CY 2026 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 2024, 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 indications for which the PA will be approved that are not otherwise excluded from Part D coverage. 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.

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Field Name	Field Type	Maximum Field Length	Field Description
Off-label Uses	CHAR Required only if a 4 is entered for PA Indication Indicator	3000	Enter the specific off-label uses for which the PA will be approved. This field must not contain any FDA-approved indications.
Exclusion Criteria	CHAR If applicable	2000	Describe any criteria (e.g. comorbid diseases, laboratory data, etc.) that would result in the exclusion of coverage for an enrollee.
Required Medical Information	CHAR If applicable	2000	Enter laboratory, diagnostic, or other medical information required for initiation or continuation of the drug(s).
Age Restrictions	CHAR If applicable	500	Enter age limitations or restrictions required for prior authorization approval.
Prescriber Restrictions	CHAR If applicable	500	Description of prescriber attribute necessary for PA to be considered, e.g. specialist in a field or registered under a certain program.
Coverage Duration	CHAR Always Required	100	Enter the duration for which the prior authorization will be approved.
Other Criteria	CHAR If applicable	3000	Enter any other relevant criteria.
Part B Prerequisite	CHAR If applicable	1	If the PA criteria requires a Part B drug before a Part D drug then please enter “1” in this field”, otherwise enter “0”. This field only applies to MAPD plans that are associated with this formulary ID.
Prerequisite Therapy Required	CHAR Always Required	1	If the PA criteria requires use of a prerequisite Part D drug then please enter “1” in this field, otherwise enter “0”.

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