OhioHealthy

Electroconvulsive Therapy (ECT) Authorization Request

To request authorization, fax the following to 330-656-2449 or 1-800-385-7085
Member Name: _____ DOB: _____ Member ID#: _____
Psychiatrist Name: _____ Tax ID: _____ NPI #: _____
Facility where ECT will be administered: _____ Number of requested units: __
Diagnosis of a psychiatric condition amenable to ECT treatment: _____

Acute request: (check all that apply)
Pretreatment symptoms rated as severe Y____ N____
Patient has undergone medication review and clearance Y____ N____ Date of clearance: _____
Need for ECT, as indicated by 1 or more of the following: (if applicable)

- ☐ Catatonia
- ☐ High risk for suicide attempt
- ☐ Intractable manic excitement [C](21)
- ☐ Neuroleptic malignant syndrome (23)(24)
- ☐ Nutritional compromise
- ☐ Pharmacotherapy not preferred due to risk of adverse effects (i.e, pregnant or elderly patients)
- ☐ Unremitting self-injury

Inadequate response to pharmacotherapy despite ALL of the following (required):

- ☐ Adequate duration and dosage
- ☐ Documented adherence
- ☐ Trials from 2 or more classes of medications with adjuvants

Extension request (check all that apply)
Extension of acute treatment as indicated by ALL of the following:

- ☐ Partial response to treatment.
  Please describe: _____
- ☐ Treatment is being re-evaluated and modified (i.e. switch from unilateral to bilateral lead placement, medication of stimulus parameters).
  Indicate: _____

Maintenance request (check all that apply):

- ☐ Clinical determination that maintenance treatment needed to reduce risk of relapse
- ☐ Adjunctive pharmacotherapy optimized as indicated
- ☐ Sessions tapers from lowest frequency that maintains response
  Indicate: _____

Documented member resistance to psychopharmacological agents demonstrated by:

Medication Name	Maximum Dose	Duration	Last Prescribed	Prescribing Physician