4.4. Utilization for Non-PA Coverage Rules

Provider vendors are strongly encouraged to initiate an ePA if the target medication has an indication that prior authorization may be required.

Additionally, coverage factors can help to determine when an ePA may be required.

Example:

Coverage Limit	Example
Gender Limit	The Gender Limit indicates coverage for females only, but the doctor wants to prescribe for a male patient.
Age Limit	The Age Limit indicates a cap at 30 years of age, but the doctor wants to prescribe for a 43-year old patient.
Quantity Limit	The Quantity Limit coverage list indicates a coverage limit of 15 days for Imitrex, a migraine treatment, but the doctor wants to prescribe a 30-day treatment.
Step Medication	The Step Medication list indicates that before Bextra (a Cox-2 inhibitor) is covered, at least one medication from the Cox-1 inhibitor category must be tried (e.g. Ibuprofen), but the doctor wants to prescribe Bextra without trying a Cox-1 inhibitor first.
Step Therapy	The Step Therapy coverage list identifies medications that must be tried before the patient can receive coverage for Retin-A, a brand of dermatologic preparation used to treat Acne, but the patient has already failed treatment with generic topical tretinoin.

4.5. Sending Prior Authorization Initiation Requests

A PAInitiationRequest should only be sent when it is reasonable to expect that the selected medication requires a prior authorization. A PAInitiationRequest should not be sent for every medication. Provider vendors should use the details from the formulary and (if implemented) Real-time Prescription Benefit solutions as the primary source of information regarding the need for a prior authorization.

Unlike other messages, Surescripts does not require provider vendors to determine ePA support by the PBM/payer. Provider vendors can initiate a PAInitiationRequest, no matter who the patient's PBM/payer is, whenever the provider has reason to believe that the medication requires a PA. All PAInitiationRequests should be addressed to EPAINI.

Provider vendors shall send information (Payer ID, IIN (previously BIN), PCN, etc.) from the Eligibility Response in all PAInitiationRequests. See ACR PA.206 in the **Application Certification Requirements** section for more information.

At a minimum, the PayerID (the Surescripts PBM Participant ID) is needed for Surescripts to be able to determine if the PBM/payer is enabled for ePA. If the provider vendor does not send a PayerID, Surescripts will return an error. In order to maximize the potential for a positive ePA response, the provider vendor needs to send all available fields referenced in the table below.

Identifier	271	PAInitiationRequest
IIN	2110C1/REF/02 REF/01 = "N6" Qualifier	BenefitsCoordination/PayerIdentification/IINNumber
PCN	2110C1/REF/03 REF/01 = "N6" Qualifier	BenefitsCoordination/PayerIdentification/ProcessorIdentificationNumber
Interchange Control Number	ISA/13	BenefitsCoordination/PayerIdentification/InterchangeControlNumber
Group Number	2110C1/REF/02 REF/01 = "6P" Qualifier	BenefitsCoordination/GroupID
PBM Member ID	2100C/NM1/09	BenefitsCoordination/PBMMemberID
Cardholder ID	2100C/REF/02 REF/01 = "HJ" Qualifier	BenefitsCoordination/CardholderID
PBM Participant ID	2100A/NM1/09	BenefitsCoordination/PayerIdentification/PayerID

4.6. Electronic Appeals

When a PBM/payer chooses to accept electronic appeals for a PA determination, they should make sure to provide as much detail as possible regarding the requirements that apply. This could include any of the following within the Appeal element:

- A descriptive PANote indicating specific information that may be needed from the prescriber in order to return an approved response
- Contact information for the PBM/payer that may indicate where a prescriber can reach out for information on the PA or appeal process
- A discrete ExpirationDate that indicates the date after which an appeal will no longer be considered for the PA

4.7. Automatically Initiating ePA for RxChange Messages

RxChange messages can be sent from the pharmacy to request changes to a received prescription. If an RxChange Type P is received and no PA has been initiated, then it should be automatically done. The RxChange response should be sent after a final determination has been received.

If an RxChange Type is received and the PA is in progress, the PriorAuthorizationStatus of the RxChange response should reflect the status.

Please be aware of the following:

- If eligibility information is less than 72 hours old, provider vendors should include all benefit information from the original Eligibility Response (271) that is listed in the **Sending Prior Authorization Initiation Requests** section.
- If eligibility information is more than 72 hours old, provider should send a new eligibility request for purposes of populating the BenefitsCoordination segment of the PAInitiationRequest.

4.8. PAInitiationResponse Reason Codes for PBM/Payers

It is recommended to use all reason codes available and not a subset of reason codes. See **Message Business Flow Response Summary** for more information.

> **Note:** The reason code "BY – Other" should only be used when the reason for the closed response is not covered under another reason code.

4.9. Re-Submitting and Re-Initiating PAInitiationRequests

It is recommended that provider vendors allow their users the ability to re-submit or re-initiate ePAs in the event of a PBM/payer processing error, or if the deadline for reply has passed. If the deadline has passed, the open question set should be cancelled with a PACancelRequest and the original PAInitiationRequest should be resubmitted with a unique PAReferenceID.

4.10. NewRx

To realize the full value of an ePA process, it is strongly recommended that prescriptions requiring a prior authorization are placed on hold and are released to the pharmacy only after a final determination is received from the PBM/payer. When the prior authorization is missing, some PBM/payers will deny the claim, which will require manual follow-up by the pharmacy.

- If the prescription must be sent prior to the ePA process being completed, the provider vendor should indicate it is in process using PriorAuthorizationStatus with the value of "R" (requested). This will let the pharmacy know that they should not initiate the prior authorization process.
- If the prior authorization has been completed and the PBM/payer indicates prior authorization is not required, the provider vendor should indicate that prior authorization is not required by returning a PriorAuthorizationStatus value of "N" (Not Required) in the NewRx.

PA Has Been Approved

To aid in claims processing at the pharmacy and eliminate duplicate prior auth workflows, the electronic prescription (NewRx) should contain the prior authorization approval number (if provided) and approved status. In the ePA response message, the approval number is found in the AuthorizationNumber element. In the NewRx, prior authorization information is found in MedicationPrescribed/PriorAuthorizationNumber and MedicationPrescribed/PriorAuthorizationStatus.

PA Has Been Denied

In situations where the prior authorization has been denied by the PBM/payer, the NewRx should indicate that the prior authorization was denied in MedicationPrescribed/PriorAuthorizationStatus.

PA Has Been Partially Denied

When providers receive a PartiallyDenied PAResponse, the request is closed. There are two options that may be utilized when a PartiallyDenied response is received. The provider may modify the existing NewRx and start a new PA reflecting the revised NewRx. The other option would be to modify the NewRx already on hold to reflect the details approved by the PBM/payer and release the prescription to the pharmacy. If releasing the NewRx with modified details, the status should reflect "A" (Accepted) and, if provided by the PBM/payer, include the AuthorizationNumber. This is not applicable for specialty pharmacies. In this type of instance, the specialty pharmacy should notify the prescriber of the response by the PBM/payer and let the prescriber know what they can change if they want to send a new prescription.

PAReferenceID and NewRx MessageID

Provider vendors may find it easier to track and associate ePA messages with NewRx messages by sharing a common identifier. Provider vendors can utilize a shared value for NewRx MessageID and PAReferenceID of PAInitiationRequest messages in order to provide efficiencies for troubleshooting and other tasks that may require knowledge of which NewRx had association with which ePA. Please see **Message Linkage** for more detail.

4.11. Attachments

Attachments serve as a way for PBM/payers to substantiate some prior authorization determinations and may be required in some instances. Surescripts strongly recommends that provider vendors support the ability to electronically send PDF attachments at a minimum. All implementations shall be able to send and receive a PDF file type per ACR PA.212 in the **Application Certification Requirements** section.

> **Note:** If the payer receives an attachment type they do not support, they must return an open PAResponse requesting the acceptable type.

NCPDP attachment types include:

- TIFF
- PNG
- JPEG
- PDF
- CDA
- CCR

Only send an attachment if the question set specifically asks for it. If you do not receive a request for an attachment, do not send one. Sending unnecessary attachments may result in manual review and delays. Message size (including attachments) is limited to a maximum of 20MB.

If an attachment is required, Surescripts recommends informing the user of the requirement and displaying the Attachment Notes per ACR PA.201

If a PBM/payer receives an attachment type they do not support, it is recommended to return an open PAResponse requesting the acceptable type.

PBM/payers should populate the QuestionSet/Header/QuestionSetContactCommunicationNumber/Fax/Number field in ePA response messages so provider vendors know where to fax any requested attachments they are unable to send electronically.

If an attachment must be sent through fax, the fax should include the PACaseID from the PAInitiationResponse to aid in linking it to the electronic messages. The provider vendor should also include in the QuestionSetComment field of the PARequest that they are faxing documentation.

4.12. Timing for Response

If the provider has not received the PAResponse within 48 hours or if no estimated timeframe was provided in an In Process PAResponse, the provider should not send another PAInitiationRequest message. Instead, the provider should either send a PACancelRequest or follow up with the PBM/payer via phone or fax. Please note that resending the same PAInitiationRequest can delay rather than expedite a request.

4.13. NDC Codes

Provider vendors should send the Representative National Drug Code (NDC) of the medication, if available, in the PAInitiationRequest. The NDC is not required by the NCPDP standard, but PBM/payers may do additional validation on this field or may return errors if not included. Sending the NDC can help ensure that the medication can be easily identified in the PBM/payer system.

A Representative NDC is an 11-digit code that depicts a category of medication regardless of package size and manufacturer/labeler. Representative NDCs should be used in the PA process to maximize the opportunity that the selected value exists among the various medication files. A Representative NDC should not be a repackaged, obsolete, private label, or unit dose NDC unless it is the only available identifier.

> **Note:** The drug database compendia should be current so the most applicable NDC available for the requested medication can be sent.

PBM/payers should not expect that provider vendors are always populating the NDC in the PAInitiationRequest and should consider additional medication matching logic in cases when the NDC is not populated. Surescripts may verify NDCs included in PAInitiationRequest messages. In the case of an obsolete NDC being discovered upon verification, Surescripts may replace the original NDC with a non-obsolete Representative NDC. When Surescripts replaces NDCs, Surescripts will provide notice of the change to the prescriber via the PANote in the corresponding PAInitiationResponse.

4.14. Empty Tags

Do not send empty elements within XML messaging. Sending empty tags may cause a message to be rejected or error out.

4.15. XML NextQuestionID Clarification for PA Question Type

Per the NCPDP SCRIPT Standard Format Implementation Guide, the NextQuestionID identifies the question the end user should answer next when it is dependent on the answer to the question. See **Document References** for more detail.

This field is required for the following QuestionTypes:

- Numeric/NextQuestionCondition/SingleComparison
- Numeric/NextQuestionCondition/RangeComparison

> **Note:** When QuestionType is Select and DefaultNextQuestionID is not provided, NextQuestionID is a required field.

If the next question in a question set is not dependent on a specific response, PBM/payers should utilize DefaultNextQuestionID at the question level as opposed to including the same NextQuestionID for each response option.

4.16. Controlled Substances

Provider vendors are able to use Electronic Prior Authorization for controlled substances even if they are currently not enabled for EPCS on the Surescripts network. There are no prohibitions in the NCPDP SCRIPT standard regarding the use of ePA for controlled substances. However, if the NewRx has been placed on hold, the release of such prescriptions should not be automated. Any EPCS prescriptions must continue to adhere to DEA audit requirements including the support of two-factor authentication and ensuring that only providers with a DEA license are permitted to issue such prescriptions.

4.17. PBM/Payer Prior Authorization Coverage Lists

The Prior Authorization coverage list is the provider vendor's primary means of knowing whether a medication needs prior authorization. PBM/payers should ensure that they are sending Prior Authorization coverage lists in their formulary files. This maximizes the ePA workflow and allows prior authorizations to be completed before the prescription arrives at the pharmacy.

When coverage restrictions exist for a medication (such as quantity limits, step therapy, etc.) and PBM/payers allow prior authorizations, the drug should be flagged in the PA coverage list and the corresponding specific coverage restriction list. This ensures that the provider vendor system can trigger PAInitiationRequests when appropriate.

When applicable, the PBM/payer returns a Coverage ID for the patient in the Eligibility Response (271). This ID must correspond to a Prior Authorization Coverage List ID found in the PBMs active formulary. This is an essential link to ensure formulary data can be made available to the prescriber during the prescription writing process. The prescriber utilizes the formulary information during the prescription writing processed to determine if the specific drug they want to prescribe requires a Prior Authorization. The locations of these IDs are as follows:

- Coverage ID = REF02 within the Eligibility Response: Loop 2110C when REF01 = "CLI" and REF02 is not NULL.
- In the Formulary File, see the Coverage List Detail Prior Authorization Formulary.

4.18. Prescription Eligibility for PA Processors (PBM/Payers, Health Plans, and Third-Party Processors)

Prescription Eligibility Responses (X12 Eligibility Response (271) Messages)

It is important that the IIN, PCN, and Group ID from the Eligibility Response (271) are included in the ePA message. These IDs can be used by Surescripts to determine the appropriate entity that should receive a PAInititiationRequest. Providing these details helps to ensure that the appropriate entity receives all intended ePA messaging. The following scenarios would result in Surescripts using IIN, PCN, and/or Group ID:

- BenefitsCoordination/PayerID is invalid or corresponds to a payer that is not enabled for ePA
- BenefitsCoordination/PayerID corresponds to a payer that does not process prior authorizations for the requested patient and/or prescription benefit (as indicated by a “CO” or “CP” PAInitiationResponse from the payer)

Health plans and third-party PA processors should work directly with their PBM/payer to ensure that these values are being populated 100% of the time in Eligibility Response (271) to ensure that all ePAs will be directed to the appropriate PBM/payer and/or PA processor.

Updating IIN/PCN/Group IDs for Directly Connected Health Plans and Third-Party PA Processors

There are health plans that have decided to use another processor for their prior authorizations. In those instances, Surescripts requires the plan-specific information (IIN/PCN/GroupID) to be able to route transactions to the correct processor. It is imperative that Surescripts is notified in advance of any changes or additions to IIN/PCN/Group ID combinations to allow for proper routing of the PAInitiationRequests.

Notes:

- If a health plan or third-party PA processor processes PAs for all plans under an individual IIN or IIN/PCN combination, that may be used in lieu of providing a list of all IIN/PCN/Group ID combinations under the specified IIN or IIN/PCN.
- Please work with a Surescripts Account Manager or open a service ticket for more information.

4.19. PBM/Payer Development and Integration

Medication and Patient Matching

The PAInitiationRequest might not include the PBM Member ID in all cases. PBM/payers must develop secondary patient-matching criteria to successfully find the patient. Unmatchable patients may go into to a manual queue for the PBM/payer, or the PAInitiationRequest may be responded to with an automated “patient not found” response.

Work Queue

There are several instances where prior authorizations might need to be manually worked:

- Medication cannot be matched
- Provider vendor sends an attachment
- Denials and other cases where you are contractually or regulatory obliged to send to a manual queue

Exceptions and Medicaid Process

PBM/payers should avoid generic prior authorization forms whenever possible. However, a generic form may be acceptable in some situations, such as for Medicaid Formulary exceptions or quantity and gender limit exceptions.

Workflow and Internal Process

PBM/payers should consider sending coded references (e.g. LOINC codes) along with questions in a question set. This will allow the provider vendor to extract information from the patient's record instead of manually answering each question.

Handling Prior Authorization Priority

With SCRIPT version 2023011 NCPDP supports a priority flag field called PAPriorityIndicator. Please see the **PAInitiationRequest Elements** for details.

Service Date

As there is no discrete ServiceDate field in the PAInitiationRequest, PBM/payers should treat the PAInitiationRequest message SentTime field as the de facto service date of the message.

4.20. Conditional Question Logic

Conditional Question Logic Purpose

The NCPDP ePA standard is designed to minimize the number of questions a provider vendor must answer when requesting prior authorization for a medication. To accomplish this, the standard has features that enable the provider vendor to present only those questions that pertain to the situation, based on:

- The patient's specific pharmacy benefit
- The particular prescribed medication
- The provider vendor's answers to clarifying questions contained in the electronic PA message

Ideally, the electronic process should be an improvement over paper and PDF forms, which often contain questions relating to multiple medications and/or patient conditions. Properly designed question logic should allow the provider to skip irrelevant questions and only concern themselves with those that apply to their patient and prescribed medication.

Using the NCPDP ePA standard, the PBM/payer and provider vendor do the work of determining the specific subset of potential questions that need to be presented to the provider. The result is that:

- The PBM/payer limits the starting set of potential questions to those relating to the particular requested medication and the terms of the patient's pharmacy benefit
- The provider vendor only presents relevant questions as the provider works through the electronic message. For example, the provider's answer about the patient's diagnosis results in the provider vendor skipping questions related to other diagnoses.

Question Logic Features

The following ePA message types may contain question sets:

- PAInitiationResponse
- PAResponse
- PAAppealResponse

The elements are available in the Question element inside the Response structure and they function the same in all three message types.

Conditional Question Logic Overview

Conditional question logic determines the next question to be answered by the provider vendor. In some cases, the next question is always the same, regardless of how the current question is answered. In other cases, the next question is based on the answer given to the current question.

PBM/payers need to ensure strict quality control on the data fields so that the conditional question logic works as desired. Otherwise, additional questions will need to be sent to the provider vendor that should have been answered on the initial question set. This creates more work for both the provider vendor and the PBM/payer.

PBM/payers should develop their question sets in the most efficient way and return only when necessary. If the PBM/payer does not provide conditional question logic, it will take provider vendors longer to answer the question sets. It will also increase work on the PBM/payer side because the PBM/payer would have to review all answers.

Other question logic features expand on the "if yes, then this; if no, then that" conditionality, enabling the next question to be determined based on:

- The answer to a multiple-choice question, or
- The range in which a numeric answer falls.

PBM/payers should avoid asking for information that is populated in other segments of the ePA message (e.g. patient age, gender, etc.) or repeating questions.

- One option to consider is to pair a technical writer with a clinician so they can work together to determine the best way for the question sets to flow in order to get the necessary information from the provider vendor as efficiently as possible.

Question Logic Examples

Below are typical situations where ePA question logic would be used to convert conditional portions of paper PA forms into their electronic equivalents. The examples call out a few NCPDP message elements that play key roles in defining and arranging questions, including:

- SequenceNumber: Indicates the order in which questions are presented.
- QuestionID: A unique identifier for each question in the message.
- DefaultNextQuestionID: Used when the same next question is appropriate regardless of the current question's answer.
- NextQuestionID: Answer-specific field used when a question's answer determines the next appropriate question.
- NoneChoiceID: In a 'select-multiple' question type, this enables a "None" option that, when selected, disables other options and clears any prior selections. Key considerations include:
  - Selecting NoneChoiceID makes other choices unselectable.
  - Any previous selections are cleared if NoneChoiceID is chosen.

Additionally, a "Next Question Condition" has been introduced to compare the submitter's choices to a single value or a range, using supported values (**LT** - less than, **GT** - greater than, **LE** - less than or equal to, and **GE** - greater than or equal to). This enables branching logic based on user selections.

- The ePA question types that support conditional, answer-based logic:
  - the Select question type: Used for Yes/No and multiple-choice questions.
  - the Numeric question type and its SingleComparison and RangeComparison options: Enable the next question to be based on the answer's relationship to a single value or a pair of lower and upper bound values.

Notes regarding the examples:

- Use of Yes/No or multiple-choice questions does not demand that conditional logic be employed. The next question following a multiple-choice can be the same regardless of the choice selected by the provider vendor.
- To accomplish this, the DefaultNextQuestionID is specified for the question, and the NextQuestionID element for each answer choice is not sent.
- The QuestionID gives a unique identity to each question in the PA. It is included for system use only, and is:
  - not intended to be presented to the end-user
  - not required to match the sequence of the overall set of questions (i.e., a question with QuestionID 999 may precede a question with QuestionID 1). Instead, the SequenceNumber determines the order in which questions are presented.
- The number of questions presented to the provider vendor may vary depending on the question types and options defined in the ePA question set. The same electronic question set could result in two or ten questions for the provider vendor.

Example 1: Yes/No Questions

This example is of a conditional next question logic based on Yes/No questions.

Original paper PA form:

- What is the patient's diagnosis?
- Has the patient had past use of any generic SSRI for the treatment of depression? (Y/N)
- If not, does the patient have a history of contraindication, allergy, or intolerance to generic SSRIs?
- Is the patient currently taking the requested medication with a beneficial response?

Electronic version:

Sequence Number	Question ID	Default Next Question ID	Question Type	Question Text	Choice Text	Next Question ID
1	0640	406	FreeText	What is the patient's diagnosis?		
2	406		Select	Has the patient had past use of any generic SSRI for the treatment of depression?	Y	888
					N	999
3	888	999	Select	Does the patient have a history of contraindication, allergy, or intolerance to generic SSRIs?	Y	
					N	
4	999	END	Select	Is the patient currently taking the requested medication with a beneficial response?	Y	
					N	

The two-provider vendor question/answer possibilities examples below show how questions may vary based on how the prior question was answered.

Provider vendor question/answer possibilities:

- What is the patient's diagnosis? **Depression**
  - Has the patient had past use of any generic SSRI for the treatment of depression? **Y**
  - Does the patient have a history of contraindication, allergy, or intolerance to generic SSRIs? **Y**
  - Is the patient currently taking the requested medication with a beneficial response? **N**
- What is the patient's diagnosis? **Depression**
  - Has the patient had past use of any generic SSRI for the treatment of depression? **N**
  - Is the patient currently taking the requested medication with a beneficial response? **N**

Example 2: Multiple-Choice Between Diagnoses

This example is of a conditional next question logic based on a multiple-choice questions between diagnoses.

Original paper PA form:

Patient's Diagnosis

- If the diagnosis is asthma, is the patient currently using an orally inhaled corticosteroid?
- If the diagnosis is asthma and the patient is not currently using an orally inhaled corticosteroid, does the patient have a history of intolerance or failure to that treatment?
- If the diagnosis is asthma, does the patient have contraindications (such as allergy) to inhaled corticosteroids?
- If the diagnosis is asthma, is the patient physically able to use an orally inhaled corticosteroid device?
- If the diagnosis is allergic rhinitis, is the patient currently using a nasally inhaled corticosteroid?
- If the diagnosis is allergic rhinitis and the patient is not currently using a nasally inhaled corticosteroid, does the patient have a history of intolerance or failure to that treatment?
- If the diagnosis is allergic rhinitis, does the patient have contraindications (such as allergy) to inhaled corticosteroids?
- If the diagnosis is allergic rhinitis, is the patient physically able to use a nasally inhaled corticosteroid device?
- If the diagnosis is exercise-induced asthma, is the patient effectively able to use a metered dose inhaler (i.e., albuterol)?
- If the diagnosis is exercise-induced asthma and the patient is not effectively able to use a metered dose inhaler (i.e., albuterol), please explain the reason.

Electronic version:

Sequence Number	Question ID	Default Next Question ID	Question Type	Question Text	Choice Text	Next Question ID
1	0123		Select	What is the patient's diagnosis?	asthma	2000
					exercise-induced asthma	3000
					allergic rhinitis	4000
2	2000		Select	Is the patient currently using an orally inhaled corticosteroid?	Y	2002
					N	2001
3	2001	2002	Select	Does the patient have a history of intolerance or failure using an orally inhaled corticosteroid?	Y	
					N	
4	2002	2003	Select	Does the patient have contraindications (such as allergy) to inhaled corticosteroids?	Y	
					N	
5	2003	END	Select	Is the patient physically able to use an orally inhaled corticosteroid device?	Y	
					N	
6	3000		Select	Is the patient currently using a nasally inhaled corticosteroid?	Y	3002
					N	3001
7	3001	3002	Select	Does the patient have a history of intolerance or failure using a nasally inhaled corticosteroid?	Y	
					N	
8	3002	3003	Select	Does the patient have contraindications (such as allergy) to inhaled corticosteroids?	Y	
					N	
9	3003	END	Select	Is the patient physically able to use a nasally inhaled corticosteroid device?	Y	
					N	
10	4000		Select	Is the patient effectively able to use a metered dose inhaler (i.e., albuterol)?	Y	END
					N	4001
11	4001	END	FreeText	Please explain the reason the patient is not		

Sequence Number	Question ID	Default Next Question ID	Question Type	Question Text	Choice Text	Next Question ID
				effectively able to use a metered dose inhaler.		

The four provider vendor question/answer possibilities examples below show how questions may vary based on how the prior question was answered.

Provider vendor question/answer possibilities:

- What is the patient's diagnosis? **Asthma**
  - Is the patient currently using an orally inhaled corticosteroid? **Y**
  - Does the patient have contraindications (such as allergy) to inhaled corticosteroids? **N**
  - Is the patient physically able to use an orally inhaled corticosteroid device? **N**
- What is the patient's diagnosis? **Asthma**
  - Is the patient currently using an orally inhaled corticosteroid? **N**
  - Does the patient have a history of intolerance or failure using an orally inhaled corticosteroid? **Y**
  - Does the patient have contraindications (such as allergy) to inhaled corticosteroids? **N**
  - Is the patient physically able to use an orally inhaled corticosteroid device? **N**
- What is the patient's diagnosis? **Allergic Rhinitis**
  - Is the patient effectively able to use a metered dose inhaler (i.e., albuterol)? **Y**
- What is the patient's diagnosis? **Allergic Rhinitis**
  - Is the patient effectively able to use a metered dose inhaler (i.e., albuterol)? **N**
  - Please explain the reason the patient is not effectively able to use a metered dose inhaler. **The patient… [clinical reason]**

Example 3: Numeric Answer

This example is of a conditional next question logic based on a numeric answer.

Original paper PA form:

- What is the patient's age?
- If the patient is 36 or older, does the patient have a documented diagnosis of acne vulgaris?
- If the patient is 36 or older, does the patient have a documented diagnosis of actinic keratosis?
  - If yes, does the patient have lesions on the face?

Electronic version:

Sequence Number	Question ID	Default Next Question ID	Question Type	Question Text	Choice Text	Comparison Operator	Comparison Value	Next Question ID
1	100	END	Numeric (Single Comparison)	What is the patient's age?		GE	36	200
2	200	300	Select	Does the patient have a documented diagnosis of acne vulgaris?	Y			
					N			
3	300		Select	Does the patient have a documented diagnosis of actinic keratosis?	Y			400
					N			END
4	400	END	Select	Does the patient have lesions on the face?	Y			
					N			

The four provider vendor question/answer possibilities examples below show how questions may vary based on how the prior question was answered.

Provider vendor question/answer possibilities:

- What is the patient's age? **18**
- What is the patient's age? **41**
  - Does the patient have a documented diagnosis of acne vulgaris? **N**
  - Does the patient have a documented diagnosis of actinic keratosis? **N**
- What is the patient's age? **41**
  - Does the patient have a documented diagnosis of acne vulgaris? **N**
  - Does the patient have a documented diagnosis of actinic keratosis? **Y**
  - Does the patient have lesions on the face? **Y**

Further details on question types and question logic can be found in the NCPDP SCRIPT implementation guide's section Question Set Usage.

4.21. Sending and Receiving PANotifications

Sending PANotification - Provider Vendor

- If the NewRx is released prior to receiving the PAResponse (PARequest submitted):
  - Send the PANotification with status of 'R' (Requested) OR;
  - Send the PriorAuthorizationStatus of 'R' in the NewRx.
  - Once the PAResponse is received, send pharmacy a second PANotification with final determination status.
- If the NewRx is sent after receiving the PAResponse:
  - PANotification with the final determination status can be sent OR;
  - Send the PriorAuthorizationStatus in the NewRx.
- If the provider vendor receives an RxChange P and submits PARequest:
  - Send the PANotification with status of 'R' (Requested) OR;
  - Once the PAResponse is received, send pharmacy a PANotification with final determination status OR;
  - Send the PriorAuthorizationStatus in the RxChange Response.
- If the provider vender chooses to send a PANotification alongside another transaction with PriorAuthorizationStatus, they should reflect the same status.

Receiving PANotification - Provider Vendor

It is recommended that the prior authorization status received be displayed to the end user upon receipt.

Sending PANotification - Pharmacy Software Vendor

- If the prior authorization is started using another method (fax, portal), send the prescriber a PANotification with the status of 'R' (Requested).
- If the prior auth was completed using another method (fax, portal), send the prescriber a PANotification with the final determination received.
- When sending a PANotification to a provider vendor, the RelatestoMessageID should be the MessageID of the NewRx.

Receiving PANotification - Pharmacy Software Vendor

- It is recommended that the PriorAuthorizationStatus received be displayed to the end user.
- If the pharmacy vendor has received the PriorAuthorizationStatus (in a NewRx, RxChangeResponse, or PANotification), no further action for the prior authorization is needed (additional adjudication checks, or kicking off a manual prior authorization process for that patient and medication combination.)

5. Element Details

This chapter provides detailed element tables for each message used in the Prior Authorization (PA) transaction set. These tables define the structure, usage, and requirement designation for each element within the message, including whether an element is mandatory, conditional, recommended, or optional, as well as any applicable Surescripts business rules.

Each message is presented in a separate section to support modular review and implementation. The element tables are intended to be used in conjunction with the applicable schema and this Companion Guide to ensure accurate construction and processing of Native PA transactions.

The sections include:

Requirement Designation

Element Tables

Codified Field Usage for Federal Medication Terminologies (FMT) Codes

> **Note:** This guide includes data elements only where Surescripts has specific requirements or further explains the field usage. Refer to the schema for a complete list of fields.

5.1. Requirement Designation

This table defines the requirement designation for each message element and explains how each element is expected to be used within the specification:

Code	Description
mandatory	The element must be used per the specification (e.g., XML schema validation).
conditional	The element is to be used per the conditions specified.
business rule	If sent, the element must be used per the Surescripts business rule. **Note**: Not all business rules reside in this table.
recommended	Surescripts recommends sending the element as a best practice.
optional	Some fields do not have specific conditions. Data should be sent if available.
not used	Not used by Surescripts.

5.2. Element Tables

5.2.1. Message Header Elements

Element	Code	Comments
To	mandatory	The identification of the intended receiver of the message. This field contains the identification number of the recipient. For all PAInitiationRequests, this field contains EPAINI. For all subsequent Request messages, it will contain the Participant ID of the PBM/payer/third-party processor. For Response messages, this field contains the SPI of the provider vendor.
@Qualifier	conditional	business rule If the To field is sent, then the Qualifier must also be sent. Values: **D** = Prescriber ID (Used for SPI) **PY** = Payer (PBM/payer or third-party processor Participant ID) **ZZZ** = Mutually Defined (used when sending to EPAINI)
From	mandatory	The identification of the sender of the message. This field contains the identification number of the sender. This field contains the SPI (Surescripts Provider ID) of the provider vendor, the Participant ID of the PBM/payer or third-party processor, or EPAINI.
@Qualifier	conditional	business rule If the From field is sent, then the Qualifier must also be sent. Values: **D** = Prescriber ID (Used for SPI) **PY** = Payer (PBM/payer or third-party processor Participant ID) **ZZZ** = Mutually Defined (only used when Surescripts is responding from EPAINI)
MessageID	mandatory	The sender should ensure the combination of the From and MessageID elements is unique for at least 18 months. Surescripts recommends an unformatted Globally Unique Identifier (GUID).
RelatesToMessageID	conditional	Relates to Message ID is required by Surescripts and usage details are further illustrated in the **Message Linkage** section. This field is the MessageID of the most recent and relevant message in the workflow, including outside of only ePA conversational messaging. This is required for PAInitiationRequest, PAInitiationResponse, PARequest, PAResponse, PAAppealRequest, PAAppealResponse, PACancelRequest, PACancelResponse, Error, Verify, and Status.
SentTime	mandatory	Date of the transmission. Please see **UTC Time Format** section.
SenderSoftware	mandatory	Identifies the entity responsible that generated the message. Contains the software vendor name, product, and version/release. These fields were previously blocked by Surescripts when passing the message on to the receiver. They will now be passed on to the receiver.
SenderSoftwareDeveloper	mandatory	Identifies the entity responsible for the software that generated the message. The developer may be a software vendor or, if the software was developed "in-house", the developer is the entity actually sending the message (e.g., a chain). The value transmitted is determined by the Sender Software Developer.

Element	Code	Comments
SenderSoftwareProduct	mandatory	The text field that identifies the software developer's product, as determined by the software developer.
SoftwareVersionRelease	mandatory	The text field that identifies the version and release of the software product, as determined by the software developer.
TestMessage	conditional	When sent, allowable values must match platform that message is being sent to. Values: **1** = Test (Required in staging environment) All other values = Live (Production) Surescripts does not recommend sending this field within the production environment.
Message Indicator Flag	conditional	Not applicable to prior authorization transactions.
ISA13	conditional	This is the Interchange Control Number ISA13 value from the Eligibility response X12 271 transaction.

5.2.2. PAInitiationRequest Elements

Note: Refer to the schema for a complete list of fields, including details for PAInitiationResponse elements.

Element	Code	Comments
PAInitiationRequest **Note:** It is recommended to populate as many conditional elements as possible to maximize the prior authorization experience.		
PAReferenceID	mandatory	Assigned by the prescribing system on the initial message and is used as a tracking identifier on all request and response prior authorization messages to tieback related prior authorization messages. The identifier must be unique per prescribing system for at least 18 months. **Note:** PAReferenceID shall be established with the PARequest when responding to a Prior Authorization renewal request (unsolicited PAInitiationResponse).
PAPriorityIndicator	recommended	Indicates the requested PA processing priority. If PAPriorityIndicator is not populated, standard priority will be assumed. Values: **S** - Standard Priority **X** - Urgent/Expedited Priority **Note:** This value should be echoed on subsequent transactions. The priority may also be changed on the PARequest if the provider feels that the patient's health is at risk.
BenefitsCoordination **Note:** The fields below may be returned in the Eligibility Response (271). If a PBM/payer returns active coverage, these fields should be populated with the returned value. Please see **Sending Prior Authorization Initiation Requests** for more detail**.**		
PayerIdentification	conditional	
PayerID	conditional	Surescripts Participant ID assigned to the PBM/payer.
ProcessorIdentificationNumber	conditional	The PCN associated to the patient’s benefit.
IINNumber	conditional	The IIN associated to the patient’s benefit.
MutuallyDefined	conditional	The 271 message’s ISA13 control number.
PayerName	conditional	PBM/payer name.
CardholderID	conditional	Assigned cardholder ID for the patient. **Note:** PBM/payers may validate patients based on cardholder ID.

Element	Code	Comments
CardHolderName	conditional	Cardholder name. **Note:** PBM/payers may validate patients based on cardholder name.
GroupID	conditional	ID number identifying the health plan group.
GroupName	conditional	Name of the health plan group.
PBMMemberID	conditional	PBM/payer-assigned member ID for the patient.
Patient **Note:** Refer to the schema for a complete list of fields.		
Identification	mandatory	Usage requirements: • If patient identification data exists, include the Identification element and populate its child elements. • If no patient identification data is available, include the Identification element but leave it empty (no child elements).
SocialSecurity	conditional	Patient's Social Security Number. Not recommended to send unless explicitly required by a specific business or regulatory process.
GenderAndSex	mandatory	Values: • **M** - Male • **F** - Female • **U** - Not Specified or Unknown • **N** - Non-binary - An umbrella term for people with gender identities that fall somewhere outside of the traditional conceptions of strictly either female or male.
PregnancyIndicator	conditional	Code indicating the patient as **pregnant** or **non-pregnant**.
Address	mandatory	Parent element for patient address information.
AddressLine1	mandatory	Patient's primary address line.
CIty	mando	Patient's city.

Element	Code	Comments
	ry	
StateProvince	conditional	Changed from **Mandatory** in v2017071 to **Conditional**. Recommended for optimal EPA experience.
PostalCode	conditional	Changed from **Mandatory** in v2017071 to **Conditional**. Recommended for optimal EPA experience.
Prescriber **Note:** The prescriber relates to the person requesting the prior authorization.		
Identification	mandatory	Some PBM/payers may validate prescriber data against NPPES or other prescriber directories using the fields under Identification.
NPI	mandatory	NPI of the prescriber.
Address	mandatory	Parent element for patient address information.
AddressLine1	mandatory	Patient's primary address line.
CIty	mandatory	Patient's city.
StateProvince	conditional	Changed from **Mandatory** in v2017071 to **Conditional**. Recommended for optimal EPA experience.
PostalCode	conditional	Changed from **Mandatory** in v2017071 to **Conditional**. Recommended for optimal EPA experience.
MedicationPrescribed		
DrugDescription	mandatory	Drug name (full drug name, strength, and form). For a compound, the names of the ingredients in the compound or the prescriber's preferred name should be communicated here. See **DrugDescription** Best Practices section for more information.
DrugCoded	conditional	

Element	Code	Comments
NDC	mandatory	The NDC must be a valid 11-digit code and should meet the qualifications for a Representative NDC.
ProductCode	conditional	Product Identifier. The Representative NDC is recommended unless the message contains Quantity Code List Qualifier "CF" or the CompoundInformation element is present. See **NDC Codes** for more information.
Strength	conditional	
StrengthForm/Code	conditional	Must be a valid FMT code. See **Codified Field Usage for Federal Medication Terminologies (FMT) Codes** for details.
Strength UnitOfMeasure/Code	conditional	Must be a valid FMT code. See **Codified Field Usage for Federal Medication Terminologies (FMT) Codes** for details.
Quantity	mandatory	
Quantity UnitOfMeasure	mandatory	Must be a valid FMT code. See **Codified Field Usage for Federal Medication Terminologies (FMT) Codes** for details.
PADaysSupplyDosePerDay	conditional	MedicationPrescribed/DaysSupply or PADaysSupply and PADosesPerDay must be a whole number. Just one of these fields need to be submitted. **Note:** In order to allow PBM/payers to provide the most accurate response, provider vendors should include DaysSupply for the requested medication within PAInitiationRequests. PBM/payers use days supply in order to determine if prescribers are requesting a quantity outside of the plan limit. Failure to provide days supply could result in unnecessary question sets being returned to prescribers or additional work.
Diagnosis	conditional	Provider vendors should send the valid version of diagnosis codes in the PAInitiationRequest. Sending diagnosis codes may speed up the process. **Note:** If sending ICD-10 codes (Qualifier ABF), sending systems should not include decimal codes for message/submission.
ClinicalInformation Qualifier	mandatory	Qualifier for how the diagnosis was obtained. Values: **1** - Prescriber/Prescriber Supplied **2** - Pharmacy Inferred **3** - Patient **4** - Other Source

Element	Code	Comments
Qualifier	mandatory	Defines the code list used for the diagnosis code.
Value	mandatory	Code for the diagnosis.
Description	mandatory	Description of the diagnosis code.
Sig	conditional	
SigText	mandatory	SigText will be used to convey patient instructions for use or administration and should be constructed and transmitted in a patient-friendly manner. Sigs should not be truncated because important information can be lost.
Provider **Note:** The provider loop can offer additional contacts beyond the prescriber if there were follow up questions to the PAInitiationRequest.		
Identification	conditional	
NPI	mandatory	NPI of the initiating party.
Name	mandatory	Initiating party's name. See ACR PA.204 in the **Application Certification Requirements** section for more information.
CommunicationNumbers	mandatory	
PrimaryTelephone	mandatory	Initiating party's phone number. See ACR PA.204 in the **Application Certification Requirements** section for more information.
Fax	conditional	Initiating party's fax number.
Address	mandatory	Parent element for patient address information.

Element	Code	Comments
AddressLine1	mandatory	Patient's primary address line.
CIty	mandatory	Patient's city.
StateProvince	conditional	Changed from **Mandatory** in v2017071 to **Conditional**. Recommended for optimal EPA experience.
PostalCode	conditional	Changed from **Mandatory** in v2017071 to **Conditional**. Recommended for optimal EPA experience.

5.2.3. PARequest Elements

This section defines the element tables for the **PARequest** message, providing detailed specifications for each element and its expected usage within the request transaction. The tables are organized by structure to support clear implementation of the message hierarchy and associated data requirements.

The following subsections include:

Root Level PARequest Elements

Attachment Elements

Request Elements

> Each subsection outlines the elements specific to that portion of the message, including requirement designations, usage conditions, and any applicable Surescripts business rules.

5.2.3.1. Root Level PARequest Elements

Element	Code	Comments
PARequest		
PAReferenceID	mandatory	Assigned by the prescribing system on the initial message and is used as a tracking identifier on all request and response prior authorization messages to tieback related prior authorization messages. The identifier must be unique per prescribing system for at least 18 months. **Note:** PAReferenceID shall be established with the PARequest when responding to a Prior Authorization renewal request (unsolicited PAInitiationResponse).
BenefitsCoordination		
PayerIdentification	conditional	
PayerID	conditional	Surescripts Participant ID assigned to the PBM/payer.
ProcessorIdentificationNumber	conditional	The PCN associated to the patient's benefit.
IINNumber	conditional	The IIN associated to the patient's benefit.
MutuallyDefined	conditional	The 271 message's ISA13 control number.
PayerName	conditional	PBM/payer name.
CardholderID	conditional	Assigned cardholder ID for the patient. **Note:** PBM/payers may validate patients based on cardholder ID.
CardHolderName	conditional	Cardholder name. **Note:** PBM/payers may validate patients based on cardholder name.
GroupID	conditional	ID number identifying the health plan group.
GroupName	conditional	Name of the health plan group.

Element	Code	Comments
PBMMemberID	conditional	PBM/payer-assigned member ID for the patient.
Patient **Note:** Refer to the schema for a complete list of fields.		
Identification	conditional	
SocialSecurity	conditional	Patient's Social Security Number. Recommended to not send.
GenderAndSex	mandatory	Values: **M** - Male **F** - Female **U** - Not Specified or Unknown **N** - Non-binary - An umbrella term for people with gender identities that fall somewhere outside of the traditional conceptions of strictly either female or male.
Pregnancy Indicator	conditional	Code indicating the patient as **pregnant** or **non-pregnant**.
Prescriber **Note:** The prescriber relates to the person requesting the prior authorization.		
Identification	mandatory	Some PBM/payers may validate prescriber data against NPPES or other prescriber directories using the fields under Identification.
NPI	mandatory	NPI of the prescriber.
MedicationPrescribed		
DrugDescription	mandatory	Drug name (full drug name, strength, and form). For a compound, the names of the ingredients in the compound or the prescriber's preferred name should be communicated here. See **Drug Description** Best Practices section for more information.
DrugCoded	conditional	
NDC	mandatory	The NDC must be a valid 11-digit code and should meet the qualifications for a Representative NDC.

Element	Code	Comments
ProductCode	conditional	Product Identifier. The Representative NDC is recommended unless the message contains Quantity Code List Qualifier “CF” or the CompoundInformation element is present. See **NDC Codes** for more information.
Strength	conditional	
StrengthForm/Code	conditional	Must be a valid FMT code. See **Codified Field Usage for Federal Medication Terminologies (FMT) Codes** for details.
StrengthUnitOfMeasure/ Code	conditional	Must be a valid FMT code. See **Codified Field Usage for Federal Medication Terminologies (FMT) Codes** for details.
Quantity	mandatory	
QuantityUnitOfMeasure	mandatory	Must be a valid FMT code. See **Codified Field Usage for Federal Medication Terminologies (FMT) Codes** for details.
PADaysSupplyDosePerDay	conditional	MedicationPrescribed/DaysSupply or PADaysSupply and PADosesPerDay must be a whole number. Just one of these fields need to be submitted. **Note:** In order to allow PBM/payers to provide the most accurate response, provider vendors should include DaysSupply for the requested medication within PAInitiationRequests. PBM/payers use days supply in order to determine if prescribers are requesting a quantity outside of the plan limit. Failure to provide days supply could result in unnecessary question sets being returned to prescribers or additional work.
Diagnosis	conditional	Provider vendors should send the valid version of diagnosis codes in the PAInitiationRequest. Sending diagnosis codes may speed up the process. Note: If sending ICD-10 codes (Qualifier ABF), sending systems should not include decimal codes for message/submission.
ClinicalInformationQualifier	mandatory	Qualifier for how the diagnosis was obtained. Values: **1** - Prescriber/Prescriber Supplied **2** - Pharmacy Inferred **3** - Patient **4** - Other Source
Qualifier	mandatory	Defines the code list used for the diagnosis code.

Element	Code	Comments
Value	mandatory	Code for the diagnosis.
Description	mandatory	Description of the diagnosis code.
Sig	conditional	
SigText	mandatory	SigText will be used to convey patient instructions for use or administration and should be constructed and transmitted in a patient-friendly manner. Sigs should not be truncated because important information can be lost.
Provider		
Identification	conditional	
NPI	mandatory	NPI of the initiating party.
Name	mandatory	Initiating party's name. See ACR PA.204 in the **Application Certification Requirements** section for more information.
CommunicationNumbers	mandatory	
PrimaryTelephone	mandatory	Initiating party's phone number. See ACR PA.204 in the **Application Certification Requirements** section for more information.
Fax	conditional	Initiating party's fax number.

5.2.3.2. Attachment Elements

Element	Code	Comments
AttachmentSource	mandatory	Indicates that the information was retrieved from the patient's medical record.
AttachmentData	mandatory	Base 64 encoded string that represents the attachment.
ClinicalInformation	conditional	Describes the CDA or CCR, if included.
CDA	mandatory	Either CDA or CCR is mandatory, if ClinicalInformation is included.
TemplateID	mandatory	CDA TemplateID for the Continuity of Care Document (CCD).
CCR	mandatory	Either CDA or CCR is mandatory, if ClinicalInformation is included.
Version	mandatory	CCR version.
MIMEType	mandatory	MIME type for the attachment: application/hl7-sda+xml application/x-ccr application/pdf image/jpeg image/tiff image/png

5.2.3.3. Request Elements

Element	Code	Comments
SolicitedModel	mandatory	Surescripts only supports solicited PARequests, unsolicited PARequests are not supported.
PACaseID	mandatory	PBM/payer-assigned identifier for this request.
DeadlineForReply	mandatory	Deadline for response (echoed from PAInitiationResponse).

5.2.4. PAResponse Elements

Element	Code	Comments
PAResponse		
PAReferenceID	mandatory	Assigned by the prescribing system on the initial message and is used as a tracking identifier on all request and response prior authorization messages to tieback related prior authorization messages. The identifier must be unique per prescribing system for at least 18 months. **Note:** PAReferenceID shall be established with the PARequest when responding to a Prior Authorization renewal request (unsolicited PAInitiationResponse).
BenefitsCoordination		
PBMMemberID	conditional	PBM/payer-assigned member ID for the patient.
Patient **Note:** Refer to the schema for a complete list of fields.		
Identification	conditional	
SocialSecurity	conditional	Patient's Social Security Number.
GenderAndSex	mandatory	Values: **M** - Male **F** - Female **U** - Not Specified or Unknown **N** - Non-binary - An umbrella term for people with gender identities that fall somewhere outside of the traditional conceptions of strictly either female or male.
PregnancyIndicator	conditional	Code indicating the patient as **pregnant** or **non-pregnant**.
Pharmacy		
Identification	mandatory	
NCPDPID	mandatory	NCPDP Provider ID Number of Pharmacy.
NPI	mandatory	National Provider ID of Pharmacy.

Element	Code	Comments
Buisness Name	mandatory	Name of Pharmacy.
CommunicationNumbers	mandatory	Phone Number of Pharmacy.
Prescriber **Note:** The prescriber relates to the person requesting the prior authorization.		
Identification	mandatory	
NPI	mandatory	NPI of the Prescriber.
CommunicationNumbers	mandatory	Prescriber's phone number.
MedicationPrescribed		
DrugDescription	mandatory	Drug name (full drug name, strength, and form). For a compound, the names of the ingredients in the compound or the prescriber's preferred name should be communicated here. See **DrugDescription** Best Practices section for more information.
DrugCoded	conditional	
NDC	mandatory	The NDC must be a valid 11-digit code and should meet the qualifications for a Representative NDC.
ProductCode	conditional	Product Identifier. The Representative NDC is recommended unless the message contains Quantity Code List Qualifier "CF" or the CompoundInformation element is present. See **NDC Codes** for more information.
Strength	conditional	
StrengthForm/Code	conditional	Must be a valid FMT code. See **Codified Field Usage for Federal Medication Terminologies (FMT) Codes** for details.

Element	Code	Comments
StrengthUnitOfMeasure/Code	conditional	Must be a valid FMT code. See **Codified Field Usage for Federal Medication Terminologies (FMT) Codes** for details.
Quantity	mandatory	
QuantityUnitOfMeasure	mandatory	Must be a valid FMT code. See **Codified Field Usage for Federal Medication Terminologies (FMT) Codes** for details.
PADaysSupplyDosePerDay	conditional	MedicationPrescribed/DaysSupply or PADaysSupply and PADosesPerDay must be a whole number. Just one of these fields need to be submitted. **Note:** In order to allow PBM/payers to provide the most accurate response, provider vendors should include DaysSupply for the requested medication within PAInitiationRequests. PBM/payers use days supply in order to determine if prescribers are requesting a quantity outside of the plan limit. Failure to provide days supply could result in unnecessary question sets being returned to prescribers or additional work.
Diagnosis	conditional	Provider vendors should send the valid version of diagnosis codes in the PAInitiationRequest. Sending diagnosis codes may speed up the process. **Note:** If sending ICD-10 codes (Qualifier ABF), sending systems should not include decimal codes for message/submission.
ClinicalInformationQualifier	mandatory	Qualifier for how the diagnosis was obtained. Values: **1** - Prescriber/Prescriber Supplied **2** - Pharmacy Inferred **3** - Patient **4** - Other Source
Qualifier	mandatory	Defines the code list used for the diagnosis code.
Value	mandatory	Code for the diagnosis.
Description	mandatory	Description of the diagnosis code.
Sig	conditional	

Element	Code	Comments
SigText	mandatory	SigText will be used to convey patient instructions for use or administration and should be constructed and transmitted in a patient-friendly manner. Sigs should not be truncated because important information can be lost.

5.2.5. PAAppealRequest Elements

Element	Code	Comments
Request	mandatory	
PACaseID	mandatory	PBM/payer-assigned identifier for the PA that is being appealed.
AppealCaseID	conditional	Only returned in an PAAppealResponse if there are additional questions. If returned by PBM/payer, provider vendors should include in subsequent PAAppealRequest messages.
DeadlineForReply	conditional	If the PBM/payer returns a question set in their PAAppealResponse, the subsequent PAAppealRequest must be returned by this date/time.
QuestionSet	conditional	If the PBM/payer returns a Question Set in their PAAppealResponse, the subsequent PAAppealRequest would contain the question set and associated answers.
PANote	conditional	Free text note describing reason for the appeal. **Note:** Some PBM/payers may approve or deny appeal requests solely based on PANote. If this field is not included in the first PAAppealRequest, some PBM/payers may deny the appeal.

5.2.6. PAAppealResponse Elements

Element	Code	Comments
Response/ResponseStatus	mandatory	An appeal response can be approved/denied based on the free text note from the original PAAppealRequest.
Approved/Appeal/IsEAppealSupported	mandatory	An appeal response may be appealed, if supported.
Denied/Appeal/IsEAppealSupported	mandatory	An appeal response may be appealed, if supported.
Open	mandatory	PBM/payers may return a question set requesting additional information if they are unable to approve or deny the appeal request based on the originally submitted information.

5.2.7. PACancelRequest/Response Elements

For information on PACancelRequest and PACancelResponse, see **Message Descriptions**.

Element Name	Code	Comments
PACaseID	mandatory	PBM/payer assigned identifier for the PA that is being cancelled.
CancelReasonCode	conditional	Should be sent to indicate cancel reason to PBM/payer. **Note:** This element only applies to the PACancelRequest.

5.2.8. PANotification Elements

Element	Code	Comments
PACaseID	mandatory	PBM/payer assigned identifier for request.
PriorAuthorizationStatus	mandatory	Status of the prior authorization as sent. Options include: **A – Approved**: The medication was approved by the payer. **F – Deferred**: The medication request is being reviewed by the payer. **D – Denied**: The medication was not approved by the payer. **N – Not Required**: A prior authorization is not required for this medication. **R – Requested**: The action of obtaining a prior authorization is being sought. **P – Partially Denied**:The product was partially denied by the payer.
Medication Prescribed/DrugDescription	mandatory	Drug name (full drug name, strength, and form). For a compound, the names of the ingredients in the compound or the prescriber's preferred name should be communicated in this field. See **Drug Description** section for more information.
Medication Prescribed/SIGText	mandatory	SigText will be used to convey patient instructions for use or administration and should be constructed and transmitted in a patient-friendly manner. Sigs should not be truncated because important information can be lost.

5.3. Codified Field Usage for Federal Medication Terminologies (FMT) Codes

For a list of FMT codes, go to: **http://evs.nci.nih.gov/ftp1/NCPDP/About.html**. Use the valid value from the appropriate row of the downloaded data. This list should be updated on a monthly basis.

The table below includes some example fields.

Codified Field/Field Code	Comment
StrengthForm/Code	Use the NCPDP StrengthForm Terminology rows from the downloaded data. This list should be updated on a monthly basis.
StrengthUnitOfMeasure/Code	Use the NCPDP StrengthUnitOfMeasure Terminology rows from the downloaded data.
QuanityUnitOfMeasure/Code	Use the NCPDP QuantityUnitOfMeasure Terminology rows from the downloaded data.
DoseUnitOfMeasure/Code	Use the NCPDP DoseUnitOfMeasure Terminology rows from the downloaded data.
DEASchedule	Use the NCPDP DEASchedule Terminology rows from the downloaded data.

6. Application Certification Requirements

Validation of this product for use on the Surescripts network confirms conformance with prior authorization transaction requirements, including the ability to support standards-based, secure exchange of clinical and administrative data between providers and payers. The Application Certification Requirements (ACRs) defined in this section establish the functional and data handling expectations that participating systems must meet to ensure consistent and reliable prior authorization workflows.

Conformance to these requirements supports successful integration with the Surescripts network by promoting interoperability, reducing variability in message processing, and enabling predictable system behavior across participants. These requirements are aligned with applicable industry standards, including the NCPDP ePA standard, and are used as the basis for certification and ongoing compliance.

Refer to the following ACR topics for details:

Provider Vendor Requirements

Provider Vendor and PBM/Payer Requirements

PBM/Payer Requirements

6.1. Provider Vendor Requirements

PA.200: The application shall make available for display the ResponseStatus and each occurrence of a PANote from all response transactions.

> **Note:** Multiple responses of the same type may be received.

PA.201: When the PBM/payer provides a question set in the PAInitiationResponse, the application shall display:

- QuestionSetContactCommunicationNumber
- DeadlineForReply
- AttachmentNotes (when attachment required)

PA.202: The application shall require all specified questions to be answered (not blank) and an order, prior to sending the PARequest.

PA.203: In the event that a PA has been canceled by the initiator or closed by the PBM, and the prior authorization is still desired, a new PAInitiationRequest shall be sent.

PA.204: When the prescriber and main prior authorization contact vary, the application shall utilize the Provider composite to supply the prior authorization contact name and PrimaryTelephone.

PA.205: Provider vendors shall not send a PAAppealRequest if the value of the IsEAppealSupported field is "false" in the PAResponse.

PA.206: Prescribing vendors who are utilizing the Surescripts Eligibility 270/271 messages shall populate the first BenefitsCoordination element with the associated information returned in a Surescripts 271 message. If more than one active coverage is returned, only the single coverage information utilized to write the prescription is sent. The 271 message's ISA13 control number shall be populated in the BenefitsCoordination/InterchangeControlNumber field in all instances including scenarios where there is no active coverage.

PA.207: Either MedicationPrescribed/DaysSuppy or MedicationPrescribed/PADaysSupplyDosesPerDay shall be populated in the PAInitiationRequest when available.

PA.208: If the PAInitiationRequest includes a PAPriorityIndicator flag, the priority must be displayed to the end user. The value of "S" (Standard Priority) should be the default if the data element is sent in the transaction.

PA.209: The application shall make available for display the ExpirationDate to the prescriber for a Prior Authorization renewal request (unsolicited PAInitiationResponse).

PA.210: If a PBM/payer requires an attachment in an answered question, the application shall not allow a request to be sent without the attachment composite being populated.

PA.211: When both a brand and generic NDC exist for a medication, in the PAInitiationRequest provider vendors shall submit the drug description and NDC of the form of the medication they want to prescribe for the patient.

PA.214: The application shall support the ePA question set conditional logic as outlined in the NCPDP ePA standard.

PA.219: The drug name shall be an item that is currently available for dispensing. If there are active NDCs available, an inactive/obsolete NDC shall not be used. Customers are expected to work with their drug compendia vendor to satisfy this requirement.

S.203: Sender demographic information shall match what was registered by the customer in the Surescripts Directory. When a prescribing system utilizes the Surescripts Learning Directory service, this requirement is satisfied for learned locations.

S.208: Codified values within a message shall not conflict with the related textual concept.

Example 1:

Field Name	Proper Use	Improper Use
DrugDescription	Primariea 10mg/10ml liquid	
DrugCoded/Strength/StrengthValue	10	<empty>
DrugCoded/Strength/StrengthUnitOfMeasure/Code	C42576 (mg/ml)	
DrugCoded/Strength/StrengthForm/Code	C42953	

Example 2:

Field Name	Proper Use	Improper Use
DrugDescription	Amoxicillin 500 mg oral capsule	
DrugCoded/Strength/StrengthValue	500	250
DrugCoded/Strength/StrengthUnitOfMeasure/Code	C28253 (Milligram)	C28254 (Milliliter)
DrugCoded/Strength/StrengthForm/Code	C25158 (Capsule)	C42998 (Tablet)

6.2. Provider Vendor and PBM/Payer Requirements

PA.212: Payer and submitter systems shall be able to send and receive PDF attachments at a minimum.

PA.213: Participant applications shall not allow users/systems to respond multiple times to a message the application has already sent. The only exceptions are: the INProcess PAResponse followed by an Approved/Denied PAResponse message; and PARequest/PAResponses when additional information is requested.

PA.220: Customers shall support the scenarios detailed in the Message Flow section of this guide.

S.200: Customers shall be able to receive syntactically valid maximum and minimum populated messages. Optional data elements (and values therein) shall not cause message failure.

S.201: Customers shall ensure all messages are syntactically correct before transmission to Surescripts.

S.205: The sender shall ensure the combination of the From and MessageID elements, for all messages including Error, is unique for at least 18 months. Surescripts recommends an unformatted Globally Unique Identifier (GUID).

S.206: System shall support user entry and display of up to three digits to the right of the decimal place, without the system rounding or truncating. The decimal point is represented by a period and shall be used as follows:

- Only when there are significant digits to the right of the decimal
- When there is a digit before and after the decimal point
- Not with whole numbers

For example, consider the following possible values:

Correct Format Examples	Incorrect Format Examples
2.5	.27
0.15	3.00
21	14.

S.209: The customer shall implement and maintain a Surescripts approved drug compendia that is updated at least monthly.

6.3. PBM/Payer Requirements

PA.215: If the PBM/health plan receives a PAInitiationRequest or PARequest that contains a PAPriorityIndicator of "X" (expedited), the PBM/health plan shall process the request and respond in an expedited manner. If the PAInitiationRequest or PARequest needs to be manually reviewed for priority, then the PBM/health plans shall make the priority indicator available for display.

PA.216: If the provider vendor populates the Provider composite, the PBM system shall make the Provider composite contents available to be viewed by the user.

PA.217: The PBM/payer system shall make available for display the QuestionSetComment from the PARequest and the PAAppealRequest if the prior authorization request would otherwise be denied or approved with modifications.

PA.218: The PBM/payer system shall only send one PAResponse with a status of 'InProcess' and include the ExpectedResponseDate and/or PANote. This PAResponse is to be followed by a subsequent PAResponse with the final determination or request for additional information.

7. Message Examples

This chapter provides sample electronic prior authorization messages based on the NCPDP SCRIPT standard. These examples illustrate commonly used transactions, including request, response, status, and error scenarios, to help you understand how messages are structured and exchanged across the workflow.

Use these examples as a reference when building and validating your integration. They reflect typical use cases but are not exhaustive. Always refer to the official schema and standards documentation for complete requirements.

This section includes the following message example information:

7.1. PA Submitted by a Person Other than the Prescriber

In this example, the initiator of the prior authorization process is a staff member in the provider vendor's organization who can be reached at a different phone number than the prescriber. To provide this additional contact information, the ePA standard enables the initiating person to provide their separate contact information in the Provider element of the prior authorization message (see Provider Elements in the NCPDP SCRIPT Implementation Guide for more information). If the PBM/payer needs to call or fax the initiator during processing, it uses the contact information contained in this Provider element rather than the phone or fax in the Prescriber segment.

The requested medication is Lovenox (Lovenox 40 MG Per 0.4 ML Prefilled Syringe; RxNorm SBD 854236; NDC 58016487201).

> **Note:** This example does not include the Status messages or any other part of the normal message flow.

This section contains the following message example:

PAInitiationRequest (from Initiating Party)

7.1.1. PAInitiationRequest (from Initiating Party)

XML

```
<?xml version="1.0" encoding="utf-8"?>
<Message DatatypesVersion="20230115" TransportVersion="20230115" TransactionDomain="SCRIPT"
TransactionVersion="20230115" StructuresVersion="20230115" ECLVersion="20230115">
    <Header>
        <To Qualifier="ZZZ">EPAINI</To>
        <From Qualifier="D">6842917100001</From>
        <MessageID>4e55ea3f923b4e14a436a3f08554f488</MessageID>
        <SentTime>2015-09-04T17:18:14.1Z</SentTime>
        <SenderSoftware>
            <SenderSoftwareDeveloper>MDLITE</SenderSoftwareDeveloper>
            <SenderSoftwareProduct>443</SenderSoftwareProduct>
            <SenderSoftwareVersionRelease>2.1</SenderSoftwareVersionRelease>
        </SenderSoftware>
        <TestMessage>false</TestMessage>
    </Header>
    <Body>
        <PAInitiationRequest>
            <PAReferenceID>c7eb89cc8a3c43c8818e456627a91c2d</PAReferenceID>
            <BenefitsCoordination>
                <PayerIdentification>
                    <PayerID>P00000000001192</PayerID>
                    <ProcessorIdentificationNumber>PCN9110</ProcessorIdentificationNumber>
                    <IINNumber>994336</IINNumber>
                </PayerIdentification>
                <PayerName>PBMA</PayerName>
                <CardholderID>209837423</CardholderID>
                <CardHolderName>
                    <LastName>JOHNSON</LastName>
                    <FirstName>RONALD</FirstName>
                    <MiddleName>C</MiddleName>
                </CardHolderName>
                <GroupID>0998723</GroupID>
                <GroupName>9110/3TIER/25</GroupName>
                <PBMMemberID>0398473070389475</PBMMemberID>
            </BenefitsCoordination>
            <Patient>
                <HumanPatient>
                    <Identification>
                        <MedicareBeneficiaryID>333445556A</MedicareBeneficiaryID>
                    </Identification>
                    <Names>
                        <Name>
                            <LastName>SMITH</LastName>
                            <FirstName>MAUREEN</FirstName>
                        </Name>
                    </Names>
                    <GenderAndSex>
                        <AdministrativeGender>F</AdministrativeGender>
                    </GenderAndSex>
                    <DateOfBirth>
                        <Date>1934-11-27</Date>
                    </DateOfBirth>
                    <Address>
                        <AddressLine1>201 GOLDEN LANE</AddressLine1>
                        <AddressLine2>APT 204</AddressLine2>
                        <City>CINCINNATI</City>
```

```
                <StateProvince>OH</StateProvince>
                <PostalCode>45233</PostalCode>
                <CountryCode>US</CountryCode>
            </Address>
        </HumanPatient>
    </Patient>
    <Pharmacy>
        <Identification>
            <NCPDPID>7701631</NCPDPID>
            <NPI>7878787879</NPI>
        </Identification>
        <BusinessName>CINCINNATI PHARMACY</BusinessName>
        <Address>
            <AddressLine1>100 OMNIBUS LANE</AddressLine1>
            <City>CINCINNATI</City>
            <StateProvince>OH</StateProvince>
            <PostalCode>45202</PostalCode>
            <CountryCode>US</CountryCode>
        </Address>
        <CommunicationNumbers>
            <PrimaryTelephone>
                <Number>8595559000</Number>
            </PrimaryTelephone>
        </CommunicationNumbers>
    </Pharmacy>
    <Prescriber>
        <NonVeterinarian>
            <Identification>
                <NPI>1992091797</NPI>
            </Identification>
            <Names>
                <Name>
                    <LastName>ePA-MessageManager30</LastName>
                    <FirstName>Provider</FirstName>
                </Name>
            </Names>
            <Address>
                <AddressLine1>123 Main st</AddressLine1>
                <City>Minneapolis</City>
                <StateProvince>MN</StateProvince>
                <PostalCode>55123</PostalCode>
                <CountryCode>US</CountryCode>
            </Address>
            <CommunicationNumbers>
                <PrimaryTelephone>
                    <Number>6518553000</Number>
                </PrimaryTelephone>
                <Fax>
                    <Number>6518553001</Number>
                </Fax>
            </CommunicationNumbers>
        </NonVeterinarian>
    </Prescriber>
    <MedicationPrescribed>
        <DrugDescription>LOVENOX 40 MG PER 0.4 ML PREFILLED SYRINGE</DrugDescription>
        <Product>
            <DrugCoded>
                <NDC>58016487201</NDC>
                <Strength>
```

```
                        <StrengthValue>100</StrengthValue>
                        <StrengthForm>
                            <Code>C42945</Code>
                        </StrengthForm>
                        <StrengthUnitOfMeasure>
                            <Code>C42576</Code>
                        </StrengthUnitOfMeasure>
                    </Strength>
                </DrugCoded>
            </Product>
            <Quantity>
                <Value>30</Value>
                <CodeListQualifier>38</CodeListQualifier>
                <QuantityUnitOfMeasure>
                    <Code>C48540</Code>
                </QuantityUnitOfMeasure>
            </Quantity>
            <DaysSupply>30</DaysSupply>
            <Diagnosis>
                <ClinicalInformationQualifier>1</ClinicalInformationQualifier>
                <Qualifier>ABF</Qualifier>
                <Value>E11.9</Value>
                <Description>DIABETES MELLITUS</Description>
            </Diagnosis>
            <Sig>
                <SigText>INJECT 40 MG SUBCUTANEOUSLY ONCE DAILY</SigText>
            </Sig>
        </MedicationPrescribed>
        <Provider>
            <Identification>
                <NPI>7777777777</NPI>
            </Identification>
            <Names>
                <Name>
                    <LastName>WEISS</LastName>
                    <FirstName>TERRY</FirstName>
                    <Suffix>RN</Suffix>
                </Name>
            </Names>
            <CommunicationNumbers>
                <PrimaryTelephone>
                    <Number>8595559880</Number>
                </PrimaryTelephone>
                <Fax>
                    <Number>8595559770</Number>
                </Fax>
            </CommunicationNumbers>
        </Provider>
    </PAInitiationRequest>
</Body>
</Message>
```

7.2. PBM/Payer Requests Additional Information Using PAResponse

In this example (unrelated to the previous example) a PBM/payer uses the PAResponse message to request additional information from the provider vendor. Specifically, this scenario illustrates a situation where the PBM/payer receives a valid attachment in the provider vendor's PARequest message—but of a type it cannot process. In response, the PBM/payer asks the provider vendor to provide the information in a different form.

The example below illustrates the following exchange between the provider and the patient's PBM/payer:

- The provider vendor sends a PARequest containing the completed question set and an attached patient clinical summary in CCD format. The PBM/payer returns a Status response.
- The PBM/payer determines that the supplied attachment was not of the requested type and sends the provider vendor a PAResponse requesting a supported attachment type. The provider vendor returns a Status response.
- The provider vendor sends a PARequest containing an attached patient clinical summary in PDF format. The PBM/payer returns a Status response and then completes the PA process by sending a PAResponse containing approval.

> **Note:** This example only shows these three messages to illustrate the business scenario. There would also be PAInitiationRequest, PAInitiationResponse, Status, Verify, and/or Error messages.

The requested medication is Lovenox (Lovenox 40 MG Per 0.4 ML Prefilled Syringe; RxNorm SBD 854236; NDC 58016487201).

The prior authorization questions to be completed by the prescriber are:

1. Is this patient home self-administering? (Y/N)
2. Is the medication to be used to treat prophylaxis? (Y/N)
3. [IF YES] When was or will the surgery be done? (Date without time portion)
4. [Continue to question #6]
   Is the medication to be used for treatment of DVT? (Y/N)
5. [IF YES] What is the patient's current weight (in pounds)? (Numeric)
6. Describe result of warfarin use (include INR and date drawn) or reason why patient can't use warfarin. You may attach supporting information in a PDF document. (Free text)

This section contains the following examples:

PARequest (from Prescriber – Initial Submission)

PAResponse (from PBM/Payer)

PARequest (from Prescriber – Additional Information Submission)

7.2.1. PARequest (from Prescriber – Initial Submission)

The prescriber provides the information for the follow-up question in the format indicated in the question set (by attaching a PDF document to the PARequest message).

XML

```
<?xml version="1.0" encoding="utf-8"?>
<Message DatatypesVersion="20230115" TransportVersion="20230115" TransactionDomain="SCRIPT"
TransactionVersion="20230115" StructuresVersion="20230115" ECLVersion="20230115">
  <Header>
    <To Qualifier="PY">P99999999999999</To>
    <From Qualifier="D">77777777</From>
    <MessageID>1234569</MessageID>
    <RelatesToMessageID>1234567</RelatesToMessageID>
    <SentTime>2014-07-02T14:12:14.1Z</SentTime>
    <Security>
      <Sender>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Sender>
      <Receiver>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Receiver>
    </Security>
    <SenderSoftware>
      <SenderSoftwareDeveloper>MDLITE</SenderSoftwareDeveloper>
      <SenderSoftwareProduct>443</SenderSoftwareProduct>
      <SenderSoftwareVersionRelease>2.1</SenderSoftwareVersionRelease>
    </SenderSoftware>
  </Header>
  <Body>
    <PARequest>
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      <BenefitsCoordination>
        <PBMMemberID>333445555</PBMMemberID>
      </BenefitsCoordination>
      <Patient>
        <HumanPatient>
          <Names>
            <Name xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
              <LastName>SMITH</LastName>
              <FirstName>MARY</FirstName>
            </Name>
          </Names>
          <GenderAndSex>
            <AdministrativeGender>F</AdministrativeGender>
          </GenderAndSex>
          <DateOfBirth>
            <Date>1954-12-25</Date>
          </DateOfBirth>
          <Address>
            <AddressLine1>45 EAST ROAD SW</AddressLine1>
            <City>CLANCY</City>
            <StateProvince>WI</StateProvince>
            <PostalCode>54999</PostalCode>
            <CountryCode>US</CountryCode>
          </Address>
        </HumanPatient>
      </Patient>
      <Pharmacy>
        <Identification>
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          <NPI>7878787878</NPI>
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      <CommunicationNumbers>
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        </PrimaryTelephone>
      </CommunicationNumbers>
    </Pharmacy>
    <Prescriber>
      <NonVeterinarian>
        <Identification>
          <NPI>666666666</NPI>
        </Identification>
        <Names>
          <Name xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
            <LastName>JONES</LastName>
            <FirstName>MARK</FirstName>
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          <StateProvince>TN</StateProvince>
          <PostalCode>37777</PostalCode>
          <CountryCode>US</CountryCode>
        </Address>
        <CommunicationNumbers>
          <PrimaryTelephone>
            <Number>6152219800</Number>
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        </CommunicationNumbers>
      </NonVeterinarian>
    </Prescriber>
    <MedicationPrescribed>
      <DrugDescription xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">LOVENOX 40 MG PER 0.4 ML PREFILLED SYRINGE</DrugDes
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            <StrengthForm>
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            </StrengthForm>
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              <Code>C42576</Code>
            </StrengthUnitOfMeasure>
          </Strength>
        </NonDrugCoded>
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        </QuantityUnitOfMeasure>
      </Quantity>
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      <Diagnosis>
        <ClinicalInformationQualifier>1</ClinicalInformationQualifier>
        <Qualifier>ABF</Qualifier>
```

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            <Value>E11.9</Value>
            <Description>DIABETES MELLITUS</Description>
          </Diagnosis>
          <Sig>
            <SigText>INJECT 40 MG SUBCUTANEOUSLY ONCE DAILY</SigText>
          </Sig>
        </MedicationPrescribed>
        <Attachment>
          <AttachmentSource>Patient Medical Record</AttachmentSource>
          <AttachmentData />
          <CDA>
            <TemplateID>2.16.840.1.113883.10.20.22.1.2</TemplateID>
          </CDA>
          <MIMEType>application/hl7-sda+xml</MIMEType>
        </Attachment>
        <Request>
          <SolicitedModel>
            <PACaseID>A101</PACaseID>
            <DeadlineForReply>
              <DateTime>2014-10-01T23:59:59</DateTime>
            </DeadlineForReply>
            <QuestionSet>
              <Header>
                <QuestionSetID>QS101</QuestionSetID>
                <QuestionSetTitle>Lovenox PA Form</QuestionSetTitle>
                <QuestionSetDescription>Please provide all information requested. Failure to complete this form in its entirety may
                <QuestionSetContactCommunicationNumber>
                  <PrimaryTelephone>
                    <Number>5555551212</Number>
                  </PrimaryTelephone>
                </QuestionSetContactCommunicationNumber>
                <AttachmentRequired>false</AttachmentRequired>
              </Header>
              <Question>
                <QuestionID>Q1</QuestionID>
                <SequenceNumber>1</SequenceNumber>
                <QuestionText>Is this patient home self-administering?</QuestionText>
                <DefaultNextQuestionID>Q2</DefaultNextQuestionID>
                <QuestionType>
                  <Select>
                    <SelectMultiple>false</SelectMultiple>
                    <Choice>
                      <ChoiceID>Q1C1</ChoiceID>
                      <SequenceNumber>1</SequenceNumber>
                      <ChoiceText>Yes</ChoiceText>
                      <AdditionalFreeTextIndicator>NA</AdditionalFreeTextIndicator>
                    </Choice>
                    <Choice>
                      <ChoiceID>Q1C2</ChoiceID>
                      <SequenceNumber>2</SequenceNumber>
                      <ChoiceText>No</ChoiceText>
                      <AdditionalFreeTextIndicator>NA</AdditionalFreeTextIndicator>
                    </Choice>
                    <Answer>
                      <SubmitterProvidedAnswer>
                        <ChoiceID xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">Q1C1</ChoiceID>
                      </SubmitterProvidedAnswer>
                    </Answer>
                  </Select>
```

```
      </QuestionType>
    </Question>
    <Question>
      <QuestionID>Q2</QuestionID>
      <SequenceNumber>2</SequenceNumber>
      <QuestionText>Is the medication to be used to treat prophylaxis?</QuestionText>
      <QuestionType>
        <Select>
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          <Choice>
            <ChoiceID>Q2C1</ChoiceID>
            <SequenceNumber>1</SequenceNumber>
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            <AdditionalFreeTextIndicator>NA</AdditionalFreeTextIndicator>
            <NextQuestionID>Q3</NextQuestionID>
          </Choice>
          <Choice>
            <ChoiceID>Q2C2</ChoiceID>
            <SequenceNumber>2</SequenceNumber>
            <ChoiceText>No</ChoiceText>
            <AdditionalFreeTextIndicator>NA</AdditionalFreeTextIndicator>
            <NextQuestionID>Q4</NextQuestionID>
          </Choice>
          <Answer>
            <SubmitterProvidedAnswer>
              <ChoiceID xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">Q2C2</ChoiceID>
            </SubmitterProvidedAnswer>
          </Answer>
        </Select>
      </QuestionType>
    </Question>
    <Question>
      <QuestionID>Q3</QuestionID>
      <SequenceNumber>3</SequenceNumber>
      <QuestionText>When was or will the surgery be done?</QuestionText>
      <DefaultNextQuestionID>Q6</DefaultNextQuestionID>
      <QuestionType>
        <Date>
          <IsDateTimeRequired>false</IsDateTimeRequired>
        </Date>
      </QuestionType>
    </Question>
    <Question>
      <QuestionID>Q4</QuestionID>
      <SequenceNumber>4</SequenceNumber>
      <QuestionText>Is the medication to be used for treatment of DVT?</QuestionText>
      <QuestionType>
        <Select>
          <SelectMultiple>false</SelectMultiple>
          <Choice>
            <ChoiceID>Q4C1</ChoiceID>
            <SequenceNumber>1</SequenceNumber>
            <ChoiceText>Yes</ChoiceText>
            <AdditionalFreeTextIndicator>NA</AdditionalFreeTextIndicator>
            <NextQuestionID>Q5</NextQuestionID>
          </Choice>
          <Choice>
            <ChoiceID>Q4C2</ChoiceID>
            <SequenceNumber>2</SequenceNumber>
```

```
                    <ChoiceText>No</ChoiceText>
                    <AdditionalFreeTextIndicator>NA</AdditionalFreeTextIndicator>
                    <NextQuestionID>Q6</NextQuestionID>
                  </Choice>
                  <Answer>
                    <SubmitterProvidedAnswer>
                      <ChoiceID xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">Q4C1</ChoiceID>
                    </SubmitterProvidedAnswer>
                  </Answer>
                </Select>
              </QuestionType>
            </Question>
            <Question>
              <QuestionID>Q5</QuestionID>
              <SequenceNumber>5</SequenceNumber>
              <QuestionText>What is the patient's weight (in pounds)?</QuestionText>
              <DefaultNextQuestionID>Q6</DefaultNextQuestionID>
              <QuestionType>
                <Numeric>
                  <IsNumeric>true</IsNumeric>
                  <Answer>
                    <SubmitterProvidedNumericAnswer>164</SubmitterProvidedNumericAnswer>
                  </Answer>
                </Numeric>
              </QuestionType>
            </Question>
            <Question>
              <QuestionID>Q6</QuestionID>
              <SequenceNumber>6</SequenceNumber>
              <QuestionText>Describe result of Warfarin use (include INR and date drawn) or reason why patient can't use Warfarin.
              <DefaultNextQuestionID>END</DefaultNextQuestionID>
              <QuestionType>
                <FreeText>
                  <IsFreeText>true</IsFreeText>
                  <Answer>
                    <SubmitterProvidedAnswer>Patient tried Warfarin without success. See attached CCD with treatment history.</Sub
                  </Answer>
                </FreeText>
              </QuestionType>
            </Question>
          </QuestionSet>
        </SolicitedModel>
      </Request>
    </PARequest>
```

PARequest (from Prescriber) Example Element Details

> **Note:** The table below does not explain every element displayed in the XML example.

Element	Value	
To	P99999999999999:PY	ID of the receiving PBM/payer; PY means it is the payer.
From	77777777:D	SPI assigned to the prescriber; D is the qualifier for a Prescriber ID.
MessageID	1234569	Initiating system trace number for the transmission. Echoed back in the response message in RelatesToMessageID.
RelatesToMessageID	1234567	Used to link the most recent message received from a trading partner in the conversation to this subsequent message.
SentTime	2014-07-02T14🕐14.1Z	Date and time message was sent: 07/02/2014 14🕐14.1 PM
PARequest	PARequest	Message type.
SenderSoftwareDeveloper, SenderSoftwareProduct, SenderSoftwareVersionRelease	MDLITE:443:2.1	Sender Software Developer: MDLITE Sender Software Product: 443 Sender Software Version Release: 2.1
PrescriberOrderNumber		Not sent. Not applicable.
RxReferenceNumber		Not sent. Not applicable.
PAReferenceID	77XX2	Assigned by the prescribing system on the initial message and is used as a tracking identifier on all request and response prior authorization messages to tieback related prior authorization messages. The identifier must be unique per prescribing system for at least 18 months. **Note:** PAReferenceID shall be established with the PARequest when responding to a Prior Authorization renewal request (unsolicited PAInitiationResponse).
PBMMemberID	333445555	PBM/payer-assigned member ID for the patient.
SocialSecurity	333445555	Patient's Social Security Number.
LastName, FirstName	SMITH:MARY	Patient's name.
Gender	F	Patient's gender.
DateOfBirth	1954-12-25	Patient's date of birth.
Address	45 EAST ROAD SW, CLANCY, WI, 54999	Patient's address.
NCPDPID	7701630	NCPDP Provider ID Number of Pharmacy.
NPI	7878787878	National Provider ID of Pharmacy.
StoreName	MAIN STR...	Name of Pharmacy.
CommunicationNumber	6155555656	Phone Number of Pharmacy.

Element	Value	
NPI	666666666	NPI of the Prescriber.
LastName, FirstName	JONES:MARK	Prescriber's name.
Address	211 CENTRAL ROAD, JONESVILLE, TN, 37777	Prescriber's address.
CommunicationNumber	6155559800	Prescriber's phone number.
DrugDescription	LOVENOX 40 MG PER 0.4 ML PREFILLED SYRINGE	Drug prescribed is Lovenox 40 MG per 0.4 ML Prefilled Syringe.
Strength	100	100 is the strength.
StrengthForm	C42945	C42945 is the code for "injectable solution".
StrengthUnitOfMeasure	C42576	C42576 is the code for "milligrams per milliliter".
Quantity	30:38	Quantity is 30. 38 is the code value for Original Qty.
QuantityUnitOfMeasure	C48540	C48540 is the code for "Syringe".
DaysSupply	30	30 is the number of days supply.
Diagnosis Code	E11.9	E11.9 is the diagnosis code for Diabetes mellitus.
SigText	INJECT 40 MG SUBCUTANEOUSLY ONCE DAILY	INJECT 40 MG SUBCUTANEOUSLY ONCE DAILY... is the Sig.
Attachment		
AttachmentSource	Patient medical record	Indicates that the information was retrieved from the patient's medical record.
AttachmentData	Base64-encoded CCD document	Attached CCD document (BASE64 encoded).
CDA:TemplateID	2.16.840.1.113883.10.20.22.1.2	CDA TemplateID for the Continuity of Care Document (CCD).
MIMEType	application/hl7-sda+xml	MIME type for CDA documents.
Request		
SolicitedModel	SolicitedModel	
PACaseID	A101	PBM/payer-assigned identifier for this request.
DeadlineForReply	2014-10-01T23:59:59	Deadline for response (echoed from PAInitiationResponse).
QuestionSet		
QuestionSet		A question set is included in the PBM/payer's response.
Header		
QuestionSetID	QS101	PBM/payer-assigned ID for this question set.
QuestionSetTitle	Lovenox PA Form	Title of the question set, "Lovenox PA Form" can be presented to the end-user.
QuestionSetDescription	Please provide all information requested. Failure to complete this	Instructions for the end-user.

Element	Value	
	form in its entirety may result in delayed processing or an adverse determination for insufficient information.	
QuestionSetContactPhoneNumber	5555551212	Contact phone number at the PBM/payer for questions related to this PA process.
AttachementRequired	N	
Question 1		
Question		
QuestionID	Q1	PBM/payer-assigned ID for this question.
QuestionText	Is this patient home self-administering?	Question text to be displayed to the end-user.
SequenceNumber	1	Order of this question relative to other questions in this question set.
DefaultNextQuestionID	Q2	Next question to display regardless of the answer to this question.
Select		Type of this question is Select.
SelectMultiple	N	Only one answer may be returned for this question. (No)
Choice - First choice		
ChoiceID	Q1C1	PBM/payer-assigned ID for this choice.
ChoiceText	Yes	Text to be presented to the end-user.
SequenceNumber	1	Order of this choice relative to other choices for this question.
AdditionalFreeTextIndicator	NA	No additional free text is allowed when selecting this choice.
Choice - Second choice		
ChoiceID	Q1C2	PBM/payer-assigned ID for this choice.
ChoiceText	No	Text to be presented to the end-user.
SequenceNumber	2	Order of this choice relative to other choices for this question.
AdditionalFreeTextIndicator	NA	No additional free text is allowed when selecting this choice.
Answer		
PrescriberProvidedAnswer		
ChoiceID	Q1C1	ChoiceID associated with the selected choice.
Question 2		

Element	Value	
Question		
QuestionID	Q2	PBM/payer-assigned ID for this question.
QuestionText	Is the medication to be used to treat prophylaxis?	Question text to be displayed to the end-user.
SequenceNumber	2	Order of this question relative to other questions in this question set.
Select		Type of this question is Select.
SelectMultiple	N	Only one answer may be returned for this question. (No)
Choice		First choice
ChoiceID	Q2C1	PBM/payer-assigned ID for this choice.
ChoiceText	Yes	Text to be presented to the end-user.
SequenceNumber	1	Order of this choice relative to other choices for this question.
NextQuestionID	Q3	Next question to be answered if this choice is selected.
AdditionalFreeTextIndicator	NA	No additional free text is allowed when selecting this choice.
Choice		Second choice
ChoiceID	Q2C2	PBM/payer-assigned ID for this choice.
ChoiceText	No	Text to be presented to the end-user.
SequenceNumber	2	Order of this choice relative to other choices for this question.
NextQuestionID	Q4	Next question to be answered if this choice is selected.
AdditionalFreeTextIndicator	NA	No additional free text is allowed when selecting this choice.
Answer		
PrescriberProvidedAnswer		
ChoiceID	Q2C2	ChoiceID associated with the selected choice.
Question 3 - Conditional question to be asked if Question 2 answer is Yes		
Question		
QuestionID	Q3	PBM/payer-assigned ID for this question.
QuestionText	When was or will the surgery be done?	Question text to be displayed to the end-user.
SequenceNumber	3	Order of this question relative to other questions in this question set.
DefaultNextQuestionID	Q6	Next question to display regardless of the answer to this question.

Element	Value	
Date		Type of this question is Date.
IsDateTimeRequired	N	Time information is not required in the response to this question. (No)
Note: This question was not answered based on the NextQuestionID of the previously selected answer.		
Question 4		
Question		
QuestionID	Q4	PBM/payer-assigned ID for this question.
QuestionText	Is the medication to be used for treatment of DVT?	Question text to be displayed to the end-user.
SequenceNumber	4	Order of this question relative to other questions in this question set.
Select		Type of this question is Select.
SelectMultiple	N	Only one answer may be returned for this question. (No)
Choice - First choice		
ChoiceID	Q4C1	PBM/payer-assigned ID for this choice.
ChoiceText	Yes	Text to be presented to the end-user.
SequenceNumber	1	Order of this choice relative to other choices for this question.
NextQuestionID	Q5	Next question to be answered if this choice is selected.
AdditionalFreeTextIndicator	NA	No additional free text is allowed when selecting this choice.
Choice - Second choice		
ChoiceID	Q4C2	PBM/payer-assigned ID for this choice.
ChoiceText	No	Text to be presented to the end-user.
SequenceNumber	2	Order of this choice relative to other choices for this question.
NextQuestionID	Q6	Next question to be answered if this choice is selected.
AdditionalFreeTextIndicator	NA	No additional free text is allowed when selecting this choice.
Answer		
PrescriberProvidedAnswer		

Element	Value	
ChoiceID	Q4C1	ChoiceID associated with the selected choice.
Question 5 - Conditional question to be asked if previous question's answer is Yes		
Question		
QuestionID	Q5	PBM/payer-assigned ID for this question.
QuestionText	What is the patient's current weight (in pounds)?	Question text to be displayed to the end-user.
DefaultNextQuestionID	Q6	Next question to display regardless of the answer to this question.
SequenceNumber	5	Order of this question relative to other questions in this question set.
IsNumeric		Type of this question is Numeric.
Answer		
PrescriberProvidedAnswer	164	
Question 6		
Question		
QuestionID	Q6	PBM/payer-assigned ID for this question.
QuestionText	Describe result of Warfarin use (include INR and date drawn) or reason why patient can't use Warfarin. You may attach supporting information in a PDF document.	Question text to be displayed to the end-user.
DefaultNextQuestionID	END	Last question in the question set.
SequenceNumber	6	Order of this question relative to other questions in this question set.
IsFreeText	Y	Indicates this is a free text question. (Yes)
Answer		
PrescriberProvidedAnswer	Patient tried Warfarin without success. See attached CCD with treatment history.	

7.2.2. PAResponse (from PBM/Payer)

The PBM/payer reviews the prescriber's PARequest and determines that it needs additional information. The PBM/payer returns a PAResponse containing another question set with one follow-up question.

XML

```
<?xml version="1.0" encoding="utf-8"?>
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TransactionVersion="20230115" StructuresVersion="20230115" ECLVersion="20230115">
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    <From Qualifier="PY">P99999999999999</From>
    <MessageID>8890</MessageID>
    <RelatesToMessageID>1234569</RelatesToMessageID>
    <SentTime>2014-12-02T17:05:12.1Z</SentTime>
    <Security>
      <Sender>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Sender>
      <Receiver>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Receiver>
    </Security>
    <SenderSoftware>
      <SenderSoftwareDeveloper>MD80SYSTEM</SenderSoftwareDeveloper>
      <SenderSoftwareProduct>80</SenderSoftwareProduct>
      <SenderSoftwareVersionRelease>15.2</SenderSoftwareVersionRelease>
    </SenderSoftware>
  </Header>
  <Body>
    <PAResponse>
      <PAReferenceID>77XX2</PAReferenceID>
      <BenefitsCoordination>
        <PBMMemberID>333445555</PBMMemberID>
      </BenefitsCoordination>
      <Patient>
        <HumanPatient>
          <Names>
            <Name xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
              <LastName>SMITH</LastName>
              <FirstName>MARY</FirstName>
            </Name>
          </Names>
          <GenderAndSex>
            <AdministrativeGender>F</AdministrativeGender>
          </GenderAndSex>
          <DateOfBirth>
            <Date>1954-12-25</Date>
          </DateOfBirth>
          <Address>
            <AddressLine1>45 EAST ROAD SW</AddressLine1>
            <City>CLANCY</City>
            <StateProvince>WI</StateProvince>
            <PostalCode>54999</PostalCode>
            <CountryCode>US</CountryCode>
          </Address>
        </HumanPatient>
      </Patient>
      <Pharmacy>
        <Identification>
          <NCPDPID>7701630</NCPDPID>
          <NPI>7878787878</NPI>
```

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      </Identification>
      <BusinessName>MAIN STREET PHARMACY</BusinessName>
      <CommunicationNumbers>
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        </PrimaryTelephone>
      </CommunicationNumbers>
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    <Prescriber>
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        <Identification>
          <NPI>666666666</NPI>
        </Identification>
        <Names>
          <Name xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
            <LastName>JONES</LastName>
            <FirstName>MARK</FirstName>
          </Name>
        </Names>
        <Address>
          <AddressLine1>211 CENTRAL ROAD</AddressLine1>
          <City>JONESVILLE</City>
          <StateProvince>TN</StateProvince>
          <PostalCode>37777</PostalCode>
          <CountryCode>US</CountryCode>
        </Address>
        <CommunicationNumbers>
          <PrimaryTelephone>
            <Number>6152219800</Number>
          </PrimaryTelephone>
        </CommunicationNumbers>
      </NonVeterinarian>
    </Prescriber>
    <MedicationPrescribed>
      <DrugDescription xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">LOVENOX 40 MG PER 0.4 ML PREFILLED SYRINGE</DrugDes
      <Product>
        <NonDrugCoded>
          <Strength>
            <StrengthValue>100</StrengthValue>
            <StrengthForm>
              <Code>C42945</Code>
            </StrengthForm>
            <StrengthUnitOfMeasure>
              <Code>C42576</Code>
            </StrengthUnitOfMeasure>
          </Strength>
        </NonDrugCoded>
      </Product>
      <Quantity>
        <Value>30</Value>
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        <QuantityUnitOfMeasure>
          <Code>C48540</Code>
        </QuantityUnitOfMeasure>
      </Quantity>
      <DaysSupply>30</DaysSupply>
      <Diagnosis>
        <ClinicalInformationQualifier>1</ClinicalInformationQualifier>
        <Qualifier>ABF</Qualifier>
```

```
            <Value>E11.9</Value>
            <Description>DIABETES MELLITUS</Description>
          </Diagnosis>
          <Sig>
            <SigText>INJECT 40 MG SUBCUTANEOUSLY ONCE DAILY</SigText>
          </Sig>
        </MedicationPrescribed>
        <Response>
          <ResponseStatus>
            <Open>
              <PACaseID>A101</PACaseID>
              <MoreInformationRequired>
                <Header>
                  <QuestionSetID>QS101-FOLLOWUP</QuestionSetID>
                  <QuestionSetTitle>Lovenox PA Form - Follow up question(s)</QuestionSetTitle>
                  <QuestionSetDescription>Thank you for your request. The additional information identified here is required to fini
                  <QuestionSetContactCommunicationNumber>
                    <PrimaryTelephone>
                      <Number>5555551212</Number>
                    </PrimaryTelephone>
                  </QuestionSetContactCommunicationNumber>
                  <AttachmentRequired>false</AttachmentRequired>
                </Header>
                <Question>
                  <QuestionID>FOLLOWUP_Q1</QuestionID>
                  <SequenceNumber>1</SequenceNumber>
                  <QuestionText>Describe result of Warfarin use (include INR and date drawn) or reason why patient can't use Warfari
                  <DefaultNextQuestionID>END</DefaultNextQuestionID>
                  <QuestionType>
                    <FreeText>
                      <IsFreeText>true</IsFreeText>
                    </FreeText>
                  </QuestionType>
                </Question>
                <DeadlineForReply>
                  <DateTime>2014-10-02T23:59:59</DateTime>
                </DeadlineForReply>
              </MoreInformationRequired>
              <PANote>We currently cannot process CDA documents. Please answer this question regarding the patient's previous use of
            </Open>
          </ResponseStatus>
        </Response>
      </PAResponse>
    </Body>
  </Message>
```

PAResponse (from PBM/payer) Example Element Details

> **Note:** The table below does not explain every element displayed in the XML example.

Element	Value	Note
To	77777777:D	ID of the prescriber; D is the qualifier for a Prescriber ID.
From	P99999999999999:PY	ID of the sending PBM/payer; PY means it is the payer.
MessageID	8890	PBM/payer system trace number for the transmission. Echoed back in the response message in RelatesToMessageID.
RelatesToMessageID	1234569	Used to link the most recent message received from a trading partner in the conversation to this subsequent message.
SentTime	2014-12-02T17:05:12.1Z	Date and time message was sent: 12/02/2014 17:05:12.1 PM
PAResponse	PAResponse	Message type.
SenderSoftwareDeveloper, SenderSoftwareProduct, SenderSoftwareVersionRelease	MD80SYSTEM:80:15.2	Sender Software Developer: MD80SYSTEM Sender Software Product: 80 Sender Software Version Release: 15.2
PrescriberOrderNumber		Not sent. Not applicable.
RxReferenceNumber		Not sent. Not applicable.
PAReferenceID	77XX2	Assigned by the prescribing system on the initial message and is used as a tracking identifier on all request and response prior authorization messages to tieback related prior authorization messages. The identifier must be unique per prescribing system for at least 18 months. **Note:** PAReferenceID shall be established with the PARequest when responding to a Prior Authorization renewal request (unsolicited PAInitiationResponse).
PBMMemberID	333445555	PBM/payer-assigned member ID for the patient.
SocialSecurity	333445555	Patient’s Social Security Number.
LastName, FirstName	SMITH:MARY	Patient’s name.
Gender	F	Patient's gender.
DateOfBirth	1954-12-25	Patient’s date of birth.
Address	45 EAST ROAD SW, CLANCY, WI, 54999	Patient’s address.
NCPDPID	7701630	NCPDP Provider ID Number of Pharmacy.
NPI	7878787878	National Provider ID of Pharmacy.
StoreName	MAIN STR...	Name of Pharmacy.

Element	Value	Note
CommunicationNumber	6155555656	Phone Number of Pharmacy.
NPI	666666666	NPI of the Prescriber.
LastName, FirstName	JONES:MARK	Prescriber's name.
Address	211 CENTRAL ROAD, JONESVILLE, TN, 37777	Prescriber's address.
CommunicationNumber	6152219800	Prescriber's phone number.
DrugDescription	LOVENOX 40 MG PER 0.4 ML PREFILLED SYRINGE	Drug prescribed is Lovenox 40 MG per 0.4 ML Prefilled Syringe.
Strength	100	100 is the strength.
StrengthForm	C42945	C42945 is the code for "injectable solution".
StrengthUnitOfMeasure	C42576	C42576 is the code for "milligrams per milliliter".
Quantity	30:38	Quantity is 30. 38 is the code value for Original Qty.
QuantityUnitOfMeasure	C48540	C48540 is the code for "Syringe".
DaysSupply	30	30 is the number of days supply.
Diagnosis Code	E11.9	E11.9 is the diagnosis code for Diabetes mellitus.
SigText	INJECT 40 MG SUBCUTANEOUSLY ONCE DAILY	INJECT 40 MG SUBCUTANEOUSLY ONCE DAILY... is the Sig.
Response		
PACaseID	A101	PBM/payer-assigned identifier for this request.
ResponseStatus	Open	
DeadlineForReply	2014-10-02T23:59:59	Deadline for responding to this case in datetime format.
QuestionSet		
QuestionSet		A question set is included in the PBM/payer's response.
Header		
QuestionSetID	QS101-FOLLOWUP	PBM/payer-assigned ID for this question set.
QuestionSetTitle	Lovenox PA Form - Follow up question(s)	Title of the question set, "Lovenox PA Form - Follow up question(s)" can be presented to the end-user.
QuestionSetDescription	Thank you for your request. The additional information identified here is required to finish processing the case. Please provide at your earliest convenience; the case will remain open until the date specified in this message.	Instructions for the end-user.

Element	Value	Note
QuestionSetContactPhoneNumber	5555551212	Contact phone number at the PBM/payer for questions related to this PA process.
AttachementRequired	N	
Question 1		
Question		
QuestionID	FOLLOWUP_Q1	PBM/payer-assigned ID for this question.
QuestionText	Describe result of Warfarin use (include INR and date drawn) or reason why patient can't use Warfarin. You may attach supporting information in a PDF document.	Question text to be displayed to the end-user.
DefaultNextQuestionID	END	Last question in the question set.
SequenceNumber	1	Order of this question relative to other questions in this question set.
IsFreeText	Y	Indicates this is a free text question. (Yes)

7.2.3. PARequest (from Prescriber – Additional Information Submission)

The prescriber provides the information for the follow-up question in the format indicated in the question set (by attaching a PDF document to the PARequest message).

XML

```
<?xml version="1.0" encoding="utf-8"?>
<Message DatatypesVersion="20230115" TransportVersion="20230115" TransactionDomain="SCRIPT"
TransactionVersion="20230115" StructuresVersion="20230115" ECLVersion="20230115">
  <Header>
    <To Qualifier="PY">P99999999999999</To>
    <From Qualifier="D">77777777</From>
    <MessageID>1234570</MessageID>
    <RelatesToMessageID>8890</RelatesToMessageID>
    <SentTime>2014-06-11T08:05:12.1Z</SentTime>
    <Security>
      <Sender>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Sender>
      <Receiver>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Receiver>
    </Security>
    <SenderSoftware>
      <SenderSoftwareDeveloper>MDLITE</SenderSoftwareDeveloper>
      <SenderSoftwareProduct>443</SenderSoftwareProduct>
      <SenderSoftwareVersionRelease>2.1</SenderSoftwareVersionRelease>
    </SenderSoftware>
  </Header>
  <Body>
    <PARequest>
      <PAReferenceID>77XX2</PAReferenceID>
      <BenefitsCoordination>
        <PBMMemberID>333445555</PBMMemberID>
      </BenefitsCoordination>
      <Patient>
        <HumanPatient>
          <Names>
            <Name xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
              <LastName>SMITH</LastName>
              <FirstName>MARY</FirstName>
            </Name>
          </Names>
          <GenderAndSex>
            <AdministrativeGender>F</AdministrativeGender>
          </GenderAndSex>
          <DateOfBirth>
            <Date>1954-12-25</Date>
          </DateOfBirth>
          <Address>
            <AddressLine1>45 EAST ROAD SW</AddressLine1>
            <City>CLANCY</City>
            <StateProvince>WI</StateProvince>
            <PostalCode>54999</PostalCode>
            <CountryCode>US</CountryCode>
          </Address>
        </HumanPatient>
      </Patient>
      <Pharmacy>
        <Identification>
          <NCPDPID>7701630</NCPDPID>
          <NPI>7878787878</NPI>
```

```
      </Identification>
      <BusinessName>MAIN STREET PHARMACY</BusinessName>
      <CommunicationNumbers>
        <PrimaryTelephone>
          <Number>6155555656</Number>
        </PrimaryTelephone>
      </CommunicationNumbers>
    </Pharmacy>
    <Prescriber>
      <NonVeterinarian>
        <Identification>
          <NPI>666666666</NPI>
        </Identification>
        <Names>
          <Name xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
            <LastName>JONES</LastName>
            <FirstName>MARK</FirstName>
          </Name>
        </Names>
        <Address>
          <AddressLine1>211 CENTRAL ROAD</AddressLine1>
          <City>JONESVILLE</City>
          <StateProvince>TN</StateProvince>
          <PostalCode>37777</PostalCode>
          <CountryCode>US</CountryCode>
        </Address>
        <CommunicationNumbers>
          <PrimaryTelephone>
            <Number>6152219800</Number>
          </PrimaryTelephone>
        </CommunicationNumbers>
      </NonVeterinarian>
    </Prescriber>
    <MedicationPrescribed>
      <DrugDescription xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">LOVENOX 40 MG PER 0.4 ML PREFILLED SYRINGE</DrugDes
      <Product>
        <NonDrugCoded>
          <Strength>
            <StrengthValue>100</StrengthValue>
            <StrengthForm>
              <Code>C42945</Code>
            </StrengthForm>
            <StrengthUnitOfMeasure>
              <Code>C42576</Code>
            </StrengthUnitOfMeasure>
          </Strength>
        </NonDrugCoded>
      </Product>
      <Quantity>
        <Value>30</Value>
        <CodeListQualifier>38</CodeListQualifier>
        <QuantityUnitOfMeasure>
          <Code>C48540</Code>
        </QuantityUnitOfMeasure>
      </Quantity>
      <DaysSupply>30</DaysSupply>
      <Diagnosis>
        <ClinicalInformationQualifier>1</ClinicalInformationQualifier>
        <Qualifier>ABF</Qualifier>
```

```
            <Value>E11.9</Value>
            <Description>DIABETES MELLITUS</Description>
          </Diagnosis>
          <Sig>
            <SigText>INJECT 40 MG SUBCUTANEOUSLY ONCE DAILY</SigText>
          </Sig>
        </MedicationPrescribed>
        <Attachment>
          <AttachmentSource>Patient Medical Record</AttachmentSource>
          <AttachmentData />
          <MIMEType>application/pdf</MIMEType>
        </Attachment>
        <Request>
          <SolicitedModel>
            <PACaseID>A101</PACaseID>
            <DeadlineForReply>
              <DateTime>2014-10-02T23:59:59</DateTime>
            </DeadlineForReply>
            <QuestionSet>
              <Header>
                <QuestionSetID>QS101-FOLLOWUP</QuestionSetID>
                <QuestionSetTitle>Lovenox PA Form - Follow up question(s)</QuestionSetTitle>
                <QuestionSetDescription>Thank you for your request. The additional information identified here is required to finish
                <QuestionSetContactCommunicationNumber>
                  <PrimaryTelephone>
                    <Number>5555551212</Number>
                  </PrimaryTelephone>
                </QuestionSetContactCommunicationNumber>
                <AttachmentRequired>true</AttachmentRequired>
              </Header>
              <Question>
                <QuestionID>FOLLOWUP_Q1</QuestionID>
                <SequenceNumber>1</SequenceNumber>
                <QuestionText>Describe result of Warfarin use (include INR and date drawn) or reason why patient can't use Warfarin.
                <DefaultNextQuestionID>END</DefaultNextQuestionID>
                <QuestionType>
                  <FreeText>
                    <IsFreeText>true</IsFreeText>
                    <Answer>
                      <SubmitterProvidedAnswer>Please see the attached PDF containing dates of the patient's use of Warfarin and INR
                    </Answer>
                  </FreeText>
                </QuestionType>
              </Question>
            </QuestionSet>
          </SolicitedModel>
        </Request>
      </PARequest>
    </Body>
</Message>
```

7.3. Error Example (XML)

At multiple points in the process, an Error message can be generated. The following is an example of an Error message.

XML

```xml
<?xml version="1.0" encoding="utf-8"?>
<Message DatatypesVersion="20230115" TransportVersion="20230115" TransactionDomain="SCRIPT"
TransactionVersion="20230115" StructuresVersion="20230115" ECLVersion="20230115">
  <Header>
    <To Qualifier="D">7777777</To>
    <From Qualifier="PY">P99999999999999</From>
    <MessageID>9XX</MessageID>
    <RelatesToMessageID>1234569</RelatesToMessageID>
    <SentTime>2014-08-20T10:25:12.1Z</SentTime>
    <Security>
      <Sender>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Sender>
      <Receiver>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Receiver>
    </Security>
    <SenderSoftware>
      <SenderSoftwareDeveloper>MD80SYSTEM</SenderSoftwareDeveloper>
      <SenderSoftwareProduct>80</SenderSoftwareProduct>
      <SenderSoftwareVersionRelease>15.2</SenderSoftwareVersionRelease>
    </SenderSoftware>
  </Header>
  <Body>
    <Error>
      <Code>900</Code>
      <DescriptionCode>3000</DescriptionCode>
      <Description>Prescriber NPI is invalid. Fails LUHN check</Description>
    </Error>
  </Body>
</Message>
```

7.4. Status Example (XML)

A Status message is used to relay acceptance of a message back to the sender. The following is an example of a Status message.

XML

```xml
<?xml version="1.0" encoding="utf-8"?>
<Message DatatypesVersion="20230115" TransportVersion="20230115" TransactionDomain="SCRIPT"
TransactionVersion="20230115" StructuresVersion="20230115" ECLVersion="20230115">
  <Header>
    <To Qualifier="D">1234567890123</To>
    <From Qualifier="PY">1234563</From>
    <MessageID>888333</MessageID>
    <RelatesToMessageID>123</RelatesToMessageID>
    <SentTime>2014-05-16T14:17:12.1Z </SentTime>
    <Security>
      <Sender>
        <TertiaryIdentification>12345</TertiaryIdentification>
      </Sender>
      <Receiver>
        <TertiaryIdentification>678</TertiaryIdentification>
      </Receiver>
    </Security>
    <SenderSoftware>
      <SenderSoftwareDeveloper>MDLITE</SenderSoftwareDeveloper>
      <SenderSoftwareProduct>443</SenderSoftwareProduct>
      <SenderSoftwareVersionRelease>2.1</SenderSoftwareVersionRelease>
    </SenderSoftware>
  </Header>
  <Body>
    <Status>
      <Code>010</Code>
    </Status>
  </Body>
</Message>
```

7.5. Verify Example (XML)

Surescripts uses a Verify message as a response for certain messages. The following is an example of what a Verify message may look like.

XML

```xml
<?xml version="1.0" encoding="utf-8"?>
<Message DatatypesVersion="20230115" TransportVersion="20230115" TransactionDomain="SCRIPT"
TransactionVersion="20230115" StructuresVersion="20230115" ECLVersion="20230115">
  <Header>
    <To Qualifier="D">1234567890123</To>
    <From Qualifier="PY">1234563</From>
    <MessageID>888333</MessageID>
    <RelatesToMessageID>123</RelatesToMessageID>
    <SentTime>2014-10-15T10:15:12.1Z</SentTime>
    <Security>
      <Sender>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Sender>
      <Receiver>
        <TertiaryIdentification>ACCT_ID_INSERTED_BY_SS</TertiaryIdentification>
      </Receiver>
    </Security>
    <SenderSoftware>
      <SenderSoftwareDeveloper>MDLITE</SenderSoftwareDeveloper>
      <SenderSoftwareProduct>443</SenderSoftwareProduct>
      <SenderSoftwareVersionRelease>2.1</SenderSoftwareVersionRelease>
    </SenderSoftware>
  </Header>
  <Body>
    <Verify>
      <VerifyStatus>
        <Code>010</Code>
      </VerifyStatus>
    </Verify>
  </Body>
</Message>
```

8. Message Processing Summary

This section explains the message processing that takes place for messages exchanged between a message sender and a message receiver. These messages are initiated in the form of a request and an acknowledgement response message is returned. The sender stays connected until the receiver sends an acknowledgment response. Depending on connectivity, the actual message vehicle may vary.

The system (Surescripts) stores round-trip messages until the receiver acknowledges the message or until the specified time limit has elapsed. If the timeout elapses before the message is processed, Surescripts will return an error message to the sender as the reply (explained below).

> **Note:** Errors are not necessarily processed in the order as shown below. The row number is there to help the reader indicate which error code they may be discussing.

Row	Event	Process	Type of SCRIPT message	SCRIPT Code	SCRIPT Description Code	Message Text
1.0	Surescripts receives a message.					
1.1		Surescripts fails to recognize the sender OR the message is malformed.	NA (HTTP 400 Bad Request Error is returned rather than a SCRIPT message)	NA	NA	Bad request.
1.2		Sender security credentials are missing.	Error	900 – Message rejected	Blank	Missing authentication info in header. [Additional message-specific error specifics]
1.3		Sender security credentials are invalid.	Error	900 – Message rejected	Blank	Authentication failed. Invalid username/password. [Additional message-specific error specifics]
1.4		The incoming message exceeds Surescripts' size limit of 20MB.	NA (HTTP 500 Internal Server Error is returned rather than a SCRIPT message)	NA	NA	Internal server error.
1.5		Any other system-related error which makes it impossible for Surescripts to accept the message.	NA (HTTP 500 Internal Server Error is returned rather than a SCRIPT message)	NA	NA	Internal server error.
2.0	Surescripts processe	No acknowledgement is sent to the sender at this stage of processing.				

Row	Event	Process	Type of SCRIPT message	SCRIPT Code	SCRIPT Description Code	Message Text
	s the message.					
2.1		Surescripts determines that the sending system is not certified to send this type of message.	Error	700 – Configuration error	4030 – Sender not allowed to send this message type.	Sender portal does not support this message type.
2.2		Surescripts determines that the receiving system is not certified to receive this type of message.	Error	700 – Configuration error	4040 – Receiver does not support receiving this message type.	Receiver portal does not support this message type.
2.3		Sender portal configuration error at Surescripts.	Error	700 – Configuration error	4020 – Intermediary system error.	Surescripts system error. Sender portal configuration error.
2.4		Receiver portal configuration error at Surescripts.	Error	700 – Configuration error	4020 – Intermediary system error.	Surescripts system error. Receiver portal configuration error.
2.5		Surescripts determines that the sender's provider vendor SPI or PBM/payer Unique ID was not found in the Surescripts directory.	Error	700 – Configuration error	4030 – Sender not allowed to send this message type.	Sender ID not in directory.
2.6		Surescripts determines that the receiver's SPI or PBM/payer Unique Identifier is not valid.	Error	700 – Configuration error	4040 – Receiver does not support receiving this message type.	Receiver ID not in directory.
2.7		Surescripts determines that the sending provider vendor SPI has not been authorized to send this type of message. (The sender's SPI has not been assigned the ePA service level.)	Error	700 – Configuration error	4030 – Sender not allowed to send this message type.	Sender not allowed to send this type of message.

Row	Event	Process	Type of SCRIPT message	SCRIPT Code	SCRIPT Description Code	Message Text
2.8		Surescripts determines that the receiving provider vendor SPI or PBM/payer unique identifier does not support this type of message. (The sender's SPI or PBM/payer unique identifier has not been assigned the ePA service level.)	Error	700 – Configuration error	4040 – Receiver does not support receiving this message type.	Receiver does not support this message type.
2.9		Surescripts fails to recognize the type of message.	Error	900 – Message rejected		Unable to recognize incoming data as a supported message type.
2.10		Based on the message type, Surescripts determines that a syntax error is present.	Error	900 – Message rejected	3000 – Does not follow NCPDP standard or implementation guide rules.	Invalid syntax. Message fails schema validation. [Additional message-specific error specifics]
2.11		Message fails Surescripts business rule validations.	Error	900 – Message rejected	3000 – Does not follow NCPDP standard or implementation guide rules.	Message fails Surescripts validations. The NDC must be a valid 11-digit code and should meet the qualifications for a Representative NDC. Namespace / version validation: • DatatypesVersion is invalid [field that is in error] doesn't match expected value 2023011 • ECLVersion is invalid [field that is in error] doesn't match expected value 2023011 • PA-StructuresVersion is invalid [field that is in error] doesn't match expected value 2023011 • StructuresVersion is invalid [field that is in error] doesn't match expected value 2023011

Row	Event	Process	Type of SCRIPT message	SCRIPT Code	SCRIPT Description Code	Message Text
						• TransactionVersion is invalid [field that is in error] doesn't match expected value 2023011 • TransportVersion is invalid [field that is in error] doesn't match expected value 2023011 • TransactionDomain is invalid [field that is in error] doesn't match expected value SCRIPT NPI LUHN check: • (Prescriber, Provider, Supervisor, Pharmacy, Facility) Identification/NPI is invalid. Fails LUHN check. PayerID in PAInitiationRequest: • PAInitiationRequests must include PayerID in BenefitsCoordination element PAInitiationRequests addressed to EPAINI: • All PAInitiationRequests must be addressed to EPAINI DaysSupply, PADaysSupply, or PADosesPerDay: • MedicationPrescribed/DaysSupply or PADaysSupply and PADosesPerDay must be a whole number Prescriber Fax: • Prescribers fax number is required

Row	Event	Process	Type of SCRIPT message	SCRIPT Code	SCRIPT Description Code	Message Text
						PO Box in Address Line 1: • A PO Box must not be sent in Address Line 1 for the Pharmacy, Prescriber, Facility, Supervisor, or Provider elements Unsolicited PAInitiationResponse: • Unsolicted PAInitiationResponse must be addressed to EPAINI Renewals for expiring PA: • Renewals for expiring PA must include the expire PACaseID and ExpirationDate AuthorizationDetail or AuthorizationPeriod in Closed – CF PAInitiationResponse: • Closed Prior Authorization with a duplicate/approved Reason code require either an Authorization Detail or Authorization Period Unsolicited PARequest: • Unsolicited model is not supported. AuthorizationDetail or AuthorizationPeriod in Approved PAResponse: • Appoved PA responses require either an Authorization Detail or Period AuthorizationDetail and AuthorizationPeriod in

Row	Event	Process	Type of SCRIPT message	SCRIPT Code	SCRIPT Description Code	Message Text
						PartiallyDenied PAResponse: • Partially denied PA response require both an Authorization Detail and Period AuthorizationDetail or AuthorizationPeriod in Closed – CF PAResponse: • Closed Prior Authorization with a duplicate/approved Reason code require either Authorization Detail or Authorization Period • The application shall make the AuthorizationDetail and AuthorizationPeriod available for display when receiving a PAResponse AuthorizationDetail or AuthorizationPeriod in PAAppealResponse: • Appoved PAAppeal responses require either an Authorization Detail or Period Improper use of QS quantity code: • script:MedicationPrescribed/structures: Quantity is invalid if Value is >0, Code List Qualifier must be 38 but was 'QS' or • script:MedicationPrescribed/structures: Quantity is invalid if Value is 0,

Row	Event	Process	Type of SCRIPT message	SCRIPT Code	SCRIPT Description Code	Message Text
						Code List Qualifier must be QS but was '38' Invalid Days Supply value: • DaysSupply is invalid Value is [field that is in error], Days Supply must be an integer with 3 or fewer digits • Invalid DescriptionCode in Status message: • DescriptionCode: [field that is in error] is invalid for Status messages • NextQuestionID/DefaultNextQuestionID Validation: • QuestionSet/Question/DefaultNextQuestionID is invalid for QuestionID [Question #]. DefaultNextQuestionID must be a QuestionID or END • QuestionSet/Question/QuestionID: Q# is invalid. Question ID must be unique.
2.12		Surescripts experiences a system failure during processing.	Error	900 – Message rejected		Surescripts system error.
3.0	Surescripts passes the message on to the recipient.					
3.1		Surescripts is unable to deliver the message to the receiver (e.g. could not establish communication session).	Error (For Sender)	600 – Communication problem –	4000 – Intermediary is unable to deliver	Communication problem. Try again later. Unable to deliver message to receiver.

Row	Event	Process	Type of SCRIPT message	SCRIPT Code	SCRIPT Description Code	Message Text
				try again later	message to the recipient.	
3.2		The message times out before a response is given.	Error (For Sender)	600 – Communication problem – try again later	008 – Request timed out before response could be received.	Connection with receiver timed out before response was returned. Status of message at receiver is unknown.
3.3		Recipient is unable to recognize the type of message or does not have enough info to create an NCPDP Error message. Recipient sends Surescripts HTTP 400 response and text message that indicates "Message cannot be identified nor processed".	HTTP 400 (from receiver) Error (For Sender)	602 – Receiver System Error	007 – Internal processing Error has occurred	From receiver: "Message cannot be identified nor processed".
4.0	Recipient responds to the message.					
4.1		Surescripts is unable to process the response from the recipient.	Error (to the sender of the original message)	For Sender: 600 – Communication problem – try again later	For Sender – 4010 – Intermediary is unable to process response from recipient	Unable to process response from receiver. Message delivered but status of message at receiver is unknown.
4.2		The recipient returns an Error message.	Pass through Error to initiating party	Surescripts passes Error message through	[as populated by the recipient]	[as populated by the recipient]
4.3		The recipient returns a valid Status message.	Status (to initiating party)	010 or 000 (As populated by the recipient)		**Note:** If the recipient is the end point and the return message is a Status, the Status code is 010. If the recipient is not an end point, the Status code is 000.

9. Message Business Flow Response Summary

The following table shows details on how a customer should respond to certain business scenarios using the appropriate message type, reason code, and response text when applicable. This table does not represent all codes.

> **Note:** Error codes are constrained by the schema. Reason code "BY" (meaning other) should only be used when there is not a more explicit reason code available.

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
PA Initiation	**Initiation main flow: PBM/payer returns a PA question set in response to a syntactically valid PAInitiationRequest message from the provider system.**					
1.1	Provider system submits a valid PAInitiationRequest message to a PBM/payer. PBM/payer returns a question set to be completed by the prescriber.	PAInitiation Response	Open	N/A	N/A	
	Alternative flows in response to a syntactically valid PA Initiation message from the provider system.					
1.2	Prior authorization is not needed for this patient and medication.	PAInitiation Response	Closed	CC - Prior Authorization not required for patient/medication		
1.3	The patient in the request not recognized by the PBM/payer.	PAInitiation Response	Closed	CD - Cannot find matching patient		
1.4	The patient in the request is not covered by the PBM/payer.	PAInitiation Response	Closed	CE - Patient not eligible (does not have coverage with the PBM/payer)		
1.5	Requested PA is a duplicate of one that has already been approved. PBM/payer responds with information about the	PAInitiation Response	Closed	CF - Prior Authorization duplicate/approved		

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
	previously submitted request.					
1.6	Requested PA is a duplicate of another in-process request.	PAInitiation Response	Closed	CG - Prior Authorization duplicate/in process		
1.7	Prescriber for PA Request is not allowed to submit	PAInitiation Response	Closed	CM - Prescriber not allowed to submit PA Request		
1.8	The receiving PBM/payer is not the PA processor for this patient.	PAInitiation Response	Closed	CO - The receiver is not the PA processor for this patient	The responder should include text providing information about how to contact the third-party processor, if known.	When the PBM/payer returns this reason code, Surescripts will try to determine the third-party processor for the PA and generate a 2nd PAInitiationRequest if one is found.
1.9	Prescriber for PA Request is not allowed to submit	PAInitiation Response	Closed	CM - Prescriber not allowed to submit PA Request		
1.10	The receiving PBM/payer does not process PA for this patient and medication combination.	PAInitiation Response	Closed	CP - The receiver is not the PA processor for this patient and medication combination	The responder should include text providing information about how to contact the third-party processor, if known.	When the PBM/payer returns this reason code, Surescripts will generate a 2nd PAInitiationRequest to try and determine the third-party processor for the PA.
1.11	Requested PA is a duplicate of another denied request.	PAInitiation Response	Closed	CY - Prior Authorization duplicate/denied		

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
1.12	Prior Authorization is not available for this drug/product under patient's plan.	PAInitiation Response	Closed	FM - Product not covered by this plan. Prior Authorization not available. (Used when the drug will not be covered even if the provider does a PA)		
1.13	Prior Authorization is not required for the prescription amount.	PAInitiation Response	Closed	FN - Prescription within prescribing limits. Prior Authorization not required for PATIENT/MEDICATION. (Used when there are coverage rules in place, but the prescriber is not going outside of them)		
1.14	Patient's plan will pay for the drug up to certain coverage limits for quantity and/or days supply.	PAInitiation Response	Closed	FO - Coverage limits may exist for quantity and/or days supply. Plan will pay up to coverage limit. Prior Authorization not required for PATIENT/MEDICATION. (Used when the plan will only pay up to a certain amount, but not above)		If the PBM/Health Plan is going to send this, include details about the coverage limit in the PANote

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
1.15	Coverage limits have been exceeded and exceptions cannot be made. If prescribing within limits, PA is not required.	PAInitiation Response	Closed	FP - Coverage limits have been exceeded, exception not available. Prior Authorization not required for PATIENT/MEDICATION when within coverage limit.		
1.16	There is an active PA on file for this patient/medication combination.	PAInitiation Response	Closed	FQ - Active PA on file.		
1.17	The Product Code submitted in the PA is not valid.	PAInitiation Response	Closed	FR - Submitted Product Code is not valid. Please resolve and resubmit.		
1.18	The receiving PBM/payer does not support ePA in this case.	PAInitiation Response	Closed	BX - Electronic Prior Authorization not currently supported by PBM/payer for this health plan/disease state/medication. Submit via other methods.		BX should only be used when the PBM/payer is the prior authorization processor, but ePA is not available for that health plan or drug.
1.19	Other business exception. For example: Version of ICD diagnosis code sent is not supported. OR	PAInitiation Response	Closed	BY - Other not covered by other values	The responder should include text describing the exception	Surescripts will send a closed response with a reason code BY and a note: 'Sorry but Surescripts cannot process this PA request

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
	Duplicate message, denied.					electronically. Please refer to the original instructions from the PBM for information on how to process this prior authorization manually.
PARequest	**PARequest Main flow: PBM/payer approves the PA (Solicited ePA workflow) in response to a syntactically valid PARequest message from the provider system.**					
2.1	Provider system submits a valid PARequest message to a PBM/payer. PBM/payer returns its approval.	PAResponse	Approved	N/A	N/A	
	Alternative flows: In response to a syntactically valid PARequest message from the provider system					
2.2	Denied response	PAResponse	Denied	N/A		
2.3	The PBM/payer requires additional information from the provider. It responds with a message containing a question set with additional questions.	PAResponse (Including another question set)	Open	N/A		

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
2.4a	Answer in PARequest is incomplete or invalid. PBM/payer asks again.	PAResponse (Including another question set)	Open	N/A	The responder should indicate the question at issue	
2.4b	A notification that the request is in process, including the expected resolution date if known.	PAResponse	InProcess	N/A		
2.4c	A notice indicating that the prior authorization has been approved by the payer, but with some limits. These limits may include pharmacy type, quantity, days supply, number of cycles, or refills.	PAResponse	PartiallyDenied	N/A		
2.4d	Answer in PARequest is incomplete or invalid. PBM/payer closes the case.	PAResponse	Closed	CN - Response content is inconsistent with the question	The responder should indicate the question at issue. Provider needs to open a new case.	
2.5a	Message attachment is valid, but the PBM/payer doesn't support the attachment type. PBM/payer requests that the provider system provide the information in	PAResponse	Open	N/A	The PBM/payer should suggest a different way for the provider to provide the information	

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
	a different form, using another question set.					
2.5b	Message attachment is valid, but the PBM/payer doesn't support the attachment type. PBM/payer processes the request ignoring the attachment, if it is not needed.	PAResponse	PBM/payer processes normally	PBM/payer processes normally		
2.6a	PARequest was received after the DeadlineForReply stated in the associated PAInitiationResponse message. The PBM/payer closes the PA case.	PAResponse	Closed	BY - Other not covered by other values	Message received after Deadline to Reply [plus any additional text from the PBM/payer]	
2.6b	PARequest was received after the DeadlineForReply stated in the associated PAInitiationResponse message. The PBM/payer ignores the date and processes anyway.	PAResponse	PBM/payer processes normally	PBM/payer processes normally		
2.7	After submitting a PARequest message, but before the PBM/payer has responded with a PAResponse, the provider requests by means other than the PA Cancel Request message that their case be closed. The	PAResponse	Closed	CJ - Closed by Provider		

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
	PBM/payer returns a PAResponse message indicating the case was closed by the provider.					
2.8	After the provider submits a PARequest message, but before the PBM/payer has responded with a PAResponse, the patient contacts the PBM/payer by phone or other means and requests that the case be closed. The PBM/payer returns a PAResponse message indicating the case was closed by the member.	PAResponse	Closed	CK - Closed by Member		
2.9	Requested PA is a duplicate of one that has already been approved. PBM/payer responds with information about the previously submitted request.	PAResponse	Closed	CF - Prior Authorization duplicate/approved		
2.10	Requested PA is a duplicate of another in-process request.	PAResponse	Closed	CG - Prior Authorization duplicate/in process		
2.11	PBM/payer is not able to accept the request from the prescriber identified in the PARequest message.	PAResponse	Closed	CM - Prescriber not allowed to submit PARequest		

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
2.12	Other business exception.	PAResponse	Closed	BY - Other not covered by other values	The responder should include text describing the exception	
2.13	The PBM/health plan/processor closes the case for an undefined reason.	PAResponse	Closed	CH – Closed by PBM/health plan/processor	The responder should include text describing the closed reason.	
2.14	The PBM/health plan closes the case due to communication with the member.	PAResponse	Closed	CK – Closed by member	The responder should include text describing the closed reason.	
2.15	The PBM/health plan/processor does not accept the attachment type sent by the submitter.	PAResponse	Open	CL – Attachment type (MIME type) type not supported	The responder should avoid sending this reason code if possible and should instead return an Open response indicating that the originally provided attachment is not supported by the receiver. Responders may not return an error if an unsupported attachment type is received. All attachment types supported by the NCPDP ePA standard must be received without error, per ACR PA.212.	
2.16	Requested PA is a duplicate of another denied request.	PAResponse	Closed	CY - Prior Authorization duplicate/denied		
2.17	Provider responded after deadline to reply. PA must be reinitiated.	PAResponse	Closed	FL - Provider responded after deadline to reply. PA must be reinitiated		

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
2.18	Prior Authorization is not available for this drug/product under patient's plan.	PAResponse	Closed	FM - Product not covered by this plan. Prior Authorization not available. (Used when the drug will not be covered even if the provider does a PA)		
2.19	Prior Authorization is not required for the prescription amount.	PAResponse	Closed	FN - Prescription within prescribing limits. Prior Authorization not required for PATIENT/MEDICATION. (Used when there are coverage rules in place, but the prescriber is not going outside of them)		
2.20	Patient's plan will pay for the drug up to certain coverage limits for quantity and/or days supply.	PAResponse	Closed	FO - Coverage limits may exist for quantity and/or days supply. Plan will pay up to coverage limit. Prior Authorization not required for PATIENT/MEDICATION. (Used when the plan will only pay up to a certain amount, but not above)		If the PBM/Health Plan is going to send this, include details about the coverage limit in the PANote

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
2.21	Coverage limits have been exceeded and exceptions cannot be made. If prescribing within limits, PA is not required.	PAResponse	Closed	FP - Coverage limits have been exceeded exception not available. Prior Authorization not required for PATIENT/MEDICATION when within coverage limit.		
2.22	There is an active PA on file for this patient/medication combination.	PAResponse	Closed	FQ - Active PA on file.		
2.23	The Product Code submitted in the PA is not valid.	PAResponse	Closed	FR - Submitted Product Code is not valid. Please resolve and resubmit.		
PAAppeal	**PA Appeal Main flow: PBM/payer approves the Appeal in response to a syntactically valid PAAppealRequest message from the provider system.**					
3.1	Provider system submits a valid PAAppealRequest message to a PBM/payer. PBM/payer returns its approval.	PA Appeal Response	Approved	N/A	N/A	
	Alternative flows in response to a syntactically valid PA Appeal message from the provider system					

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
3.2	Denied response. PBM/payer returns its denial.	PA Appeal Response	Denied	N/A		
3.3	PBM/payer requests additional information. PBM/payer returns a request for additional information (by including a question set in its response).	PA Appeal Response	Open	N/A		
3.4a	Answer in PA Appeal Request is incomplete or invalid. PBM/payer asks again.	PA Appeal Response (Including another question set)	Open	N/A	The responder should indicate the question at issue	
3.4b	Answer in PA Appeal Request is incomplete or invalid. PBM/payer closes the case.	PA Appeal Response	Closed	CN - Response content is inconsistent with the question	The responder should indicate the question at issue	
3.5	The provider submits a PA Appeal Request for a case where electronic appeal is not available. The PBM/payer notifies	PA Appeal Response	Closed	BY - Other not covered by other values	Electronic appeals are not supported for this case [plus any additional text from the PBM/payer]	

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
	the provider system that electronic appeal is not available for this case.					
3.6a	PA Appeal Request was received after the DeadlineForReply stated in an earlier PAAppealResponse message. The PBM/payer closes the PA appeal case.	PA Appeal Response	Closed	BY - Other not covered by other values	Message received after Deadline to Reply [plus any additional text from the PBM/payer]	
3.6b	PA Appeal Request was received after the DeadlineForReply stated in an earlier PAAppealResponse message. The PBM/payer ignores the date and continues to process.	PA Appeal Response	PBM/payer processes normally	PBM/payer processes normally		
3.7	After the provider submits a PARequest message, the patient contacts the PBM/payer by phone or other means and requests that the case be closed. The PBM/payer returns a PA Appeal Response message indicating the case was closed by the member.	PA Appeal Response	Closed	CK - Closed by Member		
3.8	Requested PA is a duplicate of one that has already been approved. PBM/payer responds with	PA Appeal	Closed	CF - Prior Authorization duplicate/approved		

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
	information about the previously submitted request.	Response				
3.9	Requested PA is a duplicate of another in-process request.	PA Appeal Response	Closed	CG - Prior Authorization duplicate/in process		
3.10	PBM/payer is not able to accept the request from the prescriber identified in the PARequest message.	PA Appeal Response	Closed	CM - Prescriber not allowed to submit PARequest		
3.11	Other business exception.	PA Appeal Response	Closed	BY - Other	The responder should include text describing the exception	
3.12	The PBM/payer/health plan/processor closes the case for an undefined reason.	PA Appeal Response	Closed	CH - Closed by PBM/health plan/processor	The responder should include text describing the closed reason.	
3.13	The PBM/payer/health plan/processor does not accept the attachment type sent by the submitter.	PA Appeal Response	Open	CL - Attachment type (MIME) type not supported	The responder should not send this reason code. All attachment types supported by the NCPDP ePA standard must be received without error, per ACR PA.212.	
PACan	**PA Cancel Main flow: PBM/payer successfully cancels the PA case in response to a syntactically valid PACancelRequest message from the provider system**					

Event ID	Event	Response Message Type	Response Status (ResponseStatus element)	Reason Code (Response Status: ReasonCode)	Standard Response Text (ResponseStatus: PANote)	Comments
cel						
4.1	Provider system submits a valid PACancelRequest message to a PBM/payer. PBM/payer returns its approval of the PA Cancel Request.	PA Cancel Response	Approved	N/A	N/A	
	Alternative Flows in response to a syntactically valid PACancelRequest message from the provider system					
4.2	PA Case ID was not found by the PBM/payer.	PA Cancel Response	Denied	BZ - Can't find PACaseID		
4.3	The PBM/payer is unable to locate a case matching the submitted Case ID and patient information.	PA Cancel Response	Denied	CA - Unable to locate based on insufficient information/identifiers do not match		
4.4	The provider submits a PA Cancel Request for a case that has already been determined.	PA Cancel Response	Denied	CB - Request already processed/final determination has been made		
4.5	Other business exception.	PA Cancel Response	Denied	BY - Other not covered by other values	The responder should include text describing the exception	

10. Message Linkage

Message linkage requirements and best practices are described in the table below. Four key fields are used to link messages together, as defined below. This linkage allows a software system to tie one message to another. For example, on a PAInitiationResponse the PBM/payer system needs to find the PAInitiationRequest to which the provider vendor is referring. This linkage should be done in an automated manner.

> **Note:** NCPDP refers to message linkage as trace number.

MessageID – The unique number assigned to each message. This ID initiates the electronic linking of subsequent message types.

RelatesToMessageID – The MessageID of the most recent and relevant message in the workflow. Please note that in unsolicited messages, such as PANotification, the RelatestoMessageID may not be present.

PAReferenceID – Assigned by the prescribing system on the initial message (or on PARequest message for Prior Authorization renewal requests) and is used by the prescribing system as a tracking identifier on all request and response prior authorization messages. The identifier must be unique per prescribing system for at least 18 months.

PACaseID – PBM/payer-assigned identifier for this request and used by the PBM/payer as a tracking identifier on all request and response prior authorization messages.

PAInitiationRequest and Response Fields

PAInitiationRequest	PAInitiation Response	PARequest	PA Response
MessageID = 123	MessageID = ABC	MessageID = 456	MessageID = DEF
RelatesToMessageID: If Eligibility and native Formulary are used, RelatesToMessageID contains the Interchange Control Number (ISA13 of Eligibility Response (271)). If On-Demand Formulary is used, then RelatesToMessageID contains the On-Demand Formulary Response MessageID. If RTPB is used, then RelatesToMessageID contains the RTPB Response MessageID. If RxChange is used, RelatesToMessageID contains the RxChange Request MessageID. **Note**: If multiple products are used, use the latest MessageID that was used as a trigger for the PA.	RelatesToMessageID = 123	RelatesToMessageID = ABC	RelatesToMessageID = 456
PAReferenceID = XYZ	PAReferenceID = XYZ	PAReferenceID = XYZ	PAReferenceID = XYZ
PACaseID = N/A	PACaseID = 999	PACaseID = 999	PACaseID = 999
Status	Status	Status	Status
MessageID = 111	MessageID = 222	MessageID = 333	MessageID = 444
RelatesToMessageID = 123	RelatesToMessageID = ABC	RelatesToMessageID = 456	RelatesToMessageID = DEF

PA Appeal and Cancel Request and Response

PA Appeal Request	PA Appeal Response	PA Cancel Request	PA Cancel Response
MessageID = 789	MessageID = GHI	MessageID = 012	MessageID = JKL
RelatesToMessageID = DEF	RelatesToMessageID = 789	RelatesToMessageID relates to the most recent message received from your trading partner. See definition above. Since PA Cancel Requests can be sent at any time after receiving case ID, this would relate to the most recent message. For example, if this was sent after provider sent the PARequest (and had not yet received a PAResponse from the PBM/payer) the RelatesTo ID would be ABC.	RelatesToMessageID = 012
PAReferenceID = XYZ	PAReferenceID = XYZ	PAReferenceID = XYZ	PAReferenceID = XYZ
PACaseID = 999	PACaseID = 999	PACaseID = 999	PACaseID = 999
Status	Status	Status	Status
MessageID = 555	MessageID = 666	MessageID = 777	MessageID = 888
RelatesToMessageID = 789	RelatesToMessageID = GHI	RelatesToMessageID = 012	RelatesToMessageID = JKL

Third-Party Processor Message Linking

When PBM/payers return a CO or CP reason code, the message becomes marked as closed for third-party processing. If Surescripts' third-party processor search finds a match, Surescripts creates a secondary PAInitiationRequest based upon the initial PAInitiationRequest. The recipient is updated and a secondary MessageID with a prefix of EPAINI is sent to the third-party processor. When the third-party processor responds, the message has a RelatesToMessageID that has a prefix of EPAINI and references the secondary PAInitiationRequest.

> **Note:** If the PBM/payer referenced is not connected to Surescripts for electronic prior authorization but the third-party processor is, Surescripts forwards the message to the third-party processor as if they were the PBM/payer – no modifications to the MessageID are made.

PAInitiationRequest and Response from Third-Party Processor

PAInitiationRequest (To EPAINI)	PAInitiationResponse (From PBM/Payer - Closed for Third Party)	Second PAInitiationRequest (To Third Party)	Second PAInitiationResponse (From Third Party)**	PARequest (To Third Party)	PAResponse (From Third Party
MessageID = 123	MessageID = ABC	MessageID = EPAINI321	MessageID = DEF	MessageID = 789	MessageID = 010
RelatesToMessageID contains the Interchange Control Number (ISA13 of Eligibility Response (271)).	RelatesToMessageID = 123	RelatesToMessageID = ABC	RelatesToMessageID = EPAINI321	RelatesToMessageID = DEF	RelatesToMessageID = 789
PAReferenceID = XYZ	PAReferenceID = XYZ	PAReferenceID = XYZ	PAReferenceID = XYZ	PAReferenceID = XYZ	PAReferenceID = XYZ
PACaseID = N/A	PACaseID = N/A	PACaseID = N/A	PACaseID = 123456	PACaseID = 123456	PACaseID = 123456
Status	Status	Status	Status	Status	Status
MessageID = 111	MessageID = 222	MessageID = 333	MessageID = 444	MessageID = 555	MessageID = 666
RelatesToMessageID = 123	RelatesToMessageID = ABC	RelatesToMessageID = EPAINI321	RelatesToMessageID = DEF	RelatesToMessageID = 789	RelatesToMessageID = 010

Note: If Surescripts cannot find a third-party processor, Surescripts will return a Closed PAInitiationResponse with EPAINI in the From field.

PANotification Sent Right After/Alongside PARequest

PAInitiationRequest	PAInitiationResponse	PARequest	PA Notification	PA Response
MessageID=123	MessageID = ABC	MessageID = 456	MessageID = DEF	MessageID = 789
RelatesToMessageID: If Eligibility and native Formulary are used, RelatesToMessageID contains the Interchange Control Number (ISA13 of Eligibility Response (271)). If On-Demand Formulary is used, then RelatesToMessageID contains the On-Demand Formulary Response MessageID.	RelatesToMessageID = 123	RelatesToMessageID = ABC	RelatesToMessageID = 456	RelatesToMessageID =456

PANotification Sent Right After/Alongside PAResponse

PAInitiationRequest	PAInitiation Response	PARequest	PA Response	PA Notification
MessageID=123	MessageID = ABC	MessageID = 456	MessageID = DEF	MessageID = 789
RelatesToMessageID: If Eligibility and native Formulary are used, RelatesToMessageID contains the Interchange Control Number (ISA13 of Eligibility Response (271)). If On-Demand Formulary is used, then RelatesToMessageID contains the On-Demand Formulary Response MessageID.	RelatesToMessageID = 123	RelatesToMessageID = ABC	RelatesToMessageID = 456	RelatesToMessageID =DEF

PANotification Sent Right After/Alongside PARequest and PAResponse

PAInitiationRequest	PAInitiation Response	PARequest	PA Notification	PA Response	PA Notification
MessageID=123	MessageID = ABC	MessageID = 456	MessageID = DEF	MessageID = 789	MessageID = GHI
RelatesToMessageID: If Eligibility and native Formulary are used, RelatesToMessageID contains the Interchange Control Number (ISA13 of Eligibility Response (271)). If On-Demand Formulary is used, then RelatesToMessageID contains the On-Demand Formulary Response MessageID.	RelatesToMessageID = 123	RelatesToMessageID = ABC	RelatesToMessageID = 456	RelatesToMessageID =456	RelatesToMessageID =789

11. NCPDP Translation

For details on translating between Surescripts versions of the NCPDP SCRIPT standard, refer to the ePA Translation Matrix below:

ePA Translation Matrix.xlsx

Note: The DEA restricts digitally signed fields from being truncated or dropped during EPCS translation; therefore, it is important to know the version of the receiving system.

12. Disclaimers

Guide Disclaimer

In the event that the Participant chooses to make any software changes based upon recommendations in this guide, the Participant acknowledges and agrees that Surescripts Network shall bear no responsibility or liability for the Participant's changes or any effects thereof. The Participant shall also be required to transition to the new guide at such time as said guide is published, which may involve different or additional parameters than are published in this guide.

Examples Disclaimer

Examples provided throughout this guide are not intended to be all-inclusive. This pertains to example workflows, element-specific (field) examples, or message examples. Participants should not restrict coding to the examples used herein.

When developing, this guide should be used along with additional documentation referenced and applicable customary coding standards.

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13. Document Change Log

2026-08-21

Section Title	Change Description
N/A	N/A - Developer Portal - initial release