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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@regence.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:
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Provider Information

Treating Provider Name & Credentials:		NPI #:	Tax ID#:
Agency Name:			
Service Address:			
Phone #:		Fax #:	
Contact Name:	Phone #:	Confidential voicemail <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/>		___ / ___ to ___ / ___	
Augmenting Agent <input type="checkbox"/>		___ / ___ to ___ / ___	
Augmenting Agent <input type="checkbox"/>		___ / ___ to ___ / ___	
Augmenting Agent <input type="checkbox"/>		___ / ___ to ___ / ___	
Augmenting Agent <input type="checkbox"/>		___ / ___ to ___ / ___	
Augmenting Agent <input type="checkbox"/>		___ / ___ to ___ / ___	
Augmenting Agent <input type="checkbox"/>		___ / ___ 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: