Lucet™

TMS TREATMENT REQUEST FORM

ARBCBS: send completed faxes to 816-237-2382

Patient's name: _____ Patient's ID#:_____

Date of Birth: _____ Date of Request_____

Requesting Physician's Name:_____Phone #: _____

Referring Physician's Name:_____TMS start date: _____

Date of contact with referring physician**:** _____

Address where services are being rendered**:**_____

Tax ID#:: _____NPI#:: _____

UR Fax Number: _____ UR Name/Phone number: _____

TMS should not exceed five days per week for six weeks, then taper as follows: three treatments during week 7, two treatments week 8 and one treatment last week (T = 39). FULL MEDICAL POLICY available at:
TMS-policy-final-2022 9-27-21.pdf (LucetHealth.com)

Primary Diagnosis: _____

Other diagnoses: _____

Age at first diagnosis:_____Age at first hospitalization: _____

Current episode duration (# months): _____

Antidepressant medication trials during this current depressive episode:

Must document 4 trials, at least 2 with augmentation

Antidepressant only trials					
#	**Antidepressant Max daily dose**	**Start date**	**End Date**	**Discontinued due to lack of efficacy or adverse reaction**	**Document % response or disabling ADR**
1				☐ Efficacy ☐ Adverse Reaction	
2				☐ Efficacy ☐ Adverse Reaction	
3				☐ Efficacy ☐ Adverse Reaction	
Antidepressant with augmentation trials					
#	**Antidepressant + Augmentation Max daily dose**	**Start date of combined trial**	**End date of combined trial**	**Reason for discontinuation**	**Document % response or disabling ADR**
1				☐ Efficacy ☐ Adverse Reaction	
2				☐ Efficacy ☐ Adverse Reaction	
3				☐ Efficacy ☐ Adverse Reaction	

List last 2 hospitalizations if any:

Facility Name	Date (year)	Length of Stay

List last 2 prior ECT Treatment Episodes if any:

MD Name	Facility	Start date	# in Series	Results = %response

Maintenance ECT dates and results: _____

Evidence-Based Psychotherapy Trials: (DBT, CBT, ITP etc.) *Must document at least one full episode.*

Type	Name of Clinician	Start Date	End date	Results = %response

Documentation of current levels of impairment (work, school, social, family, sleep, mood etc.):

_____

_____

_____

Current Depression Rating Scale: (*acceptable scales:* BDI, MADRS, CGS, IDS-SR, IDS-C, PHQ-9)

Scale used:_____

Pre-Treatment Score: _____ Date: _____

_____

_____

Other clinical information or comments:

CPT code requests for TMS treatment

90867 Maximum of one per course of treatment: Number requested = ____
90868 Maximum of 36 per course of treatment: Number requested = ____
90869 Approval of one unit will be provided for TMS request found to be medically necessary.
Requests for any additional units of 90869 should be submitted with detailed clinical rationale

_____ _____

SIGNATURE **DATE**

**** Frequent Contact with the patient's primary care and referring physician is strongly recommended. ****