**REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION REQUEST FORM**

**Please type an “x” or type content as needed in the gray boxes only.**

***NOTE: Text boxes will not expand beyond the space available***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | | | In Network | | | | | | | | | | | | | |  | | | 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? ☐ Yes ☐ No | | | | | | | | | | | | | | | | | | | | | | | |  | | 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) | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | F33.3 | | | | | Major Depressive Disorder, Recurrent Episode, Severe (Without Psychotic Features) | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Pre-treatment rating scale: | | | | | | | | | |  | GDS |  | PHQ-9 |  | | BDI | |  | | | HAM-D | | | |  | | MADRS | | | |  | QIDS |  | 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 **four 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | History of response to rTMS in a previous depressive episode; or | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Currently receiving electroconvulsive therapy (ECT); or | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Currently considering ECT; rTMS may be considered as a less invasive treatment option | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *\*****Note for reference:*** *Remission is typically defined by the following measurement scores: Beck Depression Scale (BDI) score of <9, Hamilton Depression Rating Scale (HAM-D) score of <8 on the HAM-D-17 and <11 on the HAM-D-24, Montgomery-Asberg Depression Rating Scale (MADRS) score of*  *< 10, Patient Health Questionnaire (PHQ-9) score of < 5* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***AND*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **3. A trial of an *evidence-based psychotherapy* known to be effective in the treatment of MDD of an adequate frequency and duration**  **without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms (GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS or IDS-SR).** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***AND*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **4. An order written by a psychiatrist (MD or DO) who has examined the patient and reviewed the record. The physician will have**  **experience in administering TMS therapy. The treatment shall be given under direct supervision of this physician.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Potential Contraindications (please select all applicable contraindications the patient has from the list 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 or disorders in the current depressive episode | | | | | | | | | | | | | | | | | |
|  | 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 or coils, staples, or stents | | | | | | | | | | | | | | | | | |
| ***Note:*** *Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS.* | | | | | | | | | | | | | | | | | | |
|  | Prior failed trial of an adequate course of treatment with ECT or vagus nerve stimulation (VNS) for Major Depressive Disorder | | | | | | | | | | | | | | | | | |
| The patient is currently: | | | |  | pregnant or | | |  | | nursing | | | | | | | | |
|  | | The patient has a current suicide plan or recent suicide attempt | | | | | | | | | | | | | | | | |
| Current active history of (“x” for those that apply): | | | | | | | | |  | | Eating Disorder | | |  | | Psychotic Disorder, including Schizoaffective Disorder | | |
|  | Bipolar Disorder | | | | | | | | | | | | | | | | | |
| History of (“x” for those that apply): | | | | | |  | Substance Abuse | | | | |  | Obsessive Compulsive Disorder | | | |  | Post-Traumatic Stress Disorder |
| **RETREATMENT** | | | | | | | | | | | | | | | | | | |
|  | **1. Patient met the guidelines for initial treatment AND meets guidelines currently.** | | | | | | | | | | | | | | | | | |
| ***AND*** | | | | | | | | | | | | | | | | | | |
|  | **2. Subsequently developed relapse of depressive symptoms** | | | | | | | | | | | | | | | | | |
| ***AND*** | | | | | | | | | | | | | | | | | | |
|  | **3. Responded to prior treatments as evidenced by a greater than 50% improvement in standard rating scale measurements for depressive symptoms (e.g., GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS or IDS-SR scores).** | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Post-treatment rating scale: |  | GDS |  | PHQ-9 |  | BDI |  | HAM-D |  | MADRS |  | QIDS |  | or IDS-SR | | | | | | | | | | | | | | | | | | | |
| Dates of initial treatment, if known: | | | | | |  | | | | | | | | | | | | |
| **TREATMENT TYPE(S) 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 | | | | | | | | | | | |  | | | |

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