BUTLER HOSPITAL

Thank you for contacting Butler Hospital to refer your patient for Transcranial Magnetic Stimulation (TMS) or Esketamine Therapy. Insurance company policies for these treatments have various eligibility requirements for coverage. We must collect and review detailed information about a patient's medical history and past treatment history to determine their eligibility and medical appropriateness. Below we have listed some general criteria for TMS and Esketamine Therapy coverage so you can determine whether your patient may qualify for insurance coverage of these treatments. I am referring my patient for:

☐ TMS Therapy

☐ Esketamine (Spravato)

☐ I'd like the Butler provider to evaluate my patient and recommend which treatment might be best

Transcranial Magnetic Stimulation (TMS)

Inclusion:

- Primary Diagnosis of (unipolar) Major Depressive Disorder; moderate to severe, without psychotic features, recurrent or single episode (F33.2 or F33.1)
- Documented history of (one or more) failed antidepressant trials in the current episode showing either lack of clinical response OR inability to tolerate the medication due to side effects not expected to resolve over time. Specific medication doses and start/end dates are required.
- Past trial of evidence-based psychotherapy targeting depressive symptoms

Exclusion:

Presence of non-removable metal objects in the head (excluding dental metal) or medical conditions that may increase the risk for seizures such as epilepsy, severe brain injury/trauma, stoke, or brain tumor

Esketamine (Spravato)

Inclusion:

- Primary Diagnosis of (unipolar) Major Depressive Disorder; moderate to severe, without psychotic features, recurrent or single episode (F33.2 or F33.1)
- Documented history of (one or more) failed antidepressant trials in the current episode showing either lack of clinical response OR inability to tolerate the medication due to side effects not expected to resolve over time. Specific medication doses and start/end dates are required.
- Must be currently on a stable dose of an FDA-approved oral antidepressant medication

Exclusion:

- Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheralarterial vessels) or arteriovenous malformation, intracerebral hemorrhage, and hypersensitivity toesketamine, ketamine, or any of the excipients
- Current substance use disorder unless in remission (for example, complete abstinence for one month)
- Uncontrolled hypertension (SBP<140 and DBP <80 required for dose administration)

TMS Clinic and Neuromodulation Research Facility

345 Blackstone Blvd., Providence, RI 02906

(401) 455-6632 (401) 455-6686 BRAIN@CareNE.org

BUTLER HOSPITAL

INSTRUCTIONS: Please complete this form and fax it, together with a copy of the patient's most recent office visit note, to (401) 455-6686. If you have any questions, our clinic staff can be reached at (401) 455-6632 or by email at BRAIN@CareNE.org.

REFERRING PROVIDER:

Name: _____ Agency: _____

Phone: _____ Fax: _____

CURRENT OUTPATIENT PROVIDER (if different than above):

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Phone: _____

Primary Psychiatric Diagnosis: _____ Additional Diagnoses: _____

MEDICATION TREATMENT HISTORY:

Please include all medication trials for MDD, including augmenting agents

Medication	Max Dose	Start Date	End Date	Outcome/Side Effects

TREATMENT HISTORY:

Psychotherapy? ☐ Yes ☐ No Name/Dates: _____

TBI or seizures? ☐ Yes ☐ No Describe: _____

Substance Use Disorder? ☐ Yes ☐ No Current Status: _____

Previous ECT treatment? ☐ Yes ☐ No When/where was the last treatment? _____

Previous TMS treatment? ☐ Yes ☐ No When/where was the last treatment? _____

Previous IV Ketamine? ☐ Yes ☐ No When/where was the last treatment? _____

Previous Esketamine? ☐ Yes ☐ No When/where was the last treatment? _____

ADDITIONAL NOTES/RELEVANT CLINICAL INFORMATION:

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