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Venom Checklist

_____Immunotherapy was discussed with the Physician.

_____I was given and have reviewed the immunotherapy information packet.

_____I have returned the three forms:
Immunotherapy Financial Consent Form
Immunotherapy (Allergy Shots) Consent
Shot Patient Emergency Contact Information

_____ I understand that committing to Venom injections, I will be required to have a breathing test, a 6 week follow up, and 6 month follow up as check points to ensure shots is the correct solution for my allergies and to discuss any questions.

_____I returned these three forms by either:
Completing them in the office
Mailing to: Connecticut Asthma & Allergy Center LLC
Attn: Bottle Room
836 Farmington Avenue Suite 207
West Hartford, CT 06119

I would like to start shots in:

_____ Avon _____ Hamden _____ Manchester _____ Middletown _____ West Hartford

Once the Venom Consents are received

1. The physician places the order for your immunotherapy
2. The order is approved and serum is made
3. The office will contact you to set up the first allergy shot appointment and verify the office you will be receiving your injections.

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West Hartford, CT 06119-1551
860-232-9911 Phone 860-231-7112 Fax
www.ctallergy.net

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PATIENT FINANCIAL RESPONSIBILITY – VENOM SHOTS

Patient Name: ______________________________ Insurance Company: ____________

Your physician is recommending allergen immunotherapy for you or your child.
Please call your insurance company at the Member Services phone number to confirm that this is a covered benefit. Provide the following highlighted procedure codes to the insurance company.

Venom Shot Procedure Codes	
95180	Venom desensitization
95117	Administration Injection
95145	Single Stinging Insect Venom
95146	Two Single Stinging Insect Venom
95147	Three Single Stinging Insect Venom
95148	Four Single Stinging Insect Venom
95149	Five Single Stinging Insect Venom

Are the injections covered? No ☐ YES ☐ If yes:
Do I have a deductible? NO ☐ YES ☐ $____________ Deductible Met: $____________
Do I have a co-insurance? NO ☐ YES ☐ _____%
Do I have a copay? NO ☐ YES ☐ $________
Is there a maximum/limit on number of 95117 injections? NO ☐ YES ☐ ___ per: _____ year/days
The name of the person you spoke with: ____

Date: ___/___/___ Time: _________ am/ pm Reference Number for Call: _________

This form must be completed, signed and return the our office prior to starting immunotherapy.

Signature: ____ Date: __________

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Venom, Facts and Consent
Facts About Immunotherapy

Venom shots are an attempt to build a tolerance to the insect venom to which you are allergic.

Reactions may occur. There are two types.

A LOCAL reaction usually occurs within 20 minutes after the injection although it may occur later. A local reaction is redness, swelling and itchiness at the site of the injection beyond what you should have from a mosquito bite.

A SYSTEMIC reaction usually occurs within 30 minutes after the injection. The symptoms of a systemic reaction include itchy eyes, itchy ears and throat, coughing, congestion, sneezing, throat tightness and hives. It is potentially life threatening and should be reported AS SOON AS POSSIBLE.

As systemic reactions are possible, all patients are required to wait 30 minutes in the waiting room. UNDER NO CIRCUMSTANCES CAN VENOM SHOTS BE GIVEN AT HOME. Should symptoms of a systemic reaction occur, emergency medical treatment should be sought, either in our office or at the nearest medical facility. After you are stabilized, our office should be notified.

Local reactions on the arm are used as a guide for further treatment and therefore should be reported to the nurse prior to administration of the next shot. Should they become uncomfortable, ice packs and antihistamine can be given. ALL PATIENTS SHOULD CARRY AN ANTIHISTAMINE WITH THEM ON THE DAY OF THE SHOT AND IF YOU HAVE ASTHMA YOU SHOULD CARRY YOUR INHALER WITH YOU. We would like you to be committed to getting your shots on time. If you need to be away for an extended period of time, let us know and arrangements may be made for you to receive your immunotherapy elsewhere.

Once you are receiving your venom shots monthly or every 6 weeks, you are expected to see your allergist on a regular basis at least once per year. Please notify the nurse or physician if you are taking any new medications, specifically beta-blockers, which are used in the treatment of high blood pressure, heart disease and migraine headaches. Patients on beta-blockers should not receive immunotherapy.

Venom patients should have an Epi-Pen or Epinephrine Kit. (Please make sure the expiration dates are good.)

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You or your insurance will be charged at the time of shots for the administration of the shot; extracts are billed separately for some insurance programs. Please call us at (860) 232-9911 if you should have any questions.

Desensitization consists of gradual increases on the strength and dose of venom until a maintenance level of 1cc of mcgm/ml is achieved. Although treatment can vary due to an individual patient's sensitivity, the usual treatment is as follows:

Treatment Schedule

Week #	**Patient Receives:**
1	3 shots at 30-minute intervals of each venom needed.
2	2 shots at 30-minute intervals of each venom needed.
3	2 shots at 30-minute intervals of each venom needed.
4	2 shots at 30-minute intervals of each venom needed.
5	2 shots at 30-minute intervals of each venom needed. (Patients is receiving top dose in 2 parts)
6	2 shots of each venom and remains in the office for 30 minutes.
7	1 shot of each venom and remains in the office for 30 minutes. (We will now increase time between shots)
8	1 shot of each venom and remains in the office for 30 minutes.
10	1 shot of each venom and remains in the office for 30 minutes.
13	1 shot of each venom and remains in the office for 30 minutes.
17	1 shot of each venom and remains in the office for 30 minutes.
22	1 shot of each venom and remains in the office for 30 minutes.
28	1 shot of each venom and remains in the office for 30 minutes. (From now on shots will be given in 6 weeks intervals)

Questions regarding venom treatment may be directed to our lab nurses in the West Hartford office at (860) 232-9911

I, ___________________________________, have been made aware of all the risks involved in receiving venom injection therapy.

______________________ ______________________ __________

Patient Name | Patient/Guardian Signature | Date

______________________ __________

Witness | Date

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Venom Immunotherapy Financial Consent Form

Patient Name: **Contact Number: ( ) –**

DOB: / /

Insurance plans are highly variable regarding coverage of immunotherapy treatment. There are two costs to consider. The first cost is for the "antigen" or "extract" (95165, 95146, 95147, 95148, 95149). The antigen (extract) is prepared at Ct Asthma & Allergy LLC from a recipe your physician has written. Your second cost is for the administration of the injections (95115 or 95117).

Ct Asthma & Allergy recommends that you contact your insurance carrier to find out your specific coverage. It is important to understand your insurance coverage and know your responsibility of the cost. Some Insurance plans cover immunotherapy in full, while other plans have associated deductibles, co-insurances and co-pays.

- *I acknowledge, with my signature, that I am authorizing Ct Asthma & Allergy LLC to bill my insurance company for the allergen extracts made for me/my child. I understand that, if I decide not to initiate allergen immunotherapy after the extracts have been made, I am still responsible for the cost of the extract. I acknowledge that any costs incurred for this method of treatment that is not covered by my insurance carrier, such as deductibles, co-insurances, or co-pays will be my responsibility. I also acknowledge that my allergen extracts will not be prepared until this signed consent is returned to Ct Asthma & Allergy LLC.*

I authorize the preparation and billing of the allergen extract.

____

Responsible Party Name (print) Date

____

Responsible Party Signature Date

Special Instructions

New Start Date: / /

Sets Expire: / /

Other: ______________________

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Shot Patient Emergency Contact Information **Todays Date: / /**

Patient Name: ______________________ **DOB:** _____________________

Address: __________________________ **Phone Number**: ______________

____

1st Emergency Contact: ___________________________

Relationship: __________________________________

Cell Phone: ___________________________________

Other Number: _________________________________

2nd Emergency Contact: ___________________________

Relationship: __________________________________

Cell Phone: ___________________________________

Other Number: _________________________________

CAAC Physician: ______________________ **PCP**: _______________________

Current Medications: ____________________ ____________________

____________________ ____________________

____________________ ____________________

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