



REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION REQUEST FORM

Please Fax to Carelon at 1.800.370.1116

<input type="checkbox"/> In Network		<input type="checkbox"/> Out of Network	
Member Name:		DOB:	Gender:
Health Plan:		Policy:	
Provider Name:		Provider ID:	
Address:		Email:	
Direct Phone:		Fax:	
NPI:		Tax ID:	
Primary Contact:			

1. Has a confirmed diagnosis of severe major depressive disorder (MDD) single or recurrent episode:

<input type="checkbox"/> F32.2	Major Depressive Disorder, Single Episode, Severe (Without Psychotic Features)
<input type="checkbox"/> F33.2	Major Depressive Disorder, Recurrent Episode, Severe (Without Psychotic Features)

2. Does the Member have one or more of the following?

Resistance to treatment with psychopharmacologic agents as evidenced by a lack of clinically significant response to **one** trial of psychopharmacologic agents in the current depressive episode from at least **two** different agent classes. (Each agent in the treatment trial must have been administered at an adequate course of mono- or poly-drug therapy)

Inability to tolerate psychopharmacologic agents as evidenced by **two** trials of psychopharmacological agents from at least **two** different agent classes with distinct side effects

Currently receiving or is a candidate for and has declined electroconvulsive therapy (ECT) and TMS is considered a less invasive treatment option

3. Does the Member have a history of TMS attempts in the past?

Yes No

Dates: _____

If yes, was there a positive outcome?

Yes No

4. Has the Member had an adequate trial of evidence-based psychotherapy, without significant improvement within the past 5 years?

Yes No

Type of Psychotherapy: _____

Dates of evidence-based psychotherapy trial: _____

If the Member has not had an adequate trial of evidence-based psychotherapy, what is the reason? _____

5. Please fill in the Member's psychotropic medications taken within the past five years:

Medication Name	Dose	Response (Start and End Date)	Response (Atypical Agents)
			<input type="checkbox"/> Improved <input type="checkbox"/> Inadequate Response <input type="checkbox"/> Adverse Response <input type="checkbox"/> Intolerability <input type="checkbox"/> Non-Adherence <input type="checkbox"/> Other:
			<input type="checkbox"/> Improved <input type="checkbox"/> Inadequate Response <input type="checkbox"/> Adverse Response <input type="checkbox"/> Intolerability <input type="checkbox"/> Non-Adherence <input type="checkbox"/> Other:
			<input type="checkbox"/> Improved <input type="checkbox"/> Inadequate Response <input type="checkbox"/> Adverse Response <input type="checkbox"/> Intolerability <input type="checkbox"/> Non-Adherence <input type="checkbox"/> Other:

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			<input type="checkbox"/> Improved <input type="checkbox"/> Inadequate Response <input type="checkbox"/> Adverse Response <input type="checkbox"/> Intolerability <input type="checkbox"/> Non-Adherence <input type="checkbox"/> Other:

Please list any Augmenting Agents used: _____
 If no medications were used, are they contraindicated?
 Yes No

6. Were any of these meds used during this depressive episode?

Yes, list medications: _____
 No
 If yes, was improvement inadequate at adequate dose and duration?
 Yes, list dose and duration: _____
 No
 If yes, was the medication discontinued due to side effects?
 Yes, list side effects: _____
 No

7. Please check all that apply:

- Vagus Nerve Stimulator leads in the carotid sheath
- Other implanted stimulators controlled by or that use electrical or magnetic signals
- Conductive or ferromagnetic or other magnetic-sensitive metals implanted or embedded in head or neck within 11.81 inches (30 cm) of TMS coil placement other than dental fillings
- Acute or chronic psychotic symptoms or disorder
- Neurological conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system
- Seizure disorder or history of seizures

- Substance abuse at time of treatments
- Pregnant or nursing
- Current suicide plan or suicide attempt
- Non-adherence with previous depression treatments
- History of: Bipolar Disorder PTSD OCD Eating Disorder

- None of the above

8. What is the Member's most recent score on a validated self-report depression scale (PHQ-9, MADRS, BDI, HAM-D, GDS, etc.)

Rating scale used: _____ Score: _____
 Date completed: _____

9. Treatment Request

Code	Units	Start Date	End Date
90867: initial, including cortical mapping, motor threshold determination, and delivery management			
90868: subsequent delivery and management per session			
90869: subsequent motor threshold redetermination with delivery and management			