coordinated care™

SUBMIT TO
Coordinated Care
Utilization Management Department
1145 Broadway, Suite 300
Tacoma, WA 98402
PHONE: 1.877.644.4613
FAX: 1.833.286.1086

TRANSCRANIAL MAGNETIC STIMULATION (TMS) INITIAL AUTHORIZATION REQUEST (ages 18-64)

Please complete all fields

*Date _____

Member's Name: _____ Age: _____ DOB: _____

Member's ID: _____ Which device will be used? _____

Is this device FDA approved for treatment of major depressive disorder? (Y/N): _____

TMS Coordinator Name & Phone #: _____

Ordering Psychiatrists Name: _____ Credentials: _____

Phone #: _____ Fax #: _____

Tax ID # (for TMS services, if different than the general Tax ID #): _____

Provider Address (service location): _____ State: _____

Provider Address 2: _____ State: _____

Has the ordering psychiatrist examined the patient and reviewed the record? (Y/N): _____

Does the ordering psychiatrist have experience in administering TMS therapy? (Y/N): _____

Will the treatment be given under the direct supervision of this psychiatrist? (Y/N): _____

Primary Diagnosis: _____ Code: _____

Additional Diagnosis: _____ Code: _____

Medical Conditions (list all here): _____

_____

Treatment History (required):

Prior TMS for major depressive disorder? ☐ No ☐ Yes If yes, answer the following questions:

DIAGNOSTIC TOOL USED	DATE ADMINISTERED PRE TMS	INITIAL SCORE PRE TMS	DATE ADMINISTERED POST TMS	SUBSEQUENT SCORE POST TMS

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	CHECK "YES" OR "NO" TO THE FOLLOWING (ALL QUESTIONS MUST BE ANSWERED):	Yes	No
1.	Does the patient have a suicide plan or has recently attempted suicide?	☐	☐
2.	Does the patient have a psychiatric emergency where a rapid clinical response is needed,such as marked physical deterioration or catatonia?	☐	☐
3.	Does the patient have a lifetime history of any of the following conditions:	☐	☐
	a) Obsessive Compulsive Disorder?	☐	☐
	b) Psychotic Disorder, Including Schizoaffective Disorder?	☐	☐
	c) Bipolar Disorder	☐	☐
	d) Major Depressive Disorder with Psychotic Features	☐	☐
4	Does the Patient have a history of any of the following conditions in the past year:	☐	☐
	a) Substance abuse?	☐	☐
	b) Post-traumatic Stress Disorder?	☐	☐
	c) Eating Disorder	☐	☐
5.	Has the member been diagnosed with any other neurologic conditions? (Seizures, cerebrovascular disease, dementia, movement disorders, increased intracranial pressure, ahistory of repetitive or severe head trauma, primary/secondary tumors in the central nervoussystem)	☐	☐
6.	Is the patient pregnant or nursing?	☐	☐
7.	Has the member's risk of seizure been assessed & considered safe according to the following?	☐	☐
	a) Is the patient concurrently taking medications such as tricyclic antidepressants, neuroleptic/antipsychotic medications (e.g., clozapine), or other drugs that are known to lower theth-reshold for seizures (e.g., cocaine and other CNS stimulants)?	☐	☐
	b) Does the patient have a secondary condition that may significantly alter electrolyte balance orlower seizure threshold (e.g., epilepsy, stroke, dementia, head trauma)?	☐	☐
8.	Does the patient have metal in or around the head or neck?	☐	☐
9.	Does the patient have a Vagus Nerve Stimulator or Implants controlled by physiologic signals? (Examples could include pacemakers , implantable cardioverter defibrillators)	☐	☐
10.	Has the patient failed to receive clinical benefit from Electroconvulsive Therapy for MDD?	☐	☐
11.	Will TMS be used as a booster/repeat treatment for the current episode?	☐	☐
12.	Will TMS be used as a maintenance therapy for the current episode?	☐	☐

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Diagnostic Tool Data to Support Diagnosis of Major Depression (at least one is required):

DIAGNOSTIC TOOL USED	USED DATE ADMINISTERED	SCORE	USED TO MONITOR TMS? (YES/NO)
Beck Depression Inventory II (BDIII)			
Patient Health Questionnaire 9 (PHQ9)			
Montgomery Asberg Depression Scale			
Hamilton Depression Rating Scale			

Medication Trials in the Current Episode of Major Depressive Disorder

ANTIDEPRESSANT	DOSE	DURATION AT THETHERAPEUTIC DOSING	SIDE EFFECTS		TRIAL SUCCESSFUL	
			YES & DETAILS	NO	YES	NO
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

Trials of evidence-based psychotherapy known to be effective in the treatment of MDD:

TYPE OF THERAPY	DATES	DURATION	FREQUENCY	OUTCOME	RATING SCALES USED

Specify Algorithm Used: STAR*D ☐ **TMAP** ☐

ANTIDEPRESSANT	DOSE	DURATION AT THETHERAPEUTIC DOSING	SIDE EFFECTS		TRIAL SUCCESSFUL	
			YES & DETAILS	NO	YES	NO
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐