AmeriHealth Caritas Delaware

Prior Authorization Request Form for Vagus Nerve Stimulation

Submit to: Behavioral Health Utilization Management
Fax: 1-877-234-4273
For assistance, please call: 1-855-301-5512

Please complete all sections of this form as thoroughly as possible. You may also include any additional clinical information pertinent to this authorization request.

Date:

MEMBER INFORMATION	
Member name:	Member ID number:
Date of birth:	Age:

PROVIDER INFORMATION	
Provider name:	Provider NPI/tax ID number:
Provider address:	
Provider phone:	Provider fax:
Place of service: ☐ Ambulatory surgery center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other:	
Name, NPI number, and phone and fax numbers for the above place of service:	
Name:	NPI number:
Phone number:	Fax number:

PROCEDURE INFORMATION	
Requested service or procedure:	Scheduled date of service (month/day/year):
Procedure code(s):	Primary diagnosis with code:
Secondary diagnosis with code:	Tertiary diagnosis with code:

Please answer all of the following questions:

1. Member is 18 years of age or older? ☐ Yes ☐ No
2. Member is pregnant or breast feeding? ☐ Yes ☐ No
3. Device being used is FDA approved? ☐ Yes ☐ No

For depression:

1. Member has a diagnosis of major depressive disorder, single or recurrent? ☐ Yes ☐ No
2. Member has failed four or more antidepressant trials from two different pharmacological classes **or** three or more antidepressant trials from two different pharmacological classes and an augmenting agent due to lack of improvement or intolerable side effects? ☐ Yes ☐ No
3. Continued depressive symptoms after completion of one course of electroconvulsive therapy (ECT) treatment? ☐ Yes ☐ No
4. No contraindications noted? (Select all that apply.)
   - ☐ No acute or chronic psychotic symptoms
   - ☐ No imminent risk known (e.g., suicidal ideation)
   - ☐ No current or known substance use at the time of treatment
   - ☐ No neurological conditions (e.g., dementia)
   - ☐ No left cervical vagotomy by history
   - ☐ No cardiac pacemaker or implantable cardioverter defibrillator

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For epilepsy:

1. Member is diagnosed with refractory epilepsy **and** has had epilepsy surgery? ☐ Yes ☐ No
   - Epilepsy is confirmed by EEG? ☐ Yes ☐ No
   - Member has experienced continued seizure activity after epilepsy surgery? ☐ Yes ☐ No
2. Member is diagnosed with refractory epilepsy **and is not** a candidate for epilepsy surgery **or** the member is diagnosed with generalized seizure disorder? ☐ Yes ☐ No
   - Member has failed antiepileptic drug therapy? ☐ Yes ☐ No
   - Member experienced continued seizure activity despite medication? ☐ Yes ☐ No
   - Seizure activity negatively affects activities of daily living? ☐ Yes ☐ No
   - Epilepsy confirmed by EEG? ☐ Yes ☐ No

Provider or requestor signature:
Date: