Halcyon Behavioral
P.O. Box 25159 Fresno, CA 93729-5159
Admin Phone: (855) HBI-4HLP
Member Phone: (888) 425-4800
Fax: (888)304-1429

Transcranial Magnetic Stimulation (TMS)

Pretreatment Certification Form

Patient Information

Name: _____ Date of Birth: _____ Age: ____ Sex: M F

Insurance ID#: _____ Insurance Plan/Employer: _____

Diagnosis (ICD-10): _____

The following information must be completed and submitted along with your evaluation for review. Documentation must be completed within a three-month period from the requested start date of treatment.

Name/Contact information of treatment team:

- Psychiatrist Name: _____ Phone: _____
- Therapist Name: _____ Phone: _____
- Other (Name/Specialty): _____ Phone: _____

Confirmed diagnosis of severe depression (either single or recurrent episode): ☐ Yes ☐ No

Description of response to prior treatment: _____

_____

Two (2) or more trials of psychopharmacological agents in the current or previous episode without adequate response. Treatment trials included antidepressant medication at or above the minimum effective dose and duration:

_____

_____

Treatment trials have included at least one (1) evidence-based medication augmentation therapy with mood stabilizers: ☐ Yes ☐ No

Evidence that the patient is unable to tolerate psychopharmacological agents due to serious side effects:

_____

_____

Does the patient have a history of good response to TMS treatment in a previous depressive episode?

☐ Yes ☐ No (If no, explain: _____

At least two different depression scales administered throughout treatment to monitor clinical response (ie. Beck Depression Inventory, Hamilton Depression Rating Scale, Montgomery-Asberg Depression Scale, Personal Health Questionnaire Depression Scale, or the Quick Inventory of Persistent Symptomatology).
Include copies of completed scales with this document when treatment is requested.

Halcyon Behavioral
P.O. Box 25159 Fresno, CA 93729-5159
Admin Phone: (855) HBI-4HLP
Member Phone: (888) 425-4800
Fax: (888)304-1429

Transcranial Magnetic Stimulation (TMS)

Pretreatment Certification Form

Has the patient received electro-convulsive therapy in the past and/or is TMS being considered as a less-invasive treatment option? ☐ Yes ☐ No

Has the patient received a trial evidenced-based psychotherapy in the treatment of Major Depressive Disorder?
☐ Yes ☐ No If Yes, did the psychotherapy result in any significant improvement? ☐ Yes ☐ No

Will TMS be administered by an FDA-approved TMS device in the treatment of major depression, following recommendations of the manufacturer's use or manual in a safe and effective manner?
☐ Yes ☐ No - Please specify which device will be utilized: _____

Will the treatment course follow specific stimulation parameters? (e.g. five (5) days per week for six (6) weeks, total of 30 sessions, followed by a three-week taper of three (3) treatment sessions for one week, two (2) treatment sessions the next week and one (1) treatment session the following week). ☐ Yes ☐ No

Specify: _____

_____

Does the patient have a history of seizure disorder, or is the patient currently having uncontrolled seizures?
☐ Yes ☐ No

Is the patient displaying any acute psychotic symptoms, or has the patient been diagnosed with schizophrenia, schizophrenic form, or schizoaffective disorder in the current depressive episode? ☐ Yes ☐ No

Does the individual have any neurological condition(s) that includes epilepsy, cerebrovascular disease, increased intracranial pressure, or primary or secondary tumors in the central nervous system?
☐ Yes ☐ No -If yes, list: _____

Does the individual have an implanted magnetic sensitive medical device located less than or equal to 30 cm from the TMS magnet coil? ☐ Yes ☐ No
If yes, check all that apply: ☐ Cochlear Implant ☐ Implanted Cardiac Defibrillator ☐ Pacemaker
☐ VNS stimulator ☐ Metal Aneurysm Clip ☐ Coil, Staples, or Stents ☐ Other Devices

Is this a request for maintenance of TMS treatment? ☐ Yes ☐ No

Is there a recurrence of symptoms after a previous positive response to TMS? _____

If so, what was the initial % of symptom reduction and what rating scale was used? _____

Requested Treatment Start Date: _____ *If retro-date requested, reason needed:* _____

My signature below confirms the information provided is accurate and I am providing the requested services

Provider Signature: _____ Date: _____

Provider Name (Printed): _____ Phone: _____ Fax: _____