sunflower health plan

Sunflower Product Line:

☐ Ambetter (Health Insurance Marketplace)

☐ Wellcare By Allwell (Medicare Advantage)

SUBMIT TO
Utilization Management Department
Phone: 1-877-644-4623 Fax: 1-844-824-7705

TRANSCRANIAL MAGNETIC STIMULATION (TMS) REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing. Please consider Sunflower Clinical and Payment Policies (www.sunflowerhealthplan.com/providers/resources/clinical-payment-policies.html), as appropriate.

PATIENT INFORMATION

Name _____

Date of Birth _____

Member ID# _____

Social Security # _____

Health Plan # _____

PROVIDER INFORMATION

Provider Name _____

Group Name _____

Provider Tax ID# _____ NPI# _____

Fax# _____ Phone# _____

Referral Source _____

PROVISIONAL DSM-V DIAGNOSIS The provider must report all diagnoses being considered for this patient.

Primary _____ R/O _____ R/O _____

CLINICAL INFORMATION

1. Will the TMS be administered using a Food and Drug Administration (FDA) cleared device and used in accordance with the FDA-labeled indications, such as, but not limited to, the following:

☐ BrainsWay Deep TMS
☐ MagVita TMS Therapy with MagPro R20
☐ MagVita TMS Therapy System w/Theta Burst Stimulation
☐ Neurosoft TMA (Cloud TMS)
☐ Magstim Rapid2 Therapy System
☐ Magstim Horizon Performance System
☐ Apollo TMS Therapy System
☐ Nexstim Brain Therapy
☐ Magstim Horizon TMS Therapy System Range
☐ NeuroStar TMS Therapy System
☐ Other _____

2. Is the member experiencing a current major depressive episode? ☐ Yes ☐ No
3. Is the member experiencing any current psychotic symptoms? ☐ Yes ☐ No If yes please explain:

_____

4. Has the member received psychotherapy? ☐ Yes ☐ No. If yes, answer question 5. If no, answer question 6.
5. Did member lack significant improvement in depressive symptoms despite adequate trial of evidenced-based psychotherapy? ☐ Yes ☐ No
6. Please describe the reason member did not receive psychotherapy _____
7. Has member received TMS treatment in the past? ☐ Yes ☐ No
   If yes, please answer A-D below:
   A. Has member received exactly one previous course of TMS treatment more than 6 months ago? ☐ Yes ☐ No
   B. Did the member experience greater than 50% improvement with previous TMS treatment? ☐ Yes ☐ No
   C. Has member received exactly one previous course of TMS treatment within last 12 months? ☐ Yes ☐ No
   D. Has member had a clinically significant positive response to treatment? ☐ Yes ☐ No
8. Has member had trials of at least four different antidepressants from at least two different pharmacological classes? ☐ Yes ☐ No.
   If yes, answer A-D below:
   A. At least one of these trials was for current episode of depression? ☐ Yes ☐ No
   B. Did member have inadequate improvement? ☐ Yes ☐ No
   C. Were trials at adequate doses and duration? ☐ Yes ☐ No
   D. Were trials discontinued due to intolerable side effects? ☐ Yes ☐ No

9. Has member had trials of at least three different antidepressants from at least two different pharmacological classes ☐ Yes ☐ No
   If yes, answer A-D below:
   A. At least one of these trials was for current episode of depression? ☐ Yes ☐ No
   B Did member have inadequate improvement? ☐ Yes ☐ No
   C. Were trials at adequate doses and duration? ☐ Yes ☐ No
   D. Were trials discontinued due to intolerable side effects? ☐ Yes ☐ No

10. Is antidepressant medications contraindicated for one of the following reasons? (must answer all)
   A. Is there a potential for serious medication adverse effects due to an underlying medical condition? ☐ Yes ☐ No
   B. Is there a potential for serious worsening of underlying medical condition? ☐ Yes ☐ No
   C. Is there potential for serious drug-drug interaction? ☐ Yes ☐ No
   D. Is member pregnant? ☐ Yes ☐ No ☐ N/A
   E. Is member postpartum and/or breastfeeding? ☐ Yes ☐ No ☐ N/A

11. Are there any of the following contraindications? (must answer all)
   A. Does the member have a vagus nerve stimulator lead in the carotid sheath? ☐ Yes ☐ No
   B. Does the member have any implanted stimulators controlled by or that use electrical or magnetic signals? ☐ Yes ☐ No
   C. Are there any conductive or ferromagnetic or other magnetic-sensitive metals implanted or embedded in member's head or neck? ☐ Yes ☐ No
   D. Does the member have an acute or chronic psychotic disorder? ☐ Yes ☐ No
   E. Does the member have a seizure disorder or history of a seizure disorder? ☐ Yes ☐ No
   F. Does the member abuse any substances at the time of referral or at start of TMS treatments? ☐ Yes ☐ No
   G. Does member have severe dementia? ☐ Yes ☐ No
   H. Does the member have a non-adherence with previous treatment for depression? ☐ Yes ☐ No
   I. Does the member have bullet fragments? ☐ Yes ☐ No
   J. Does the member have metallic dyes in tattoos? ☐ Yes ☐ No

11b. Other implanted stimulators controlled by or that use electrical or magnetic signals such as, but not limited to, the following:
   A. Does the member have deep brain stimulation? ☐ Yes ☐ No
   B. Does the member have a cardiac pacemaker? ☐ Yes ☐ No
   C. Does the member have a cardioverter defibrillator? ☐ Yes ☐ No
   D. Does the member have intracardiac lines? ☐ Yes ☐ No
   E. Does the member have medication pumps? ☐ Yes ☐ No

12. Which self-reporting rating scale will be used for baseline score and periodic outcome measures?
   ☐ Beck Depression Inventory
   Date administered _____ Score _____
   Date administered _____ Score _____
   ☐ PQH-9
   Date administered _____ Score _____
   Date administered _____ Score _____
   ☐ Other
   Date administered _____ Score _____
   Date administered _____ Score _____

13. What other treatment modalities have been tried (example: ECT, EMDR, Ketamine) _____

_____

14. Please provide a list of antidepressant medications and/or augmenting agents member has tried in the past as well as current medications:

_____

_____

15. Which treatment sessions are planned? ..... ☐ Repetitive transcranial magnetic stimulation ☐ Deep transcranial magnetic stimulation

16. Is the member experiencing current symptoms of Obsessive Compulsive Disorder (OCD)? ☐ Yes ☐ No

17. Has the member failed to respond to a combination of multiple trials of medication combined with Cognitive Behavioral Therapy (CBT) and/or Exposure and Response Prevention (ERP) for at least 12 weeks during the current episode of illness, as demonstrated by both of the following:
    - A. Less than 25% improvement in the Yale Brown Obsessive Compulsive Scale (Y[1]BOCS) ☐ Yes ☐ No
    - B. Failure to respond to psychopharmacologic agents is defined as a lack of clinically significant response in the current OCD episode to four trials of agents from at least two different agent classes, and one of the following:
        1. At least two of the treatment trials were administered as an adequate course of mono- or poly-drug therapy with Selective Serotonin Reuptake Inhibitors (SSRIs), Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs), clomipramine, or atypical antipsychotic augmentation involving standard therapeutic doses of at least 12 weeks duration ☐ Yes ☐ No
        2. The patient is unable to take SSRI, NSRI, clomipramine, or atypical antipsychotics due to one of the following:
            - a. Drug interactions with medically necessary medications ☐ Yes ☐ No
            - b. Inability to tolerate psychopharmacologic agents, as evidenced by trials of four such agents with distinct side effects in the current episode ☐ Yes ☐ No

18. Are there any of the following contraindications:
    - A. History of seizures ☐ Yes ☐ No
    - B. Conductive or ferromagnetic or other magnetic-sensitive metals implanted or embedded in head or neck within 30 cm of dTMS coil placement other than dental fillings (e.g. cochlear implants, implanted electrodes/stimulators, aneurysm clips or coils, stents, bullet fragments, metallic dyes in tattoos, deep brain stimulators, vagus nerve stimulators, other implanted electrodes or stimulators) ☐ Yes ☐ No
    - C. Vagus nerve stimulator leads in the carotid sheath ☐ Yes ☐ No
    - D. Other implanted stimulators controlled by or that use electrical or magnetic signals, (e.g. deep brain stimulation, cardiac pacemaker, cardioverter defibrillator, intracardiac lines and medication pumps) ☐ Yes ☐ No
    - E. Substance abuse at time of treatment ☐ Yes ☐ No
    - F. Severe dementia ☐ Yes ☐ No
    - G. Severe cardiovascular disease ☐ Yes ☐ No
    - H. Known non-adherence with previous treatment for OCD ☐ Yes ☐ No
    - I. Any mental health and substance use disorders (previously categorized as "Axis I" psychiatric disorders) other than OCD (e.g. including active alcohol or substance abuse, mood disorders, psychotic disorders, other anxiety disorders, etc.); neurological diseases or head injury; or pregnancy ☐ Yes ☐ No

19. Please list the outcome measures from the Yale Brown Obsessive Compulsive Scale (Y-BOCS)
    Date administered _____ Score _____

    Date administered _____ Score _____

20. Notes/comments or additional clinical _____

    _____

    _____

SERVICES REQUESTED

CODE REQUESTED	UNITS REQUESTED	HOURS	START AND END DATES
90867			
90868			
90869			

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.)

STANDARD REVIEW:
Standard 14-day time frame will be applied.

Clinician Signature Date

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

Clinician Signature Date

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