TRANSCRANIAL MAGNETIC STIMULATION (TMS)
INITIAL AUTHORIZATION REQUEST
COMPLETE ALL FIELDS
SIGN AND FAX TO: 855-454-8155

Date: ____________________

Patient's Name: ____________________________________ **Age**: ____ **DOB:** _________________

Pt's Insurance ID #: ___________________ **Which Device will be used?** ______________________

Is this Device FDA approved for treatment of Major Depressive Disorder? (Y/N) ______

TMS coordinator Name & Phone #: ____

Single Case Agreement (SCA) contact name, (if applicable): ______________________________

SCA contact Phone #: __________________________ **SCA Fax #:** ______________________

Ordering Psychiatrist Name: ____ **Credentials:** _____

Phone #: ___________________________________ **Fax #:** ________________________________

Tax ID # ***(for TMS services, if different than the general TAX ID #)*****:** ________________________________

Provider Address ***(Service location)*****:** ____ **State:** ____

Provider Address 2: ____ **State:** _____

Has the ordering psychiatrist examined the patient and reviewed the record? (Y/N) ____
Does the ordering psychiatrist have experience in administering TMS therapy? (Y/N) ____
Will the treatment be given under the direct supervision of this psychiatrist? (Y/N) ____

Primary Diagnosis: _____________________________ **Code:** ___________________

Additional Diagnosis: ___________________________ **Code:** ___________________

Medical Conditions (list all here): ____

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Treatment History [Required]:

Prior TMS for Major Depressive Disorder? Yes___ No___ If yes, answer the following questions:

DIAGNOSTIC TOOL USED	DATE ADMINTERED PRE TMS	INITIAL SCORE PRE TMS	DATE ADMINISTERED POST TMS	SUBSEQUENT SCORE POST TMS

Check "Yes" Or "No" To The Following (All Questions Must Be Answered):	Yes	No
1. Does the patient have a suicide plan or has recently attempted suicide?		
2. Does the patient have a psychiatric emergency where a rapid clinical response is needed, such as marked physical deterioration or catatonia?		
3. Does the patient have a lifetime history of any of the following conditions:		
a) Obsessive Compulsive Disorder?		
b) Psychotic Disorder, Including Schizoaffective Disorder?		
c) Bipolar Disorder		
d) Major Depressive Disorder with Psychotic Features		
4. Does the Patient have a history of any of the following conditions in the past year:		
a) Substance abuse?		
b) Post-traumatic Stress Disorder?		
c) Eating Disorder		

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5. Has the member been diagnosed with any other neurologic conditions? (Seizures, cerebrovascular disease, dementia, movement disorders, increased intracranial pressure, a history of repetitive or severe head trauma, primary/secondary tumors in the central nervous system)		
6. Is the patient pregnant or nursing?		
7. Has the member's risk of seizure been assessed & considered safe according to the following?		
a) *Is the patient concurrently taking medications such as tricyclic antidepressants, neuroleptic/antipsychotic medications (e.g., clozapine), or other drugs that are known to lower the threshold for seizures (e.g., cocaine and other CNS stimulants)?*		
b) Does the patient have a secondary condition that may significantly alter electrolyte balance or lower seizure threshold (e.g., epilepsy, stroke, dementia, head trauma)?		
8. Does the patient have metal in or around the head?		
9. Does the patient have a Vagus Nerve Stimulator or Implants controlled by physiologic signals? (Examples could include pacemakers , implantable cardioverter defibrillators)		
10. Has the patient failed to receive clinical benefit from Electroconvulsive Therapy for MDD?		
11. Will TMS be used as a booster/repeat treatment for the current episode?		
12. Will TMS be used as a maintenance therapy for the current episode?		

Diagnostic Tool Data to Support Diagnosis of Major Depression [at least one is required]:

DIAGNOSTIC TOOL USED	DATE ADMINISTERED	SCORE	USED TO MONITOR TMS? Yes/No	
Beck Depression Inventory II (BDI II)				
Patient Health Questionnaire 9 (PHQ 9)				
Montgomery Asberg Depression Scale				
Hamilton Depression Rating Scale				

Medication Trials in the Current Episode of Major Depressive Disorder

Antidepressant	Dose	Duration At The Therapeutic Dosing	Side Effects		Trial Successful	
			Yes & Details	No	Yes	No

Trials of evidence-based psychotherapy known to be effective in the treatment of MDD:

Type of Therapy	Dates	Duration	Frequency	Outcome	Rating Scales used

Specify Algorithm Used: STAR*D TMAP

Lifetime Anti-Depressant Trials with Intolerable Side Effects

Antidepressant	Dose	Dates	Duration (Weeks)	Side Effects		Trial Successful	
				Yes & Details	No	Yes	No

Signature: ________________________________ **Date:** ____________________