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Immunotherapy Checklist

___ Immunotherapy was discussed with the Physician.

___ I was given and have reviewed the immunotherapy information packet.

___ I have returned the three forms:

Immunotherapy Financial Consent Form
Immunotherapy (Allergy Shots) Consent
Shot Patient Emergency Contact Information

___ I understand that by committing to SCIT, I will be required to have a 6 week follow up, and 6 month follow up as check points to ensure SCIT is the correct solution for my allergies and to discuss any questions with a provider.

___ I returned these three forms by either:

Completing them in the office
Mailing to: Connecticut Asthma & Allergy Center LLC
Attn: Bottle Room
836 Farmington Avenue Suite 207
West Hartford, CT 06119

I would like to start shots in:

___ Avon ___ Hamden ___ Manchester ___ Middletown ___ West Hartford

Once the Immunotherapy Consents are received

1. The physician places the order for your immunotherapy.
2. The order is approved, and serum is made.
3. The office will contact you to set up the first allergy shot appointment and verify the office you will be receiving your injections.

836 Farmington Ave, Ste 207
West Hartford, CT 06119-1551
860-232-9911 Phone 860-231-7112 Fax
www.ctallergy.net



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FACTS ABOUT IMMUNOTHERAPY (ALLERGY SHOTS)

Immunotherapy, or the most familiar term, allergy shots, is a preventative treatment for allergy symptoms due to inhaled substances such as pollen, house dust mite, molds, and animal dander. It is also administered to people highly allergic to insect venom. Immunotherapy involves the administration of gradually increasing doses of those allergens to which the person is allergic. The incremental increase of the allergen given in the shots causes the immune system to become less sensitive to the substances. Immunotherapy can lead to a reduction in the symptoms that would otherwise follow allergen exposure. The production of protective antibodies, similar to those made in response to bacterial vaccines (such as tetanus vaccine), may play a role in the beneficial effects of allergy injection therapy. There are also changes in the cellular (T-cell) immune system that appear to be important in how shots work. Allergy shots are not always successful. However, approximately 70-80% of those placed on immunotherapy are helped by this treatment. Allergy shots are a supplement to environmental controls and medications when these modes of therapy have not provided adequate benefit. Frequently, patients may need to take their medications with the allergy shots to feel well.

Administration

Allergy shots are given initially once (or occasionally twice) weekly with various concentrations of allergen extracts. Patients may receive one to four injections at each visit depending on how the physician has prepared that patient's individualized extracts. The initial injections consist of a small amount of the least concentrated (weakest) extract. Each week the patient receives a slightly higher dose. The rate at which the dose can be increased may depend on the patient's degree of sensitivity.

Usually, a patient will reach the top or maintenance dose about 26-28 weeks (six months) after immunotherapy is started, provided the patient adheres to the schedule and things go as planned. The maintenance dose is given initially every one to two weeks and then the interval is usually extended to every three to four weeks. Immunotherapy is generally continued for four to five years.

Important Things to Know

Immunotherapy requires a time commitment on the part of patients. If patients miss more than two to three consecutive weeks of their allergy shots, schedule changes will be necessary, and this could delay the benefits of treatment. Most patients do not see any significant improvement in their symptoms for four to six months, and in some cases, it may take longer.

Many patients develop swelling, redness, and itching at the site of the injection and when they are large, they are called local reactions. These reactions are usually controlled with antihistamines, ice, and elevation. Systemic reactions are the serious reactions that have led to the requirement that all patients must stay in the physician's office for 30 minutes after each injection. Systemic reactions may cause symptoms such as sneezing, nasal congestion, itchy throat, hives, tightness in the chest, wheezing, dizziness, or loss of consciousness and require prompt medical attention. In rare instances, deaths have been reported (one in 2.5 million shots) following severe systemic reactions due to allergy shots.

Once patients are receiving maintenance immunotherapy, they are expected to see their physician on a regular basis, at least once a year, or more frequently if they have asthma or if recommended by the physician. These visits are important so the doctor can determine the effectiveness of therapy and modify if it necessary. Also, the physician needs to be updated on any changes in the patient's health and particularly any new medications they may be taking which may impact on the allergy shots.

Immunotherapy can be very effective for allergic rhinitis/conjunctivitis and allergic asthma, as well as insect sting allergy. Patients (and parents) are encouraged to ask their physician about immunotherapy and what role it may have in the management of their (or their child's) allergies.

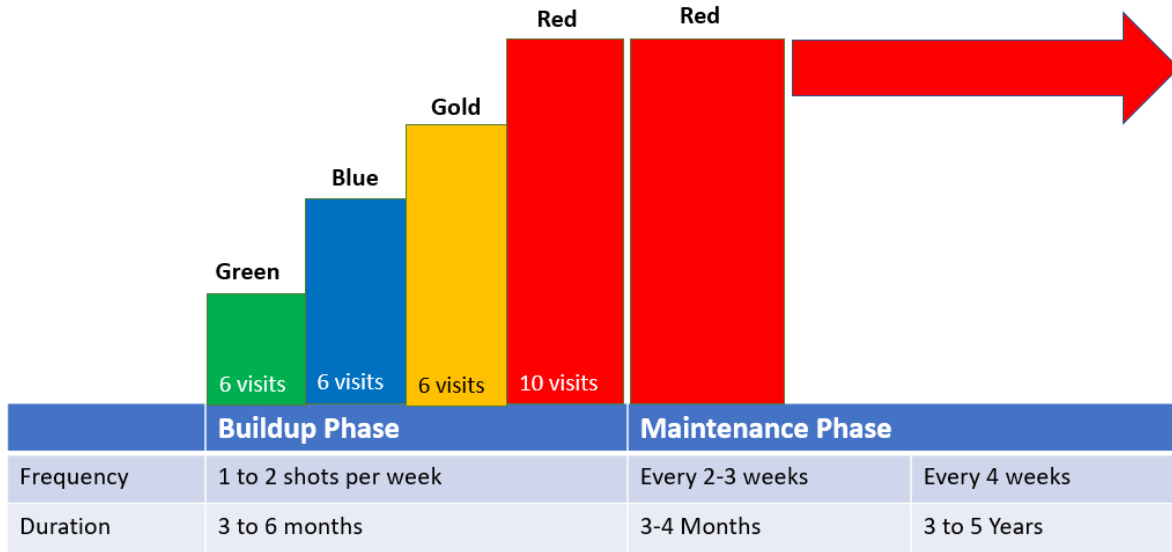
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Subcutaneous Immunotherapy Schedule



The above chart demonstrates a typical build up and maintenance schedule provided there are no missed appointments or reactions noted.



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Immunotherapy (Allergy Shots) Consent

Immunotherapy (allergy shots) is an attempt to build a resistance or tolerance to the things to which you are allergic. Seventy to eighty percent of those placed on allergy shots are helped to a significant degree. You may need to take antihistamines, decongestants, nasal sprays, or asthma therapy with the injections in order to feel well. **ALLERGY SHOTS ARE A SUPPLEMENT TO ENVIRONMENTAL CONTROL AND/OR MEDICAL MANAGEMENT WHERE THOSE MODES OF THERAPY HAVE FAILED TO BRING ABOUT THE DESIRED BENEFIT.** It must be understood that allergy shots are a time and financial commitment. They are used to reduce future, not current, symptoms.

Allergy shots are given once or twice a week starting with a very dilute (weak) dose. Each week the dose is increased until a maximum level is reached. This is called the maintenance dose. Provided you adhere to the schedule and things go as planned, this build-up phase will take approximately six months. Shots are then given every two, three, and eventually four-week intervals. Allergy shots are not given at intervals greater than four weeks with the exception of insect sting allergy, which can be given up to every six weeks. If you go more than two to three weeks from your scheduled shot date, dose and schedule changes will have to be made.

Most patients may not see any significant improvement in their symptoms for six months. In some cases, improvement may take longer. The average treatment course is four to five years with the patient receiving injections once per month.

Reactions: As you are receiving extracts to which you are allergic, it is possible that a reaction may occur.

- **Local:** Redness, swelling, and itchiness at the site of the injection similar to a mosquito bite or insect sting. These reactions usually occur within 20 minutes after the injection, although they can occur hours later. They will usually clear in 24 to 48 hours.
- **Systemic:** The symptoms of a systemic reaction may include itchy skin, itchy eyes, itchy ears and throat, coughing, congestion, sneezing, wheezing, throat tightness and hives. This reaction occurs usually within 30 minutes after the injection. Systemic reactions can be dangerous. Early recognition is important so that treatment can be started.

- Our patients and parents are required to wait 30 minutes in the waiting room.
- On day of shots, you should carry an antihistamine with you. We can provide you with one.

After leaving the office, should symptoms of tightness of the throat, difficulty in breathing, or any other symptoms of a systemic reaction occur, emergency medical treatment should be sought at our office or the nearest Emergency Room. After you are stabilized, our office should be notified as soon as possible.

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Local reactions that occur on the arm are used as a guide for further treatment. Please report them to the nurse prior to administration of the next shot. Should they become uncomfortable at home or in our office, ice packs and an antihistamine can be given. **If you have asthma, you should carry your Bronchodilator inhaler with you.**

Allergy shots can be potentially dangerous. Persons have died from shots (estimated 1 death every 2.5 million shots). We cannot give allergy shots if you are feeling uncomfortable from allergies, asthma, a cold, or fever. **Please let the nurse know if you are not feeling well BEFORE your shot is given.** Proper medical treatment should be instituted, and shots rescheduled.

For best results, we would like you to be committed to getting your shots regularly. If you need to be away for an extended period of time, please let us know and arrangements may be made for you to receive your immunotherapy elsewhere. Allergy shots cannot be given at your home. They can be given at a college infirmary, business medical office or summer camp if a doctor is on site and available to treat potential systemic reactions.

Once you are receiving your allergy shots monthly, you are expected to see your allergist on a regular basis, at least once per year (or more frequently if you have asthma). These visits are important so that the doctor can determine the effectiveness of the therapy and modify it if necessary.

Please notify the nurse or physician if you are taking any new medications (specifically Beta Blockers which are used in the treatment of high blood pressure, heart disease and migraine headaches). Patients on Beta Blockers should not receive immunotherapy unless the increased risks have been discussed and consented to with the treating CAAC physician.

Should you become pregnant, allergy shots can be continued with some adjustments of dose. We generally do not start pregnant patients on allergy shots.

Depending on your insurance coverage, you may need to pay a co-pay and/or a deductible towards your extracts and/or injection administration.

Please call us with any questions you may have at (860) 232-9911

I, _____, have been made aware of the risks and obligations involved in receiving allergy injections therapy. Parents must remain in waiting room with patients under 16 years of age.

Patients Name

Patients or Guardians Signature Date

Witness Date



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PATIENT FINANCIAL RESPONSIBILITY - ALLERGY SHOTS

Patient Name: _____ Insurance Company: _____

Your physician is recommending allergen immunotherapy for you or your child.

Please call your insurance company at the Member Services phone number to confirm that this is a covered benefit. Provide the following highlighted procedure codes to the insurance company.

Allergy Shot Procedure Codes	
95115	Administration of Single Injection
95117	Administration of Multiple Injections
95165	Multiple Dose Vial – billed per unit **

**Units billed may vary from 6 units – 120.

Are the injections covered? No YES If yes:
 Do I have a deductible? NO YES \$_____ Deductible Met: \$_____
 Do I have a co-insurance? NO YES _____%
 Do I have a copay? NO YES \$_____
 Is there a maximum/limit on number of 95165 units? NO YES
 If **Yes**, how many ____ per: ____year/days
 Is there a maximum/limit on number of 95115/95117 injections? NO YES
 If **Yes**, how many ____ per: ____year/days
 The name of the person you spoke with: _____

Date: ___/___/___ Time: _____ am/ pm Reference Number for Call: _____

PLEASE NOTE: The serum is created specifically for you or your child. If you decide to not initiate the allergen immunotherapy after the serum has been made or decide to discontinue the program without consulting your CAAC physician, your insurance company will be billed. You may be responsible for a portion of the cost. This form must be completed, signed, and returned to our office prior to starting immunotherapy.

Signature: _____ Date: _____



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Immunotherapy Financial Consent Form

Patient Name: _____ **Contact Number:** () -

DOB: / /

Insurance plans are highly variable regarding coverage of immunotherapy treatment. There are two costs to consider. The first cost is for the “antigen” or “extract” (95165). The antigen (extract) is prepared at CT Asthma & Allergy LLC from a prescription your CT Asthma & Allergy Center physician has written. The second cost is for the administration of the injections (95115 or 95117). Your therapy is built up in 4 levels. All 4 levels are created at the same time (a kit) because the strongest is made first and diluted down to your starting dose. Depending on your insurance you will either be billed up front for all 4 levels or billed for each level individually as you advance (Bill by level).

CT Asthma & Allergy LLC recommends that you contact your insurance carrier(s) to verify your specific coverage. It is important to understand your insurance coverage and know your responsibility of the cost. Some Insurance plans cover immunotherapy in full, while other plans have associated deductibles, co-insurances, and co-pays.

- *I acknowledge, with my signature, that I am authorizing CT Asthma & Allergy LLC to bill my insurance company for the allergen extracts made for me/my child. I understand that, if I decide not to initiate allergen immunotherapy after the extracts have been made, I am still responsible for the cost of the extract. I acknowledge that any costs incurred for this method of treatment that is not covered by my insurance carrier, such as deductibles, co-insurances, or co-pays will be my responsibility. I also acknowledge that my allergen extracts will not be prepared until this signed consent is returned to CT Asthma & Allergy LLC.*

I authorize the preparation and billing of the allergen extract.

_____ Date

Responsible Party Name (print)

_____ Date

Responsible Party Signature

<p><u>Special Instructions</u></p> <p>New Start Date: / / </p> <p>Sets Expire: / / </p> <p>Other: _____</p>



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Shot Patient Emergency Contact Information

Today's Date: / /

Patient Name: _____

DOB: _____

Address: _____

Phone Number: _____

1st Emergency Contact: _____

Relationship: _____

Cell Phone: _____

Other Number: _____

2nd Emergency Contact: _____

Relationship: _____

Cell Phone: _____

Other Number: _____

CAAC Physician: _____ **PCP:** _____

Current Medications: _____

