



Repetitive Transcranial Magnetic Stimulation (rTMS) Authorization Request Form

Securely email form to: outpatient_team@carelon.com

Please attach your intake assessment for TMS that documents the items below for: diagnosis (and associated symptoms), past trials of TMS, psychotherapy, psychopharmacology, and psychometric measurement.

<input type="checkbox"/> In Network		<input type="checkbox"/> Out of Network	
Member Name:		DOB:	Gender:
Health Plan:		Policy #:	
Date and Time of Request:			
Treating Clinician/Facility:			
If the treating clinician is not making this request, has the treating clinician been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Phone #:		NPI/TIN:	
Servicing Clinician/Facility:			
Phone #:		NPI/TIN:	

1. Diagnosis code and description:

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

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was there a positive outcome? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

<input type="checkbox"/> Yes <input type="checkbox"/> 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?

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

Medication Name	Dose	Dates of Use (Start and End Dates)	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 _____
			<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 _____

(continued)



Medication Name	Dose	Dates of Use (Start and End Dates)	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 _____
Please list any Augmenting Agents used: _____			
If no medications were used, are they contraindicated? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Were any of these meds used during this depressive episode?			
<input type="checkbox"/> Yes, list medications: _____ <input type="checkbox"/> No			
If yes, was improvement inadequate at adequate dose and duration?			
<input type="checkbox"/> Yes, list dose and duration: _____ <input type="checkbox"/> No			
If yes, was the medication discontinued due to side effects?			
<input type="checkbox"/> Yes, list side effects: _____ <input type="checkbox"/> No			
6. Please check all that apply:			
<input type="checkbox"/> Vagus Nerve Stimulator leads in the carotid sheath <input type="checkbox"/> Other implanted stimulators controlled by or that use electrical or magnetic signals <input type="checkbox"/> 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 <input type="checkbox"/> Acute or chronic psychotic disorder <input type="checkbox"/> Seizure disorder or history of seizure disorder <input type="checkbox"/> Substance abuse at time of treatments <input type="checkbox"/> Severe dementia <input type="checkbox"/> Non-adherence with previous depression treatments <input type="checkbox"/> None of the above			
7. Will the first treatment session include determining correct magnetic pulse strength and placement of the magnetic coil?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
8. What is the Member's most recent score on a validated self-report depression rating scale?			
Rating scale used:			
Score:			
Date completed:			