AmeriHealth Caritas™
New Hampshire

Outpatient Electroconvulsive Therapy (ECT) Prior Authorization Request Form

Submit to Utilization Management
Fax: 1-833-469-2264
For assistance, please call 1-833-472-2264

Authorization is based on medical necessity. Incomplete or illegible forms will delay processing.

Please provide all relevant clinical information, including failed medication trials if applicable.
A telephonic review may be required if additional clinical information is required to determine medical necessity.

Please note: If member is currently hospitalized, request for ECT will be completed by telephonic review during clinical concurrent review for mental health inpatient stay.

Date of request:	Requested start date:	Tentative end date:
Type of request		
☐ Initial outpatient — # of units:	☐ Maintenance outpatient — # of units:	

Demographic information		
Patient name:		
Date of birth:	Age:	Medicaid or member ID number or SSN:

Provider information		
Treating provider name:	Agency name:	
Phone:	Fax:	Medicaid, NPI, or tax ID number:
Address:		

☐ In network ☐ Out of network ☐ In credentialing process (If out of network, please complete the section below.)
Utilization Management will contact provider directly before giving an authorization.

1. Specialty of provider to meet the needs of the member:
2. Continuity of care concerns:
3. Accessibility/availability of provider:
4. Clinical rationale:

Diagnoses		
Primary diagnosis:	**Secondary diagnosis:**	**Tertiary diagnosis:**

Acute/short-term clinical information

If any of 1 – 3 are selected, please skip to box B; if 4 is selected, please move to box A.
☐ 1. Depression, mania, or psychosis **with** active suicidal ideation with intent.
☐ 2. Catatonia not due to a medical condition **or** persistent despite medical condition.
☐ 3. Neuroleptic malignant syndrome with inadequate response or failure to respond to supportive medical treatment **or** continued residual symptoms.
☐ 4. Depression, mania, or psychosis **without** active suicidal ideation with intent.

Box A (please select all that apply):
☐ Failed medication trials at adequate doses and duration or stopped due to adverse effects
☐ Comorbid medical condition and medications contraindicated
☐ Unable to wait on medication effectiveness due severity of symptoms and high risk of morbidity
☐ Previous positive response to ECT

Box B — must select both:
☐ Pre-ECT workup completed and clearance given
☐ Informed consent obtained

Continuation/maintenance ECT clinical information
Please select all that apply: ☐ Previous positive response to ECT ☐ ECT due to depressive symptoms ☐ Comorbid medical condition and medications contraindicated ☐ History of or current resistant symptoms ☐ ECT plus medications produced better response than medications alone ☐ Partial or complete relapse of symptoms after ECT stopped ☐ Member prefers ECT
Pre-ECT workup completed and clearance given **and** informed consent obtained ☐ Yes ☐ No Please select one of the below: ☐ Not needed due to acute/short-term ECT completed within last 90 days ☐ Continuation or maintenance starting more than 90 days after completion of acute/short-term ECT ☐ Annual workup completed for maintenance ECT Both are required: ☐ 20 or fewer treatments planned ☐ Treatment will be completed within one year

Provider signature: Date: