REQUEST FORM
FOR REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION

Fax: 1-877-502-1044

Member Name:	DOB:	Gender:
Date and Time of Request:		
Treating Clinician/Facility:		
If the treating clinician is not making this request, has the treating clinician been notified? ☐ Yes ☐ No		
Telephone #:	NPI/TIN:	
Servicing Clinician/Facility:		
Telephone #:	NPI/TIN:	

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 _____

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 at least six weeks duration of psychopharmacologic agents at the minimum dose 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

☐ A previous trial of rTMS has been effective as defined by improvement on one of the following rating scales: symptoms (GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS, or IDS-SR)

***Note for reference:** Remission is typically defined by the following measurement scores: Beck Depression Scale (BDI) score of <9, Hamilton Depression Rating Scale (HAM-D) score of <8 on the HAM-D-17 and <11 on the HAM-D-24, Montgomery-Asberg Depression Rating Scale (MADRS) score of < 10, Patient Health Questionnaire (PHQ-9) score of < 5.

QIDS; Quick Inventory of Depressive Symptomatology
IDS-SR: Inventory of Depressive Symptomatology Self-Rated Version

TMS: Transcranial Magnetic Stimulation

rTMS: Repetitive Transcranial Magnetic Stimulation

AND

□ **3. An order written by a psychiatrist (MD or DO) who has examined the patient and reviewed the record. The psychiatrist must have experience in administering TMS therapy. The treatment shall be given under direct supervision of this psychiatrist. .**

Contraindications (please select all applicable contraindications the patient has from the list below):

☐ Seizure disorder or any history of seizures (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)

☐ Presence of acute or chronic psychotic symptoms or disorders in the current depressive episode

☐ Neurological conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, history of repetitive or severe head trauma, or primary or secondary tumors in the central nervous system

☐Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 cm from the TMS magnetic coil or other implanted metal items including but not limited to a cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, vagus nerve stimulation (VNS), or metal aneurysm clips or coils, staples, or stents.

Note: *Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS.*

ECT: Electroconvulsive Therapy

The patient is currently: ☐ pregnant or ☐ nursing

□ The patient has a current suicide plan or recent suicide attempt

Current active history of (check those that apply):

☐ Eating Disorder

☐ Psychotic Disorder, including Schizoaffective Disorder

☐ Bipolar Disorder

History within the last year:

☐ Substance Abuse

☐Obsessive Compulsive Disorder

☐ Post-Traumatic Stress Disorder

RETREATMENT

□ **1. Patient met the guidelines for initial treatment AND meets guidelines currently**

AND

☐ **2. Subsequently developed relapse of depressive symptoms**

AND

□ **3. Responded to prior treatments as evidenced by a greater than 50% improvement in standard rating scale measurements for depressive symptoms (e.g., GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS or IDS-SR scores).**

Post-treatment rating scale: GDS_____, PHQ-9_____, BDI_____, HAM-D_____, MADRS_____, QIDS_____, or IDS-SR _____

Dates of initial treatment, if known:

TREATMENT TYPE(S) REQUESTED

FDA-approved TMS device to be used for the following treatment:

☐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, PERSESSION		
☐90869	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — SUBSEQUENT MOTOR THRESHOLD REDETERMINATION WITH DELIVERY AND MANAGEMENT		