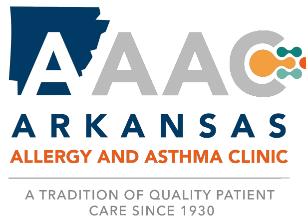

IMMUNOTHERAPY (ALLERGY INJECTIONS)

PURPOSE

Allergy injections are used to decrease your sensitivity to allergy-causing substances so that exposure to the offending allergens (pollens, dust, molds, venoms, etc.) will result in fewer symptoms. This does not mean that allergy shots are a substitute for avoidance of the known allergens which is the treatment of choice. Allergy injections have been shown to lead to the formation of blocking or protective antibodies and a gradual decrease in the allergy antibody level. These changes may permit you to tolerate exposure to the allergens with fewer symptoms. You in effect become protected from the allergens. The amount of this desensitization occurs to a different extent for each person.

EFFICACY

Improvement should not be expected immediately. It usually develops gradually over 9 to 12 months. About 90% of allergic individuals on injections get significant improvement of their symptoms, but symptoms may not go away completely.

PROCEDURE AND DURATION OF TREATMENT

Allergy injections are begun at a very low dose. The dose is gradually increased on a regular basis (usually once or twice weekly) until a therapeutic dose ("maintenance dose") is reached. This frequency reduces the chance of reactions and permits the maintenance dose to be reached in a reasonable amount of time. This usually takes approximately six to nine months if there are no problems along the way and shots are received on a regular basis. Maintenance doses are usually given every two weeks and the goal is to eventually spread the injections out to every four weeks over a period of several years. Allergy shots should not be started if it is anticipated that they cannot be taken regularly. Injections may be discontinued if visits are frequently missed due to the increased risk of reactions.

REACTIONS TO IMMUNOTHERAPY

Local reactions (redness, warmth, swelling, itching, or tenderness at the site of the injection) may occur in most patients receiving injections and usually subside in a day or so. Large local reactions and generalized (systemic) reactions may occur in 1-5% of patients receiving allergy injections and usually occur during the build-up phase, although they can occur at any time during the course of treatment. These reactions necessitate a dosage adjustment. These generalized reactions may include, but are not limited to, any and all of the following: itchy eyes, nose, or throat, runny nose, nasal congestion, sneezing, and tightness in the throat or chest, coughing, or wheezing. Some may experience lightheadedness, faintness, drop in blood pressure, nausea and vomiting, hives, and under extreme conditions, shock. A severe systemic reaction potentially can be fatal, but this is most unusual.

Allergy injections should be administered at a medical facility with a physician present since occasional reactions may require immediate therapy. Any medical facility that gives allergy injections should be equipped to treat any reaction that may occur. You should check with the facility to be certain that this is the case. You must wait at least 30 minutes after each injection in the medical facility so that in the unlikely event of a generalized reaction you can be quickly treated and kept under observation, thereby decreasing the likelihood of a more severe reaction.

TREATMENT OF REACTIONS

Simple local reactions that consist of swelling of the arm, redness or tenderness at the site of the injection are best handled with simple measures such as local cold compress or the use of medications such as an antihistamine, ASA, or Tylenol. At the first sign of a systemic reaction, Adrenalin (Epinephrine) is usually given to counteract the reaction. Severe reactions that include chest symptoms are treated the same way any asthmatic attack would be treated. **If, after you leave the medical facility, you experience a generalized reaction from an allergy injection, please either return to the medical facility or proceed to the nearest emergency room.** Before additional injections are given or for questions or assistance, please call Arkansas Allergy & Asthma Clinic, P.A. at (501) 227-5210 or 1-800-256-5844.

ALLERGY INJECTION GUIDELINES

Injection Hours	Little Rock Office 5 Executive Center Court Little Rock, AR 72211 (501) 227-5210	Conway Office 400 Salem Road, Ste. 4 Conway, AR 72034 (501) 329-0237
Monday	7:30 am – 5:45 pm	9:00 am – 5:00 pm
Tuesday	7:30 am – 4:45 pm	9:00 am – 4:00 pm
Wednesday	7:30 am – 11:45 am	*– CLOSED –*
Thursday	7:30 am – 4:45 pm	9:00 am – 4:00 pm
Friday	7:30 am – 4:45 pm	*– CLOSED –*

INTERVAL BETWEEN INJECTIONS: Initially injections can be given every two to eight days, unless otherwise stated by the nurse. Once a maintenance dose is reached, injections are usually given every two weeks.

WAITING PERIOD: All patients should wait their allotted time (usually 30 minutes) after receiving their injection. The nurse or receptionist should check the injection site before the patient leaves the waiting room. Patients not waiting their allotted time will assume the responsibility of recognizing reaction symptoms.

MINOR PATIENTS: Minor patients should not be dropped off and left alone to receive allergy injections. This is in case an emergency should occur with the minor patient. NOTE: Patients who are licensed drivers are allowed to receive allergy injections without an adult present.

LOCAL REACTIONS: Local reactions of redness, swelling, itching, warmth and slight discomfort may occur at the injection site. Redness and swelling up to two inches in diameter is considered normal. Any redness/swelling in excess of that should be reported either by calling our office or when checking in at the front desk ***BEFORE*** the next injection.

SYSTEMIC REACTION: These generalized reactions may include, but are not limited to, any and all of the following: itchy eyes, nose, or throat, runny nose, nasal congestion, sneezing, and tightness in the throat or chest, coughing, or wheezing. Some may experience lightheadedness, faintness, drop in blood pressure, nausea and vomiting, hives, and under extreme conditions, shock. A severe systemic reaction is most unusual, but can be potentially fatal. A reaction of this nature should be reported ***IMMEDIATELY***.

AFTER HOURS EMERGENCY: For after-hours emergencies, please call the Medical Exchange (501) 663-8400 and ask for the doctor on call for Arkansas Allergy & Asthma Clinic, P.A.

NO INJECTION CRITERIA:

Fever. If the patient's temperature is more than 100ºF, the injection should be delayed until the fever has been down for at least 24 hours.

Asthma patients with chest congestion. If the patient is experiencing chest congestion/wheeze/chest tightness, then the injection should be delayed until those symptoms have cleared. If the asthmatic patient's peak flow reading is below 80% of expected, then the injection will not be given. The patient should wait at least 24 hours after an asthma attack to receive an injection.

BETA-BLOCKERS: If you are taking allergy injections and have been placed on beta-blocker medications, you should notify the shot nurse/doctor ***IMMEDIATELY***.

PRESCRIPTION REFILLS: Please contact your pharmacy for all refill requests.

MISSED INJECTIONS: If you have missed your scheduled injection by several weeks (or months), please call ahead so a dosage adjustment may be made before you arrive.

ALLERGY INJECTION CHARGES: There are two charges for allergy injections. **The first charge** is for the allergy extract. The extract is priced by dosages per bottle. Bottles contain 6-10 doses, depending on whether you are building or at your maintenance dose. Most patients will use 5-6 bottles the first year, and 3-4 bottles each year afterwards for each extract. The shot room nurses will notify you when they will be ordering additional extract. **The second charge** is an injection administration fee. This will be billed after every injection.

Allergy immunotherapy may be covered by your insurance, but you will need to check your individual policy. It is your responsibility to keep your insurance referral current, if required; otherwise, you will be billed for the cost of your extract and injection.

RECEIPT OF IMMUNOTHERAPY (ALLERGY INJECTIONS) INFORMATION & CONSENT FORM

MEDICAL CONSENT

I certify that I was present and heard the oral presentation and received printed material regarding allergy immunotherapy from Arkansas Allergy & Asthma Clinic, P.A. I understand the nature, risks, and benefits of allergy immunotherapy. I have been given the opportunity to ask any and all questions that I may have and I am satisfied that they have been fully answered. If I have any questions in the future, I may contact Dr. _______________ or a designated employee of Arkansas Allergy & Asthma Clinic, P.A. at (501) 227-5210 or 1-800-256-5844.

Therefore, I do hereby give consent for ____ ***(patient)*** to be given allergy shots over an extended period of time and at specified intervals as prescribed by a physician of Arkansas Allergy & Asthma Clinic, P.A. I have read the allergy immunotherapy guidelines and agree to follow them.

I consent and authorize the treatment of any reactions that may occur as a result of an allergy shot.

____ ________________
Printed Name of Allergy Shot Patient Patient Number

____ ________________
Signature of Allergy Shot Patient Date

____ ________________
Signature (Authorizing Consenting Party/Relationship) Date

____ ________________
Witness Signature Date

AI Patients:

Location: _________ LR ________Conway

Bulk Patients:

Medical Office to Administer Injections: ____

Address/Phone

ARKANSAS
ALLERGY AND ASTHMA CLINIC
A TRADITION OF QUALITY PATIENT CARE SINCE 1930

Financial Consent for Immunotherapy

I understand that by giving my consent for immunotherapy, I give consent for extract/serum to be custom formulated for my injections and that I will be charged for the full amount of the serum even if I later decide not to receive the injections. I acknowledge that my insurance may impose a limit on the number of units they may cover. If the number of units required exceeds my insurance limitations, then I will assume financial responsibility for these non-covered units. I also understand that this serum is designated for my use only. **It has been explained to me that additional extract orders will be required to continue my immunotherapy treatment, and that I assume financial responsibility for these additional orders. It has also been explained to me that any outstanding extract balances must be paid before a new order can be fulfilled. I am aware that payment arrangements are available to me if needed.**

Outstanding Account Balance	Payment Arrangement
$50-$250	Up to 4 months to pay at a minimum payment of $50 per month
$250-$500	Up to 6 months to pay at a minimum payment of $100 per month
$500 and above	Up to 8 months to pay at a minimum payment of $150 per month

____ ________________
Signature (Authorizing Consenting Party) Date

I certify that I received this document from the above patient or consenting party.

____
Printed Name of AAAC Representative

____ ________________
Signature of AAAC Representative Date