Carelon Behavioral Health
Repetitive Transcranial Magnetic Stimulation
Request Form

The population for which efficacy has been shown in the literature is that with treatment resistant depression. Generally speaking, in accordance with the literature, individuals would be considered to have treatment resistant depression if their current episode of depression was not responsive to two trials of medication in different classes for adequate duration and with treatment adherence. The decision to recommend the use of rTMS derives from a risk/benefit analysis for the specific member. This analysis considers the diagnosis of the member and the severity of the presenting illness, the member's treatment history, any potential risks, anticipated adverse side effects and the expected efficacy. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.

☐ In Network		☐ Out of Network	
Member Name:	DOB:	☐ Between 18 and 70 years of age	Gender:
Policy #:			
Date and Time of Request:	Treating Clinician/Facility:		Phone #:
If the treating clinician is not making this request, has the treating clinician been notified? ☐ Yes ☐ No			
Phone #:	NPI/TIN:		
Servicing Clinician/Facility:			
Phone #:	NPI/TIN:		

INITIAL TREATMENT

1. Has a confirmed diagnosis of severe major depressive disorder (MDD) single or recurrent episode:	
☐ F32.2	Major Depressive Disorder, Single Episode, Severe (Without Psychotic Features)
☐ F33.2	Major Depressive Disorder, Recurrent Episode, Severe (Without Psychotic Features)
Pre-treatment rating scale: GDS , ___PHQ-9 ,____ BDI ,____ HAM-D,____ MADRS, ____ QIDS, _____ or IDS-SR ____ .	
AND	
2.One or more of the following:	
☐ Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to two adequate trials of at least six weeks duration of psychopharmacologic agents in the current depressive episode from at least two different agent classes as documented by standardized rating scales that reliably measure depressive symptoms (GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS, or IDS-SR); or ☐ Inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents from at least two different agent classes (at least one of which is in the antidepressant class), with distinct side effects; or	

AND
☐ Diagnosis of MDD **not** made in the context of current or past history of manic, mixed or hypomanic episode.
☐ The member has **no active** (within the past year) substance use or eating disorders.
☐ Member has no recent history of obsessive compulsive disorder or post-traumatic stress disorder.
☐ Members has no recent history of a psychotic disorder, including schizoaffective disorder, bipolar disease, or major depression with psychotic features.
☐ The individual does not have any medical conditions or impairments that would prevent beneficial utilization of services.
☐ The individual **does not require** 24-hour medical/nursing monitoring or procedures provided in a hospital setting.
☐ Members does not have a suicide plan or has recently attempted suicide.
☐ Members does not have a neurological conditions that includes epilepsy, cerebrovascular disease, dementia, Parkinson's disease, multiple sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the CNS.
☐ No presence of vagus nerve stimulator leads in the carotid sheath.
AND
☐ The order for treatment is written by a physician who has examined the Member and reviewed the record, has experience in administering rTMS therapy and directly supervises the procedure (on site and immediately available).

TREATMENT TYPE REQUESTED			
FDA-approved TMS device to be used for the following treatment:			
☐ 90867	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — INITIAL, INCLUDING CORTICAL MAPPING, MOTOR THRESHOLD DETERMINATION, AND DELIVERY AND MANAGEMENT		
☐ 90868	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — SUBSEQUENT DELIVERY AND MANAGEMENT, PER SESSION		
☐ 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 and ETC treatment within the past three years.			
TMS Treatment Dates:	Response:	TMS Treatment Dates:	Response: