



Transcranial Magnetic Stimulation (rTMS) Authorization Request Form

Call the number on the back of the member's ID card to verify benefits

Date Submitted: _____

Fax completed rTMS authorization request form and one completed depression screening tool (listed in section 2) to 330-656-2449 or 1-800-385-7085

Member Information

Member name: _____ DOB: _____ Member ID#: _____

Diagnosis code(s): _____

Psychiatrist Information: MD or DO (Please check one)

Name: _____ State _____ License#: _____

OhioHealthy Provider ID: _____ Tax ID: _____ NPI: _____

Phone number (_____) _____ Fax number: (_____) _____

Clinical Indications for initial Transcranial Magnetic Stimulation:

1) Initial Transcranial Magnetic Stimulation (rTMS) treatment with ALL of the following:

Treatment is rendered by a psychiatrist Y____ N____

Individual meets the DSM-V criteria for unipolar major depression Y____ N____

Individual has moderate to severe depression as defined by use of a validated, evidence-based depression monitoring tools (i.e. PHQ-9 score of 10 or greater, HAM-D score of 14 or greater, or QIDS-SR16 score of 11 or greater) Y____ N____

Monitoring tool score _____

2) Individual is resistant to psychopharmacologic agents as demonstrated by ALL of the following:

Individual has tried 4 different medications each at their therapeutic range Y____ N____

Individual has tried each medication for a minimum of 6 weeks Y____ N____

The medications were from at least 2 different classes of anti-depressants Y____ N____

Clinical Indications for repeat Transcranial Magnetic Stimulation:

1) Repeat Transcranial Magnetic Stimulation (rTMS) with ALL of the following:

Treatment is rendered by a psychiatrist Y____ N____

Individual had 50% or greater improvement on their depression monitoring tool after prior repetitive transcranial magnetic stimulation (rTMS) treatment Y____ N____

Monitoring tool score before initial treatment _____ After initial treatment _____ Current score _____

Medication Name	Maximum Dose	Duration	Last Prescribed	Prescribing Physician

Check CPT codes requested: Therapeutic repetitive transcranial magnetic stimulation treatment:

90867 Planning 90868 Delivery & Management 90869 Readjustment