UNIVERSITY of SOUTH FLORIDA
Student Success
Student Health & Wellness Center

Immunizations Compliance Office
12530 USF Bull Run Dr. SWC 310 Tampa, FL 33620
Phone: 813-974-2331 Fax: 813-974-5888

New Antigen Patient Packet

The Student Health & Wellness Center (SHWC) at the University of South Florida (USF) welcomes all new patients seeking to continue their immunotherapy while attending USF. It is our goal to provide safe and timely immunotherapy to our patients as an extension and under the direction of the patient's Referring Allergist. The *New Antigen Patient Packet* contains all the necessary information and guidance for a smooth transition of immunotherapy treatment. New antigen patients should review this packet with their allergist as there are required orders needed from the Allergist.

Documents included in packet

- New Antigen Patient Guidelines
- New Antigen Patient Agreement and Consent to be signed by patient
- Antigen Clinic Contraindicated Medication List
- Referring Allergist Agreement to be signed by patient's allergist

New Antigen Patient Guidelines

1. Initial injections must be administered at Allergist office.
2. If greater than six (6) months since last injection, patient must restart treatment at Allergist office.
3. Complete WRITTEN instructions/orders must be submitted by Allergist on office letterhead. This information may be faxed to our office or given to patient to deliver. Instructions/orders must include the following information:
    - Patient's name
    - Dosage schedule
    - Frequency of injections
    - Contents of each vial
    - Concentration of each vial
    - Expiration date of vial(s) – (month/day/year)
    - Pre-medication prior to injections: Dose and time (if indicated)
    - Administration log with concentration dose amount & date of last injection(s)
    - Dose adjustment for missed/late injections
    - Dose adjustment for local reactions
    - Minimal number of days between injections
    - Peak Flow Parameters & Peak Flow Meter device (if indicated)
    - Epi-Pen device (current). Patient will be instructed to obtain script from Allergist to replace the device prior to exp. date.
    - Most recent visit summary with medical diagnosis and relevant medical history
    - ICD-10 Dx Code for insurance billing

4. Antigen extracts must be labeled with the patient's name, vial contents, concentration, and expiration date. Extracts should be stored in a vial box.
5. Antigen extracts can **NOT** be mailed to USF SHWC. We cannot guarantee adequate temperature while in transit. Patients must bring antigen extracts, **secured in an appropriate vial box** supplied by the allergist office, to Antigen Screening appointment in a cooler and ensure the extracts are kept cold.
6. Updated instructions/orders and date of last injection are required for all new vials of antigen extract even if the vials contain the same antigens.
7. All Antigen Patients must carry an epinephrine injection device (Epi-Pen/Auvi-Q). Antigen injections will not be administered if patient does not have this device at the appointment. Allergist is to provide patient with prescription.
8. If the USF SHWC Antigen Nurse or Medical Director have concerns or questions about the immunotherapy treatment, they have the right to postpone treatment, consult with the patient's Allergist, and/or refer patient back to Allergist for evaluation.
9. The patient must be free of systemic reactions to antigen injections for at least six (6) months or for the period under treatment with the allergist if less than six (6) months.
10. New patients will call the USF SHWC appointment line at 813-974-2331 to make an initial Antigen Screening appointment. At this appointment, the patient will bring written instructions/orders from the Allergist as described above, antigen extracts in a cooler, and epi pen. The patient will meet with the USF Antigen Nurse who will review the allergist instructions/orders, inspect and verify antigen extracts, and review clinic policy and Patient Agreement and Consent. **NO injections will be given at this appointment**. All required documents will be submitted to USF SHWC Medical Director for review and approval. This may take 3-5 business days. No injections will be administered until Immunotherapy treatment is approved by the USF SHWC Medical Director. If required documents are missing or clarification is needed, the Antigen Nurse or patient will contact Allergist. This may delay submission to the USF SHWC Medical Director, therefore, delaying injections.
11. At each antigen injection appointment, the patient will be screened before injection to ensure there are no contraindications for immunotherapy. This screening includes: illness, recent use of inhaler/epi pen, reactions to previous injections, antihistamine use, start of new medication including beta blockers, pregnancy, and timing of injection. If patient meets screening criteria and has epinephrine auto injector, then injection(s) will be administered per order. If patient does not meet screening criteria, then injections will be postponed.
12. The patient must arrive 15 minutes before appointment. Appointments may be rescheduled if patient arrives late.
13. The patient must stay 30 minutes after injection in designated observation area and will have injection sites checked every 10 minutes by Antigen Nurse.
14. Insurance will be billed accordingly. If patient does not have insurance and is self-pay the fees for services are:
    - Screening Appointment: $24
    - Single injection $15
    - Multiple injections $20
    - In the event of an anaphylactic reaction, there will be additional charged for any emergency management services provided.

15. During school breaks: winter, spring and summer, many patients will need to continue their injections at their allergist office at home. The patient will be responsible for signing out antigen extracts and ensure they extracts are kept cold. The Antigen Nurse will work with patient and make sure the patient has a copy of the most recent injection log to bring back to allergist office. The patient is responsible for bringing back the antigen extracts and updated injection log with last injection date and dose when they return to campus at their next appointment. The patient must keep the antigen extracts cold at all times while in transit. If the extracts are new, the patient must bring new instructions/orders. Antigen extracts can **NOT** be mailed.
16. The USF SHWC reserves the right to dismiss a patient from services due to patient's non-compliance with the above guidelines. Also, a patient may be dismissed from services due to chronic no-shows and missing appointments.
17. In the event a patient experiences and anaphylaxis reaction, USF SHWC staff and medical provider will follow the USF SHWC Anaphylaxis Management Protocol.

We look forward to meeting the health and medical needs of all our patients. New Antigen Patients should call USF SHWC at 813-974-2331 to schedule their first Antigen Screening appointment with our Antigen Nurse once the patient has received all required written instructions/orders from Allergist. The Allergist office can also fax the required written instructions/orders to 813-974-5888.

ANTIGEN CLINIC SERVICES CONTRAINDICATED MEDICATIONS WITH IMMUNOTHERAPY

Beta-Blockers are medications that are used to manage a variety of conditions including high blood pressure, angina, headaches, and glaucoma. These medications can also make allergy injections unsafe. It is impossible to accurately predict the degree of risk for an individual patient taking beta-blockers; therefore, AVOIDANCE is the only reliable prevention strategy.

Please notify an antigen nurse if you are taking any beta-blocker or antidepressant medications. **INJECTIONS WILL NOT BE GIVEN** if you are taking any beta-blocker medications, including these examples listed below. If unsure about any medication, ask an Antigen Nurse.

BETA-BLOCKERS - GENERAL

Brand Name	*Generic Name*
Betapace	Sotalol
Blocadren	Timolol Maleate
Brevibloc	Esmolol HCL
Bystolic	Nebivolol
Cartrol	Carteolol HCL
Copressor HCT	Metoprolol/HCTZ
Coreg	Carvedilol
Corgard	Nadolol
Corzide	Nadolol/bendroflumethiazide
Desyrel	Trazodone HCL
Elavil	Amitriptyline HCL
Inderal/Inderal-LA	Propranolol
Inderide	Propranolol/HCTZ
Kerlone	Betaxolol
Levatol	Penbutolol
Lopressor	Metoprolol Tartrate
Pamelor	Nortriptyline HCL
Normozide/Normodyne	Labetalol
Norpramin	Desipramine HCL
Sectral	Acebutolol HCL
Tenoretic	Atenolol/Chlorthalidone

BETA-BLOCKERS - GENERAL (Cont.)

Brand Name	*Generic Name*
Tenoretoz	
Tenormin	Atenolol
Timolide	Timolol Maleate/HCTZ
Tofranil	Imipramine HCL

Toprol	Metoprolol Succinate
Trandate	Labelalol
Triavil	Penphenazine Amitriptyline HCL
Visken	Pindolol
Zebeta	Bisoprolol Fumarate
Ziac	Bisoprolol Fumarate/HCTZ

BETA-BLOCKERS - OCULAR (EYE)

Betagan	Levobunolol
Betaxon	Levo-betaxolol
Betoptic	Betaxolol
Timoptic, Betimol	Timolol Maleate
Occupress	Carteolol
Optopranolol	Metipranolol

Any Antidepressant Drug

Exceptions: Prozac, Zoloft, Paxil, Wellbutrin

Reference: Physicians' Desk Reference 2021-2022
Reviewed and Updated: 2/2025

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New Antigen Patient Agreement and Consent for Immunotherapy

I request to receive my allergy immunotherapy at University of South Florida Student Health & Wellness Center and I agree to the following:

- □ I have read the *New Antigen Patient Packet* including the *New Antigen Patient Guidelines* and agree to comply with these guidelines.
- □ I will attend all scheduled appointments and will bring my epinephrine auto injector device.
- □ I understand that if I do not meet the screening criteria as described in the *New Antigen Patient Guidelines,* my injections will be postponed until it is safe for me to receive my injections.
- □ I understand that I must wait 30 minutes after my injections and will stay in designated area for observation.
- □ I understand that I must bring my antigen extracts to my screening appointment and ensure my antigen extracts are kept cold. Extracts cannot be mailed.
- □ I understand that my Allergist, _____, must provide written instructions/orders, and my treatment plan must be approved by the USF SHWC Medical Director before I can start my antigen injections.
- □ I have been given the opportunity to asking questions about my immunotherapy treatment and my questions have been answered.

Consent for Immunotherapy at USF SHWC

I, _____, have read and fully understand the *New Antigen Patient Packet*, *New Antigen Patient Guidelines* and the *New Antigen Patient Agreement and Consent for Immunotherapy.* I also understand that if I am unwilling to comply with the requirements as stated, I may be refused this service by Student Health Services as stated above.

I authorize the Student Health Services clinic staff to release information regarding my antigen therapy to_____ and _____.
Name of Allergist office **Print Name(s)**

_____ _____
Patient's Signature Date

_____ _____
SHWC RN, Witness Date

_____ _____
Executive/Medical Director and/or Designee Date

USF SHWC Patient Identification Sicker HERE

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To Referring Allergist:

The University of South Florida Student Health and Wellness Center (USF SHWC) has been collaborating with Referring Allergists to ensure a smooth transition of immunotherapy care while our mutual patient attend school at USF for many years. To provide safe and efficient care to our patients, we are asking that you do the following:

- ✓ Review our *New Antigen Patient Guidelines* with your patient
- ✓ Review and sign the *Referring Allergist Agreement*
- ✓ Complete WRITTEN instructions/order as described in the *Referring Allergist Agreement*
- ✓ Ensure patient has a current epinephrine auto injector device (Epi-pen or Auvi-q) or a prescription to get a device.

The required documentation can be either sent to our office with the patient or faxed to (813) 974-5888 Attention USF SHWC Antigen Nurse. We will not be able to start immunotherapy until all documents are received and our Medical Director approves treatment.

Please note that we have multiple medical providers in our clinic and are prepared to manage anaphylaxis and systemic reactions.

We look forward to serving your patient while they receive their immunotherapy at USF SHWC. If you have any questions, please contact our Immunization Coordinator/Antigen Nurse at 813-974-5917.

Thank you,

Dr. Joseph Puccio MD, Medical Director

Kelley Huelle, BSN, RN Immunization Coordinator/Antigen Nurse

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Referring Allergist Agreement

Allergist Agreement

My patient, _____, is requesting the University of South Florida Student Health and Wellness Center to administer antigen immunotherapy extracts provided by my office.

I agree to the following:

- □ I will provide antigen immunotherapy extracts in adequately labeled* vials for administration by USF SHWC trained nursing staff. Extract vials will be properly stored in a box for transport by the patient. I understand that extract vials can **NOT** be mailed to USF SHWC.
  ***Patient name, antigens name, dilution, expiration date**
- □ I will provide detailed instructions on office letter head that will include:
  - Patient's name
  - Dosage schedule
  - Frequency of injections
  - Contents of each vial
  - Concentration of each vial
  - Expiration date of vial(s) – (month/day/year)
  - Pre-medication prior to injections: Medication, dose and time (if indicated)
  - Administration log with concentration dose amount & date of last injection(s)
  - Dose adjustment for missed/late injections
  - Dose adjustment for local reactions
  - Minimal number of days between injections
  - Peak Flow Parameters & Peak Flow Meter device (if indicated)
  - Epi-Pen device (current) or prescription
  - Most recent visit summary with medical diagnosis and relevant medical history
  - ICD-10 Dx Code for insurance billing
- □ I will continue to be responsible for the management of the patient's immunotherapy and be available to USF SHWC staff for questions or modification to patient's treatment plan.
- □ I understand that USF SHWC requires all antigen patients to have an epinephrine auto injector device with them at each appointment in order to receive their allergy injections. I will provide the patient a prescription for this device.
- □ I have read and reviewed, with the patient, the USF SHWC *New Antigen Patient Guidelines* and the above *Referring Allergist Agreement.*

I authorize the USF Student Health and Wellness Center to provide Immunotherapy to my patient under my direction per instructions that I have provided. The patient will continue to follow-up with me as directed.

_____ _____
Allergist Signature Date

_____
Allergist Printed Name

OFFICE STAMP