VENOM IMMUNOTHERAPY (VIT) Consent Form

1. I understand that allergy injections/shots are a treatment to gradually reduce allergies and prevent life-threatening reactions to insect stings. By receiving increasing amounts of venom allergens (from wasps, yellow jackets, bees, and hornets) to which I am / my child is allergic, this helps make my / my child's immune system become less sensitive (desensitized) to them and decreases my/my child's allergy symptoms over time.
2. I understand that allergy injection(s) are given once to twice per week beneath the skin of the upper arm. Once the maintenance dose is achieved after several months of injection(s), the frequency of injection(s) may be decreased to once a month. After the first year of treatment, injections may be given every 4 to 6 weeks and thereafter, every 6 to 8 weeks. The total duration of venom immunotherapy depends upon the clinical history. I understand that I / my child will need periodic assessment with the allergist to determine if this therapy should be continued or altered.
3. I understand that venom immunotherapy does not take the place of avoidance of insect stings to which I am / my child is known to be sensitized/allergic. I / my child will still need to carry an epinephrine autoinjector at all times. I understand that there is no guarantee that this therapy will result in a cure or complete resolution of my symptoms. I recognize that I / my child may still need to take allergy medications.
4. I understand that this procedure is generally safe, but that certain risks accompany any treatment. Local reactions are common. General (systemic) reactions are less common but can be serious and even fatal. Risks associated with allergy injection(s) include but may not be limited to:
    - pain or discomfort from the injection
    - local reaction (swelling, itching, tenderness at injection site)
    - generalized reaction (itchy eyes, nose, or throat, sneezing, runny/stuffy nose, tightness in throat or chest, coughing, wheezing, lightheadedness, flushing, difficulty swallowing, sudden nausea, vomiting/diarrhea, hives/swelling)
      ** Any of the above symptoms may occur after the first or even after a series of injections. They may also occur immediately or be delayed (several hours after receipt of an allergy shot.)
    - failure to obtain the desired effect
    - need for additional therapy
5. I understand that allergy injection(s) should **only** be administered in a medical facility where a Physician, Physician's Assistant, or Nurse Practitioner is present and immediately available to treat any possible adverse reaction. **I understand that I / my child need(s) to remain in a medical setting for thirty (30) minutes after the injection(s).**

   While treatment for a reaction that occurs during the waiting period is administered in the office, a severe reaction may require transport to an emergency room for further treatment. The monitoring of prolonged or delayed symptoms may also necessitate transfer to an emergency room.
6. For children younger than 16 years of age, a parent/legal guardian or authorized adult (*Consent to Treat a Minor* form has been signed) must accompany the child. For minors between 16 and 18 years of age, a parent/legal guardian must complete the *Consent to Treat a Minor* form so that the child may come unaccompanied for allergy shot(s).
7. I understand that ACE inhibitors **may increase the chance of a systemic reaction to venom immunotherapy** and that beta-blockers and ACE inhibitors, **may increase the chance that such a reaction is more difficult to treat.** However, according to the Practice Parameters on

Anaphylaxis (2015) written by an expert panel of allergists, the *benefits* of venom immunotherapy clearly *outweigh* the potential risks associated with beta-blockers or ACE inhibitors in those patients with anaphylaxis to stinging insects.

Beta-blockers are commonly used to treat high blood pressure, arrhythmias (abnormal heartbeats), glaucoma (elevated eye pressure), migraine headaches, tremors, panic attacks, and thyroid disease.

ACE inhibitors are commonly used to treat high blood pressure, congestive heart failure, and provide kidney benefits in certain diseases.

If taking either medication, I have discussed with my prescribing physician of the beta-blocker and/or ACE inhibitor about alternative medications. If I am / my child **is not** currently taking a beta-blocker or ACE inhibitor medication, **I agree to notify NW Asthma & Allergy Center if such a medication is prescribed to me/my child.**

I acknowledge that **[____I am not / my child is not / ___ I am / my child is]** presently taking a beta-blocker medication *(see examples below).*

I acknowledge that **[____I am not / my child is not / ___ I am / my child is]** presently taking a ACE inhibitor medication.

EXAMPLES

Beta-Adrenergic Blockers

- acebutolol hydrochloride (*Sectral*)
- atenolol (*Tenormin*)
- betaxolol hydrochloride (*Kerlone*)
- bisoprolol fumarate (Zebeta, Ziac)
- esmolol hydrochloride (Brevibloc)
- metoprolol (*Lopressor,Toprol XL*)
- penbutolol sulfate (*Levatol*)
- nadolol (*Corgard*)
- nebivolol (*Bystolic*)
- propranolol (*Inderal, InnoPran*)
- timolol maleate (*Biocadren*)
- sotalol hydrochloride (*Betapace, Sorine*)

Alpha/Beta-Adrenergic Blockers

- carvedilol (*Coreg*)
- labetalol hydrochloride (*Trandate, Normodyne*)

Combination Products

- *Corzide* (nadolol)
- *Dutoprol* (metoprolol)
- Inderide (propranolol)
- *Lopressor* (metoprolol)
- *Tenorectic* (atenolol)
- *Timolide* (timolol)
- *Ziac* (bisoprolol)

Eye Drops

- betaxolol (*Betoptic*)
- carteolol (*Octupress*)
- levobunolol (*Betagan*)
- metipranolol (*OptiPranolol*)
- timolol (*Betimol, Timoptic*)

EXAMPLES

ACE inhibitors

- benazepril (*Lotensin*, *Lotensin Hct)*
- captopril *(Capoten)*
- enalapril (*Vasotec*)
- fosinopril *(Monopril*)
- lisinopril (*Prinivil, Zestril*)
- moexipril (*Univasc*)
- perindopril (*Aceon*)
- quinapril (*Accupril*)
- ramipril (*Altace*)
- trandolapril (*Mavik*)

Combination Products

- *Accuretic* (quinapril)
- *Amblobenz* (benazepril)
- *Capozide* (captopril)
- *Lexxel* (enalapril)
- *Lotensin* (benazepril)
- *Lotrel* (benazepril)
- *Monopril* (fosinopril)
- *Prestalia* (perindopril)
- *Prinzide* (lisinopril)
- *Quinaretic* (quinapril)
- *Uniretic* (moexipril)
- *Tarka* (trandolapril)
- *Vaseretic* (enalapril)
- *Zestoretic* (lisinopril)

8. Additional risks apply to me / my child in receiving allergy injections because of the presence of the following medical condition(s):

   [ ] Heart condition: Heart disease, irregular heart rhythms, and other heart conditions

   [ ] Seizure disorder

   These conditions carry a greater risk of decreased oxygen level and a drop in blood pressure during a systemic allergic reaction. Treatment with epinephrine used for severe allergic reaction may also result in irregular heart rhythms and poor outcome. I understand that the physicians at Northwest Asthma & Allergy Center, in accordance with Practice Parameters outlined by expert allergists, consider these relative contraindications for allergen immunotherapy.

9. I understand that yearly refills require my signed consent.

10. I have had the opportunity to contact my insurance carrier to determine my / my child's coverage for allergen immunotherapy. **Billing codes for the insurance company include:**
    - **venom mix: CPT 95145 – 95149**
    - **injections codes: CPT 95115 – 1 injection; CPT 95117 – 2 or more injections**

    I understand that I / my child may incur a fee for medical provider review if time since last injection is beyond the protocol.

    For additional billing questions, contact Patient Accounts Dept. at 206-512-1150. Signed consent forms can be sent as PDFs to forms@nwasthma.com. In the subject line of the email, please include the **location** of the office that you are seen & the **legal first & last name** of the patient.

I have read and understand the information presented in this consent form including the purpose of venom immunotherapy, its potential risk and alternatives to this treatment. I have had the opportunity to ask questions which have been answered to my satisfaction. I understand that there is a potential risk in taking beta-blocker and/or ACE inhibitor drugs while on immunotherapy.

I understand that venom immunotherapy is given at specific intervals over an extended period, and I consent and authorize this course of treatment for me/my child. I authorize Northwest Asthma & Allergy Center to prepare the appropriate venom extracts to be used for my/my child's injection therapy. In signing this consent, I accept full responsibility for the cost of the venom extracts and injection fees for me / my child.

I agree that I/my child will remain in the doctor's office for 30 minutes after each shot is administered. I further consent to the performance of additional procedures as indicated or considered necessary in the judgment of the treating physician to treat any reactions to the allergy injection(s).

Printed Name of Patient	Date of Birth
Responsible Party/Guarantor Printed Name	Relationship to Patient
Patient/Responsible Party/Guarantor Signature	Date
Healthcare Provider's Signature	Date