LHV

LOWER HUDSON VALLEY E.A.P

Mental Health & Substance Use Disorder Services

Transcranial Magnetic Stimulation Request

Patient name:	Member name:
ID #:	Paient date of birth:
Current age:	Patient address:
Member contact number:	
Requesting transcranial magnetic stimulation (TMS) office information	
Physician name:	Phone #:
Office manager name:	Phone #:
Email address:	Fax #:
Address:	
Provider NPI #:	Tax ID #:
Outpatient practitioners' information (if different from or in addition to the TMS physician)	
Psychiatrist name:	Phone #:
Therapist name:	Phone #:

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, specify disorder: _____

☐ Individual has failed to significantly respond to prior pharmacotherapy:

- If checked, please mark which applies:
  - ☐ Individual has had trials from two or more classes of medications with inadequate response despite adequate duration and dosage and documented adherence.
  - ☐ Individual has an inability to tolerate pharmacotherapy as evidenced by four trials of agents with documented side effects.

☐ Individual has a history of positive response to TMS in a previous depressive episode and has had a recurrence of symptoms.

- If checked, there was greater than 50% improvement in the individual's depressive symptoms as evidenced by a standard rating scale that reliably measures depressive symptoms.
  ☐ Yes
  ☐ No
- If checked Yes, 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 Symptomatology-Systems Review (IDS-SR)
  - ☐ Montgomery-Åsberg Depression Rating Scale (MADRS)
  - ☐ Patient Health Questionnaire Depression Scale (PHQ-9)
  - ☐ Quick Inventory of Depressive Symptomatology (QIDS)

☐ 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 user manual.

- If checked, specify device: _____

The treatment course will not exceed the following specified stimulation parameters:

☐ The standard treatment course of five days a week for six weeks (total of 30 sessions), followed by a three week taper of three TMS treatments in one week, two TMS treatments the next week, and one TMS treatment in the last week

☐ The SAINT treatment method – 10 sessions a day over five consecutive days

TMS will be administered under which paradigm?

☐ Theta burst (three min) ☐ Short Protocol (19 min) ☐ Original Protocol (37.5 min)

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

☐ 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, 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 stimulator (VNS)
  - ☐ Deep brain stimulator
  - ☐ Metal aneurysm clips or coils, staples, or stents
  - ☐ Other device not listed above: _____

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		
90869 — Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management		
Other, specify:		
Other, specify:		

List all current diagnoses (ICD-10):

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

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 of three treatments in one week, two treatments the next week, and one treatment the last week. Is the proposed treatment consistent with these parameters?	
• The number of units per week:	

Is this a request for maintenance TMS treatment?	
• If so, what is the date of the most recent treatment received?	
Is there a recurrence of symptoms after a previous positive response to TMS?	
• If so, what was the initial % of symptom reduction and what rating scale of depression was used?	
• What will be the duration and frequency of sessions during this phase of treatment?	

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 and sign: _____ /_____

Date: _____