

*ALLERGY AND ASTHMA CENTER*  
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[WWW.NOVAALLERGY.COM](http://WWW.NOVAALLERGY.COM)

**ORAL IMMUNOTHERAPY/ FOOD DESENSITIZATION / FOOD CHALLENGE**  
**CONSENT FORM**

*Patient Name:* \_\_\_\_\_ *DOB:* \_\_\_\_\_

*Date of challenge:* \_\_\_\_\_

The patient, named above, is going to undergo a medically supervised food challenge to a food that she is allergic to, either via clinical history, clinical reaction, ImmunoCAP RAST lab test results, and/or skin test results. The challenge will be done in the Allergy and Asthma Center under the close supervision of the physician and/or physician assistant.

There is a risk of a severe systemic anaphylactic reaction with the challenge that may require emergency treatment, calling of 911, sending patient to the nearest emergency room/tertiary care center, administering epinephrine, Benadryl, bronchodilators, and/or steroids via appropriate measures. Risks include hypotension, diffuse urticarial (hives), angioedema, respiratory distress, wheezing, rash, nausea, vomiting, diarrhea, and/or abdominal cramping.

The procedure will start at a low dose of the food and then the dosage of the food will be gradually increased as tolerated per the physician/physician assistant discretion. This gradual increase may be conducted over days, weeks, and/or months at the physician's discretion. Please look into the patient's actual chart note on the date of the challenge for details on the procedure and recommendations. Detailed instructions on home dosing will be provided to the patient and/or legal guardian and must be followed accurately.

If the patient tolerates only part of a full dose of the food, then the physician/physician assistant may request that the patient ingest this same tolerated amount of food daily at home under close supervision of the legal guardian. There is a continued risk of systemic anaphylaxis even with this tolerated dose. Patient or legal guardian must have a current epinephrine auto-injector (and must understand how and when to administer it) and Benadryl. The patient or legal guardian must also have access to 911 and a local emergency room.

After every dose, including the one administered at the Allergy and Asthma Center, there is a risk of a late allergic reaction. If the late phase reaction occurs, the patient or legal guardian must treat it as instructed and go to the nearest emergency room.

Desensitization to an allergenic food is a non-standardized protocol. The Allergy and Asthma Center starts at a low dose as tolerated, then recommends that the patient ingests that dose on a regular basis until the next increase in dosage. The next increase in dosage will only be at the Allergy and Asthma Center since there is a more significant risk of an allergic reaction.

Studies that discuss OIT (oral immunotherapy) include:

[http://www.jaci-inpractice.org/article/S2213-2198\(14\)00576-5/abstract](http://www.jaci-inpractice.org/article/S2213-2198(14)00576-5/abstract)

[http://www.jacionline.org/article/S0091-6749\(09\)00556-9/abstract](http://www.jacionline.org/article/S0091-6749(09)00556-9/abstract)

<https://www.ncbi.nlm.nih.gov/pubmed/26194541>

<https://www.ncbi.nlm.nih.gov/pubmed/22624442>

[www.nejm.org/doi/full/10.1056/NEJMoa1200435#t=article](http://www.nejm.org/doi/full/10.1056/NEJMoa1200435#t=article)

The challenge CPT code of 95076 will be submitted to the patient's commercial insurance policy per our practice policy with an ICD-10 diagnosis code of food allergy (specific as to the type of food, i.e. nut, milk, egg). However, if the insurance does not cover the costs of the challenge, it is the patient's (or legal guardian's) responsibility for the full cost of this procedure.

It is the responsibility of the patient/ legal guardian to bring the food to the office on the day of the challenge in the form as requested by the healthcare provider.

The patient cannot have been wheezing, febrile, have acute pharyngitis, have acute hives or viral like symptoms for at least 72 hours prior to the challenge.

The patient cannot have had any antihistamines for at least five days prior to the challenge.

I, the patient / legal guardian, have read the above information and understand the risks and benefits of the procedure.

DOB \_\_\_\_\_

Patient Name

\_\_\_\_\_

Legal guardian / Parent

\_\_\_\_\_

Date of challenge