Repetitive Transcranial Magnetic Stimulation (rTMS) Authorization Request Form

Securely email form to: outpatient_team@carelon.com

Please attach your intake assessment for TMS that documents the items below for: diagnosis (and associated symptoms), past trials of TMS, psychotherapy, psychopharmacology, and psychometric measurement.

☐ 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		
Phone #:	NPI/TIN:	
Servicing Clinician/Facility:		
Phone #:	NPI/TIN:	

1. Diagnosis code and description:

2. Does the Member have a history of TMS attempts in the past?

☐ Yes
☐ No

If yes, was there a positive outcome?
☐ Yes
☐ No

3. Has the Member had an adequate trial of evidence-based psychotherapy, without significant improvement within the past 5 years?

☐ Yes
☐ No

Type of psychotherapy:

Dates of evidence-based psychotherapy trial:

If the Member has not had an adequate trial of evidence-based psychotherapy, what is the reason?

4. Please fill in the Member's psychotropic medications taken within the past five years:

Medication Name	Dose	Dates of Use (Start and End Dates)	Response Atypical Agents
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-adherence ☐ Other ____________
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-adherence ☐ Other ____________
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-adherence ☐ Other ____________
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-adherence ☐ Other ____________
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-adherence ☐ Other ____________

(continued)

Medication Name	Dose	Dates of Use (Start and End Dates)	Response Atypical Agents
			☐ Improved ☐ Inadequate Response ☐ Adverse Response ☐ Intolerability ☐ Non-adherence ☐ Other _____

Please list any Augmenting Agents used: _____

If no medications were used, are they contraindicated?

☐ Yes
☐ No

5. Were any of these meds used during this depressive episode?

☐ Yes, list medications:_____
☐ No

If yes, was improvement inadequate at adequate dose and duration?

☐ Yes, list dose and duration:_____
☐ No

If yes, was the medication discontinued due to side effects?

☐ Yes, list side effects:_____
☐ No

6. Please check all that apply:

☐ Vagus Nerve Stimulator leads in the carotid sheath
☐ Other implanted stimulators controlled by or that use electrical or magnetic signals
☐ Conducive or ferromagnetic or other magnetic-sensitive metals implanted or embedded in head or neck within 11.81 inches (30 cm) of TMS coil placement other than dental fillings
☐ Acute or chronic psychotic disorder
☐ Seizure disorder or history of seizure disorder
☐ Substance abuse at time of treatments
☐ Severe dementia
☐ Non-adherence with previous depression treatments
☐ None of the above

7. Will the first treatment session include determining correct magnetic pulse strength and placement of the magnetic coil?

☐ Yes
☐ No

8. What is the Member's most recent score on a validated self-report depression rating scale?

Rating scale used:

Score:

Date completed: