



# Allergy and Asthma Consultants

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## Immunotherapy Authorization

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of First Shot: \_\_\_\_\_

Your doctor has recommended allergy shots (immunotherapy) as treatment for your allergies and/or asthma. Immunotherapy is a technique to change the body's response to those substances that are contributing to your allergy problems. This technique, used by doctors for over 80 years, has been recently proven to be effective in treating hay fever and asthma by a series of scientific experiments. Immunotherapy is unfortunately not effective for food or drug allergies.

If you choose to begin immunotherapy, specific treatment antigens will be made for you based on the local reactions you had from allergy skin testing. You will have up to 6 antigen vials and receive up to 6 allergy shots depending on the number of positive skin tests. The injections are split to give you more potent allergens. Too many antigens in one bottle dilute each other, decreasing their potency. Also, if you experience a local reaction with one injection, the other injections can be advanced with this method.

Allergy injections are recommended weekly or twice weekly if possible. In most cases, the dose is advanced until maintenance, or your highest dose is reached. This is approximately 100,000 times as potent as your starting dose. At this point we can usually decrease the frequency to every two weeks.

Allergy shots are recommended for at least 2-3 years after maintenance is reached. It is unclear whether stopping injections will cause symptoms to return, but many patients will have long-lasting results. The frequency of injections can often be decreased to every 4 weeks after maintenance is reached.

We require that all patients wait 20 minutes after their injections as a precaution against an allergic reaction. Fortunately these are quite rare and easily treated in the allergist's office. We find that most reactions occur in the first 20 minutes. You will receive a prescription for an auto-injector of adrenaline (EpiPen®) and instructions on its use when you begin allergy shots. If you experience a serious reaction after leaving the office you should immediately use the EpiPen as directed, return to our office or go to the nearest emergency room. These reactions would include generalized hives or rashes, shortness of breath or wheezing, or loss of consciousness.

Some patients experience redness, itching or a small bump at the site of injection. This will usually subside in 2-3 hours. If this is a discomfort, ice may be applied or an antihistamine pill may be helpful.

Immunotherapy is not recommended if you are taking beta blocker medications or MAO inhibitor medications. If you are given medication for treatment of high blood pressure, glaucoma or depression, please inform our office before your next injection.

Immunotherapy is not inexpensive but has proven to be cost-effective as compared to chronic medication use over several years. The charge for your shots includes the cost for mixing the personal allergy vials as well as the cost of the injection. Most insurance plans pay for these charges as they would any other medical charge. However, we strongly recommend that you check with your individual insurance plan to find how they reimburse these charges. You are ultimately responsible for charges they do not cover.

Allergy immunotherapy has been proven to be highly effective in treating hay fever and asthma, provided you reach maintenance dose. It will not cure your allergies, but it may significantly decrease the symptoms you are having and the amount of medications you are taking. Please feel free to ask us any questions you may have regarding this procedure.

*I, the undersigned, have read and understand the above information and have discussed the benefits, risks and alternatives of allergy skin testing with my doctor.*

*I hereby verify that I am not on any "beta blocker medication" and am not pregnant to the best of my knowledge.*

*I therefore authorize Brian S. Lipson, M.D., and/or his associates to perform allergy skin testing and to treat any adverse reaction that may occur.*

Date \_\_\_\_\_ Patient, Parent or Guardian \_\_\_\_\_

Witness \_\_\_\_\_