Transcranial Magnetic Stimulation Request Form

Instructions: Please complete all sections to assist with timely review. Fax completed form to **844-442-8012**.

Care manager name:	Reference number:

Member name:	ID number:
Member DOB:	Current age:
Member address:	Member contact phone:

Requesting Transcranial Magnetic Stimulation (TMS) office information

Physician's name:	Phone number:
Provider NPI:	Provider Tax ID:
Office manager name:	Phone number:
Office address:	

Outpatient practitioner's information (if different from TMS physician)

Psychiatrist's name:	Phone number:
Therapist's name:	Phone number:

Please check all that apply:

☐ Request is for TMS of the brain.
☐ Individual is an adult.
☐ Individual has a confirmed diagnosis of severe major depressive disorder (MDD) single or recurrent episode.
☐ TMS is requested for treatment of a disorder other than severe MDD. If checked, please specify disorder:
☐ Individual has failed to significantly respond to prior treatment.
☐ Individual has had four trials of psychopharmacologic agents in the current depressive episode.
☐ Treatment trials have included at least two different agent classes, at or above the minimum effective dose and duration.
☐ Treatment trials have included at least two evidence-based augmentation therapies. • Augmentation therapy: A drug regimen consisting of one or more drugs, which are not antidepressant drugs, added to increase the efficacy of an antidepressant drug in an adult with MDD. An example would be to add Pindolol to Flouxetine.

☐ Individual is unable to tolerate psychopharmacologic agents as evidenced by four trials with distinct side effects.

☐ Individual has a history of responses to TMS in a previous depressive episode.

☐ If individual has a history of TMS, there was a greater than 50% improvements in the individual's symptoms as evidenced by a standard rating scale that reliably measures depressive symptoms. If checked, please mark the rating scale used to document the individual's symptoms:

- ☐ Beck Depression Inventory (BDI)
- ☐ Geriatric Depression Scale (GDS)
- ☐ Hamilton Depression Rating Scale (HAMD)
- ☐ Inventory of Depressive Symptomology-Systems Review (IDS-SR)
- ☐ Montgomery-Asberg Depression Rating Scale (MADRS)
- ☐ Personal Health Questionnaire Rating Scale (PHQ-9)
- ☐ Quick Inventory of Depressive Symptomology (QUDS)

☐ Individual is currently receiving electroconvulsive therapy (ECT), and TMS is considered less invasive.

☐ Individual is a candidate for and has declined ECT, and TMS is considered a less invasive treatment option.

☐ Individual has had a trial of an evidence-based psychotherapy known to be effective in the treatment of MDD.
If checked, please mark which of the following apply:

- ☐ Psychotherapy trial had an adequate frequency and duration.
- ☐ Psychotherapy trial **did not** result in a significant improvement in depressive symptoms.

☐ Individual's depressive symptoms were documented by a standardized rating scale that reliably measures depressive symptoms. If checked, please mark the rating scale used to document their symptoms:

- ☐ Beck Depression Inventory
- ☐ Geriatric Depression Scale
- ☐ Hamilton Depression Rating Scale
- ☐ Inventory of Depressive Symptomology-Systems Review
- ☐ Montgomery-Asberg Depression Rating Scale
- ☐ Personal Health Questionnaire Depression Scale
- ☐ Quick Inventory of Depressive Symptomology

☐ TMS will be administered by a U.S. Food and Drug Administration (FDA) approved device for the treatment of MDD in a safe and effective manner according to the manufacturer's manual.

If checked, specify device:

☐ The treatment course will not exceed the following specified stimulation parameters: five days a week for six weeks (total of 30 sessions), followed by a three-week taper of treatments; three TMS treatments the first week, two TMS treatments the following week, and one TMS treatment in the last week.

☐ Individual has a seizure disorder or history of seizure (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrenct).

☐ Individual has acute or chronic psychotic symptoms or disorders (such as schizophrenia, schizophreniform, or schizoaffective disorder) in the current depressive episode.

☐ Individual has a neurological condition(s) that includes epilepsy, cerebrovascular disease, dementia,

increased intracranial pressure, having a history of repetitive or severe head trauma, or primary or secondary tumors in the central nervous system (CNS).
☐ Individual has an implanted magnetic-sensitive medical device located less than or equal to 30 centimeters from the TMS magnetic coil or other implanted metal items. **Note:** Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS. If checked, please mark the following if it applies to the individual: ☐ A cochlear implant ☐ Implanted cardioverter defibrillator (ICD) ☐ Pacemaker ☐ Vagus nerve simulator (VNS) ☐ Metal aneurysm clips or coils, staples, or stents ☐ Other device not listed:
List all current ICD-10 diagnoses:

Specific focus of treatment for this member

For the current episode of depression, list the medication trials:

Medication antidepressants	Date of trial	Maximum dose	Duration of trial	Outcome, side-effects, other relevant info

If assessed for ECT, why is ECT not being utilized?
List psychotherapy trials and outcomes (indicate model of psychotherapy used):
What standardized rating scale of depression was used? What were the results (score/range):
The FDA and manufacturer's user manual specify stimulation parameters of five days per week for six weeks (total of 30 sessions), followed by a three-week taper; three treatments the first week, two treatments the following week, and one treatment the last week. Is the proposed treatment consistent with these parameters? ☐ Yes ☐ No What is the number of units per week?
Is this a request for maintenance TMS treatment? ☐ Yes ☐ No If so, what is the date of the most recent treatment received?

You may also submit any additional information relevant to your request for authorization, such as a copy of the TMS intake evaluation or any full psychiatric evaluation done within a three-month period from the requested start of treatment.

By signing below, you are confirming that the information you have provided on this form is accurate and complete based on your clinical assessment of the patient and the records available to you as of the date of this request.

Print MD name:	Date:
Signature:	