



Transcranial Magnetic Stimulation Request

Instructions: Please complete all sections to assist with timely review. Fax completed form to 866-834-7469 (toll-free).

UM # (if received): _____

Member Name: _____

ID #: _____

Member Date of Birth: _____

Current Age: _____

Member Address: _____

Member Contact Number: _____

Requesting TMS Office Information

Physician Name: _____

Phone #: _____

TMS Coordinator Name: _____

Phone #: _____

Fax #: _____

Email Address: _____

Address: _____

Provider NPI #: _____

Tax ID #: _____

Please check all that apply...

Request is for transcranial magnetic stimulation (TMS) of the brain Yes No

Request is for Theta burst stimulation (TBS) Yes No

Treatment parameters use either high frequency (HF-rTMS) or low frequency (LF-rTMS) rTMS, with frequencies of less than 1 Hz to 20 Hz (prescribed treatment protocol). Yes No

Has the patient previously received TMS in the past 30 days? Yes No

If checked "Yes" please provide the authorization number for the previous treatment if available. _____

- Is this request for maintenance TMS treatment Yes No
(Maintenance treatment is treatment that continues after remission has been achieved. Full remission refers to no significant signs or symptoms of major depression for at least 2 months)
- Is this request for Continuation Treatment Yes No
(Continuation of acute treatment is a course that begins after the acute/index course, lasts up to 6 months, and is designed to prevent worsening of symptoms and continue treatment for a depressive episode that has not yet remitted).
- Member responded to initial treatment Yes No
(Defined as): 1) Previous Response to TMS as shown by 50% reduction in severity relative to pretreatment major depressive disorder symptoms as reported by a standardized rating scale AND 2) recurrence of depression based on clinically meaningful worsening of symptoms relative to best TMS response as reported by a standardized rating scale.
- Please provide standardized rating scales used to measure depressive symptoms
Initial Score _____ Final Score _____
DATE _____ DATE _____

Request is for Transcranial Magnetic Stimulation (TMS) of the brain for an acute episode of major depressive disorder, SEVERE?

Yes No

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(If Yes – please mark all of the below that apply to the individual)

- Individual is 18 years or older? Yes No
- Individual has a confirmed diagnosis of SEVERE treatment resistant major depressive disorder (MDD - single or recurrent episode) Yes No
- Individual has had an inadequate response to pharmacotherapy despite the following:
 Antidepressant trials with 2 or more classes with:
 - Adequate duration and dosage;
 - Documented adherence; OR
 - Inability to tolerate treatment of 2 trials of agents with documented side effects. Yes No

TMS will be administered by a U.S. Food and Drug Administration (FDA) approved device Yes No

If checked, specify device: _____

The standard treatment course will not exceed 5 days a week for 6 weeks (total of 30 sessions), followed by a taper.

Yes No

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).

Yes No

If checked, please mark the following if it applies to the individual

- Individual has a cochlear implant
- Individual has an implanted cardioverter defibrillator (ICD)
- Individual has a Pacemaker
- Individual has a vagus nerve stimulator (VNS)
- Individual has a deep brain stimulator
- Individual has metal aneurysm clips or coils, staples, or stents.
- Other device not listed above: _____

LIST ALL CURRENT DIAGNOSES (ICD-10): _____

CPT Code	Requested Start Date	Number of Sessions/Units
90867 - Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management		
90868 - Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session		

Specific focus of treatment for this member

- **For the current or previous episode of depression, list the medication trials:**

Medication – Antidepressants	Date of trial	Maximum dose	Duration of Trial	Outcome, side-effects, adherence, other relevant info



You may also submit any additional information relevant to your request for authorization if you feel it is needed, such as a copy of the TMS intake evaluation or any full psychiatric evaluation done within a 3 month period from the requested start of treatment. That does not however substitute for completion of this form which is a requirement.

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 **MD SIGNATURE** **Date:**