Request for Authorization: Transcranial Magnetic Stimulation Request

California | Anthem Blue Cross | Medi-Cal Managed Care (Medi-Cal)

Instructions: Please submit this form electronically using our preferred method at https://Availity.com.

Member information	
Today's date:	
Member name:	
Member date of birth:	
Member age:	
Member ID number:	
Member address:	
Member phone number:	

Provider information	
Provider name (MD, DO, NP):	
Provider phone number:	
TMS coordinator name:	
TMS coordinator phone number:	
Provider tax ID:	
Provider NPI:	
Fax number:	
Email address:	
Address:	

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Outpatient provider information (if different from TMS provider)	
Psychiatrist:	
Psychiatrist phone:	
Therapist:	
Therapist phone:	

List all current diagnoses (ICD-10)

TMS CPT® codes table

CPT code	General code description	Requested date span	Requested units	Frequency limits
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management			One per treatment
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session			n/a

90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management			n/a

Select all that apply.	
1. Request is for transcranial magnetic stimulation (TMS) of the brain?	☐ Yes ☐ No
2. Request is for Theta burst stimulation (TBS)?	☐ Yes ☐ No
3. Treatment parameters use either high frequency (HF-rTMS) or low frequency (LF-rTMS) rTMS, with frequencies of less than one Hz to 20 Hz (prescribed treatment protocol).	☐ Yes ☐ No
4. Has the patient previously received TMS in the past 30 days?	☐ Yes ☐ No
If yes is selected, please provide the Anthem authorization number for the previous treatment if available:	
5. Is this request for maintenance TMS treatment? (Maintenance treatment is treatment that continues after remission has been achieved. Full remission refers to no significant signs or symptoms of major depression for at least two months)	☐ Yes ☐ No
6. Is this request for continuation treatment? (Continuation of acute treatment is a course that begins after the acute/index course, lasts up to six months, and is designed to prevent worsening of symptoms and continue treatment for a depressive episode that has not yet remitted.)	☐ Yes ☐ No
7. Member responded to initial treatment (Defined as): 1) Previous response to TMS as shown by 50% reduction in severity relative to pretreatment major depressive disorder symptoms as reported by a standardized rating scale	☐ Yes ☐ No

and 2) recurrence of depression based on clinically meaningful worsening of symptoms relative to best TMS response as reported by a standardized rating scale	
8. Please provide standardized rating scales used to measure depressive symptoms.	
Rating scale used:	
Initial score:	
Date:	
Most recent score:	
Date:	
9. Request is for Transcranial Magnetic Stimulation (TMS) of the brain for an acute episode of major depressive disorder, **severe**? If yes, please mark all of the below that apply to the individual:	☐ Yes ☐ No
• Individual is 21 years of age or older.	☐ Yes ☐ No
• If no, is member age 15 to 20?	☐ Yes ☐ No
• Individual has a confirmed diagnosis of **severe** treatment-resistant major depressive disorder (MDD — single or recurrent episode)	☐ Yes ☐ No
• Individual has had an inadequate response to pharmacotherapy despite the following: o Antidepressant trials with two or more classes with: ▪ Adequate duration and dosage ▪ Documented adherence **or** ▪ Inability to tolerate treatment of two trials of agents with documented side effects	☐ Yes ☐ No
10. TMS will be administered by a U.S. Food and Drug Administration (FDA) approved device	☐ Yes ☐ No
If checked yes, specify device:	
11. The standard treatment course will not exceed five days a week for six weeks (total of 30 sessions), followed by a taper.	☐ Yes ☐ No
12. Individual has an implanted magnetic-sensitive medical device located less than or equal to 30 centimeters from the TMS magnetic coil or other implanted metal items (Note: dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS).	☐ Yes ☐ No
If yes is selected, please mark the following if it applies to the individual:	

Individual has a cochlear implant.	☐
Individual has an implanted cardioverter defibrillator (ICD).	☐
Individual has a pacemaker.	☐
Individual has a vagus nerve stimulator (VNS).	☐
Individual has a deep brain stimulator (DBS).	☐
Individual has metal aneurysm clips or coils, staples, or stents.	☐
Individual has other device not listed above:	

Specific treatment history for this member

For the current or previous episode of depression, please list the medication trials:

Medication — antidepressants	**Date of trial**	**Maximum dose**	**Duration of trial**	**Outcome — side effects, adherence, other relevant information**

You may also submit any additional information relevant to your request for authorization if you feel it is needed, such as a copy of the TMS intake evaluation or any full psychiatric evaluation done within a three-month period from the requested start of treatment. Supplemental information does not, however, substitute for completion of this form, which is a requirement for authorization.

By signing below, you are confirming that the information you have provided on this form is accurate and complete based on your clinical assessment of the patient and the records available to you as of the date of this request.

Print MD name:	
MD signature:	
Date:	

If you are unable to submit your request through the Availity Essentials platform, you may fax this completed form toll-free to **855-473-7902**.