CY 2020 Prior Authorization File Record Layout

Required File Format = ASCII File - Tab Delimited
Do not include a header record
Filename extension should be ".TXT"

During the initial formulary submission period the file must include all Prior Authorization Group Descriptions. All records must have ADD for the Change_Type.
After the initial formulary submission period the file must include only changes.

Field Name	Field Type	Maximum Field Length	Field Description
PA_Change_Type	CHAR Always Required	3	Defines the type of change that is being made to the Prior Authorization File. During the initial formulary submission period, all rows must be "ADD." ADD = Add Group Description to file UPD = Change fields for an existing Group Description
Prior_Authorization_Group_Desc	CHAR Always Required	100	Description of the prior authorization group as it appears on the submitted formulary file. This field must exactly match the value entered in the Prior_Authorization_Group_Desc field on the Formulary File.
PA_Criteria_Change_Indicator	CHAR Always Required	1	If the PA criteria content did not change for this group description compared to CY 2019, please place a "0" in this field. If this group description is new, or the criteria content changed in any way (e.g. additional restrictions), please place a "1" in this field".
PA_Indication_Indicator	CHAR Always Required	1	This field must be populated with one of the values below. This field is used to describe the indications for which the PA will be approved. 1 = All FDA-approved Indications. This value cannot be used if the drug that requires PA is subject to Indication-Based Coverage (IBC). 2 = Some FDA-approved Indications Only. This value is to be submitted for drugs that are subject to IBC. 3 = All Medically-accepted Indications. Drugs for which the PA will be approved for all Part D medically-accepted indications (FDA-approved and compendia-supported) should be submitted with a 3. 4 = All FDA-approved Indications, Some Medically-accepted Indications. If the PA will only be approved for specific off-label uses, a 4 should be submitted. The additional off-label uses should be submitted in the subsequent Off-Label Uses field.

CY 2020 Prior Authorization File Record Layout

Field Name	Field Type	Maximum Field Length	Field Description
Off-label_Uses	CHAR Required only if a 4 is entered for PA_Indication_Indicator	3000	Enter the specific off-label uses for which the PA will be approved. This field must not contain any FDA-approved indications.
Exclusion_Criteria	CHAR If applicable	2000	Describe any criteria (e.g. comorbid diseases, laboratory data, etc.) that would result in the exclusion of coverage for an enrollee.
Required_Medical_Information	CHAR If applicable	2000	Enter laboratory, diagnostic, or other medical information required for initiation or continuation of the drug(s).
Age_Restrictions	CHAR If applicable	500	Enter age limitations or restrictions required for prior authorization approval.
Prescriber_Restrictions	CHAR If applicable	500	Description of prescriber attribute necessary for PA to be considered, e.g. specialist in a field or registered under a certain program.
Coverage_Duration	CHAR Always Required	100	Enter the duration for which the prior authorization will be approved.
Other_Criteria	CHAR If applicable	3000	Enter any other relevant criteria.

Please Note: Certain characters are restricted from HPMS. The submitted file will be rejected if any of the following characters are included in any field: 1) greater than sign (>), 2) less than sign (<), and 3) semi-colon (;).