sunflower health plan

Medicaid | Marketplace | Medicare

Sunflower Product Line:

- ☐ KanCare (Medicaid)
- ☐ Ambetter (Health Insurance Marketplace)
- ☐ 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.

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

   _____
3. Has the member received psychotherapy? ☐ Yes ☐ No. If yes, answer question 4. If no, answer question 5.
4. Did member experience lack of significant improvement in depressive symptoms despite adequate trial of evidenced-based psychotherapy?
   ☐ Yes ☐ No
5. Please describe the reason member did not receive psychotherapy _____
6. 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
7. 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
8. 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
9. 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 a 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

10. 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 members 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

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

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

    _____

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

    _____

    _____

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

13. Notes/comments or additional clinical _____

    _____

    _____

SERVICES REQUESTED

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

Not all codes are covered for all lines of business, but may be considered for in lieu of services.
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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