AmeriHealth Caritas Delaware

Outpatient Electroconvulsive Therapy (ECT) Prior Authorization Request Form

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

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 - number of units:	☐ Maintenance outpatient - number of units:	

DEMOGRAPHIC INFORMATION

Patient name:		
Medicaid ID, Social Security number, or patient ID:	Age:	Date of birth:

PROVIDER INFORMATION

Treating provider name:		
Agency name:		
Medicaid/NPI/tax ID:	Phone:	Fax:
Address:		

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

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

DIAGNOSES

Primary diagnosis:	Secondary diagnosis:	Tertiary diagnosis:

ACUTE OR 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 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 to 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

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CONTINUATION AND 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 and short-term ECT completed within last 90 days
☐ Continuation or maintenance starting more than 90 days after completion of acute and short-term
☐ Annual workup completed for maintenance ECT

Both are required:
☐ 20 or fewer treatments planned
☐ Treatment will be completed within one year

Provider or requestor signature:
Date: