commonwealth care alliance®

Date of Request

ECT Authorization Request

Clear Form

Fax completed form to (855) 341-0720

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 7 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'tl space is needed)		
Member Name:	**DOB:**	**Policy #**
Facility Name:	**Facility TIN:**	
MD Performing Treatment:	**Fax #**	☐ **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**
☐Acute Mania ☐Unipolar or bipolar depression ☐Schizophrenia	☐ Schizoaffective ☐Psychosis ☐Postpartum psychosis	☐Catatonia	☐Neuroleptic malignant syndrome	☐ 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**
☐ Suicidal ideation with intent ☐ Suicidal ideation without current intent ☐ Severe agitation or aggression ☐ Delusions ☐ Hallucinations ☐ Socially withdrawn ☐ Significant functional impairment ☐ Refusal of food/fluids presents a medical risk ☐ Unremitting self-injury and injuries requiring professional medical attention (not due to a personality disorder) ☐ Disorganized thinking or speech ☐ Grossly disorganized	☐ Malignant catatonia ☐ 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:** ☐ Failure to respond to supportive medical treatment & medication ☐ Partial response to supportive medical treatment & medication ☐ Residual catatonic/Parkinsonian symptoms resolution of acute symptoms	☐ Other: Please Specify:

Please select **ONE** from the below indicators for ECT treatment:
☐ Unipolar depression and trials of ≥ 2 different antidepressants from ≥ 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 ☐ Yes ☐ No
Primary Diagnosis (if changed):	Bilateral or unilateral treatments: ☐ Bilateral ☐ 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: