

# TMS Prior Authorization Request



**\*\*Chart Notes Required\*\***



Please fax to Behavioral Health: 503-574-8110 | Questions please call: 503-574-6400

NOTE: This form may only be used to request TMS.

Member Information		
Last Name:	First Name:	Phone:
Insurance ID #:	DOB:	
Address:	Date of Service:	Date Span Requested:
<b>Primary Care Physician (PCP):</b>		
<b>Requesting Provider:</b>		TIN#:
Address:		NPI#:
<b>Servicing Provider:</b>		TIN#:
Address:		NPI#:
<b>Servicing Facility:</b>		TIN#:
Address:		NPI#:
<b>Number of Units Requested:</b>		
ICD-10 Code(s):		CPT Code(s):
<b>In-Network Benefits: Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility.</b> <input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient   Date last seen _____		
Explanation Required:		
<b>**REQUIRED** Utilization Review Contact Information:</b>		
Name:	Phone #:	Fax#:

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## Transcranial Magnetic Stimulation Request Form

1. Has a confirmed diagnosis of severe major depressive disorder (MDD) single or recurrent episode, documented by an evidence-based depression rating scale:

Evidence based depression rating scale:

- GDS
- PHQ-9
- BDI
- HDRS
- HAM-D
- MADRS
- QIDS; or
- IDS-SR

AND

2. One of the following:

- Depression symptoms have not responded to **at least 3 antidepressant medication trials** from **at least two different agent classes**, at either the FDA-approved maximal dose or the maximally clinically-tolerated dose for a **duration of at least 6 weeks**; or
- The individual has a documented inability to tolerate the psychopharmacologic regimen described above.

AND

3. All of the following:

- Depression symptoms have not responded to a **6-week trial of an evidence-based psychotherapy** known to be effective in the treatment of MDD (unless contraindicated). Documentation must show that the trial did not significantly improve symptoms as measured by standardized rating scales; and
- TMS treatment is ordered by a board-certified psychiatrist; and
- The TMS treatment plan consists of up to 30 sessions (five days a week for six weeks) followed by six tapering sessions over three weeks (i.e. three treatments in first week, two treatments the next week, and one treatment the final week) for a maximum total of 36 sessions.
- If requesting subsequent TMS treatment*, previous TMS treatment(s) reduced clinical symptom severity, as evidenced by a 50% reduction on an evidence-based depression rating scale.

AND

4. Member has none of the following FDA contraindications for TMS:

- Actively suicidal
- History of substance use, eating disorders, or post-traumatic stress disorder whose symptoms are the primary contributors to the clinical presentation
- History of or risk factors for seizures during TMS therapy
- Individuals with vagus nerve stimulators or implants controlled by physiologic signals, including pacemakers, and implantable cardioverter defibrillators
- Individuals who are pregnant or nursing
- Individuals who have conductive, ferromagnetic, or other magnetic-sensitive metals implanted in their head within 30 cm of the treatment coil (e.g. metal plates, aneurysm coils, cochlear implants, ocular implants, deep brain stimulation devices, and stents)
- Individuals who have active or inactive implants (including device leads), including deep brain stimulators, cochlear implants, and vagus nerve stimulators
- Individuals with active psychoses or catatonia where a rapid clinical response is needed

**TREATMENT TYPE REQUESTED**

FDA-approved TMS device to be used for the following treatment:

- |                                |  |
|--------------------------------|--|
| <input type="checkbox"/> 90867 | THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — INITIAL, INCLUDING CORTICAL MAPPING, MOTOR THRESHOLD DETERMINATION, AND DELIVERY AND MANAGEMENT |
| <input type="checkbox"/> 90868 | THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — SUBSEQUENT DELIVERY AND MANAGEMENT, PER SESSION   |
| <input type="checkbox"/> 90869 | THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — SUBSEQUENT MOTOR THRESHOLD REDETERMINATION WITH DELIVERY AND MANAGEMENT                         |

**PREVIOUS MEDICATION TRIALS**

MEDICATION NAME	DOSAGE	DATES	COMMENTS

**PREVIOUS TREATMENT**

Description of previous TMS treatment within the past three years.

TMS Treatment Dates:	Response:	TMS Treatment Dates:	Response: