PerformCARE®

ECT Outpatient Prior Authorization Request Form

Member: _____ Member DOB: _____

Member Address: _____

Member MAID# (10 digits): _____ Member Phone #: _____

Provider Name: _____ Provider Phone #: _____

Person Completing Form: _____ Start Date: _____

Prescribing Physician and Contact Number (*in the event PerformCare's Physicians have a question):*

_____

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race:_____ Member's Ethnicity:_____

Member's Sexual Orientation: _____ Member's Gender Identity:_____

Member's Assigned Sex at Birth: _____ Member's Pronouns: _____

Member's Alternative Name (if applicable): _____

Member's Primary Language:

Written: _____ Spoken: _____

Check One: ☐ Initial ☐ Re-authorization Request.

Is request part of Discharge Plan from Mental Health Inpatient Admission? ☐ Yes ☐ No

If yes, please include authorization number of Inpatient Admission: _____

Previous ECT: ☐ Yes ☐ No Date of last ECT Session: _____

If yes, indicate if ECT was in outpatient and/or Inpatient and response to prior ECT?

_____

Number of treatments requested (up to 12 units for 4 weeks): _____

How often the treatments will occur: _____

Dates of Services Requested: _____

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1. Initial ECT Outpatient Criteria

Must meet A, B, C and D

A. Must meet both:

A1.☐ Diagnosis

☐ Major depressive disorder in moderate to severe depressive episode
☐ Bipolar disorder in depressed or manic or mixed state
☐ Mood disorder with psychotic features
☐ Catatonia
☐ Schizoaffective disorder bipolar or depressive types
☐ Schizophrenia and/or psychiatric syndromes associated with medical conditions and medical disorders.

(Please include Diagnosis Code(s): _____)

A.2 ☐ The member does not meet criteria for admission to a mental health inpatient unit or other more restrictive level of care or does meet guidelines criteria and does not give consent and is not being admitted involuntarily.

B. Must meet one of the following:

B1. ☐ The member has a history of inadequate response to adequate trial(s) of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s).

B2. ☐ The member is unable or unwilling to comply with or tolerate side effects of available medications or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely.

B3. ☐ The member has a history of good response to ECT during an earlier episode of the illness, is diagnosed with a recurrent episode, and prefers ECT to pharmacologic treatment.

B4.☐ The member is pregnant and the risks of providing no treatment or treatment with psychopharmacologic agents outweigh the risks of providing ECT.

B5.☐ The type and severity of the behavioral health symptoms are such that a rapid response is required, including but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia unresponsive to pharmacologic treatment, severe psychosis, severe psychiatric illness resulting in food or fluid refusal, and/or severe mania resulting in behaviors that put the individual or others at significant risk of harm (including those resulting from exhaustion) but the member cannot be admitted for inpatient treatment.

C. Must meet:

☐The member's status and/or co-morbid medical conditions do not indicate an unfavorable risk/benefit for ECT. Relative contraindications to consider include: anesthetic risk rated as American Society of Anesthesiologists level 4 or 5, unstable or severe cardiovascular disease, recent myocardial infarction, congestive heart failure, severe

valvular disease, intracerebral bleeding, aneurysm or vascular malformation or other space-occupying lesions of the brain, severe hypertension, pheochromocytoma, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary conditions such as severe chronic obstructive pulmonary disease or asthma or pneumonia, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

D. Must meet:

☐ The member and/or a legally authorized representative is able to understand the purpose, risks and benefits of ECT, and provides consent.

2. Re-Authorization ECT Outpatient Criteria (continuation of treatment for 6 months at intervals of 1 week or longer)

Must meet A, B, C, D and E.

☐ **A.** The individual has responded well to ECT.

☐ **B.** Interval psychiatric and medical evaluations are completed prior to each treatment.

☐ **C.** Frequency of sessions is at the minimum which sustains remission.

☐ **D.** Continued need for Continuation ECT is reassessed every month.

☐ **E.** Clinical treatment plans and consents are updated every month.

3. Maintenance Re-Authorization ECT Outpatient Criteria (continuation of treatment for longer than 6 months at intervals of 2 weeks or longer)

Must meet A, B, C, D and E.

☐ **A.** The individual has responded well to ECT.

☐ **B.** Interval psychiatric and medical evaluations are completed prior to each treatment.

☐ **C.** Frequency of sessions is at the minimum which sustains remission.

☐ **D.** Continued need for Continuation ECT is reassessed every six months.

☐ **E.** Clinical treatment plans and consents are updated every six months.

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Sections 4, 5,6 ,7 and 8 are REQUIRED for all Initial, Re-Authorization and Maintenance authorizations **(**request will not be processed without this information). Use separate sheet if necessary).

4. Previous anti-depressant trials (type of medications and reasons discontinued).

5. Current Psychiatric Medications:

6. Physical Health Concerns:

7. Current Symptoms/Progress

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8. Childrens and Adolescents. A, B, and C are required:

☐ **A.** The case has been reviewed by child/adolescent psychiatrist, as well as a psychiatrist who's scope of practice involves ECT.

☐ **B.** Acknowledgement that a child or adolescent's lack of response to medication or other treatment methods could be tied to unresolved/undiagnosed trauma and/or a lack of trauma specific therapy and was reviewed as part of the consideration in utilizing ECT.

☐ **C.** Acknowledgement that consent was obtained from the child or adolescent and Guardian. If the child and adolescent is under 14 or otherwise unable to consent, that the Provider documents in Provider EMR how the child or adolescent' rights and input will be respected in the process.