Patient’s Name: _________________________________________________________
Date of Birth: __________________________________________________________

Checklist for Renewal of CPT 95165

This checklist is not intended to take the place of an E/M visit. It is designed to
demonstrate everything considered when a decision is made to continue allergen
immunotherapy. There is space for comments which will be needed if changes in the
vial are to be made. Actual changes in schedule should be reflected in the new vial
order and not on this checklist.

Use of this checklist does not replace the requirement to evaluate the patient in person.

1. Current Medication Use
   □ Patient is receiving appropriate medication for optimal control.

2. Response to Immunotherapy
   □ Symptoms improved
   □ Symptoms unchanged
   □ Symptoms poorly controlled

3. Reactions to Injections
   □ Local reactions
   □ Systemic reactions

4. Antigen Content of Vials
   □ Antigen formula is appropriate for current medical status
   □ Antigen content is present at optimal concentration
   □ Antigen content of vials needs to be adjusted

5. If no evidence of benefit, injections are:
   □ Continued
   □ Discontinued
   □ Patient needs allergy re-evaluation

6. If immunotherapy >5 years, document justification for continuation

7. All of the above have been considered in making the decisions to continue
   immunotherapy.

Physician’s Signature: _________________________________________________
Date: ________________________________________________________________