MENTAL HEALTH SPECIFIC REFERRAL CHECKLIST

All referrals and authorization requests require the TRICARE West Region Referral/Authorization Form found on Availity in the TRICARE West Payer Space. In addition, Mental Health specific requests require an associated checklist. Please click on the treatment being requested below and complete the checklist and submit with your request:

1. Emergency Acute Hospital Psychiatric Admission (BH_IP_ER_MH) *(must notify TriWest within 1 business day of admission)*
2. Non-Emergency Acute Hospital Psychiatric Admission (BH_IP_ROUTINE) *(Pre-Authorization Required)*
3. Acute Hospital Psychiatric Admission Continued Stay *(Pre-Authorization Required)*
4. Emergency Inpatient SUD Detoxification ASAM 4.0 (BH_IP_ER_SUD) *(must notify TriWest within 1 business day of admission)*
5. Non-Emergency Inpatient SUD Detoxification ASAM 4.0 (BH_IP_SUD) *(Pre-Authorization Required)*
6. Inpatient SUD Detoxification ASAM 4.0 Continued Stay *(Pre-Authorization Required)*
7. Child and Adolescent under age 21 Residential Treatment Center (RTC) Admission (BH_RTC) *(Pre-Authorization Required)*[1]
8. Child and Adolescent under age 21 Residential Treatment Center (RTC) Continued Stay
9. Emergency Substance Use Disorder ASAM 3.7 Detoxification (BH_RTF_DTX_ER)
10. Non-Emergency Substance Use Disorder ASAM 3.7 Detoxification (BH_RTF_DTX)
11. Detoxification Continued Stay ASAM 3.7 SUD
12. Substance Use Disorder Rehabilitation Facility (SUDRF) Admission (BH_RTC) *(Pre-Authorization Required)*[1]
13. Substance Use Disorder Rehabilitation Facility Continued Stay
14. Partial Hospitalization Program (PHP) Admission (BH_PHP/BH_PHP_SUD) *(PCM Referral or Pre-Authorization Required)*
15. Intensive Outpatient Program (IOP) Admission (BH_IOP/BH_IOP_SUID) *(PCM Referral or Pre-Authorization Required)*
16. Opioid Treatment Programs (BH_OTP) *(Pre-Authorization Required)*
17. Psychological/Neuropsychological Testing (BH_PSYTEST) *(Pre-Authorization Required)*
18. Esketamine (BH_Spravato) *(Pre-Authorization Required)*
19. Transcranial Magnetic Stimulation (TMS) for Depression (BH_TMS) *(Pre-Authorization Required)*
20. Electroconvulsive Therapy (BH_ECT) *(Pre-Authorization Required)*
21. Medication Assisted Treatment (BH_MAT) *(Pre-Authorization Required)*
22. Long Acting Injectable Anti-psychotic Medications (BH_LAI) *(Pre-Authorization Required)*

[1] Per the TRICARE Policy Manual, Chapter 7, Section 3.2, Residential treatment is only a covered benefit for beneficiaries under the age of 21. Residential care for adults (including active duty) is not a covered benefit except for substance use disorder treatment when medically necessary. Admission to sub-acute inpatient specialty Mental Health programs may be approved on a week-to-week basis as *non-emergency acute psychiatric hospitalization* if medical necessity criteria are met.

MENTAL HEALTH SPECIFIC REFERRAL CHECKLIST

IMPORTANT NOTES

Please read the following important items regarding Mental Health specific referrals:

- Office based outpatient mental health services (psychotherapy and medication management) do not require a referral or pre-authorization except for Active-duty Service Members (ADSMs), who require a referral from their Primary Care Manager (PCM).
- Military Medical Treatment Facilities (MTFs) submit requests via MHS GENESIS. Submissions must include a level of detail to ensure the outlined medical necessity requirements are met or should include accompanying documentation as outlined in the associated checklist.
- TRICARE does not limit hospital days for psychiatric admissions.
- Requests for admission must include a face-to-face assessment by a licensed physician or mental health provider. **Phone triage or RN acceptance notes are not acceptable.**
- The beneficiary must be diagnosed with a mental disorder recognized by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD), which includes Substance Use Disorders (SUDs).
- To meet medical necessity criteria, documentation of both symptoms and impairment is required.
- Interventions/Conditions not covered include, but are not limited to:
  - Educational testing
  - Learning disorders
  - Paraphilias
  - Sex therapy
  - Couples/marital therapy
  - DSM/ICD-9 V codes
  - ICD-10 Z codes
  - Conditions not attributed to a mental disorder
  - TMS for conditions other than depression
  - Stellate ganglion blockade
  - Intravenous/intramuscular Ketamine treatment for psychiatric conditions

EMERGENCY ACUTE HOSPITAL PSYCHIATRIC ADMISSION CHECKLIST (BH_IP_ER_MH)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as an emergency room assessment or a mental health evaluation.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.1, authorizes coverage of acute hospital psychiatric care to stabilize life-threatening or severely disabling conditions within the context of a brief, intensive model of inpatient care when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD.
- ☐ Poses an **immediate** risk of **serious** harm to self or others, as assessed **by the admitting clinician**, *and*
- ☐ Requires imminent continuous skilled observation and treatment at the acute psychiatric level of care

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

NON-EMERGENCY ACUTE HOSPITAL PSYCHIATRIC ADMISSION CHECKLIST (BH_IP_ROUTINE)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as crisis assessment note, Emergency Room evaluation, recent clinician progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.1, authorizes coverage of acute hospital psychiatric care to stabilize life-threatening or severely disabling conditions within the context of a brief, intensive model of inpatient care when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD.
- ☐ Requires continuous, skilled observation and assessment by skilled nursing staff, *or* —
- ☐ Requires continued intervention by a multidisciplinary treatment team, *plus one of the following*:
  - ☐ Poses serious risk of harm to self or others, as assessed **by the referring or admitting clinician**
  - ☐ Needs high-dosage, intensive medication or somatic and/or psychological treatment with potentiallyserious side effects
  - ☐ Has an acute disturbance of mood, behavior, and or thinking

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

ACUTE HOSPITAL PSYCHIATRIC ADMISSION CONTINUED STAY CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with recent document that show continued medical necessity, such as recent clinician progress notes, nursing notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.1, directs that concurrent review of medical necessity will be conducted at least weekly. Continued stays in acute hospital psychiatric care are considered medically necessary when they meet the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD
- ☐ Still requires continuous, skilled observation and assessment by skilled nursing staff, or —
- ☐ Still requires continued intervention by a multidisciplinary treatment team, *plus one of the following*:
  - ☐ Still poses **serious** risk of harm to self or others, as assessed **by the treating clinician**
  - ☐ Still needs high-dosage, intensive medication or somatic and/or psychological treatment withpotentially serious side effects
  - ☐ Continues to demonstrate an acute disturbance of mood, behavior, and or thinking

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

EMERGENCY INPATIENT SUBSTANCE USE DISORDER DETOXIFICATION ASAM 4.0 CHECKLIST (BH_IP_ER_SUD)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting document that show medical necessity, such as Emergency Room Assessment, Psychiatrist Assessment/H & P, vital signs, nursing notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of Emergency Inpatient Detoxification when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable Substance Use Disorder (SUD) recognized by the latest version of the DSM or ICD
- ☐ Requires the personnel and facilities of a hospital for medical stabilization or to treat active medical complications of intoxication or withdrawal

Date of admission (MM/DD/YYYY):
Date of discharge (MM/DD/YYYY) *(if already discharged)*:

LOCATION OF CARE:

- ☐ Inpatient (ASAM Level 4)

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

NON-EMERGENCY INPATIENT SUBSTANCE USE DISORDER DETOXIFICATION ASAM 4.0 CHECKLIST (BH_IP_SUD)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as mental health provider assessment note, Emergency Room evaluation, recent clinician progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of Non-Emergency Inpatient Detoxification when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable Substance Use Disorder (SUD) recognized by the latest version of the DSM or ICD
- ☐ Will require the personnel and facilities of a hospital to treat the medical complications of their SUD andto mitigate potential medical complications of withdrawal following admission

Desired date of admission (MM/DD/YYYY):

LOCATION OF CARE:

- ☐ Inpatient (ASAM Level 4)

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

INPATIENT SUBSTANCE USE DISORDER DETOXIFICATION ASAM 4.0 CONTINUED STAY CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with recent document that show continued medical necessity, such as recent clinician progress notes, nursing notes, vital signs, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of Inatient Detoxification when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable SUD recognized by the latest version of the DSM or ICD
- ☐ Still requires the personnel and facilities of a hospital to treat the medical complications of their SUD and to mitigate medical complications of withdrawal

LOCATION OF CARE:

- ☐ Inpatient (ASAM Level 4)

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

CHILD UNDER AGE 21 RESIDENTIAL TREATMENT CENTER (RTC) ADMISSION CHECKLIST[1] (BH_RTC)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychosocial assessment, clinician progress notes, nursing notes (if currently inpatient), etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.2, authorizes coverage of RTC admissions when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD
- ☐ Is under 21 years old
- ☐ Exhibits patterns of disruptive behavior with disturbances in family functioning or social relationships and persistent psychological/emotional disturbances
- ☐ Cannot be safely managed at a lower level of care
- ☐ Is anticipated to receive active clinical treatment and an individualized treatment plan that will provide a specific level of care, measurable and relevant goals, skilled interventions by qualified mental health professionals, time frames for achieving proposed outcomes, timely reviews and updates to the treatment plan that reflect thoughtful alterations in the treatment regimen, goals, and level of care required for each problem, and explanations of any failure to achieve the treatment goals and objectives
- ☐ Parent(s)/guardian(s) agree to participate in regular family therapy unless contraindicated

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

[1] Per the TRICARE Policy Manual, Chapter 7, Section 3.2, Residential treatment is only a covered benefit for beneficiaries under the age of 21. Residential care for adults (including active duty) is not a covered benefit except for substance use disorder treatment when medically necessary. Admission to sub-acute inpatient specialty Mental Health programs may be approved on a week-to-week basis as *non-emergency acute psychiatric hospitalization* if medical necessity criteria are met.

MENTAL HEALTH SPECIFIC REFERRAL CHECKLIST

RESIDENTIAL TREATMENT (RTC) CONTINUED STAY CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show a continued medical necessity, such as recent progress notes (including family therapy notes for RTC), treatment plan updates, vital signs (for eating disorder patients), etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.2, authorizes coverage of RTC when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Continues to demonstrate patterns of disruptive behavior with disturbances in family functioning or social relationships and persistent psychological/emotional disturbances AND the family continues to participate in family therapy unless contraindicated
- ☐ Is receiving active clinical treatment, i.e. skilled interventions by qualified professionals, *and* —
- ☐ Has an individualized treatment plan that includes the indicated level of care; measurable goals; timeframes for achieving them; specific therapeutic modalities used; timely reviews/updates that reflect thoughtful alterations in the treatment regimen, goals, and level of care required for each problem; feasibility of involving family; discharge planning efforts; and explanations of any failure to achieve the treatment goals and objectives

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

EMERGENCY SUBSTANCE USE DISORDER
ASAM 3.7 DETOXIFICATION (BH_RTF_DTX_ER)

Please complete the form below and save this page as a PDF. Then, submit it along with recent document that show continued medical necessity, such as recent clinician progress notes, nursing notes, vital signs, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of Inatient Detoxification when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable SUD recognized by the latest version of the DSM or ICD
- ☐ Still requires the personnel and facilities of a hospital to treat the medical complications of their SUD and to mitigate medical complications of withdrawal

LOCATION OF CARE:

- ☐ Inpatient (ASAM Level 3.7)

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

NON-EMERGENCY SUBSTANCE USE DISORDER
ASAM 3.7 DETOXIFICATION (BH_RTF_DTX)

Please complete the form below and save this page as a PDF. Then, submit it along with recent document that show continued medical necessity, such as recent clinician progress notes, nursing notes, vital signs, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of Inpatient Detoxification when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable SUD recognized by the latest version of the DSM or ICD
- ☐ Still requires the personnel and facilities of a hospital to treat the medical complications of their SUD and to mitigate medical complications of withdrawal

LOCATION OF CARE:

- ☐ Inpatient (ASAM Level 3.7)

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

DETOXIFICATION CONTINUED STAY ASAM 3.7 SUD

Please complete the form below and save this page as a PDF. Then, submit it along with recent document that show continued medical necessity, such as recent clinician progress notes, nursing notes, vital signs, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of Inpatient Detoxification when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable SUD recognized by the latest version of the DSM or ICD
- ☐ Still requires the personnel and facilities of a hospital to treat the medical complications of their SUD and to mitigate medical complications of withdrawal

LOCATION OF CARE:

- ☐ Inpatient (ASAM Level 3.7)

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

SUBSTANCE USE DISORDER REHABILITATION FACILITY (SUDRF) ADMISSION CHECKLIST (BH_RTF_SUD)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychosocial assessment, SUD history, clinician progress notes, nursing notes (if currently inpatient), etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of SUDRF admissions when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable Substance Use Disorder recognized by the latest version of the DSM or ICD
- ☐ Exhibits signs and symptoms of sufficient clinical severity to warrant inpatient/residential rehabilitation treatment, or has failed SUD treatment services provided at a lower level of care
- ☐ Is anticipated to receive active clinical treatment and an individualized treatment plan that will provide a specific level of care, measurable and relevant goals, skilled interventions by qualified mental health professionals, time frames for achieving proposed outcomes, timely reviews and updates to the treatment plan that reflect thoughtful alterations in the treatment regimen, goals, and level of care required for each problem, and explanations of any failure to achieve the treatment goals and objectives

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

SUBSTANCE USE DISORDER REHABILITATION FACILITY (SUDRF) CONTINUED STAY CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show continued medical necessity, such as recent progress notes, treatment plan updates, vital signs (for eating disorder patients), etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of SUDRF when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Continues to require inpatient/residential-level rehabilitation support to maintain sobriety
- ☐ Is receiving active clinical treatment, i.e. skilled interventions by qualified professionals, *and* —
- ☐ Has an individualized treatment plan that includes the indicated level of care; measurable goals; timeframes for achieving them; specific therapeutic modalities used; timely reviews/updates that reflect thoughtful alterations in the treatment regimen, goals, and level of care required for each problem; feasibility of involving family; discharge planning efforts; and explanations of any failure to achieve the treatment goals and objectives

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

PARTIAL HOSPITALIZATION PROGRAM (PHP) ADMISSION CHECKLIST (BH_PHP/BH_PHP_SUD)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as assessment, recent progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.4, authorizes coverage of PHP admissions for both Mental Health disorders and Substance Use Disorders when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD:
  - ☐ Mental Health Disorder
  - ☐ Substance Use Disorders (SUDs)
- ☐ Is in need of crisis stabilization, treatment of a partially stabilized mental health disorder or SUD, or requires intensive clinical services following discharge from an inpatient program
- ☐ Is suffering significant impairment from a mental disorder/SUD that interferes with age-appropriate functioning, *or*—
- ☐ Is in need of clinically intensive rehabilitative programming and medical monitoring to managewithdrawal symptoms from alcohol, sedative-hypnotics, opioids, or stimulants
- ☐ Is unable to maintain adequate functioning to engage in a course of outpatient therapy
- ☐ Is able, with appropriate support, to maintain a basic level of functioning to permit PHP services
- ☐ Has no substantial imminent risk of harm to self or others

IS THE REQUESTED CARE:

- ☐ New request for Partial Hospitalization Program care
- ☐ Continuation of prior Partial Hospitalization Program care

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

INTENSIVE OUTPATIENT PROGRAM (IOP) ADMISSION CHECKLIST (BH_IOP/BH_IOP_SUID)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychosocial assessment, recent progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.15, authorizes coverage of Intensive Outpatient Program (IOP) admissions for both Mental Health disorders and Substance Use Disorders when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD:
  - ☐ Mental Health Disorder
  - ☐ Substance Use Disorders (SUDs)
- ☐ Is experiencing significant impairment that interferes with age-appropriate functioning
- ☐ Is in need of crisis stabilization, treatment of a partially stabilized mental health disorder or SUD, or requires transition services following discharge from an inpatient program
- ☐ Requires more intensive treatment than would be available in a typical outpatient environment, but is sufficiently stable so as not to warrant Partial Hospitalization (e.g., IOPs typically provide 6-9 hours of programming a week, with a minimum of 2 hours per treatment day)
- ☐ Is expected to receive an individualized treatment plan that is expected to be effective for the patient and permit treatment at the least intensive level

IS THE REQUESTED CARE:

- ☐ New request for Intensive Outpatient Program care
- ☐ Continuation of prior Intensive Outpatient Program care

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

OPIOID TREATMENT PROGRAM (OTP) ADMISSION CHECKLIST (BH_OTP)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychosocial assessment, recent progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.16, authorizes coverage of Opioid Treatment Program (OTP) for management of withdrawal symptoms from opioids and medically supervised withdrawal from maintenance medications when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Diagnosis:
  - ☐ Has an active diagnosis of Opioid Use Disorder moderate or severe based on the latest versionof the DSM, *or*
  - ☐ Has an active diagnosis of Opioid Use Disorder in remission at high risk for recurrence or overdose
- ☐ Voluntarily chose treatment with Medication for Opioid Use Disorder and that all relevant facts concerning the use of Medications for Opioid Use Disorder are clearly and adequately explained to the patient.
- ☐ Provides informed consent to treatment.

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING CHECKLIST (BH_PSYTEST)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as recent psychological evaluation, progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.9, authorizes coverage of Psychological/Neuro-psychological testing when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a documented mental status exam in their medical chart
- ☐ Requires testing for the following reason(s) (check all that apply):
  - ☐ A diagnostic assessment (as required for the Autism Care Demonstration program)
  - ☐ An assessment of baseline cognitive functioning
  - ☐ Repeat testing to assess change from baseline
  - ☐ Testing to clarify or inform an existing diagnosis
  - ☐ An evaluation of functional deficits
  - ☐ An assessment of lack of treatment response

THE TESTING:

- ☐ Will not include a Reitan-Indiana battery for patients under 5, or under 13 when self-administered
- ☐ Will not be conducted for any of the following reasons:
  - Academic placement
  - Determining the presence and/or nature of a learning disorder
  - Influencing custody determinations or job placements
  - General screening to determine if the individual suffers from a mental disorder
  - Teachers or parents have requested it
  - Placement in a Residential Treatment Center (RTC) or Partial Hospitalization Program (PHP)
  - When billed by a provider not employed by or under contract with the patient's RTC or PHP

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

ESKETAMINE (SPRAVATO™) CHECKLIST (BH_SPRAVATO)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychiatric assessment, recent progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.7, authorizes coverage of esketamine treatment when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Is 18 years of age or older
- ☐ Will be treated by a provider enrolled in the FDA's Spravato™ Risk Evaluation and Mitigation Strategy (REMS) program
- ☐ Has a documented diagnosis for which esketamine has received FDA approval for use:
  - ☐ Treatment-Resistant Depression (i.e., failure to respond to two adequate trials of antidepressants in different categories, e.g., SSRI, SNRI, NDRI, etc.)
  - ☐ Major Depressive Disorder with suicidal ideation or behavior
- ☐ Does not have any of the following contraindications:
  - Current or history of blood vessel aneurysms
  - Current or history of Arteriovenous (AV) malformations
  - History of Intracerebral hemorrhage
  - Current Pregnancy

IS THE REQUESTED CARE:

- ☐ New request for Esketamine treatment
- ☐ Continuation of Esketamine treatment

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

MENTAL HEALTH SPECIFIC REFERRAL CHECKLIST

TRANSCRANIAL MAGNETIC STIMULATION (TMS) CHECKLIST (BH_TMS)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychiatric assessment, recent progress notes, and any other relevant information.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.7, authorizes coverage of TMS when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Is at least 15 years old or meets the state-specific age requirement if higher than 15
- ☐ Has a documented diagnosis of active Treatment-Resistant Depression (i.e., failure to respond to two adequate trials of antidepressants in different categories, e.g., SSRI, SNRI, NDRI, etc.)
- ☐ Is being recommended for rTMS or Deep TMS (not MeRT, SAINT, or other emerging technologies)
- ☐ Will have TMS performed by a TRICARE Authorized Mental Health provider (Psychiatrist, Psychiatric Nurse Practitioner, etc)
- ☐ Does not have any of the following contraindications:
  - Implanted ferromagnetic material
  - History of seizures
  - Cardiac pacemaker
  - Implanted defibrillator
  - Implanted medical pump
  - Severe cardiovascular disease

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

ELECTROCONVULSIVE THERAPY (ECT) CHECKLIST (BH_ECT)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychiatric assessment, recent progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.7, section 5.2.8, authorizes coverage of Electroconvulsive Therapy (ECT) when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Is at least 13 years old or meets the state-specific age requirement if higher than 13
- ☐ Is currently experiencing at least one of the following:
  - ☐ Treatment-Resistant Depression (i.e., failure to respond to two adequate trials ofantidepressants in different categories, e.g., SSRI, SNRI, NDRI, etc.)
  - ☐ Mania
  - ☐ Psychosis
  - ☐ Catatonia
  - ☐ Other psychiatric conditions limiting adequate nutrition and hydration
- ☐ Has failed to respond to clinically reasonable trials of other evidence-based treatments

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

MENTAL HEALTH SPECIFIC REFERRAL CHECKLIST

MEDICATION ASSISTED TREATMENT (MAT) CHECKLIST (BH_MAT)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychiatric assessment, recent progress notes, and any other relevant information.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.17, authorizes MAT coverage for the treatment of Substance Use Disorders when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a documented diagnosis of moderate to severe substance use disorder per the most recent version of the DSM.
- ☐ Is at risk for withdrawal syndrome as evidenced by either abnormal vital signs or elevated scores on clinically based scales.
- ☐ Displays signs or symptoms of alcohol, sedative/hypnotic, or opioid withdrawal.
- ☐ Does not require around-the-clock nursing care.
- ☐ Is participating in and adhering to a comprehensive management program including psychosocialsupport.

REQUESTED MEDICATION ASSISTED TREATMENT:

- ☐ Naltrexone (Vivitrol) (J2315)
- ☐ Buprenorphine Extended Release Subcutaneous Injection (Sublocade)
  - Dose less than or equal to 100mg (Q9991)
  - Dose greater than 100mg (Q9992)
- ☐ Buprenorphine Extended Release Subcutaneous Injection (Brixadi)
  - Therapy duration is less than or equal to 7 days (J0577)
  - Therapy durations is greater than 7 days and up to 28 days (J0578)
- ☐ Buprenorphine Subdermal Implant (Probuphine) (J0570)

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

MENTAL HEALTH SPECIFIC REFERRAL CHECKLIST

LONG-ACTING INJECTABLE (LAI) ANTIPSYCHOTICS CHECKLIST (BH_LAI)

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychiatric assessment, recent progress notes, and any other relevant information.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.7, authorizes Long-Acting Injectable Anti-Psychotics for the treatment of covered Mental Health Conditions when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Is age 18 or older.
- ☐ Has a documented diagnosis for which the requested LAI has an FDA-approved indication.
- ☐ Has provided informed consent for the requested LAI or has a court-appointed surrogate (if applicable) who has provided such consent.
- ☐ Has a history of nonadherence to oral antipsychotic therapy or has a clinical rationale for using an LAI in lieu of oral antipsychotic therapy.
- ☐ Has previously taken the requested LAI or an equivalent dose of an oral preparation of the same medication (may substitute risperidone for paliperidone) for at least one week.
- ☐ Has demonstrated clinical improvement on the LAI previously or the equivalent oral medication.
- ☐ Has tolerated the LAI previously or the equivalent oral medication with minimal to no side effects that are well managed.
- ☐ Does not have a diagnosis of dementia.
- ☐ Is participating in and adhering to a comprehensive management program including psychosocial support.

REQUESTED MEDICATION ASSISTED TREATMENT:

- ☐ Paliperidone palmitate (Invega Sustenna) (J2426)
- ☐ Olanzapine pamoate (Zyprexa Relprevy) (J2358)
- ☐ Aripiprazole monohydrate (Abilify Maintena) (J0401)
- ☐ Paliperidone palmitate (Invega Trinza) (J2427)
- ☐ Aripiprazole lauroxil (Aristada) (J1944)
- ☐ Aripiprazole lauroxil (Aristada Initio) (J1943)
- ☐ Paliperidone palmitate (Invega Hafyera) (J2429)
- ☐ Risperidone sub-Q (Uzedy) (J2799)
- ☐ Aripiprazole (Abilify Asimtufii) (J0123)
- ☐ Paliperidone palmitate (Erzofri) (J2428)

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	