PerformCARE®

Transcranial Magnetic Stimulation (TMS) Prior Authorization Form

Member Name: _____

DOB:_____ MAID# (10 digits): _____

Member Address: _____ Member Phone: _____

Provider Name: _____ Provider Phone: _____

Person Completing Form: _____

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: _____

Release of Information for PerformCare: ☐ Yes ☐ No

Check One: ☐ Initial ☐ Re-Authorization Requested Start Date: _____

Authorization Request:

Code	Description	Units
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery, and management	1
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	35
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold redetermination with delivery and management	7

***Authorization length is 7 weeks**

Admission Criteria

A. ☐ Adults ages 18 and above.

B. Current Diagnoses:

☐ Major Depressive Disorder (without psychosis)

☐ Have no contraindications to TMS treatment. Including that there have been no ferromagnetic objects in the head/neck area including no vagus nerve stimulator leads.

AND

☐ Currently in moderate to severe Major Depressive Episode (MDE), as defined by DSM 5 (or current version).

AND

Meet any **one** of the following criteria:

☐ Have failed 2 or more antidepressant medications as defined below.

Meet A & B

☐ (A) Adequate Dose: The member should have been treated with a dose that is consistent with the recommended/appropriate therapeutic range for that medication.

☐ (B) Adequate Duration: A sufficient trial period of at least 4 weeks at an appropriate therapeutic dose.

AND

Meet C or D

☐ (C) A Lack of Therapeutic Response: Despite optimal duration and dosage, the member does not achieve a significant improvement in symptoms. This should be measured by standardized clinical scales and/or the provider's clinical judgment.

☐ (D) Intolerable Side Effects: the member experiences side effects that are significant enough to preclude continued use of the medication (even if there is some degree of symptom improvement)

OR

☐ Antidepressant medications contraindicated for **one or more** of the following reasons:

☐ Potential for serious medication adverse effects due to underlying medical condition or a history of such reaction.

☐ Potential for serious worsening of underlying medical condition, or history of such as worsening with antidepressant treatment.

☐ Potential serious drug-drug interaction or a history of such a reaction.

☐ Pregnancy.

☐ Postpartum and breast feeding.

☐ Have positively responded to TMS treatment in the past.

Other Diagnoses: _____

C. Previous TMS Treatment

☐ Yes. If yes:

- Date Prior Treatment Completed: _____

- Significant positive response to prior TMS treatment

  ☐ Yes ☐ No

D. Criteria for Maintenance Treatment of Major Depressive Disorder. Meet both of the following criteria:

☐ Have previously met criteria for acute treatment of MDD as noted outlined above.

AND

☐ Have relapsed within one year or less of cessation of TMS for acute treatment of depressive episode despite psychopharmacologic maintenance treatment OR have relapsed within one year or less of cessation of TMS for acute treatment of depressive episode and cannot tolerate psychopharmacologic maintenance treatment.

Additional Clinical Information: