

ECT Authorization Request

Request Information

Expedited Request (by checking this box I certify that this request meets the below criteria for being Expedited and I will supply justification*)

Criteria for Expedited: Waiting for a decision under the standard time frame (up to 14 calendar days) could place the member's life, health, or ability to regain maximum function in serious jeopardy

***Justification for Expedited:**
(Attach pages if add'l space is needed)

Member Name:	DOB:	Policy #
Facility Name:		Facility TIN:
MD Performing Treatment:	Fax #	<input type="checkbox"/> Out of Network
Provider Contact Name:		Contact Phone:
Procedure Code:	Primary Diagnosis:	Requested # of Sessions:
Service Start Date:	Service End Date:	Frequency:

For concurrent/ongoing requests, please go to Page 3

Please select **ONE** diagnosis from either Group A, B OR C below:

Diagnosis Group A	Diagnosis Group B	Diagnosis Group C	Other
<input type="checkbox"/> Acute Mania <input type="checkbox"/> Unipolar or bipolar depression <input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizoaffective <input type="checkbox"/> Psychosis <input type="checkbox"/> Postpartum psychosis	<input type="checkbox"/> Catatonia	<input type="checkbox"/> Neuroleptic malignant syndrome <input type="checkbox"/> Other: Please Specify:

Please select **ALL** relevant symptoms from the list below that correspond with the selected diagnosis:

Diagnosis Group A Symptoms:	Diagnosis Group B Symptoms	Diagnosis Group C Symptoms	Other
<input type="checkbox"/> Suicidal ideation with intent <input type="checkbox"/> Suicidal ideation without current intent <input type="checkbox"/> Severe agitation or aggression <input type="checkbox"/> Delusions <input type="checkbox"/> Hallucinations <input type="checkbox"/> Socially withdrawn <input type="checkbox"/> Significant functional impairment <input type="checkbox"/> Refusal of food/fluids presents a medical risk <input type="checkbox"/> Unremitting self-injury and injuries requiring professional medical attention (not due to a personality disorder) <input type="checkbox"/> Disorganized thinking or speech <input type="checkbox"/> Grossly disorganized	<input type="checkbox"/> Malignant catatonia <input type="checkbox"/> Catatonia not due to a medical condition or persisting despite treatment of the underlying medical condition	The below symptoms are relevant to Neuroleptic Malignant Syndrome ONLY : <input type="checkbox"/> Failure to respond to supportive medical treatment & medication <input type="checkbox"/> Partial response to supportive medical treatment & medication <input type="checkbox"/> Residual catatonic/Parkinsonian symptoms resolution of acute symptoms	<input type="checkbox"/> Other: Please Specify:

Please select **ONE** from the below indicators for ECT treatment:

- Unipolar depression and trials of ≥ 2 different antidepressants from \geq different classes and at adequate doses and duration or stopped due to intolerable adverse effects
 - Bipolar depression and trials of ≥ 2 different medications with established effectiveness for bipolar depression and at adequate doses and duration or stopped due to intolerable adverse effects
 - Trials of ≥ 2 different antipsychotic or mood stabilizing medications and at adequate doses and duration or stopped due to intolerable adverse effects
 - Medications contraindicated due to comorbid medical condition or potential for dangerous interaction with medications needed for comorbid medical condition
 - Substantial morbidity or mortality associated with delay in pharmacotherapeutic response
 - History of positive response to prior ECT
 - Other clinical information (add comment)
- For Neuroleptic Malignant Syndrome ONLY (choose one):**
- Failure to respond, or only partial response, to supportive medical treatment and medication
 - Residual catatonic or Parkinsonian symptoms following resolution of acute symptoms
 - Other clinical information (add comment)

Pre-electroconvulsive Therapy (ECT) workup including informed consent

Do you have a signed informed consent for ECT treatment in the record? Yes No

Pre-electroconvulsive therapy (ECT) workup completed, and clearance given? Yes No

Complete the Following for Concurrent Reviews Only

Treatment Information

Date last ECT session completed:	Number of sessions completed since last authorization:
Start Date of Next Session:	Estimated Series End Date:
Frequency:	Positive response to acute or short-term ECT <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Diagnosis (if changed):	Bilateral or unilateral treatments: <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral

Please select ONE or more from the below indicators for Continuation of ECT or Maintenance:

- Electroconvulsive therapy was administered for major depressive episode
- Medications contraindicated due to comorbid medical condition or potential for dangerous interaction with medications needed for comorbid medical condition
- Current or history of medication refractory or resistant symptoms
- Better response was obtained from electroconvulsive therapy plus medication than from medication alone
- History of previous positive response to electroconvulsive therapy (ECT) followed by partial or complete relapse when ECT was stopped
- Patient prefers electroconvulsive therapy
- Other clinical information (Please specify):

Pre-electroconvulsive Therapy (ECT) workup including informed consent

Please choose ONE from the list below:

- Workup not needed because acute or short term ECT completed within last 90 days
- Workup completed and clearance given for continuation or maintenance ECT starting greater than 90 days after completion of acute or short-term ECT
- Workup completed and clearance given for annual workup and clearance for ongoing ECT
- Other clinical information (Please specify):

Additional Comments: