TALLAHASSEE
ALLERGY, ASTHMA & IMMUNOLOGY
SPECIALIZING IN ADULT AND PEDIATRIC ALLERGIC DISORDERS

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VENOM IMMUNOTHERAPY

General Information

One to two million Americans have allergic reactions to insect venoms (i.e. fire ant, honey bee, wasp, etc.). These allergic reactions may present as burning, itching, or swelling at the site of the sting; generalized welts (hives); itchy eyes, nose, and throat; nose congestion; tightness in the throat or chest; coughing, wheezing: lightheadedness: faintness; nausea and vomiting. Documented death as a result of reactions from stinging insects occurs in about forty persons per year. However, the numbers are probably four to five times greater since these fatalities may occur without reporting that they are associated with a known insect sting.

Purified insect venoms are available for individuals with stinging insect allergy. Insect venom immunizations give almost 100% protection against subsequent reactions in previously allergic individuals. Extract for the imported fire ant immunotherapy is derived from the whole insect.

What is Venom Immunotherapy?

This immunotherapy is the injection of purified venom(s) into allergic individuals. These injections diminish the body's allergic reactions to insect stings.

How Immunotherapy Works

The protective mechanisms are: decrease in skin sensitizing antibody (IgE) which causes the allergic reaction; increase in the blocking antibody (IgG); and decreased allergic cellular responses, all of which actively block the allergic reaction.

How Treatment is Given

The selection of venom immunotherapy is based on the patient's history, allergy skin tests, and/or RAST blood tests. Increasing doses of venom are given once to twice weekly initially for approximately 6 to 12 weeks. The dose interval is then gradually increased to every four weeks. After one year, injections are given every six weeks or sometimes longer. Skin tests will be repeated in several years to determine if sensitivity is lost.

Possible Immunotherapy Side Effects

Immunotherapy should be given at a medical facility with a physician present. Occasionally, allergic reactions occur which require immediate medical therapy. Since most of the reactions occur within **thirty minutes** following the injection, you will be asked to stay in the medical facility for this length of time.

It is normal to have allergic reactions that often occur at the injection site (arm), such as redness, swelling, itching or pain; avoid rubbing, patting or kneading your arms. Applying cold packs and taking antihistamines can alleviate these symptoms.

Other allergic reactions may include hay fever type symptoms hives, flushing, lightheadedness, asthma, and, rarely, life threatening reactions. Allergy shots are usually safe and effective if standard guidelines for allergy injections and appropriate safeguards are followed.

Benefits and Alternatives

The venom treated patient has a less than 5% reaction reoccurrence rate (these are usually mild and consist of hives) after a challenge sting, whereas the reaction rate for untreated patients is up to 60%. Alternatives to venom immunotherapy are avoidance of stinging insects and carrying adrenalin.

Patients for Whom Venom Immunotherapy is Recommended

Patients with life threatening allergic reactions and positive skin tests or RAST blood tests

Precautions

Adrenalin should be carried at all times. Once maintenance (top dose) immunotherapy is achieved, there is much less need for such a precaution. However, it is still recommended that an adrenalin containing syringe be available.

Please read the handout entitled ***TAAI Immunotherapy Policy (on back).***

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TAAI IMMUNOTHERAPY POLICY

The following guidelines are very important for safe administration of your allergy injections.

1. Please read this information carefully. This office is open for allergy injections on:
   - Monday and Wednesday 8 am-11 am and 1 pm- 4 pm
   - Tuesday and Thursday 10 am-1 pm and 3 pm-6 pm
   - Friday 7 am-11 am

   No appointment is necessary; simply check in at the front window and notify the staff that you are here for a shot. A 48 hour interval is necessary between injection times.
2. You need to **TAKE YOUR ANTIHISTIMINE** on your **SHOT DAYS**, at least 1 hour prior to receiving your shot.
3. **YOU MUST WAIT IN THE OFFICE AT LEAST 30 MINUTES AFTER RECEIVING YOUR INJECTION** to make certain that you do not experience an allergic reaction. These symptoms consist of any of the following: itchy eyes, nose, or throat, nasal congestion, runny nose, tightness in the throat or chest, coughing, increased wheezing, lightheadedness, faintness, nausea, hives, or generalized itching. Report these or any other symptoms to the nurse immediately so that appropriate treatment may be instituted.
4. **Do not exercise for two (2) hours following your injections(s)**
5. If you have a fever or are wheezing, you should be assessed by the physician before receiving your injection.
6. All injection sites must be checked by a nurse before leaving the office.
7. If, after leaving the office, you experience excessive swelling or tenderness in your arms, please tell the nurse prior to receiving your next injection. If you experience more severe symptoms such as wheezing, generalized rash, or throat swelling, please notify the office immediately.
8. **ALL CURRENT MEDICATIONS OR CHANGES IN MEDICATION (including BETA BLOCKERS)** made by **any** physician must be brought to the attention of the nurse or physician ***before*** receiving your injection. **Notify** the medical staff if there is a possibility that you may be **PREGNANT.**
9. If you are receiving your shots in another physician's office:

   A. It is our policy that injections should only be given by a physician/or nurse. A medical doctor should be in the building at the time of your injection. Adrenalin (epinephrine) and other medications as well as appropriate equipment to treat allergic reactions should be available in the office where you receive your injection therapy.

   B. **Please notify this office at least two weeks in advance if new vials of allergy extract are needed. Always bring your current dosage sheet with you at the new vial visit so that appropriate alterations in the dosage can be made.** This dosage schedule is part of your medical record and the original or a copy should be returned to this office when you return for a new vial evaluation. The date of each injection should be recorded on the sheet.

   C. Please do not discontinue your injections without consulting this office and follow the time intervals outlined by the doctor on the injection sheet for optimal therapeutic results.

   D. If there is an interval longer than one month between injections, you should consult this office by telephone or in person before receiving your next injection.

   E. Do not continue using extract after the expiration date on the label.
10. If you have any questions regarding your injections, these instructions, or allergy symptoms, please contact this office.

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IMMUNOTHERAPY PATIENT CONSENT FORM

By signing below to start or re-start Immunotherapy (allergy injections) from Tallahassee Allergy, Asthma & Immunology (TAAI) I am acknowledging and consenting to the following:

- I have reviewed the Immunotherapy Background Information and TAAI Policy regarding Immunotherapy; I agree to follow and abide by all TAAI Immunotherapy Policies.
- I have had an opportunity to ask my physician questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.
- I understand Immunotherapy will only be administered with a medical physician present since occasional reactions may require immediate treatment. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, can be serious but rarely fatal.
- I agree to **take my antihistamine on my shot days** at least 1 hour prior to receiving my shot.
- I agree to **update** the nurse **prior** to receiving my shot of **any** changes to my medication intake or medical history; including the addition of **BETA BLOCKERS** or the possibility that I may be **PREGNANT.**
- I agree to **WAIT** for **30 MINUTES** after each injection **inside the medical facility**; unless otherwise indicated **ALL MINORS MUST BE ACCOMPANIED by a parent/guardian (see back)** for their entire shot visit **inside the medical facility.** Failure to wait the required amount of time after an injection may make it necessary to modify your treatment.
- I will report any and all adverse reactions to the staff immediately.
- I understand I am making at least a 1 year commitment to weekly injections during the buildup phase and a total commitment of at least 3 years. Missing injections will prolong the length of my therapy.
- I acknowledge once I sign this consent form I am financially liable for all costs associated with my Immunotherapy treatment (TAAI will file any in network insurance that has been provided to them).
- By signing below, I am stating that I am aware of the TAAI Immunotherapy Policy and agree to abide by it.
- Furthermore, I affirm that I will not attempt to have my shots administered by anyone other than then the office of the licensed physician indicated below. If I need to transfer to another physician I will contact TAAI for further instructions and to have a new consent form completed by the new physician.

PATIENT Name _____

Patient Signature/Relationship_____ Date_____
**Parent/Guardian Signature & Relationship if patient is a minor (For Minors See Back for More Information)

Shot Location: ☐ TAAI ☐ FSU **FSU-Initial dose PLUS 1st dose of Red Vial MUST be administered in our Main Office ☐ Amelia Medical ☐ Other (**$15 fee per ship/complete below**) **Signed Consent (below) MUST be received and Shipping fee MUST be paid by patient PRIOR to shipping**

Physician Name_____

Physician Address_____

Physician Phone_____ Physician Fax_____

By signing below, I have read the "TAAI-Outside Office Policy" (2 pages) and I agree to adhere to said policy; I also agree that there will be a licensed physician on site at all times of administration and 30 minute post administration wait time for allergy injections; my office will fax TAAI updated IT administration logs as requested and call with any questions regarding dosing, schedule and reactions.

Physician Signature_____ Date_____

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CONSENT FOR MINORS - - Receiving Immunotherapy without Parent/Guardian present

***PATIENTS UNDER 18:**

I give permission for my son/daughter, _____ (patient) to come in to Tallahassee Allergy, Asthma & Immunology and receive allergy shots every week. He/She may come in with the following sibling(s) (16 yrs old or older) or other adult(s) (ie: grandparent, babysitter, etc) and will follow all requirements of the office as per the TAAI Policy & Consent regarding Immunotherapy. If any alteration in his/her treatment is needed, the office will notify me immediately. I understand that I will need to be present for all office visits with the doctor.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

***PATIENTS 16-18 ONLY:**

I give permission for my son/daughter, _____ (patient) to come in to Tallahassee Allergy, Asthma & Immunology and receive allergy shots every week. He/She may come in alone and will follow all requirements of the office as per the TAAI Policy & Consent regarding Immunotherapy. If any alteration in his/her treatment is needed, the office will notify me immediately. I understand that I will need to be present for all office visits with the doctor.

*Parent/Guardian Signature_____ Date_____