# Repetitive Transcranial Magnetic Stimulation Level 2 (PA2)

**Controlled Unclassified Information**

**Submission Instructions**: This authorization request should be submitted to the CCE/NPN Medical Director to ensure that all of the requirements are met and appropriately documented. All documentation for completed rTMS treatment authorization requests, including completed "Repetitive Transcranial Magnetic Stimulation (rTMS) Treatment Request Forms," must be maintained in the member's medical record.

## Request Information

Request Date_____ Request Type_____

Date of Last Provider Visit_____ Date of Last Authorization_____

Episode Type_____ Date of Service_____

### Case Exception

Yes_____ No_____ If yes, explain in Clinical Summary section at the end of the form

## Member and Provider/Requester Information

### Member Information

Last_____ First_____ MI_____

Date of Birth_____ Member #_____ Member Type_____

### Provider Information

CCE/NPN_____

Requesting Provider Name_____

Requesting Provider Credentials_____

Requesting Provider Email_____

Requesting Provider Phone_____ Requesting Provider Fax_____

## Mental Health History

Date of most recent comprehensive psychiatric assessment by the rTMS Requesting Psychiatrist_____

Major Depressive Disorder (MDD) diagnosis for which rTMS treatment is being requested_____

Date of MDD Onset_____

Date of most recent MDD episode onset_____

Is the MDD Certified? _____Yes Certification effective date_____

_____No Explain how the MDD is WTC-related or medically associated to a certified WTC-related condition

_____

## Mental Health History (cont.)

**Other certified mental health condition(s):**

_____

_____

_____

**Certification Effective Date(s):**

_____

_____

_____

**Other non-certified mental health condition(s):**

_____

_____

_____

**Symptom Onset Date(s):**

_____

_____

_____

## Diagnostic Assessment Requirements

*Please indicate if the member has or has not had a history of any of the below conditions. All items must be addressed.*

| Does the member have a history of any of the following? | Yes | No |
|---|---|---|
| Schizophrenia | ☐ | ☐ |
| Schizophreniform Disorder | ☐ | ☐ |
| Schizoaffective Disorder | ☐ | ☐ |
| MDD with psychotic features in the current depressive episode | ☐ | ☐ |
| Bipolar Disorder (Type I or II) with current episode manic or hypomanic | ☐ | ☐ |
| Untreated substance or alcohol use disorder | ☐ | ☐ |
| Epilepsy, seizure disorder or any history of seizures (except those induced by electroconvulsive therapy (ECT) or isolated febrile seizures in infancy or childhood without subsequent treatment or recurrence) | ☐ | ☐ |
| Parkinson's Disease | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ |
| Cerebrovascular Disease | ☐ | ☐ |
| Dementia | ☐ | ☐ |
| Increased intracranial pressure | ☐ | ☐ |
| Repetitive or severe head trauma | ☐ | ☐ |
| Primary or secondary central nervous system tumor(s) | ☐ | ☐ |
| Any other degenerative neurologic condition (when there is a mild degenerative neurologic condition without seizures and MDD is clearly present, rTMS may still be appropriate as determined by the Program-affiliated Licensed Psychiatric Physician). | ☐ | ☐ |
| The presence of an implanted magnetic-sensitive medical device located ≤30 cm from the rTMS magnetic coil or other implanted metal items (e.g., cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, Vagus nerve stimulator (VNS), or metal aneurysm clips or coils, staples or stents) | ☐ | ☐ |
| Actively hospitalized for any reason that is a clinical contraindication to rTMS or, if hospitalized, such hospitalization would not result in a barrier to timely completion of a course for rTMS, if rTMS is clinically indicated in accordance with MCD criteria. | ☐ | ☐ |

# Treatment History Requirements

*To meet requirements, this section must document adherence to a regimen of evidence-based psychotherapy that did not improve depressive symptoms and one or more of the following: resistance to treatment with psychopharmacologic agents in the current depressive episode, inability to tolerate psychopharmacologic agents, history of response to rTMS in a previous depressive episode, and/or currently receiving electro-convulsive therapy (ECT).*

## Regimen of Evidence-Based Psychotherapy

Evidence-based psychotherapy

Termination Reason

| Start Date | Termination Date | Psychotherapy treatment session frequency (per week) | Psychotherapy treatment duration (weeks) |
|---|---|---|---|
| | | | |

Standardized instrument used to assess depression severity

Additional clinical information

| Pre-treatment depression severity score | Assessment Date | Post-treatment depression severity score | Assessment Date |
|---|---|---|---|
| | | | |

## Additional Treatment History

Does the member have resistance to treatment with psychopharmacologic agents, as shown by a lack of a clinically significant response to one trial of psychopharmacologic agents in the current depressive episode from at least two different agent classes? Yes ☐ No ☐

*If yes, fill out Antidepressant Trials section below*

Does the member have an inability to tolerate psychopharmacologic agents, as shown by two trials of psychopharmacologic agents from at least two different agent classes, with distinct side effects? Yes ☐ No ☐

*If yes, fill out Antidepressant Trials section below*

Has the member previously received rTMS with a positive response during a previous depressive episode? Yes ☐ No ☐

If yes, provide the percentage of improvement using a standard rating scale measurement for depressive symptoms _____

Is the member receiving electro-convulsive therapy (ECT)? Yes ☐ No ☐

Additional evidence-based psychotherapy trials

[1]Standardized rating scales for assessing severity of depression include: Beck Depression Inventory (BDI); Hamilton Rating Scale for Depression (HAM-D); Inventory of Depressive Symptomatology – Clinician-Rated (IDS-C); Inventory of Depressive Symptomatology – Self-Report (IDS-SR); Montgomery-Asberg Depression Rating Scale (MADRS); Patient Health Questionnaire – 9 (PHQ-9); Quick Inventory of Depressive Symptomatology – Clinician-Rated (QIDSC); and Quick Inventory of Depressive Symptomatology – Self-Report (QIDS-SR). See https://www.apa.org/depression-guideline/assessment

## Antidepressant Trial 1

*Complete this section only if instructed by the above questionnaire. Each medication trial must be from a different therapeutic class.*

Antidepressant Medication

Start Date

Initial Dose

Duration of treatment at initial dose (weeks)

Maximum Dose

Duration of treatment at maximum dose (weeks)

Did the member demonstrate any compliance concerns? ☐ Yes, explain below ☐ No

Termination Date

Termination Reason

Standardized Instrument Used to Assess Depression Severity

Additional Clinical Information

| Pre-treatment Depression Severity Score | Assessment Date | Post-treatment Depression Severity Score | Assessment Date |
|---|---|---|---|
| | | | |

Percent change in depression severity score

*Percent change should be calculated as ([Pre-treatment score]-[Post-treatment score])/Pre-treatment score x 100%*

## Antidepressant Trial 2

Antidepressant Medication

Start Date

Initial Dose

Duration of treatment at initial dose (weeks)

Maximum Dose

Duration of treatment at maximum dose (weeks)

Did the member demonstrate any compliance concerns? ☐ Yes, explain below ☐ No

Termination Date _____ Termination Reason _____

Standardized Instrument Used to Assess Depression Severity

Additional Clinical Information _____

| Pre-treatment Depression Severity Score | Assessment Date | Post-treatment Depression Severity Score | Assessment Date |
|---|---|---|---|
| | | | |

Percent change in depression severity score _____

Additional Antidepressant Trials

## Treatment Plan Requirements

*Please describe the treatment plan for the requested rTMS treatment episode.*

rTMS treatment start date

rTMS treatment completion date

Frequency of acute phase treatment sessions (visits/week)

Duration of acute phase treatment sessions (weeks)

Frequency of taper phase treatment sessions (visits/week)

Duration of taper phase treatment sessions

Total number of proposed acute phase treatment sessions

Total number of proposed taper phase treatment sessions[2]

Total number of proposed treatment sessions

**Attestation Statement:** As the rTMS Requesting Psychiatrist completing this form, I attest that I have personally performed a comprehensive psychiatric assessment of this member, ≤ 30 days from the rTMS treatment authorization request date, for the purpose of ensuring the appropriateness of rTMS treatment for this member's treatment-resistant, moderate to severe MDD without psychotic features. I have evaluated all possible co-morbid and/or underlying medical and mental health conditions and ruled out all of these conditions as the primary cause of the member's current depressive symptoms and determined that rTMS treatment is appropriate for this member's treatment-resistant, moderate to severe MDD without psychotic features at this time. I have discussed all of the risks and benefits of rTMS treatment with this member and satisfactorily addressed all of his/her questions and concerns about rTMS treatment, and he/she desires to proceed with rTMS treatment.

**rTMS Requesting Psychiatrist Signature**_____ **Date**_____

[2]A new PA2 is required if the member encounters a subsequent MDD episode or relapse of MDD symptoms ≥ 3 months after the final rTMS taper treatment session for the most recent prior rTMS treatment episode.

## Clinical Narrative

*Please provide a clinical summary describing the medical necessity for the rTMSprocedures/services requested and how they relate to the treatment or management of the certified WTC-related condition and/or MAC.*

## Medical Director Decision

| CCE/NPN Medical Director Name | CCE/NPN Medical Director Credentials | CCE/NPN Medical Director PA 2 Decision |
|---|---|---|
| | | |

CCE/NPN Medical Director comments

**CCE/NPN Medical Director Signature** _____ **Date**_____