NEW AVENUES / MBHN: Request for TMS Treatment

New Avenues Inc.
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PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	DATE OF REQUEST:
DOB:	SSN: XXX-XX-	HEALTH PLAN:	ID NUMBER:

TMS REQUEST

☐ 90867 Initial Mapping ☐ 90868 Subsequent Session ☐ 90869 Subsequent motor threshold re-determination

Authorization should begin:	Number of sessions requested:

COVERAGE LIMITATIONS

TMS IS NOT CONSIDERED REASONABLE/ NECESSARY WHEN USED AS TREATMENT MODALITY FOR PATIENTS WITH ANY OF THE FOLLOWING:	Presence of psychotic symptoms in current depressive episode; Dementia or other neurologic conditions such as epilepsy, cerbrovascular disease, Parkinson's, multiple sclerosis, increased intracranial pressure, history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system; Chronic or acute psychotic disorder such as schizophrenia, schizophreniform disorder, or schizoaffective disorder; Active current substance use; Seizure disorder or any history of seizure (except those induced by ECT or isolated febrile seizures in infancy with subsequent treatment or recurrence); TMS should not be used in patients who have conductive, ferromagnetic or other magnetic-sensitive metals implanted in their head which are non-removable and within 30cm of the TMS magnetic coil. Examples include Cochlear implants, implanted electrodes/stimulators, aneurysm clips or coil, stents, and bullet fragments.

CLINICAL STATUS

Initial Diagnosis Date:	☐ F32.2 Major Depressive Affective Disorder Single Episode, Severe w/o Psychotic Behavior ☐ F33.2 Major Depressive Affective Disorder Recurrent Episode, Severe w/o Psychotic Behavior
Current Diagnosis:	Symptoms:
High Risk Factors:	☐ SUICIDALITY: Not Present Ideation Plan Means Prior Attempt ☐ HOMICIDALITY Not Present Ideation Plan Means Prior Attempt

Current Medications: (Including Dosage, Frequency, Start Date)	
PRIOR TREATMENT	
Prior Inpatient Hospitalization Dates:	PCP:
Outpatient Previous Treatment Providers:	Medications:
ECT: How many total sessions were performed for patient to reach maximum benefit:: _____	Other:
COVERED INDICATIONS	
Please include written evidence to support indication(s) selected.	☐ Resistance to treatment with psychopharmacologic agents as evidenced by a lack of clinically significant response to (4) four trials of such agents, from a minimum of two different agent classes, in the current depressive episode. At least one class of the treatment trials must have been administered an adequate course of mono or poly drug therapy; ☐ Inability to tolerate psychopharmacologic agents as evidenced by trials for four such agents with distinct side effects; ☐ History of good response to TMS in previous episode; ☐ If patient is currently receiving ECT therapy, TMC may be considered reasonable and necessary as a less invasive treatment option; ☐ ECT is not considered appropriate because of poor response, issues with occupational impairment or time off.
Describe Compliance and Response to Prior Treatment. Give rationale for the TMS at this time. (If concurrent review: Based on patient's perception what percentage of improvement has been gained following TMS Treatment? From the provider's perception what percentage of improvement has been gained following TMS Treatment?	

PROVIDER NAME PRINTED: _____FACILITY/ORGANIZATION:_____

SIGNATURE: _____ DATE: _____

TMS IS ADMINISTERED BY A U.S. FOOD AND DRUG ADMINISTRATION (FDA) CLEARED DEVICE FOR THE TREATMENT OF MDD IN A SAFE AND EFFECTIVE MANNER ACCORDING TO THE MANUFACTURER USER MANUAL AND SPECIFIED STIMULATION PARAMETERS, 5 DAYS A WEEK FOR 6 WEEKS (TOTAL OF 30 SESSIONS), FOLLOWED BY A 3 WEEK TAPER OF 3 TMS TREATMENTS IN 1 WEEK, 2 TMS TREATMENTS THE NEXT WEEK, AND 1 TMX TREATMENT IN THE LAST WEEK.