NORTHWEST ASTHMA & ALLERGY CENTER

ENVIRONMENTAL ALLERGEN IMMUNOTHERAPY (AIT) CONSENT

1. I understand allergy injections/shots treat environmental allergies. By receiving increasing amounts of allergens (such as dust mites, pollens, and animal dander) to which I am allergic, helps make my/my child's immune system become less sensitive (desensitized) to them and decrease 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 every two to four weeks. The total duration of allergen immunotherapy is usually three to five years. I understand that I/my child will need periodic assessments with the allergist to determine if this therapy should be continued or altered. With yearly refills, the starting dose will be lowered, and I/my child will receive weekly injection(s) before returning to the maintenance dose.

3. I understand that allergen immunotherapy does not take the place of avoidance of allergens to which I am/my child is known to be sensitized/allergic. Improvement is often not seen immediately and may not be apparent for up to one year. 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 severe 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 appear 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).**

6. While treatment for a reaction during the waiting period is administered in the office, a severe reaction may require transport to an emergency room for further treatment. Monitoring prolonged or delayed symptoms may also necessitate transfer to an emergency room.

   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 16-18 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 shots.

7. Beta-blockers commonly treat high blood pressure, arrhythmias (abnormal heartbeats), glaucoma (elevated eye pressure), migraine headaches, tremors, panic attacks, and thyroid disease. These medications **may increase the chance that a systemic reaction to immunotherapy is more difficult to treat.**

   If taking a beta-blocker, I have discussed with my prescribing physician of the beta-blocker about alternative medications. If no alternative medicine is available, for some patients, the benefits of allergen immunotherapy (i.e., improved quality of life/allergy symptoms) may outweigh the possible risks while taking a beta-blocker.

   I acknowledge that **[____I am <u>not</u>/my child is <u>not</u> OR ___ I am/my child is]** presently taking a beta-blocker medication. **If I am/my child is not currently taking a beta-blocker medicine, I agree to notify NW Asthma & Allergy Center if such a medication is prescribed to me/my child.**

<u>EXAMPLES</u>	
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*)

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
   [ ] No heart condition or 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 reactions may also result in irregular heart rhythms and poor outcomes. 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 my/my child's antigen will not be made without my signed consent. Yearly refills also require my signed consent. You will be notified in 2 to 4 weeks that your antigen is ready. Please call the office if you have not heard from NAAC within that time.

10. I understand the cost for the antigen can vary depending upon the anticipated dose(s) (based on the number of mixes, the starting dose(s), and the dosing frequency) that I/my child will receive. The insurance company will be billed for the anticipated doses that I/my child will receive. The cost for antigen preparation generally decreases when the maintenance level is reached. The administration of injections is billed separately based on the number of injections. I understand that I/my child may incur a fee for medical provider review if the time since the last injection is beyond the protocol.

11. 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:

    - antigen mix (95165 for environmental allergens)
    - injections codes (95115 for 1 injection or 95117 for 2 or more injections)

    Contact Patient Accounts Dept. for additional billing questions at (206) 512-1150. Signed consent forms can be sent as PDFs to forms@nwasthma.com

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

I understand that allergen immunotherapy is given at specific intervals over an extended period, and I consent to and authorize this course of treatment for me /my child. I authorize Northwest Asthma & Allergy Center to prepare the relevant allergenic extracts to be used for my/my child's injection therapy. In signing this consent, I accept full financial responsibility for the cost of the antigen 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 treating physician's judgment to treat any reactions to the allergy injection(s).

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