Asthma & Allergy Clinic of Marin and San Francisco Inc.

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PATIENT INFORMATION ON IMMUNOTHERAPY/ ALLERGY SHOTS

What is Allergen Immunotherapy (IT)?

Allergen Immunotherapy (IT), also known as "Allergy Shot", is a preventative treatment used to relieve allergy symptoms of hay fever, allergic asthma, atopic dermatitis or bee allergy. It requires the administration of gradually increasing amounts of allergic material such as pollen, mold spores, dust mites, animal dander and/or insects to a patient over time. These incremental increases cause the immune system to become less sensitive to the allergen, reducing the symptoms when the same allergen is encountered in the future.

How is IT Performed?

The process of allergen immunotherapy begins with the injection of a weak concentration of an allergen extract. Injections of increasingly stronger concentrations are given until patient reaches the top or maintenance dose. The rate at which the concentration can be increased depends on the patients' degree of sensitivity.

How often should I come in?

Normally, the patient will start with injections 1 - 3 times per week during the increasing or "build up" phase. This usually takes 4-6 months (35-40 injections). Injections will gradually decrease to every 2 weeks and then every 3-4 weeks when patient reaches the maintenance dose (Therapeutic maintenance dose may differ from person to person).

What happen if I am going on vacation?

Your injection dose will be adjusted, depending on how long you will be gone. If you have to be away for more than a month, please check with the nurse for advice. If you have not been in for more than a month since your last shot, please call before you come in (we may need to readjust your dose).

When do I see any improvement?

The benefits of immunotherapy, in terms of reduced allergy symptoms, can begin during the build up phase, but may take as long as 12 months. Improvement with IT may be progressive throughout the IT treatment period. Effectiveness of IT appears to be related to the length of treatment and the dose of the allergen. In a small percentage of patients, there is no improvement after a year of maintenance then IT is discontinued. However, if symptoms do improve, injections are usually continued for at least 4 to 5 years, sometimes longer. IT is the only treatment with potential to cure an allergy. Many clinical studies have shown that 80-90% of patients' allergies improve and that the treatment usually remains effective for at least 3 years after shots are discontinued.

Do I continue my current allergy medications?

Yes! You should take all the medications as prescribed, especially during the first year. In fact it is recommended that you take an antihistamine couple hours before your shot in order to reduce the chances of severe reaction. You should also have annual follow up visits with the doctor to update the effectiveness of your IT so that changes may be made in your IT or medications if necessary.

PATIENT INFORMATION ON IT (CON'T)

What are the possible reaction?

Local reactions are common, which include: swelling, itching or tenderness at the site of the injection. These local reactions usually subside in a day or less.

Generalized (systemic) reactions may also occur (1-5%). These generalized reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat, runny nose, nasal congestion, sneezing, tightness in the throat or chest, coughing, wheezing. Also, some may experience lightheadedness, faintness, nausea and vomiting, hives, and, under extreme conditions, shock. Therefore, patient must wait in the office for at least 30 minutes after each injection so that generalized reactions can be quickly treated.
After your shot, you should wait for at least two hours before doing any extraneous exercise. (May cause a more severe reaction due to increased blood flow.)

What should I do if I have reaction after I leave the office?

If your injection site has increased swelling or itchiness (delay local reaction), which is normal, you may take your antihistamine and apply a cold compress. **Please inform the nurse before your next shot, so that necessary dose adjustments can be made.**
For delayed systemic reactions, you should either return to our office immediately or proceed to the nearest emergency room.

Can I get my shot if I am sick?

You should not come in for your shot if you have a fever, cold, or any upper respiratory infection. You should wait for a week to come in. If you are taking a *beta blocker* (medication for high blood pressure, heart disease, or glaucoma), you should not get an allergy shot.

Can I get my shot if I am pregnant?

Yes, but you do need to inform the nurse. You should also schedule an appointment with one of the doctors to review your medications because some medications, may not be safe to use during pregnancy.

Will my insurance cover my IT?

Most insurance plans covers IT treatment, but coverage varies from plan to plan. The copay may be different from your office visit. Please call your insurance provider in regards to your share of cost. There are two fees for IT:

1. Antigen mix (procedure code 95165 #50units)
   Initial extract $900 per year. Renewal extract (yearly or when out of supply) $450
   **Some insurance may require to be billed quarterly.
2. Antigen for Venom (procedure code 95145-95148)
   Initial extract sets: $1300 - $2500 per venom (depends on which venom)
   Renewal vials: $650 - $1250 per venom (depends on which venom)
3. Allergy injection(s) (procedure code 95115 or 95117) - $27/single injection; $35/two or more injections. The number of injections is based on your skin test results.

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CONSENT TO RECEIVE IMMUNOTHERAPY (ALLERGY SHOTS)

1. I hereby give permission to receive allergy shots at AACMSF office.
2. I have been given a copy of and have read the "Patient Information on Immunotherapy (IT)". I understand the risks and benefits of receiving IT.
3. I have been given the opportunity to ask any and all questions that I may have and am satisfied that they have been fully answered.
4. I have been advised that AACMSF will mix antigen for my IT. Antigen will be automatically renewed yearly unless I notify the office at least a month in advance.
5. The antigen mixture for my IT is custom formulated for me for my specific allergen sensitivity. **I understand I am responsible for payment of the antigen even if circumstances, for any reason, prevent me from completing a full treatment plan**.
6. I understand that I may not be permitted to take my allergen vials to another clinic for administrations due to safety or insurance coverage reason. (i.e. Brown & Toland insurance bundle the reimbursement for antigen and injection)
7. I understand I should have a follow-up appointment with my physician yearly while I am on allergy shots. ***I understand that I cannot have an office visit and allergy shot administration on the same day due to my insurance coverage limitation.***
8. I understand that injections may cause localized redness and swelling soon after my injection. On rare occasions, severe systemic reaction such as hives, difficulty breathing and shock can occur soon after an injection. To ensure proper treatment of any possible reactions, **it is MANDATORY to wait in the doctor's office for a minimum of 30 minutes after each injection**. I understand this policy is for my own safety and to ensure that my response to treatment is optimal. I consent to the treatment of any reactions that may occur as a result of an allergic reaction. **BY DECLINING TO WAIT, I ACCEPT ALL RESPONSIBILITY FOR ANY ADVERSE REACTIONS WHICH MAY OCCUR FROM RECEIVING ALLERGY INJECTIONS.**
9. I understand that I should report any current illness before allergy shots are administered. I should also inform the clinic's nurse or physician if I am taking a beta blocker (a common form of blood pressure or heart medication).
10. I understand if I do not follow the above policy, I may not be permitted to receive immunotherapy at AACMSF.

I have read and understand the content of this form and have received a copy.
I give my consent for Immunotherapy Treatment

Print Name of Patient	Date of Birth
Patient/Parent/Guardian – Signature	Date
Witness Signature	Date
Physician Signature	Date Formula Written