AmeriHealth Caritas
New Hampshire

Prior Authorization Request Form for Vagus Nerve Stimulation (VNS)

Submit to Utilization Management
Fax: 1-833-469-2264
For assistance, please call 1-833-472-2264

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

☐ Initial treatment request	☐ Repeat course of treatment request	Date of request:

Member information		
Member name:	Date of birth:	Age:
Medicaid or member ID number:	Date of request:	

Provider information	
Provider name:	NPI/TIN number:
Provider address:	
Provider phone:	Provider fax:
Place of service (name, NPI number, and phone and fax numbers):	
☐ Ambulatory surgery center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other:	
Name, NPI number, and phone and fax numbers for selected place of service:	
Name:	NPI number:
Phone:	Fax:

Procedure information	
Requested service/procedure:	
Scheduled date of service (month/day/year):	Procedure codes:
Primary diagnosis with code:	
Secondary diagnosis with code:	
Tertiary diagnosis with code:	

Please answer all of the following questions:

1. Is member 18 years old or older? ☐ Yes ☐ No
2. Is member pregnant or breastfeeding? ☐ Yes ☐ No
3. Is device being used FDA approved? ☐ Yes ☐ No

For depression:

1. Does the member have a diagnosis of major depressive disorder, single or recurrent? ☐ Yes ☐ No
2. Has the member 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 a lack of improvement or intolerable side effects? ☐ Yes ☐ No
3. Does the member have continued depressive symptoms after completing one course of ECT treatment? ☐ Yes ☐ No
4. Are there 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 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. Is the member diagnosed with refractory epilepsy **and** have they had epilepsy surgery? ☐ Yes ☐ No
   - Has epilepsy been confirmed by EEG? ☐ Yes ☐ No
   - Has the member experienced continued seizure activity after epilepsy surgery? ☐ Yes ☐ No
2. Is the member diagnosed with refractory epilepsy **and not** a candidate for epilepsy surgery **or** is the member diagnosed with generalized seizure disorder? ☐ Yes ☐ No
   - Has the member failed antiepileptic drug therapy? ☐ Yes ☐ No
   - Has the member experienced continued seizure activity despite medication? ☐ Yes ☐ No
   - Does seizure activity negatively affect activities of daily living? ☐ Yes ☐ No
   - Has epilepsy been confirmed by EEG? ☐ Yes ☐ No

Provider signature: Date: