

An eligible patient for NeuroStar TMS Therapy has shown resistance, during the current episode of Major Depressive Disorder, to **one** treatment. The treatment must have been administered for at least four weeks, at or above the minimum effective dose as defined by the attached Approved Treatment List. The ATR will clarify and capture for your records a patient's eligibility for NeuroStar TMS Therapy.

| | | | |
|----------|--|--------------------------|--------------------------|
| 1 | Does the patient meet the criteria for MDD as defined in the DSM-IV? | NO | YES |
| | | <input type="checkbox"/> | <input type="checkbox"/> |

Create a treatment record chart on the next page to use in answering Questions 2 - 3 below. List all treatments administered in the current episode.

For NeuroStar eligibility decisions, a **treatment** is:

1. An antidepressant medication **NOTE:** Write each medication, whether administered alone or in combination, on a separate line. For your own records, indicate combinations by circling medications administered together.
2. A medication plus an augmenting agent..... **NOTE:** If, after starting a medication, an augmenting agent was added, count that date as ending one treatment and starting another. Re-write the name of the medication and the agent on the next line.
3. A course of ECT

*Answer all questions for each line independently.
Refer to the Approved Treatment List on the back of this page for treatment names and minimum dose.
When you have completed the treatment record chart, return to this page to answer Questions 2-3.*

| | | | |
|----------|--|--------------------------|--------------------------|
| 2 | Is there at least one treatment on the chart for which all the answers are YES? | NO | YES |
| | | <input type="checkbox"/> | <input type="checkbox"/> |

If not, please create a treatment record chart for the most recent episode in which treatment occurred. Return to this question when the chart is complete.

| | | | |
|----------|--|--------------------------|--------------------------|
| 3 | Is there only one treatment on the chart for which all the answers are YES? | NO | YES |
| | | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer to all three questions on this page is YES, the patient is eligible for NeuroStar TMS Therapy.

Approved Treatment List



| Treatment Type | Brand Name | Minimum Effective Dose |
|--|-------------------------------|---|
| ANTIDEPRESSANT MEDICATION | | |
| TCA/Tetracyclic | | |
| Amitriptyline | Elavil® Endep® | 200 mg |
| Imipramine | Tofranil® | 200 mg |
| Desipramine | Norpramin® Pertofrane® | 200 mg |
| Trimipramine | Surmontil® | 200 mg |
| Clomipramine | Anafranil® | 200 mg |
| Maprotilene | Ludiomil® | 200 mg |
| Doxepin | Sinequan® | 200 mg |
| Nomifensine | Merital® | 200 mg |
| Nortriptyline | Pamelor® Aventyl® | 75 mg |
| Protriptyline | Vivactil® | 40 mg |
| SSRI | | |
| Fluoxetine | Prozac® | 20 mg |
| Citalopram | Celexa® | 20 mg |
| Fluvoxamine | Luvox® | 200 mg |
| Paroxetine | Paxil® | 20 mg |
| Sertraline | Zoloft® | 100 mg |
| Escitalopram | Lexapro® | 10 mg |
| Paroxetine CR | Paxil CR™ | 25 mg |
| SNRI | | |
| Venlafaxine | Effexor IR™ Effexor XR® | 225 mg |
| Duloxetine | Cymbalta® | 40 mg |
| Other Antidepressants | | |
| Bupropion | Wellbutrin® | 300 mg |
| Bupropion XL | Wellbutrin® XL | 300 mg |
| Mirtazapine | Remeron® | 30 mg |
| Nefazodone | Serzone® | 300 mg |
| Trazodone | Desyrel® | 400 mg |
| Amoxapine | Asendin® | 400 mg |
| Reboxetine | -- | 8 mg |
| MAOI | | |
| Phenelzine | Nardil® | 60 mg |
| Moclobemide | -- | 300 mg |
| Selegiline | Eldepryl® | 40 mg |
| Selegiline transdermal patch | Emsam® | 6 mg |
| Tranylcypromine | Parnate® | 40 mg |
| Isocarboxazid | Marplan® | 40 mg |
| AUGMENTING AGENT count only those listed here | | |
| Aripiprazole or other atypical | Abilify®, others | any dose |
| Lithium | Eskalith®, Lithobid®, others | any dose |
| Thyroid Hormone Replacement | Synthroid®, Levoxyol®, others | any dose |
| ECT | | |
| Unilateral, bilateral or unknown | | ≥ 7 treatments total during one episode |

| Episode Start Date | Was this treatment given at or above the minimum effective dose? | | Was the minimum effective dose sustained for at least four weeks? | | Are you at least moderately confident the patient was compliant? | | Was the clinical outcome unsatisfactory ? • Marginally improved • No change • Worse | | Are you at least moderately confident in the information source for this outcome? | |
|--------------------|--|---------------------------------|---|---------------------------------|--|---------------------------------|---|---------------------------------|---|---------------------------------|
| TREATMENT NAME | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 1 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 2 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 3 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 4 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 5 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 6 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 7 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 8 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 9 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 10 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 11 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 12 | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> |

| Episode Start Date | Was this treatment given at or above the minimum effective dose? | | Was the minimum effective dose sustained for at least four weeks? | | Are you at least moderately confident the patient was compliant? | | Was the clinical outcome unsatisfactory ? • Marginally improved • No change • Worse | | Are you at least moderately confident in the information source for this outcome? | |
|--------------------|--|--------------------------|---|--------------------------|--|--------------------------|---|--------------------------|---|--------------------------|
| TREATMENT NAME | NO | YES | NO | YES | NO | YES | NO | YES | NO | YES |
| 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| 7 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| 10 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Use both sides of the page when needed. For additional space, copy the chart.