TMS Prior Authorization Request

Chart Notes Required

Please fax to Behavioral Health: **503-574-8110** | Questions please call: 503-488-2800-855-722-8205

Note: This form may only be used to request TMS.

Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	Phone:
Address:	Date of Service:	Date Span Requested:
Primary Care Physician (PCP):		
Requesting Provider:		TIN#:
Address:		NPI#:
Servicing Provider:		TIN#:
Address:		NPI#:
Do you have an active DMAP #: ☐ Yes ☐ No ☐In Progress	All DMAP Administrative Rules, guidelines and applications to become an enrolled DMAP provider can be found at www.oregon.gov/OHA/healthplan.	
Servicing Clinic/Facility:		TIN#:
Address:		NPI#:
Do you have an active DMAP #: ☐ Yes ☐ No ☐In Progress	All DMAP Administrative Rules, guidelines and applications to become an enrolled DMAP provider can be found at www.oregon.gov/OHA/healthplan.	

ICD-10 Code(s):	CPT Code(s) and Units per CPT Code being requested:

Expedite- defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. **Request must include supporting documentation to substantiate an expedited review.**
Explanation Required:

Non-Contracted Providers will need to request an Out of Network Exception. In the event a provider is unwilling to accept DMAP rates additional documentation supporting the enhanced rate will need to be provided. Please indicate your willingness to accept DMAP rates. ☐ Yes ☐ No
In-Network Benefits: **Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility.** ☐ New Patient ☐ Established Patient | Date last seen _____
Explanation Required:

REQUIRED **Utilization Review Contact Information:**

Name:	Phone #:	Fax#:

Transcranial Magnetic Stimulation Request Form

1. Has a confirmed diagnosis of severe major depressive disorder (MDD) single or recurrent episode, documented by an evidence-based depression rating scale:
Evidence based depression rating scale: ☐ GDS ☐ PHQ-9 ☐ BDI ☐ HDRS ☐ HAM-D ☐ MADRS ☐ QIDS; or ☐ IDS-SR
AND
2.One of the following:
☐ Depression symptoms have not responded to **at least 3 antidepressant medication trials** from **at least two different agent classes**, at either the FDA-approved maximal dose or the maximally clinically-tolerated dose for a **duration of at least 6 weeks**; or ☐ The individual has a documented inability to tolerate the psychopharmacologic regimen described above.
AND
3. All of the following:
☐ Depression symptoms have not responded to a **6-week trial of an evidence-based psychotherapy** known to be effective in the treatment of MDD (unless contraindicated). Documentation must show that the trial did not significantly improve symptoms as measured by standardized rating scales; and ☐ TMS treatment is ordered by a board-certified psychiatrist; and ☐ The TMS treatment plan consists of up to 30 sessions (five days a week for six weeks) followed by six tapering sessions over three weeks (i.e. three treatments in first week, two treatments the next week, and one treatment the final week) for a maximum total of 36 sessions. ☐ *If requesting <u>subsequent</u> TMS treatment*, previous TMS treatment(s) reduced clinical symptom severity, as evidenced by a 50% reduction on an evidence-based depression rating scale.
AND
4. Member has none of the following FDA contraindications for TMS:
☐ Actively suicidal
☐ History of substance use, eating disorders, or post-traumatic stress disorder whose symptoms are the primary contributors to the clinical presentation
☐ History of or risk factors for seizures during TMS therapy
☐ Individuals with vagus nerve stimulators or implants controlled by physiologic signals, including pacemakers, and implantable cardioverter defibrillators
☐ Individuals who are pregnant or nursing
☐ Individuals who have conductive, ferromagnetic, or other magnetic-sensitive metals implanted in their head within 30 cm of the treatment coil (e.g. metal plates, aneurysm coils, cochlear implants, ocular implants, deep brain stimulation devices, and stents)
☐ Individuals who have active or inactive implants (including device leads), including deep brain stimulators, cochlear implants, and vagus nerve stimulators
☐ Individuals with active psychoses or catatonia where a rapid clinical response is needed

TREATMENT TYPE 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

PREVIOUS MEDICATION TRIALS

MEDICATION NAME	DOSAGE	DATES	COMMENTS

PREVIOUS TREATMENT

Description of previous TMS treatment within the past three years.			
TMS Treatment Dates:	Response:	TMS Treatment Dates:	Response: