



Federal Employee Program.

Prior Authorization Request Form	2.01.50 Transcranial Magnetic stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders
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Standard Fax Number: 1 (855) 895-3504	Urgent Fax Number: 1 (844) 224-0226
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Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for medical requests and requests for medications covered under the medical benefit. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: The Federal Employee Program has a 15 Calendar Day turn-around time on all Standard Prior Authorization Requests according to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

New Standard Request **New Urgent Request**

Important For Urgent Requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. *If there is no MD signature present the request will be processed as a Standard request.*

MD Signature REQUIRED For Urgent Requests Only:

Modification Or **Extension Requests Complete the Section Below:**

Date Last Authorized:	Previous Authorization Number:
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MD/NP/PA justification for modification or extension:

Patient Information:

First Name:	Last Name:
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Date of Birth:	ID Number:
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Address:

Referring/Prescribing Provider:

Name:	NPI:
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Street Address + Suite #:	Email address:
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City:	State:	Zip:	Phone:	Fax:
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Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist Type:	Contact Name and Phone Number:
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Servicing/Billing: Provider/Vendor/Lab *If same as Referring/Prescribing Provider Check Here*

Name:	NPI:
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Street Address + Suite #:	Email address:
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City:	State:	Zip:	Phone:	Fax:
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Specialist Type:	Contact Name and Phone Number:
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If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:

Group Name:	NPI:	
Street Address + Suite #:		
City:	State:	Zip:

Billing Facility (If Applicable):

Facility Name:	NPI:			
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Contact Name and Phone Number:				

Anticipated Date of Service: _____ **If Lab, Draw Date:** _____

Place of Service: (Check One Box Only or If typing replace box with an "X"):

<input type="checkbox"/> Office	<input type="checkbox"/> Home	<input type="checkbox"/> On Campus OP Hosp
<input type="checkbox"/> Acute Rehab	<input type="checkbox"/> Hospice	<input type="checkbox"/> PHP
<input type="checkbox"/> Ambulance- Air or Water	<input type="checkbox"/> Independent Clinic	<input type="checkbox"/> RTC – Psychiatric
<input type="checkbox"/> Ambulance-Land	<input type="checkbox"/> Independent Laboratory	<input type="checkbox"/> RTC – SUD
<input type="checkbox"/> Ambulatory Surgical Center	<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Intermediate Care Facility	<input type="checkbox"/> Telehealth
<input type="checkbox"/> Birthing Center	<input type="checkbox"/> IOP	<input type="checkbox"/> Urgent Care Facility
<input type="checkbox"/> Custodial Care Facility	<input type="checkbox"/> IP Psychiatric Facility	<input type="checkbox"/> Other - Please Specify:
<input type="checkbox"/> End Stage Renal Disease TX	<input type="checkbox"/> Nursing Facility	
<input type="checkbox"/> Group Home	<input type="checkbox"/> Off Campus OP Hosp	

**Please enter all codes requested; unlisted codes must have a description.
Please include the quantity for each code requested and if applicable, left, right or bilateral designations.**

ICD-10 Code(s):

CPT/HCPC Code(s):

For questions: Call FEP Authorization Requests Phone Number: 1 (800) 633-4581

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Please provide the following documentation

History and physical and/or consultation notes including:

Clinical findings

- Primary diagnosis and relevant comorbidities
 - Documentation of depression severity by standardized rating scale (i.e., PHQ-9, etc.)
 - Documentation of any current or previous seizure disorder
 - Documentation of any neurologic conditions (i.e. epilepsy, tumors, dementia, head trauma, etc.)
- Pertinent symptoms and duration
 - Documentation of absence of acute or chronic psychotic symptoms (i.e. schizophrenia, schizoaffective disorder, etc.)
- Functional limitations

Consultation

- Specialist consultation and/or recommendation (i.e., psychiatrist)
- Other pertinent multidisciplinary notes or reports (i.e. licensed therapist, nursing, etc.)

Prior treatment

- Documentation of a trial of at least **2 antidepressants** from **2 different** antidepressant classes with duration of therapy, adherence to therapy and response, **or**
 - Documentation of intolerance to pharmacologic therapy
- Documentation of a trial of psychotherapy, with frequency, duration, and response
- If applicable, previous treatment with TMS therapy, including:
 - Dates of therapy
 - Response to previous therapy

Rationale

- Reason for procedure
 - Documentation of whether patient would be a candidate for ECT therapy, and if so, why TMS therapy is preferred over ECT treatment.
- Type of procedure planned (i.e., conventional, deep or theta burst stimulation)
- Number of sessions planned daily and weekly
- Documentation that treatment will be given in a facility with adequate resuscitation support available.
- Treatment plan

View our Medical Policy online at <https://www.fepblue.org/legal/policies-guidelines>