of Tennessee

Commercial

Transcranial Magnetic Stimulation (TMS) Prior Authorization Request Form

Member Information

Member Name: _____ Members Date of Birth: ____ / ____ / _____

Member Phone Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Subscriber Name: _____

Subscriber ID: _____

Provider Information

Name of TMS Psychiatrist: _____

Facility Name: _____

Psychiatrist Address (where TMS will take place): _____

Phone Number: _____

Fax Number: _____

Tax ID: _____

Start Date of TMS Service: _____ End Date: _____

Please document how many units of each CPT® code are being requested:

_____ 90867 _____ 90868 _____ 90869

Diagnosis codes: _____

TMS Treatment Checklist

Forms must be signed and completed to be processed.

Section I

Patient Information – Initial TMS Treatment:

1. Is the patient at least 18 years of age? ☐ Yes ☐ No
2. Is the patient pregnant? ☐ Yes ☐ No
3. Does the patient have a confirmed DSM-V diagnosis of a major depressive disorder, severe? ☐ Yes ☐ No
4. Was evidenced-based psychotherapy for depression attempted of an adequate frequency without significant improvement in depressive symptoms? If yes, please describe what type of treatment, duration of treatment, and response to treatment below: ☐ Yes ☐ No

5. Is there clinical contraindication for Electroconvulsive therapy (ECT)? ☐ Yes ☐ No ☐ NA
6. Does the patient have a history of response to ECT in a previous or current episode, or an inability to tolerate ECT? ☐ Yes ☐ No ☐ NA
7. Did the patient refuse ECT? ☐ Yes ☐ No ☐ NA
8. Does the patient have any psychotic symptoms in the current depressive episode? ☐ Yes ☐ No ☐ NA
9. Does the patient have any 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?
   If "Yes," please state which condition(s): ☐ Yes ☐ No

10. Is the patient medically stable and the patient's status and/or comorbid medical conditions not contraindications for TMS? ☐ Yes ☐ No ☐ NA
11. Has the individual had previous TMS? If so, when was the last course of TMS completed? _____ ☐ Yes ☐ No
12. Does the patient and/or legal guardian understand the purpose, risks and benefits of TMS, and provide consent? ☐ Yes ☐ No
13. Is there documentation of a clinical evaluation performed by a psychiatrist who is appropriately trained to provide TMS to include all of the following:
    - psychiatric history
    - past response to antidepressant medication
    - past response to TMS
    - past response to ECT
    - mental status
    - current functioning ☐ Yes ☐ No
14. Is this request for TMS for maintenance therapy, continuous therapy, rescue therapy or extended active therapy of a patient? ☐ Yes ☐ No

Section II

Patient Information – Clinical Detail

1. What is the patient's current and previous psychiatric history?

2. Please describe the patient's mental status examination:

3. Which validated depression monitoring scale will be used to monitor symptom severity and treatment response to TMS? Please check the appropriate box:

   ☐ The Personal Health Questionnaire Depression Scale (PHQ9)

   ☐ The Beck Depression Inventory (BDI)

   ☐ The Hamilton Rating Scale for Depression (HAM-D)

   ☐ The Inventory for Depressive Symptomatology Systems Review (IDS-SR)

   ☐ The Montgomery-Asberg Depression Rating Scale (MADRS)

   ☐ The Quick Inventory of Depressive Symptomatology (QIDS)

   ☐ Other _____

4. What is the current score for the depression-monitoring instrument selected above?

5. Please complete the pharmacotherapy grid below regarding the medication trial(s) used during the current and previous depressive episodes:

Please provide all past and current medications below, including dosage, start and stop dates, and reason why they were stopped. This is key for any patient seeking TMS treatment.

Medication	Current	Past	Dosage	Times per day	Start Date	Stop Date	Why Stopped
Antidepressants							
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Medication	Current	Past	Dosage	Times per day	Start Date	Stop Date	Why Stopped
Mood Stabilizers/Anticonvulsants							
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
Atypical Antipsychotic							
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
Typical Antipsychotic							
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
Dopaminergic Stimulants Agents							
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Medication	Current	Past	Dosage	Times per day	Start Date	Stop Date	Why Stopped
Alternative/Complimentary							
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Section III

Comments

Section IV

Attestation

I understand and agree that as part of participation in the TMS treatment program, I am required to provide sufficient and accurate information for a provider evaluation of my current licensure, relevant training and/or experience, and clinical competence, and any other criteria used by BlueCross BlueShield of Tennessee for determining initial and ongoing eligibility for participation.

I certify that all information provided by me in this checklist is true, correct and complete to the best of my knowledge and belief.

Provider Signature: _____ Date: _____

Provider Printed Name: _____

By Submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided in your submission.

Please complete this form and submit it as an attachment through one of the following options. Tennessee providers may submit authorization requests at any time in Availity®. Out-of-state providers may submit authorization requests through their provider portal or Cohere®.

If you have questions about submitting a prior authorization request, please call **(423) 535-5717, option 2**, or contact your eBusiness Network Manager.

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