AmeriHealth Caritas Delaware

Transcranial Magnetic Stimulation (TMS) Request Form

Submit to: Behavioral Health Utilization Management
Fax: 1-877-234-4273
For assistance, please call: 1-855-301-5512

Please complete all sections of this form as thoroughly as possible. You may also include any additional clinical information pertinent to this authorization request.

☐ Initial treatment request	☐ Repeat course of treatment request	Date of request:

MEMBER INFORMATION

Member name:		Member ID number:
Date of birth:	Age:	Date of request:

PROVIDER INFORMATION

Requesting TMS clinician or facility:	
Address:	
Phone:	Fax:
☐ In network	
☐ Out of network (please provide clinical rationale below)	
NPI/TIN number:	
Outpatient provider information (if applicable and if different than above)	
Psychiatrist name:	Phone and fax numbers:
Therapist name:	Phone and fax numbers:

INITIAL TREATMENT REQUIREMENTS

☐ Member is 18 years or older **and**

☐ Member is not pregnant or breast feeding **and**

☐ Member has a confirmed diagnosis of severe major depressive disorder, single or recurrent **and**

☐ Resistance to prior treatment (select one or more of the following and provide documentation of unsuccessful trials):

- ☐ Inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents from at least two different agent classes, at or above the minimum effective dose and duration (at least one of which is in the antidepressant class), with distinct side effects, **or**
- ☐ Inability to tolerate psychopharmacologic agents as evidenced by three different antidepressants from at least two different agent classes, plus one with an augmenting agent. Augmentation therapy: when one or more drugs are not antidepressants, but are added to increase the effect of an antidepressant drug for adults with major depressive disorder (e.g., adding Buspirone), **or**
- ☐ Antidepressants contradicted (e.g., medical condition or serious adverse effects), **or**

☐ History of response to TMS in a previous depressive episode **or**

☐ Currently receiving electroconvulsive therapy (ECT) and TMS is considered a less invasive treatment option **or**

☐ Currently considering ECT and TMS may be considered as a less invasive treatment option

And

☐ Trial of evidence-based psychotherapy known to be effective in the treatment of major depressive disorder without significant improvement in symptoms and documented as such by standardized rating scales that reliably measure depressive symptoms (GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS, or IDS-SR)

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INITIAL TREATMENT REQUIREMENTS

And there are no known potential contraindications. Please mark if the member has any of the below:

☐ Seizure disorder or any history of seizures (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)

☐ Presence of acute or chronic psychotic symptoms

☐ Known nonadherence with previous treatment for depression

☐ Current or known substance use at time of referral or start of TMS treatments

☐ Neurological conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, history of repetitive or severe head trauma, or primary or secondary tumors in the central nervous system

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

REPEAT COURSE OF TREATMENT REQUIREMENTS

Date of initial treatment, if known:

☐ Member continues to meet the guidelines for initial course of treatment

and

☐ Member is experiencing continued depressive symptoms

and

☐ Member has responded to prior treatments, as evidenced by a greater than 50 percent improvement in standardized rating scale measurements for depressive symptoms (note rating below):

GDS: ____ PHQ-9: ____ BDI: ____ HAM-D: ____ MADRS: ____ QIDS: ____ IDS-SR: ____

TREATMENT PLAN REQUIREMENTS for both initial and retreatment (choose the requested number of units)

☐ 36 standard repetitive treatments	☐ 44 deep treatments
One time per day, five days per week for six weeks	One time per day, five days per week for four weeks
Six final sessions tapered over three weeks	24 final sessions with one time per day, two days per week for 12 weeks

Provider or requestor signature:
Date: