417 20th Street North, Suite 1100
Birmingham, AL 35203
Phone: 205-558-7475
Fax: 205-449-7049

Transcranial Magnetic Stimulation
Pre-Service Request Form

(All information requested on this form must be complete. Missing data may result in authorization delay.)

- Submission of this information by fax or phone **does not** constitute authorization of services. VIVA's Behavioral Health UR department will notify you of their decision by secure email, mail, phone or fax.
- Please fax this completed form, along with the medical records documenting the clinical indications or medical necessity to the appropriate fax number listed below. For questions regarding this form, please call 205-558-7475.
- Please submit all elective prior authorization requests at least 10 days prior to the scheduled date of service.
  - Behavioral Health: Fax 205-449-7049

PLEASE PRINT OR TYPE ONLY

Member Name:	Member ID #:	Date:
Date of Birth:		
Staff Member Submitting:		
Telephone #:		
Treating Physician:		
Treatment Date From:	Through:	

1. Has a confirmed diagnosis of severe major depressive disorder (MDD) single or recurrent episode

☐ F32.2	Major Depressive Disorder, Single Episode, Severe (Without Psychotic Features)	
☐ F32.3	Major Depressive Disorder, Recurrent Episode, Severe (Without Psychotic Features)	

AND

2. Inadequate response to pharmacotherapy despite **ALL** of the following:
   - ☐ Adequate duration and dosage
   - ☐ Documented Adherence
   - ☐ Trails from 2 or more classes of medications (i.e. SSRI, SNRI, TCA, MAOI, Other):

     Antidepressant: _____Class: _____
     Med Trail Dates: ____/ ____/ ____ to ____/ ____/ ____

     Antidepressant: _____Class: _____
     Med Trail Dates: ____/ ____/ ____ to ____/ ____/ ____

     Antidepressant: _____Class: _____
     Med Trail Dates: ____/ ____/ ____ to ____/ ____/ ____

   - No cochlear implant, deep brain stimulator, or vagus nerve stimulator
   - No metallic hardware or implanted magnetic-sensitive medical device (eg, implanted cardioverter-defibrillator, pacemaker, metal aneurysm clips or coils) at a distance within the electromagnetic field of the discharging coil (eg, less than or equal to 30 cm to the discharging coil)
   - No epilepsy or history of seizure

AND

3. An order written by a psychiatrist (MD or DO) who has examined the patient and reviewed the record. The physician will have experience in administering TMS therapy. The treatment shall be given under direct supervision of this physician.

RETREATMENT
1. Patient met the guidelines for Initial treatment AND meets guidelines currently.
AND
2. Subsequently developed relapse of depressive symptoms.
AND
3. Responded to prior treatments as evidenced by a greater than 50% improvement in standard rating scale measurements for depressive symptoms (e.g., GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS, or IDS-SR scores)
Post-treatment rating scale: GDS____, PHQ-9____, BDI____, HAM-D____, MADRS____, QIDS____, or IDS-SR____
Dates of initial treatment, if known:

TREATMENT TYPE(S) REQUESTED		
FDA-approved TMS device to be used for the following treatment:		**Number of visits requested:**
☐ 90867	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — INITIAL, INCLUDING CORTICAL MAPPING, MOTOR THRESHOLD DETERMINATION, AND DELIVERY AND MANAGEMENT	
☐ 90868	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — SUBSEQUENT DELIVERY AND MANAGEMENT, PER SESSION	
☐ 90869	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — SUBSEQUENT MOTOR THRESHOLD REDETERMINATION WITH DELIVERY AND MANAGEMENT	

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