THE OHIO STATE UNIVERSITY
HEALTH PLAN

Transcranial Magnetic Stimulation (rTMS) Authorization Form

Email completed form with required documentation to: UtilizationManagement.OSUHealthPlan@osumc.edu or fax to: (614) 292-2667

Patient Information

Patient Name:
Member ID #:
DOB:

Requesting Provider Information

Physician Name:
Office Contact Name:
Phone #:
Fax #:

Performing Provider Information: ☐ In-Network Provider ☐ Out-of-Network Provider

Provider Name:	TIN:	
Contact Name:	NPI:	
Address:		
City:	State:	Zip:
Phone #:	Fax #:	

Primary Diagnosis:

☐ F32.2 Major Depressive Disorder, single episode, severe without psychotic behavior

☐ F33.2 Major Depressive Disorder, recurrent episode, severe without psychotic behavior

In the current episode, document the psychopharmacologic agents the member has tried*: **Response: Please note changes in standardized rating scale scores if trial deemed treatment-resistant. Please attach clinical documentation as applicable.*

Rx:	Rx:	Rx:	Rx:	Rx:
Maximum dose prescribed:	Maximum dose prescribed:	Maximum dose prescribed:	Maximum dose prescribed:	Maximum dose prescribed:
Length of trial:	Length of trial:	Length of trial:	Length of trial:	Length of trial:
Date of trial:	Date of trial:	Date of trial:	Date of trial:	Date of trial:
Response:	Response:	Response:	Response:	Response:

Does the member have a history of previous good response to rTMS?
(Please circle) YES or NO
If yes, please submit the following documentation:
☐ Dates of rTMS treatment: _____
☐ Clinical evidence of improvement including standard rating scales for depressive symptoms.

In the past, has the member received ECT treatments? (Please circle) YES or NO

If yes, please provide response: _____

Does the member have any of the following contraindications?
☐ Seizures
☐ Actively using substances
☐ Ferromagnetic or other magnetic-sensitive metals implanted within 30cm of the TMS magnetic coil

Did the member begin a course of rTMS during an inpatient psychiatric admission?
(Please circle) YES or NO
If yes, provide the date rTMS treatment began: ___/____/_____
Number of treatment sessions administered to date: _____

Requesting Physician Signature: _____ Date: _____

The form should be completed by the clinician who has a thorough knowledge of the member's current clinical presentation and his/her treatment history. Please complete all parts as clearly and specifically as possible. Omissions, generalities and illegibility will result in the form being returned for completion or clarification.

For questions, please contact The OSU Health Plan at 614-292-4700

HEALTH PLAN USE ONLY:

Authorization #:	*Date Span:*	*Number of treatments:*
Approved by:	*Phone #:*	
Comments:		