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**REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (rTMS)
PRIOR AUTHORIZATION REQUEST FORM**

**BEHAVIORAL HEALTH DEPARTMENT
PHONE: (413) 787-4000 EXT. 5028 FAX: (413) 233-2800**

Please complete thoroughly. Send completed form to HNE Behavioral Health Department for review and decision.

MUST ENCLOSE RELEVANT CLINICAL DOCUMENTATION TO SUPPORT THIS REQUEST

SECTION A:

Date: _____ Patient Name: _____

Patient ID: _____ Patient Date of Birth: _____

SECTION B:

Referring Provider: _____ HNE Provider ID: _____

Address: _____

Phone: _____ Office Manager/Contact Person: _____

rTMS Provider: _____ HNE Provider ID: _____

Address: _____

Phone: _____ Office Manager/Contact Person: _____

SECTION C:

Reason for Referral:

Mental Health Diagnosis: _____

Mental Health Treatment History: _____

Psychiatric Medication History: _____

Has member gone through a trial of ECT? Yes No

If yes, by whom: _____ When: _____

If no, why not? _____

Members being referred for rTMS must present with Treatment Resistant Depression as evidenced by

- failure to respond to at least two adequate medication trials with antidepressants (of different types)
- adjunctive psychotherapy and
- a trial of a atypical antipsychotic combined with an antidepressant.

For treatment to be approved, you must answer "yes" to the following criteria.

- Yes Member must have a diagnosis of Major Depression and
- Yes Member must be referred for rTMS by an in-plan psychiatrist and
- Yes Member must have been in psychotherapy to address the depression and
- Yes Member must have tried medication to address the depression with at least two adequate medication trials with antidepressants (of different types) and
- Yes Member must have been offered a trial of Electroconvulsive Therapy (ECT) and
- Yes The in plan psychiatrist must complete the rTMS Prior Authorization Form.