Behavioral Health Utilization Management

Transcranial Magnetic Stimulation
rTMS Request Form

Instructions:

- This form is used to request an initial or continued TMS treatment.
- Please submit via email: FAXBHRepository@bridgespanhealth.com or Fax: 888-496-1540.
- Expedited request definition: *When the member or his/her provider believes that waiting for a decision within the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy.* Is this an Expedited Request? ☐ Yes ☐ No

Request for:

☐ Initial Prior Authorization

☐ Continuation of TMS. Existing Authorization number: _____

☐ TMS Device being used (i.e. NeuroStar, BrainSway, etc.): _____

NOTE: Accelerated protocols (more than one treatment session per day) for transcranial magnetic stimulation (TMS) of the brain is considered investigational for all indications. This includes the Stanford Accelerated Intelligent Neuromodulation Therapy (SAINT) protocol.

Member Information		
Member Name:	Member ID:	Date of Birth:

Provider Information			
Treating Provider Name & Credentials:		NPI #:	Tax ID#:
Agency Name:			
Service Address:			
Phone #:	Fax #:		
Contact Name:	Phone #:	Confidential voicemail ☐ Yes ☐ No	Fax #:

Prior Authorization Requirements:

☐ Current ICD-10 Diagnosis code and name: _____. Specifier: _____

- Has the customer ever been diagnosed with any other psychiatric conditions? ☐ Yes ☐ No
  If yes, please explain:

- Medical diagnoses or concerns? ☐ Yes ☐ No
  If yes, please explain:

☐ National Standardized Rating Scales being administered.

- Type: ☐ BDI. ☐ IDS-C. ☐ QIDS. ☐ MADRS. ☐ PHQ-9. ☐ HAM-D. Other: _____.
  Date of most current assessment: _____ Score: _____
- Type: ☐ BDI. ☐ IDS-C. ☐ QIDS. ☐ MADRS. ☐ PHQ-9. ☐ HAM-D. Other: _____.
  Date of previous assessment (if available): _____ Score: _____

☐ Trials of failed antidepressants. Please also include specific augmenting agents used in conjunction with antidepressants if applicable.

Name	Dosages	Start Date / End Date (MM/YY)	Response / side effects
Augmenting Agent ☐		____ / ____ to ____ / ____	
Augmenting Agent ☐		____ / ____ to ____ / ____	
Augmenting Agent ☐		____ / ____ to ____ / ____	
Augmenting Agent ☐		____ / ____ to ____ / ____	
Augmenting Agent ☐		____ / ____ to ____ / ____	
Augmenting Agent ☐		____ / ____ to ____ / ____	
Augmenting Agent ☐		____ / ____ to ____ / ____	

Additional notes about medications:

Prior Authorization Requirements (continued):

☐ Has member had history of response to TMS in previous episode: ☐ Yes ☐ No
If yes, please detail dates of treatment and response which should include pre and post treatment psychometric scores:

☐ Has the member been recommended for ECT? ☐ Yes ☐ No
If so, why is ECT not an appropriate treatment option?

Continuation Criteria

☐ TMS is demonstrating meaningful improvement as documented in current standardized rating scales

- Type: ☐ BDI. ☐ IDS-C. ☐ QIDS. ☐ MADRS. ☐ PHQ-9. ☐ HAM-D. Other: _____.
  Date of most current assessment: _____ Score: _____
- Type: ☐ BDI. ☐ IDS-C. ☐ QIDS. ☐ MADRS. ☐ PHQ-9. ☐ HAM-D. Other: _____.
  Date of previous assessment (if available): _____ Score: _____
- If no rating scales, please explain:

☐ There is reasonable expectation that continued TMS treatment will produce improvement:
Explain:

Request Details

Requested TMS Start date:

TMS Service	CPT Code	Units	Timeframe: 6 Months
Therapeutic Repetitive Transcranial Magnetic (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management.	90867		
Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment, subsequent delivery and management, per session.	90868		
Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment, subsequent motor threshold re-determination with delivery and management.	90869		

Provider name & credentials (print):	License information:
Provider signature:	Date: