Behavioral Health Repetitive Transcranial Magnetic Stimulation (rTMS) Request Form

Send fax form and supplemental documents to **717.346.5800**. Any questions, contact the Capital Blue Cross Preauthorization department **800.471.2242**.

Repetitive Transcranial Stimulation, or rTMS, has been shown to be effective for individuals who have treatment resistant depression. Treatment resistant depression often occurs in individuals currently experiencing depression, and who have not responded to at least two trials of medication. To qualify for rTMS, the medication must be in different medication classes, and the Capital member must adhere to the prescription's dosage requirements for the required duration. The provider recommending rTMS should base their decision on a risk/benefit analysis, balancing the diagnosis of a member, the severity of the presenting illness, the member's treatment history, potential risks to the member, the anticipated adverse side effects and the expected efficacy of the rTMS treatment for the member. Facilities and individual practitioners that prescribe rTMS have specific licensure and credentialing requirements; these are found in our provider manual/credentialing information.

Member information			
Member name			
Member ID		Date of birth	
Plan type			

Requesting provider information					
Provider name		NPI			
Address					
City		State		ZIP Code	
Contact name		Contact phone		Fax	

Servicing (treating) provider/facility **(If different from requesting provider listed above.)**					
Name		NPI			
Address					
City		State		ZIP Code	
Contact name		Contact phone		Fax	

Initial treatment
1. Has a confirmed diagnosis of severe major depressive disorder (MDD) single or recurrent episode: ☐ F32.2 – Major Depressive Disorder, Single Episode, Severe (Without Psychotic Features) ☐ F33.2 – Major Depressive Disorder, Recurrent Episode, Severe (Without Psychotic Features)
Pre-treatment rating scale: GDS ____, PHQ-9 ____, BDI ____, HAM-D ____, MADRS ____, QIDS ____, or IDS-SR ____. Date: _____

AND

2. One or more of the following:

☐ Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to two adequate trials of a least six weeks duration of psychopharmacologic agents in the current depressive episode from at least two different agent classes as documented by standardized rating scales that reliably measure depressive symptoms (GDS< PHQ-9, BDI, HAM_D, MADRS, QIDS, or IDS-SR); or

☐ Inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents from at least two different agent classes (at least one of which is in the antidepressant class), with distinct side effects.

AND

☐ Diagnosis of MDD **not** made in the context of current or history of manic, mixed, or hypomanic episode.

☐ The member has **no active** (within the past year) substance use or eating disorders.

☐ Member has no recent history of obsessive-compulsive disorder or post-traumatic stress disorder.

☐ Members has no recent history of a psychotic disorder, including schizoaffective disorder, bipolar disease, or major depression with psychotic features.

☐ The individual **does not require** 24-hour medical/nursing monitoring or procedures provided in a hospital setting.

☐ Member does not have a suicide plan or has recently attempted suicide.

☐ Member does not have a neurological condition that includes epilepsy, cerebrovascular disease, dementia, Parkinson's disease, multiple sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumor in the CNS.

☐ No presence of vagus nerve stimulator leads in the carotid sheath.

AND

☐ The order for treatment is written by a physician who has examined the Member and reviewed the record, has experience in administering rTMS therapy and directly supervises the procedure (on site and immediately available).

Treatment type requested			
FDA-approved TMS device to be used for the following treatment:			
		Number of units	**Start date**
☐ 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 and ECT treatment within the past three years.			
TMS treatment dates	**Response**	**ECT treatment dates**	**Response**

Capital clinical vignette
Criteria for medical necessity

☐ Resistance to treatment with pharmacological agents as evidenced by lack of response to four trials, from two agent classes.

or

☐ Resistance to treatment with pharmacologic agents as evidenced by lack of response to three trials, from two agent classes, and 1 augmenting agent.

or

☐ Inability to tolerate pharmacological agents as evidenced by trials of four such agents with distinct side effects.

or

☐ History of positive response to TMS in a previous round no < six months.

or

☐ Currently receiving ECT and TMS is considered a less invasive treatment.

Member name			
Member ID		**Date of birth**	

Current symptoms/mental status:

History of depression:

Therapy history:

Support system: