PEHP Health & Benefits

PRIOR AUTHORIZATION for TRANSCRANIAL MAGNETIC STIMULATION (TMS) and CRANIAL ELECTRICAL STIMULATION (CES)

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490. ***Please be aware that only contracted providers and locations will be authorized and that the provider (MD, DO, NP, PA, etc.) trained in transcranial magnetic stimulation must be on the premises during treatment.***

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Ordering Provider:	Provider NPI #:	Provider Tax ID #:	Provider Address:

Is *Ordering* Provider a Psychiatrist?	Contact Person:	Contact Person Phone:	Contact Person Facsimile:	Contact Person Email:
☐ No ☐ Yes		( )	( )	

Rendering Provider:	Provider NPI #:	Provider Tax ID #:	Provider Address:

Is *Rendering* Provider a Psychiatrist?	Contact Person:	Contact Person Phone:	Contact Person Facsimile:	Contact Person Email:
☐ No ☐ Yes		( )	( )	

Facility:	Facility NPI #:	Facility Tax ID #:	Facility Address:

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Dates of Service:	Place of Service: *Please check.*
☐Auth Extension ☐Pre-Auth ☐Retro Auth ☐Urgent	From: To:	☐Ambulatory Surgical Center ☐Inpatient ☐Office ☐Outpatient

Primary Diagnosis/ICD-10 Code:	Secondary Diagnosis/ICD-10 Code:

Service (s) Requested: ***Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.***

Service: ______________________________CPT/HCPCS Code: ______________ # of Sessions being Requested: __________
Please check type of service: ☐ Initial TMS Request ☐ Additional Treatment Session(s) ☐ Maintenance Therapy ☐ Re-Treatment ☐ Tapering Session(s)

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Please check type of service: ☐ Initial TMS Request ☐ Additional Treatment Session(s) ☐ Maintenance Therapy ☐ Re-Treatment ☐ Tapering Session(s)

A. Type of Cranial Stimulation Being Requested: ***Please check all that apply.***

1. ☐ Accelerated TMS
2. ☐ Bilateral TMS
3. ☐ Cerebral Electrotherapy
4. ☐ Cranial Electrical Stimulation/CES
5. ☐ Craniofacial Electrostimulation
6. ☐ Deep TMS/dTMS
7. ☐ Electric Cerebral Stimulation
8. ☐ Electrotherapeutic Sleep
9. ☐ Electrosleep
10. ☐ High Dose TMS
11. ☐ Maintenance rTMS
12. ☐ Navigated TMS/nTMS
13. ☐ Repetitive TMS/rTMS
14. ☐ Superficial/Surface TMS
15. ☐ Theta Burst TMS
16. ☐ Transcranial Direct Current Stimulation/tDCS
17. ☐ Transcerebral Electrotherapy
18. ☐ Transcranial Electrotherapy
19. ☐ Other ______________

B. Name of Machine to be used for TMS: ***Please check.***

1. ☐ BrainsWay
2. ☐ CloudTMS (CloudNeuro)
3. ☐ MagStim Horizon
4. ☐ Magventure
5. ☐ NeuroStar®
6. ☐ Other ______________

C. Type of TMS Machine Coil being used: ***Please check.***

1. ☐ Butterfly
2. ☐ Figure-8
3. ☐ H-1
4. ☐ Other ______________

(Please check service being requested.) QUESTION	YES	NO	COMMENTS/NOTES
D. ☐ **Repetitive Transcranial Magnetic Stimulation (rTMS):** 1. Is device an FDA cleared device and being utilized in accordance with the FDA labeled indications?	☐	☐	***Completion of Sections A., B., and C. required.***
2. Will rTMS be administered as superficial/surface cortical TMS using CloudTMS (CloudNeuro), MagStim Horizon, NeuroStar® TMS therapy device, or Magventure (standard protocol only), which utilize the Figure-8 or Butterfly coil, and utilized in accordance with the FDA labeled indications?	☐	☐	
3. Will rTMS be administered as deep TMS using BrainsWay device, which uses the H-1 coil, and utilized in accordance with the FDA labeled indications?	☐	☐	
4. Will the attending psychiatrist be delegating daily treatment sessions to a qualified member of the clinical staff who have been trained in transcranial magnetic stimulation and who will be evaluating the patient daily?	☐	☐	
5. Is the patient 18 years or older?	☐	☐	
6. Has a psychiatrist confirmed the diagnosis of severe major depressive disorder (single or recurrent episode), documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Scale/Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], PHQ-9, Quick Inventory of Depressive Symptomatology [QIDS], etc.)?	☐	☐	***Please include copy of any psychological testing results.***

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:

(Please check service being requested.) QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
7. Has the patient experienced inadequate response during the **current depressive episode* occurring within the past five (5) years? **Current depressive episode begins with the most recent onset of acute symptoms.*	☐	☐	
7. a. Has the patient experienced inadequate response to at least two antidepressants from at least two (2) different **classes* having different mechanisms of action at the maximally tolerated labeled dose, each used for at least eight (8) weeks? **Classes: aminoketones; monoamine oxidase inhibitors (MAOIs); noradrenaline and specific serotoninergic antidepressants (NASSAs); selective serotonin reuptake inhibitors (SSRIs); serotonin-norepinephrine reuptake inhibitors (SNRIs); tricyclic antidepressants (TCAs).*	☐	☐	
7. b. Has the patient experienced inadequate response to **augmentation therapy* along with the primary antidepressant used for at least eight (8) weeks? **Augmentation therapy is defined as any of the following: two antidepressants with different mechanisms of action used concomitantly, an antidepressant and a second-generation antipsychotic used concomitantly, or an antidepressant and lithium used concomitantly.*	☐	☐	
8. Is there documentation that the patient failed a trial of a psychotherapy known to be effective in the treatment of major depressive disorder without significant improvement in depressive symptoms for at least four (4) months and was provided by a licensed behavioral health provider?	☐	☐	
9. Does the patient have any of the following contraindications to rTMS? ***Please check all that apply.*** ☐ Abuse of substances with known abuse potential during the last 90 days. ☐ Member is suicidal. ☐ Presence of a metal implant in or around the head (*e.g., aneurysm coil or clip, metal plate, ocular implant, stent*). ☐ Presence of an implanted device (*e.g., cardiac pacemaker or defibrillator, cochlear implant, deep brain stimulator, implantable infusion pump, spinal cord stimulator, Vagus Nerve Stimulator*). ☐ Neurological condition (*e.g., cerebrovascular disease, dementia, history of repetitive or severe head trauma, increased intracranial pressure or primary or secondary tumors in the central nervous system*). ☐ Severe cardiovascular disease and hasn't been evaluated and cleared for rTMS treatment by a cardiologist.	☐	☐	
10. Is TMS being requested for any of the following conditions? ***Please check all that apply.*** ☐ Alzheimer's Disease ☐ Amyotrophic Lateral Sclerosis ☐ Anxiety Disorder ☐ Auditory Verbal Hallucinations ☐ Bipolar Disorder ☐ Blepharospasm ☐ Bulimia Nervosa ☐ Chronic Pain, including Neuropathic Pain ☐ Communication and swallowing disorders ☐ Complex Regional Pain Syndrome ☐ Differential diagnosis of Alzheimer Disease from Frontotemporal Dementia ☐ Epilepsy, including Status Epilepticus ☐ Congenital hemiparesis ☐ Dyslexia ☐ Dystonia ☐ Fibromyalgia ☐ Functional neurological disorder ☐ Insomnia ☐ Levodopa-Induced Dyskinesia ☐ Migraines ☐ Mood Disorder ☐ Multiple Sclerosis ☐ Neurodevelopmental disorders ☐ Neuropathic Pain associated with Spinal Cord Injury ☐ Obsessive-Compulsive Disorder ☐ Panic Disorder ☐ Parkinson's Disease ☐ Phantom Pain associated with Spinal Cord Injury ☐ Post-Traumatic Stress Disorder ☐ Restless Leg Syndrome ☐ Schizophrenia ☐ Smell and Taste Dysfunction ☐ Spasticity ☐ Stroke Treatment ☐ Substance Addiction ☐ Tourette Syndrome ☐ Tinnitus ☐ Traumatic Brain Injury ☐ Visual Hallucinations after Stroke	☐	☐	
E. ☐ <u>Re-Treatment Repetitive Transcranial Magnetic Stimulation (rTMS)</u>: 1. Has the patient relapsed following TMS despite other treatment approaches (e.g., psychotherapy, pharmacotherapy) as appropriate?	☐	☐	***Completion of Sections A., B., C., and D. required.***
2. Did the patient have at least 50% reduction in depressive symptoms with previous TMS, as documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Scale [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], PHQ-9, etc.)?	☐	☐	
2. a. If "Yes", was this improvement maintained for at least two (2) months after the TMS treatment course?	☐	☐	
3. Has it been at least 60 days since the completion of the prior TMS course?	☐	☐	
F. ☐ <u>Navigated Transcranial Magnetic Stimulation (nTMS)</u>: 1. Is nTMS being requested for motor function mapping and/or treatment planning for a neurological disease or disorder (*e.g., Amyotrophic Lateral Sclerosis, epilepsy, and resection of brain tumors*)?	☐	☐	
Additional Comments:			

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.