REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (rTMS) REQUEST FORM - CALIFORNIA

(Commercial Specific)

Please send securely to:
Email: BH_FaxCypressOPUM@carelon.com
Fax: 562-246-3655

☐ In Network	☐ Out of Network	
Member Name:	DOB:	Gender:
Age (Note: Prior authorization is not required for Commercial membership *under* the age of 18 yrs):		
Health Plan:	Policy:	
Rendering Provider Name:	Provider ID:	
NPI:	Tax ID:	
Provider Group/Clinic:		
Service Address:		
Email:	Fax:	
Primary Contact:	Phone:	

1. Protocol to be used:

☐ iTBS to left DLPFC
☐ High frequency rTMS to left DLPFC
☐ Low frequency rTMS to right DLPFC
☐ Bilateral for Late-Life Depression (If used as first line TMS for under 65 years of age, please provide rationale):

_____
_____
_____
_____

☐ Bilateral rTMS to DLPFC (R low frequency then L high frequency)
☐ Accelerated iTBS to left DLPFC
☐ Bilateral TBS to DLPFC (R continuous TBS then L intermittent TBS)

2. Has a confirmed diagnosis of major depressive disorder (MDD):

☐ Yes ☐ No	Diagnosis/CPT Code: Click or tap here to enter text.

3. Presents with one or more of the following?

Did the member have an adequate trial of evidence-based therapy? ☐ Yes ☐ No

If yes, type of psychotherapy received: (Example: Cognitive-behavior Therapy (CBT), Interpersonal Therapy (IPT), Behavioral Activation (BA))
Click or tap here to enter text.

Dates: Click or tap here to enter text.

Check the applicable items below:

☐ Lack of clinically significant response to an adequate course of psychotherapy.

If psychotherapy was not tried, is it considered to be contraindicated?
☐Yes ☐No

If contraindicated, please explain why: Click or tap here to enter text.

If not contraindicated, please explain why psychotherapy was not tried: Click or tap here to enter text.

☐ Lack of clinically significant response to an adequate course of treatment with a single psychopharmacologic agent for the treatment of depression.

☐ For treatment of severe major depression with psychotic features, a combination of an antidepressant and an antipsychotic was tried and did not result in an adequate response.

Does the patient continue to have active psychotic symptoms?

☐Yes ☐No

If pharmacology was not tried, are medications contraindicated?
☐Yes ☐No

If contraindicated, please explain why: Click or tap here to enter text.

If not contraindicated, please explain why pharmacology was not tried: Click or tap here to enter text.

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

☐ Yes ☐ No
Dates: Click or tap here to enter text.

If yes, was there a positive outcome as noted by a 40-50% score reduction on rating scale(s)? ☐ Yes ☐ No

5. Please fill in the Member's history of psychotropic medications:

Medication Name	Is Medication Current?	Maximum Dosage Tried	Dates Taken	Response
	☐ Yes ☐ No			☐ Improved ☐ Inadequate Response at Adequate Dose and Duration ☐ Adverse Response ☐ Side-effects ☐ Non-Adherence ☐ Augmenting agent

	☐ Yes ☐ No			☐ Improved ☐ Inadequate Response at Adequate Dose and Duration ☐ Adverse Response ☐ Side-effects ☐ Non-Adherence ☐ Augmenting agent
	☐ Yes ☐ No			☐ Improved ☐ Inadequate Response at Adequate Dose and Duration ☐ Adverse Response ☐ Side-effects ☐ Non-Adherence ☐ Augmenting agent
	☐ Yes ☐ No			☐ Improved ☐ Inadequate Response at Adequate Dose and Duration ☐ Adverse Response ☐ Side-effects ☐ Non-Adherence ☐ Augmenting agent
	☐ Yes ☐ No			☐ Improved ☐ Inadequate Response at Adequate Dose and Duration ☐ Adverse Response ☐ Side-effects ☐ Non-Adherence ☐ Augmenting agent
	☐ Yes ☐ No			☐ Improved ☐ Inadequate Response at Adequate Dose and Duration ☐ Adverse Response ☐ Side-effects ☐ Non-Adherence ☐ Augmenting agent

6. Considerations for Current Medication(s):

Will medication(s) remain the same during this course of TMS treatment?

☐Yes

☐No, list planned changes: Click or tap here to enter text.

Is the member currently taking benzodiazepine(s)?

☐Yes

If not listed in the table above, list dosage, frequency, and for how long: Click or tap here to enter text.

If yes, will they be tapered down or off during TMS treatment? Click or tap here to enter text.

☐No

7. What is the Member's most recent score on a validated self-report depression scale (PHQ-9, MADRS, BDI, HAM-D, GDS, etc.)?

Rating scale used: Click or tap here to enter text.

Date completed: Click or tap here to enter text.

Score: Click or tap here to enter text.

8. Treatment Request

Code	Units	Start Date	End Date
90867: initial, including cortical mapping, motor threshold determination, and delivery management			
90868: subsequent delivery and management per session			
90869: subsequent motor threshold redetermination with delivery and management			