ASURIS NORTHWEST HEALTH

Behavioral Health Utilization Management

Transcranial Magnetic Stimulation

rTMS Request Form

Please fully complete all sections. Once finished you may fax this form and supporting clinical documents via email: FAXBHRepository@asuris.com or Fax: (888) 496-1540.

Request for:

☐ Initial Prior Authorization

☐ Continuation of TMS. Existing Authorization number: _____

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

Expedited request ☐ No ☐ Yes

Defined as: 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.
If yes, explanation required:

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

Provider Information		
Treating Provider Name:	NPI:	TIN:
Service Address:		
Phone #:	Fax #:	
Contact person:	Phone #:	Fax #:

Agency Information ☐ **Same as Treating provider above**		
Agency name:		
Tax ID:	NPI:	
Address:		
Phone #:	Fax #:	
Contact person:	Phone #:	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: _____

☐ Member is over 18 years old or older: ☐ Yes ☐ No.
If no, please explain:

☐ Trials of failed antidepressant (minimum of 3). Please also include specific augmenting agents used in conjunction with antidepressants if applicable.

Name	Dosages	Start Date / End Date (MM/YY)	Response / side effects
		____ / ____ to ____ / ____	
		____ / ____ to ____ / ____	
		____ / ____ to ____ / ____	
		____ / ____ to ____ / ____	
		____ / ____ 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?

☐ Has member participated in psychotherapy known to be effective in treating Major Depressive Disorder, (i.e. CBT, DBT, ACT, etc.) for a duration of at least 6 weeks at 1x week without improvement? Detail below.

Provider name	Type of therapy	Frequency of therapy	Start Date / End Date (MM/YY)
			____ / ____ to ____ / ____
			____ / ____ to ____ / ____
			____ / ____ to ____ / ____
			____ / ____ to ____ / ____
			____ / ____ to ____ / ____

- If not, please outline the reasons psychotherapy, such as Cognitive Behavioral Therapy, cannot be done:

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 (print):	License information:
Provider signature:	Date: