BUTLER HOSPITAL
a Care New England Hospital

TMS Clinic and Neuromodulation Research Facility
345 Blackstone Blvd., Providence, RI 02906
OFFICE: 401.455.6632 | FAX: 401.455.6686 | EMAIL:BRAIN@CareNE.org

Thank you for contacting Butler Hospital to refer your patient for Transcranial Magnetic Stimulation (TMS) or Esketamine Therapy. Insurance companies have coverage policies for these treatments; however, we must review and collect detailed information to determine eligibility and medical appropriateness. Although each insurance plan is different, we have listed some general TMS and Esketamine guidelines for you to review to see if your patient may be a potential fit for these treatments.

Transcranial Magnetic Stimulation (TMS)
Inclusion:

- **Primary Diagnosis of unipolar Major Depressive Disorder; moderate to severe, without psychotic features (F33.2 or F33.1)**
- Documented history of failed antidepressant trials (dates/doses/duration is required) showing either lack of clinical response or inability to tolerate medication
- Trial of evidence-based psychotherapy

Exclusion:

- Presence of metallic objects in the head (excluding mouth) or medical conditions that may increase the risk for seizures such as history of seizures, epilepsy, severe brain injury/trauma, stoke, or brain tumor

Esketamine (Spravato)
Inclusion:

- **Primary Diagnosis of unipolar Major Depressive Disorder; moderate to severe, without psychotic features (F33.2 or F33.1)**
- Documented history of failed antidepressant trials (dates/doses/duration is required) showing either lack of clinical response or inability to tolerate medication
- Must be currently on a stable dose of an oral antidepressant

Exclusion:

- Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels) or arteriovenous malformation, intracerebral hemorrhage, and hypersensitivity to esketamine, ketamine, or any of the excipients
- Current substance use disorder unless in remission (for example, complete abstinence for one month)
- Uncontrolled hypertension

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Instructions: Please complete the following information about your patient. Please complete and fax this form with their last office visit note to 401-455-6686. If you have any questions, our clinic staff can be reached at 401-455-6632 or by email at BRAIN@carene.org.

REFERRING PROVIDER:
Name: _____Agency: _____
Phone: _____ Fax: _____

CURRENT OUTPATIENT PROVIDER (if different than above): _____

PATIENT INFORMATION:
Name: _____ Date of Birth: _____
Phone #: _____

PSYCHIATRIC DIAGNOSIS:
Primary Psychiatric Dx: _____ Additional Dx: _____

MEDICATION TREATMENT HISTORY: Please include all current and past medications taken for mood including augmenting agents.

Medication:	Max Dose:	Start Date:	End Date:	Outcome/Side Effects:

TREATMENT HISTORY:
In psychotherapy? ◯ Yes ◯ No Therapist's name: _____
History of seizures? ◯ Yes ◯ No Current status: _____
History of substance use? ◯ Yes ◯ No Current status: _____
Previous ECT treatment? ◯ Yes ◯ No When and where was the last treatment? _____
Previous TMS treatment? ◯ Yes ◯ No When and where was the last treatment? _____
Previous Ketamine Therapy? ◯ Yes ◯ No When and where was the last treatment?

Additional Notes/Relevant Clinical Information:
_____
_____
_____

I am referring my patient for:
- ☐ **TMS Therapy**
- ☐ **Esketamine (Spravato)**
- ☐ **I'd like the Butler provider to evaluate my patient and recommend which treatment might be best**