

Transcranial Magnetic Stimulation – TMS (including Repetitive TMS – rTMS) **AUTHORIZATION REQUEST**

*Submission of this form is only a request for services and does not guarantee approval. Incomplete forms may delay processing.
All providers, including Blue Cross Blue Shield of North Carolina (Blue Cross NC) providers, must provide their NPI# below.*

Date of Request	Patient Name	Patient Blue Cross NC ID Number	Patient Date of Birth

Requesting/Ordering Provider Information		Servicing Provider or Facility Location (for services to be performed outside of the provider's office)	
Provider Name		Servicing Provider	
NPI #		Facility Name	
Street, Bldg., Suite #		Servicing provider or Facility NPI#	
City/State/Zip code		Street, Bldg., Suite #	
Phone #		City/State/Zip code	
Fax #		Fax #	

Current DX – Please list ICD-10 codes(s), Diagnosis Name, Specifier (if applicable)

ICD-10 Code		DX Name		Specifier	
ICD-10 Code		DX Name		Specifier	
ICD-10 Code		DX Name		Specifier	

Authorization Request type (check One)	<input type="checkbox"/> Initial Request <input type="checkbox"/> Extension Request and previous reference/authorization # _____	Place of Service	<input type="checkbox"/> Office <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Inpatient Hospital
Requested TMS start date		Expected End Date	
CPT (Procedure Code)	<input type="checkbox"/> 90867 and # of Treatments _____ <input type="checkbox"/> 90868 and # of Treatments _____ <input type="checkbox"/> 90869 and # of Treatments _____ <input type="checkbox"/> Other _____	Has patient had TMS previously?	<input type="checkbox"/> Yes (and last dates): _____ <input type="checkbox"/> No
Past Frequency	(X per week or per month) _____	Is this a transition after inpatient TMS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If TMS previously administered (include details of dates of TMS and prior response)	Date: _____ Response: _____ Date: _____ Response: _____ Date: _____ Response: _____ Date: _____ Response: _____		

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Current Medications (dosages, duration)																																																																				
Current psychological therapy (type, frequency, duration)																																																																				
Treatment History	<p>Please provide details related to prior treatment history and response, including service category type (i.e. Inpatient, Residential Treatment, Partial Hospitalization, Intensive Outpatient Program, regular outpatient therapy).</p> <p><input type="checkbox"/> Please indicate if including as a separate attachment if necessary.</p> <table border="1"> <thead> <tr> <th>Service Category</th> <th>Dates</th> <th>Reason for Admission</th> <th>Response</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Please list psychopharmacologic agents that member has been prescribed and trialed</p> <table border="1"> <thead> <tr> <th>Drug</th> <th>Drug Class</th> <th>Length of Trial/Start and End Dates</th> <th>Max Dose</th> <th>Member Response</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Service Category	Dates	Reason for Admission	Response																													Drug	Drug Class	Length of Trial/Start and End Dates	Max Dose	Member Response																														
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Clinical Assessment (please check all that apply)	<p><input type="checkbox"/> The order for treatment (or retreatment) is written by a psychiatrist (MD or DO) who has examined the patient and reviewed the record. The physician will have experience in administering TMS Therapy.</p> <p><input type="checkbox"/> Confirmed diagnosis of severe major depressive disorder (single or recurrent) documented by standardized rating scales that reliably measure depressive symptoms (Please include as separate attachment)</p> <p><input type="checkbox"/> Is rTMS ordered for continued treatment of the brain as maintenance therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																																																																			

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Please provide rationale for why electroconvulsive therapy would not be clinically superior to rTMS for this patient (i.e. in cases with psychosis, acute suicidal risk, catatonia or life-threatening inanition rTMS should NOT be used):

Failure of a trial of a psychotherapy known to be effective in the treatment of major depressive disorder of an adequate frequency and duration, without significant improvement in depressive symptoms, as documented by standardized rating scales that reliably measure depressive symptoms.

Please List Dates and Response to Treatment

Dates of Treatment	Response to Treatment

Does the patient exhibit any current signs or past history of? (please check all that apply)

- Seizure Disorder or any history of seizure with increased risk of future seizure
- Presence of acute or chronic psychotic symptoms or disorders (i.e. schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode
- Neurologic conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system
- Presence of an implanted magnetic-sensitive medical device located within 30 centimeters from the TMS magnetic coil or other implanted items including but not limited to a cochlear implant, implanted cardioverter defibrillator, pacemakers, vagus nerve stimulator or metal aneurysm clips or coils, staples, or stents.

For EXTENSION of acute or maintenance treatment ONLY:

- Response to acute treatment:
- Goal/Rational of continued acute treatment:

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Maintenance Treatment Rationale:

By signing below, I certify that I have appropriate authority to request prior authorization for the item(s) indicated on this request and that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in the patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Finally, I certify that I've completed this form in its entirety and I understand that an incomplete form may delay processing.

Signature: _____ Date: _____

Fax this form with required documentation to Blue Cross NC Medicare Advantage Behavioral Health @ 336-794-1556. For questions please call Care Management at 1-888-296-9790.

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