REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION REQUEST FORM

Please email to: outpatientteam@carelon.com

☐ In Network	☐ Out of Network	
Member Name:	DOB:	Gender:
Health Plan:		Member ID:
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:

☐ **F32.2**	Major Depressive Disorder, Single Episode, Severe (Without Psychotic Features)
☐ **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 a trial of psychopharmacological medications in the current depressive episode

☐ Inability to tolerate psychopharmacologic agents as evidenced by intolerable side effect(s) that are not expected to diminish or resolve with continued administration of the medication

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

3. Has the order for the TMS procedure been written by a Psychiatrist (MD or DO), who has examined the Member face-to-face and reviewed the record? (Please submit this documentation with the request form)

☐ Yes

☐ No, please explain: _____

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

☐ Yes ☐ No

Dates: _____

If yes, was there a positive outcome?

☐ Yes ☐ No ☐ PhQ-9 outcome score and date: _____

5. 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? _____

6. Please fill in the Member's psychotropic medications taken within the past five years: (attach additional information, if needed)

Medication Name	Dose	Start and End Date	Response
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-Adherence ☐ Other:
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-Adherence ☐ Other:

Medication Name	Dose	Start and End Date	Response
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-Adherence ☐ Other:
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-Adherence ☐ Other:
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-Adherence ☐ Other:
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-Adherence ☐ Other:

Please list any Augmenting Agents used: _____

If none were used, are they contraindicated?

☐ Yes Please Explain: _____ ☐ No

7. 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 ☐ No

If yes, was the medication discontinued due to side effects?

☐ Yes, list medications and side effects:

_____

_____

☐ No

8. Please check all that apply:

☐ The presence of a medically implanted magnetic-sensitive device or other implanted metal items including, but not limited to, a cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, vagus nerve stimulator (VNS), metal aneurysm clips/coils, staples, or stents, that are located less than or equal to 30 cm from the TMS magnetic coil

☐ 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 treatment

☐ 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

9. 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: _____

10. 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			