MAGELLAN HEALTH SERVICES
Getting Better All the Time

Request for Electroconvulsive Therapy (ECT)

The attending psychiatrist/treating provider must complete this form. Please provide all requested information, subject to applicable law. **Authorization for Electroconvulsive Therapy (ECT) will not be considered until all sections of this form are completed.** Please send the completed form and all attachments to: Magellan Health Services of Arizona, P.O. Box 68140, Phoenix, AZ 85082-8140, or by facsimile to 1-888-290-1285. **Please print clearly.**

I. Recipient Demographics

Name: Title XIX/XXI ☐Y ☐N SMI ☐Y ☐N	Recipient ID #: Date Of Birth:

II. Inpatient/Outpatient Treatment Provider ☐ Filled out this form

Clinic and Site: Phone #:	BHMP: Case Manager:	Inpatient Facility: Attending MD:

III. ECT Provider Information ☐ Filled out this form

Name: Site of ECT:	Fax #: Telephone #: E-Mail:

IV. Current or Provisional DSM-IV Diagnoses

Axis I	
1.	3.
2.	4.
Axis II	
1.	3.
2.	4.
Axis III	
1.	3.
2.	4.
Axis IV	
1.	
2.	
Axis V	
Current GAF:	Highest GAF in Past Year:

V. Communication with Outpatient Provider This section must be completed before rest of request will be reviewed. Verification of the communication may be requested by Magellan.

Please document communication between ECT provider and outpatient prescriber:

VI. PCP Communication

Name:	Phone:	Comments:

VII. Rationale for Requesting ECT

VIII. Psychiatric and Medical Evaluation/Examination

What is the rationale for requesting authorization for ECT (e.g., failure of adequate trials of antidepressants, specific psychiatric or physical condition, unable to tolerate medication side-effects, etc.)? Please provide the following specific details:

Level of severity of current episode: ☐**Severe** ☐**Moderate as evidenced by what symptoms or behaviors:**

SYMPTOM	SEVERITY (DESCRIBE)	DURATION
Depression		
Mania		
Psychosis		
Catatonia		
Agitation		
Energy		
ADLs		
Other		

Co-morbid issues such as Axis II or substance abuse (please describe):

Prior Pharmacologic Failures: Please identify when used simultaneously.

Medication/Max Dose	Year	Duration	Reason for failure

Prior Hospitalizations:

Facility/City	Month/Year	Reason

Current Outpatient Treatment:

Provider/City	Dates	Services

Prior ECT Treatments:

Provider/City	Dates	Outcome

Has member been compliant with past medication treatment: ☐YES If no please describe:

Does member have co-morbid medical conditions or severe side effects that prevent appropriate psychiatric medication treatment:

☐NO If Yes please describe:

If the member is pregnant does the risk of non-treatment outweigh the risk of ECT? ☐NO. If Yes please provide results of consult from Ob-Gyn MD.

Please attach copies of the following supporting documents:

- **Current admission psychiatric evaluation (No older than 7 days) to include mini-mental status exam.**
- **Current medical history and physical (No older than 7 days).**
- **Current Urine Drug Screen results.**

IX. Informed Consent

Has the recipient (and family) been educated and given informed consent for ECT? ☐ YES (Please attach copy of signed consent)

If NO, please explain:

X. Current Medications (Medical and Psychiatric)

Note: Medication contraindications: If recipient is antihypertensive with a beta blocker or calcium channel blocker, medication change to ACE inhibitor or diuretic. Lithium, Aminophylline or Theophylline should not be prescribed. Anticonvulsants should be used with caution as they complicate ECT

Medication/Dose	Reason	Duration of Use

XI. Need for Inpatient Stay during ECT

Please identify any of the following conditions that make inpatient hospitalization necessary for ECT:

☐Co-morbid medical conditions making ECT without intensive monitoring unsafe

☐Lack of social support or transportation to and from sessions

☐Severity of member symptoms

☐Member unable to comply with post-procedure instructions.

Please explain:

XII. Intensity of Service

The following requirements must be met to approve an ECT request. Magellan reserves the right to request and review the following protocols:

- Anesthesia evaluation performed by an anesthesiologist or other qualified anesthesiology professional**.**
- A medically necessary and appropriate individualized treatment plan, or its update, specific to the patient's psychiatric and/or medical conditions.
- Continuous physiologic monitoring during ECT treatment.
- Monitoring for and management of adverse effects during the procedure.
- Post-ECT stabilization and recovery services.

XII. Follow-up Plan

If recipient is inpatient, how long do you expect hospitalization to continue?

For outpatient ECT request (or after d/c from inpatient ECT), identify who will be responsible for the individual?

What other services will recipient need after completion of ECT course/discharge?

Attending Physician Signature Block

Name: (Print):	Signature:	Date:

Effective Date 7/11/13