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 (must be on the premise during treatment) and locations will be authorized.***

Section I: PATIENT INFORMATION

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

Section II: PROVIDER INFORMATION

Date Requested:	**Ordering Provider/Physician:**	**Ordering Provider/Physician NPI #:**
Ordering Provider/Physician Contact Person:	**Ordering Provider/Physician Contact Person Phone:** ( )	**Ordering Provider/Physician Contact Person Facsimile:** ( )
Rendering Provider/Physician:	**Rendering Provider/Physician NPI #:**	**Rendering Provider/Physician Tax ID #:**
Rendering Provider/Physician Contact Person:	**Rendering Provider/Physician Contact Person Phone:** ( )	**Rendering Provider/Physician Contact Person Facsimile:** ( )

Facility Name:	**Facility Address:**	**Facility NPI #:**	**Facility Tax ID #:**

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		☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

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

Service (s) Requested: *Please list all requested services/CPT codes regardless of pre-authorization requirement.*

Procedure/Service: ______________________________ CPT/HCPCS Code: ______________ # of Sessions being Requested: __________

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

Procedure/Service: ______________________________ CPT/HCPCS Code: ______________ # of Sessions being Requested: __________

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

Procedure/Service: ______________________________ CPT/HCPCS Code: ______________ # of Sessions being Requested: __________

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

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

1. ☐ Cerebral Electrotherapy
2. ☐ Cranial Electrical Stimulation (CES)
3. ☐ Craniofacial Electrostimulation
4. ☐ *Deep* Transcranial Magnetic Stimulation
5. ☐ Electric Cerebral Stimulation
6. ☐ Electrotherapeutic Sleep
7. ☐ Electrosleep
8. ☐ *Maintenance* Transcranial Magnetic Stimulation
9. ☐ *Navigated* Transcranial Magnetic Stimulation (nTMS)
10. ☐ *Repetitive* Transcranial Magnetic Stimulation (rTMS)
11. ☐ *Superficial / Surface* Transcranial Magnetic Stimulation
12. ☐ Transcranial Direct Current Stimulation (tDCS)
13. ☐ Transcerebral Electrotherapy
14. ☐ Transcranial Electrotherapy

B. Name of Machine to be used for TMS *(e.g. NeuroStar®)*:	**C. Type of Coil the Machine being used for TMS:** ***Please check.***
	1. ☐ Butterfly 2. ☐ Figure-8 3. ☐ H-1 4. ☐ Other (*please specify*): ______________

(Please check service being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
D. ☐ Repetitive Transcranial Magnetic Stimulation (rTMS): 1. Is device FDA approved and being utilized in accordance with the FDA labeled indications?	☐	☐	***Name/Brand of device being used required.***
2. Will rTMS be administered as superficial/surface cortical TMS using NeuroStar® TMS therapy device, MagVita /MagPro, (MagVenture), or CloudTMS (CloudNeuro), 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. Is the patient 21 years or older?	☐	☐	
5. Is the requesting physician a psychiatrist?	☐	☐	
6. Does the patient have a confirmed 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], Patient Health Questionnaire 9 [PHQ-9], 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. Is there documentation that the patient failed 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 (e.g., Beck Depression Scale/Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], Patient Health Questionnaire 9 [PHQ-9], etc.)?	☐	☐	***Please include copy of any psychological testing results.***
8. Is the patient currently receiving or is a candidate for electroconvulsive therapy (ECT) and rTMS is considered a less invasive equally effective treatment option (e.g., in cases with psychosis, acute suicidal risk, catatonia or life-threatening inanition rTMS should not be utilized)?	☐	☐	
9. Has the patient failed 4 trials of antidepressant agents, including 2 different agent classes, during the current depressive episode?	☐	☐	
10. Is the member unable to tolerate a therapeutic dose of medications as evidenced by documentation of 4 trials of psychopharmacologic agents with distinct side effects?	☐	☐	
11. Does the patient have any of the following contraindications to rTMS? ***Please check all that apply.*** ☐ High alcohol or illicit drug consumption. ☐ Member is suicidal. ☐ Presence of a metal implant in or around the head, such as, an aneurysm coil or clip, metal plate, ocular implant, stent. ☐ Presence of an implanted device, such as, cardiac pacemaker or defibrillator, cochlear implant, deep brain stimulator, implantable infusion pump, spinal cord stimulator, Vagus Nerve Stimulator, etc. ☐ Neurological condition, such as, cerebrovascular disease, dementia, history of repetitive or severe head trauma increased intracranial pressure or primary or secondary tumors in the central nervous system. ☐ Seizure Disorder/Epilepsy. ☐ Severe cardiovascular disease and hasn't been evaluated and cleared for rTMS treatment by a cardiologist.	☐	☐	
12. Is TMS being requested for any of the following conditions? ***Please check all that apply.*** ☐ Alzheimer's Disease ☐ Amyotrophic Lateral Sclerosis (aka Lou Gehrig's Disease) ☐ Anxiety Disorder ☐ Auditory Verbal Hallucinations ☐ Autism ☐ Bipolar Disorder ☐ Blepharospasm ☐ Bulimia Nervosa ☐ Chronic Pain, including Neuropathic Pain (e.g., Orofacial Pain, and Central Post-Stroke Pain) ☐ Communication and swallowing disorders (e.g., aphasia, including post-stroke aphasia, dysarthria, dysphagia, including post-stroke dysphagia, and linguistic deficits) ☐ Complex Regional Pain Syndrome (CRPS) ☐ Differential diagnosis of Alzheimer Disease from Frontotemporal Dementia ☐ Epilepsy, including Status Epilepticus ☐ Congenital hemiparesis ☐ Dystonia ☐ Fibromyalgia ☐ Levodopa-Induced Dyskinesia ☐ Migraines ☐ Mood Disorder ☐ Multiple Sclerosis ☐ Neurodevelopmental disorders (e.g., attention deficit/hyperactivity disorder, autism spectrum disorder, and tic 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 (e.g., Phantosmia and Phantageusia) ☐ Spasticity ☐ Stroke Treatment (e.g., Motor Impairment and Post-Stroke Hemiplegia) ☐ Substance Addiction ☐ Tourette Syndrome ☐ Tinnitus ☐ Traumatic Brain Injury (TBI) ☐ Visual Hallucinations after Stroke (Cerebrovascular Accident/CVA)	☐	☐	
E. ☐ **<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, such as, Amyotrophic Lateral Sclerosis, epilepsy, and resection of brain tumors?	☐	☐	

Additional Comments:

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