Escalation Protocols for Food Immunotherapy

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Session Overview

- OIT vs SLIT: Choosing the “right” modality
- Treatment goals & initial dosing strategies
- Challenge-based vs standard escalation routines
- Day 1 OIT dose selection (ED01, ED05)
- Early-dose food forms & formulations
- Dose increments

- Updose settings & economic considerations
- Escalation frequency & target dose selection
- SLIT escalation specifics
- Deviating from norms: Slow/low OIT

01 Treatment Goals

Treatment Goals - Influences Strategy of Escalation

Accidental Ingestion protection

Protect against trace/cross-contact exposures

Threshold Improvement

Increase the amount needed to cause a reaction; partial desensitization

SLIT or Low Dose OIT can bridge to higher thresholds

Free Eating

Unrestricted consumption of the food

Requires high-dose maintenance

Sustained Unresponsiveness/Remission

Long-lasting tolerance after stopping therapy

Highest goal

02

Initial Treatment Strategy

Challenge-Based vs Standard Routine

Standard Routine

- Start a dose without symptoms
- Predetermined dose steps
- Standardized schedule
- Less anaphylaxis risk
- More visits, slower to target
- Predictable for patient/family

Challenge-Based Routine

- Dose determined by challenge result
- Potentially shorter time to target
- Fewer total visits possible
- Requires defined challenge target:
  - “All the way”/free-eat
  - Low target: maintenance or bridge
- Inter-patient variability
- Considers “high-threshold” reactors: 25–30% of children with peanut allergy have a threshold of at least 100 mg

FAST 2026 Survey: 90% of providers start with same first dose for most patients. 10% of providers use challenge.

03 Choosing Day 1 OIT Dose

Let's examine ED01 and ED05 for starting doses

- Statistical thresholds using DBPCFC data to represent the dose that triggers an allergic reaction in 1% and 5% of the allergic population.
- **ED05:**
  - Fewer than 5% of allergic reactions occurring at this dose meet criteria for anaphylaxis.
  - No reported fatalities from food anaphylaxis for amounts at or less than ED05
  - Used in precautionary allergen labeling decisions
- Key data source: the **VITAL (Voluntary Incidental Trace Allergen Labeling)** program worked with outcomes reports and the Joint FAO/WHO Expert panel

Informs to select first day dose for SLIT or OIT: choose a goal for successful tolerance.

VITAL 3.0 vs VITAL 4.0: Allergen Reference Doses

VITAL 4.0 replaced ED01 reference doses (VITAL 3.0) with ED05 doses recommended by the FAO/WHO Expert Committee — substantially higher thresholds, in mg of allergen protein.

Allergen	VITAL 3.0 (ED01)	VITAL 4.0 (ED05)	Fold increase
Peanut	0.2 mg	2.1 mg	**10.5×**
Milk	0.2 mg	2.4 mg	**12×**
Egg	0.2 mg	2.3 mg	**11.5×**
Hazelnut	0.1 mg	3.5 mg	**35×**
Soy	0.5 mg	10.0 mg	**20×**
Wheat	0.7 mg	6.1 mg	**8.7×**
Sesame	0.1 mg	2.7 mg	**27×**
Cashew	0.05 mg	0.8 mg	**16×**
Fish (finfish)	1.3 mg	12.1 mg	**9.3×**

FAST 2026 Survey: peanut first day final protein dose:
59% 1 mg - < 5mg, 23% 5 mg - < 10mg, 13% < 1 mg, 6% >/= 10mg

Day 1 OIT Dose: Single vs Multi-Food & Multi-Dose Strategy

Single Food OIT

- Simpler protocol, easier attribution
- Lower reaction complexity
- Improved compliance?
- Breaks the ice

Multi-Food OIT

- Multiple allergens simultaneously
- Efficient for polysensitized patients
- Dose each food individually or mix?
- Reaction attribution more complex
- Start all at once vs. one food then overlap next one(s)

Multi-Dose Day 1

- 2–6 escalating doses on Day 1
- Identifies Day 1 final dose quickly
- Stop if reaction occurs
- Risk: over- or under-dosing
- Do we need more than one dose?
- Two, three, four ok?

04 Dose Increment Choices

Dose Increment Strategies

Early Dosing Phase

- Smaller increments: 25–50% per step
- More conservative with highly sensitized
- Food-specific variation: milk/egg vs peanut/nut
- Monitor for cumulative dose reactions
- Pause for illness, exercise, complications

Near-Target Dose Phase

- Larger percentage steps acceptable: 50–100%
- Frequency may slow if reactions more common
- Consider splitting increments if reactions occur
- Reassess goals near target threshold
- Track cofactors: illnesses, NSAID use, menses, exercise

05 Updose Settings

Updose Settings & Economic Considerations

In-Person Updose

- Gold standard safety monitoring
- 30–60 min observation post-dose
- Epinephrine immediately available
- Higher cost & patient burden

Telemedicine Updose

- Video-assisted home updose
- Patient self-administers with guidance
- Epinephrine must be at home
- Reduces travel burden
- Best for established patients

Unsupervised Updose

- Home updose without live supervision
- Low-risk patients or slow/gradual protocols (ex. microspoons, egg or milk ladders)
- Establish safety plan
- Most cost-effective
- Not appropriate for all patients

Economic Considerations

- Visit frequency directly impacts cost & compliance
- Telemedicine updoses reduce patient and practice burden

06

Escalation Frequency & Target Dose

Escalation Frequency

Weekly

Fastest

✅ Fastest to target dose

⚠️ Higher visit burden; more reactions?

Biweekly

Standard

✅ Balanced safety & efficiency

⚠️ More common; moderate visit frequency

Less Than Biweekly

Slowest

✅ Lower burden of visits, less risk?

⚠️ Better adherence vs. loss of interest?

FAST 2026 Survey: 67% of providers biweekly, 26% weekly, 7% other than weekly or biweekly

OIT Target Doses

Low goal: protection from small accidents/cross-contact or bridge to higher OIT

Higher than SLIT but lower than standard 250-300 mg goals (see 30mg study later)

Medium goal: protection from accidents, bridge to free-eating?

Standard protocols similar to single peanut original protocols (ex. Palforzia): 250-300mg, approx 5% of a serving

Large goal: big safety, free-eating, sustained unresponsiveness/remission?

Serving size challenge possible. Variation in protocols of using one-third to one-half of a serving

FAST 2026 Survey:

milk target < 4 yrs: 30% >90mL - 120 mL, 23% >120 mL to 180 mL, 13% 30mL - 60 mL, 10% < 30 mL

milk target 4+ yrs: 23% >120 mL to 180 mL, 17% >90mL - 120 mL OR >180mL - 240 mL OR >240 mL

07 SLIT Escalation

SLIT Escalation Protocols

Is Escalation Needed?

May not be required? Graded escalation preferred for safety and tolerability.

Starting Dose: Protocols often start 0.0025 mg–0.1 mg protein. Lower than target OIT IDE dose.

Target Dose: Protocols end 2 mg–11 mg protein. Note: some goals approximate final target OIT IDE dose.

FAST 2026 Survey: 58% providers use > 4mg to 7mg, 23% use > 1 mg to 4 mg, 12% use > 7 mg

Dose Increments

Escalation 25–300% increments per visit. Traditionally smaller steps than OIT; new protocols include cluster updoses in less visits.

Escalation Visit Frequency

Every 1–4 weeks. In-office visits only **vs.** hybrid: in-office for start and concentration increases, others by televisit.

VITAL 3.0 vs VITAL 4.0: Allergen Reference Doses

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Soy	0.5 mg	10.0 mg	**20×**
Wheat	0.7 mg	6.1 mg	**8.7×**
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Cashew	0.05 mg	0.8 mg	**16×**
Fish (finfish)	1.3 mg	12.1 mg	**9.3×**

SLIT Escalation Protocols - Examples

Windom, et al.

"Food Sublingual Immunotherapy: Safety and Simplicity of a Real Food Updosing Protocol."
JACIP 2024

TABLE I. Food sources with protein content and maintenance, or top, dose features

Food	Source	Protein content	Top dose (mL)	Top dose (mg protein)
Peanut	Light roasted 12% fat (Byrd Mill),* flour solution, 40 mg/mL	50%	0.3	6
Egg	Egg white liquid (Egglands)	111 mg/mL	0.1	11
Milk	Whole or 2% milk	33.3 mg/mL	0.3	10
Cashew	Cashew milk (Elmhurst)	16.7 mg/mL	0.3	5
Walnut	Walnut milk (Elmhurst)	12.5 mg/mL	0.3	3.8
Hazelnut	Hazelnut milk (Pacific)	8.3 mg/mL	0.5	4.2
Wheat	Vital wheat gluten, flour solution, 30 mg/mL	77%	0.3	6.9
Sesame	organic sesame (Kevala), flour solution, 35 mg/mL	50%	0.3	5.3
Sunflower seed	Sunflower milk (Lattini)	8.3 mg/mL	0.5	4.2

*Byrd Mill not currently offering peanut flour.

TABLE II. SLIT dosing schedules for cohorts 1 and 2

	Cohort 1		Cohort 2	
Visit	Dilution	Doses (mL)	Dilution	Doses (mL)
Day 1	1:1000	0.05, 0.1, 0.2	1:100	0.1, 0.2, 0.3
Updose 1	1:100	0.05, 0.1, 0.2	1:10	0.1, 0.2, 0.3
Updose 2	1:10	0.05, 0.1	1:1	0.05, 0.1
Updose 3	1:10	0.15, 0.25	1:1	0.1, 0.3
Updose 4	1:1	0.05, 0.05		
Updose 5	1:1	0.05, 0.1		
Updose 6	1:1	0.1, 0.2 (weekly increase 0.25, 0.3 at home)		

Serial doses at each visit administered 20 min apart.
Exceptions to this schedule: egg white liquid—due to high protein content there are 2 visits at 1:10 and a single 1:1 visit of 0.05 and 0.1 in cohort 2 and for cohort 1, the updose 5 was last visit; hazelnut and sunflower milk—due to lower protein content, top dose is 0.5 mL.

SLIT Escalation Protocols - Examples

SLIT Bridge to OIT

"Safety and Effectiveness of Bypassing Oral Immunotherapy Buildup With an Initial Phase of Sublingual Immunotherapy for Higher-Risk Food Allergy". Soller, et al. JACIP 2024.

- 4 to 18 years old
- SLIT 2 mg protein maintenance
- 3 to 5 visits under nurse supervision
- After 1 to 2 years of daily SLIT maintenance, offered OFC cumulative dose 300 mg protein
- Four patients (2.10%) received epinephrine, none experienced grade 4
- Subset of 20 patients had 50 low-dose OFCs to 300 mg protein
- **35 (70%) OFCs were successful, bypassing OIT buildup**

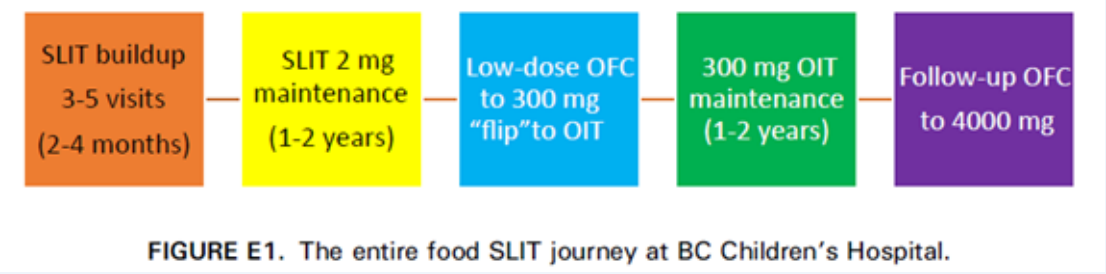


FIGURE E1. The entire food SLIT journey at BC Children's Hospital.

TABLE E1. Example of SLIT recipe using peanut powder

Dose no.	Protein (mg)	Amount (g) of peanut powder for mixture*	Water (mL) for mixture*	Daily volume (mL)
1 (optional†)	0.1	0.2	80	0.1
2 (optional†)	0.3	0.2	26.7	0.1
3	0.5	0.2	16	0.1
4	1	0.2	8	0.1
5	2	0.2	4	0.1
6 (optional‡)	4	0.2	4	0.2

*Make fresh mixture daily for powder-based mixtures. Mix well before giving. It is based on powdered peanut butter with ~6 g of protein per 15-g serving.
†Optional doses offered for most severe patients.
‡Optional dose for preschoolers.

TABLE E2. Example of SLIT recipe using walnut milk

Dose no.	Protein (mg)	Amount (mL) of walnut milk for mixture*	Water (mL) for mixture*	Daily volume (mL)
1 (optional†)	0.1	0.8	9.2	0.1
2 (optional†)	0.3	2.4	7.6	0.1
3	0.5	4	6	0.1
4	1	8	2	0.1
5	2	1	NA	0.16
6 (optional‡)	4	1	NA	0.16 mL × 2 (*or* 0.32 mL if able to hold larger volume under tongue)

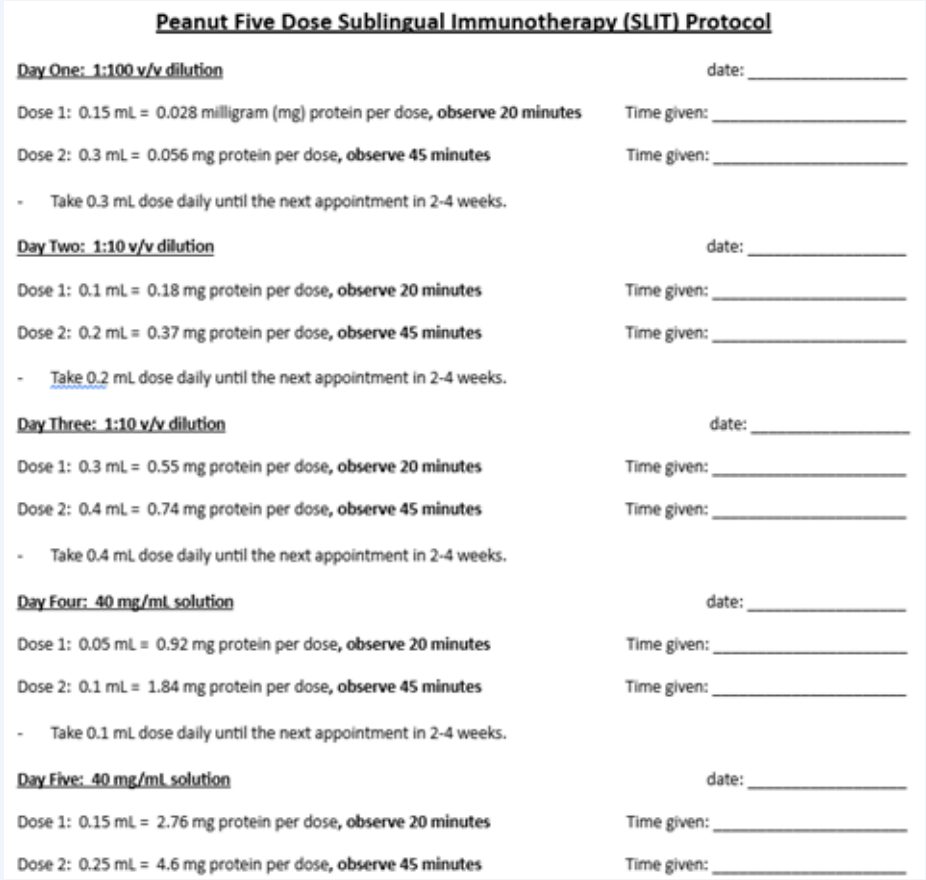
SLIT Escalation Protocols - Examples

Chicago Family Asthma & Allergy:

Two options:

1. Real food

- Two doses per visit
- Visits every 2-4 weeks
- Slow down to one dose per visit if symptoms



Peanut Five Dose Sublingual Immunotherapy (SLIT) Protocol

Day One: 1:100 v/v dilution date: _____

Dose 1: 0.15 mL = 0.028 milligram (mg) protein per dose, **observe 20 minutes** Time given: _____

Dose 2: 0.3 mL = 0.056 mg protein per dose, **observe 45 minutes** Time given: _____

- Take 0.3 mL dose daily until the next appointment in 2-4 weeks.

Day Two: 1:10 v/v dilution date: _____

Dose 1: 0.1 mL = 0.18 mg protein per dose, **observe 20 minutes** Time given: _____

Dose 2: 0.2 mL = 0.37 mg protein per dose, **observe 45 minutes** Time given: _____

- Take 0.2 mL dose daily until the next appointment in 2-4 weeks.

Day Three: 1:10 v/v dilution date: _____

Dose 1: 0.3 mL = 0.55 mg protein per dose, **observe 20 minutes** Time given: _____

Dose 2: 0.4 mL = 0.74 mg protein per dose, **observe 45 minutes** Time given: _____

- Take 0.4 mL dose daily until the next appointment in 2-4 weeks.

Day Four: 40 mg/mL solution date: _____

Dose 1: 0.05 mL = 0.92 mg protein per dose, **observe 20 minutes** Time given: _____

Dose 2: 0.1 mL = 1.84 mg protein per dose, **observe 45 minutes** Time given: _____

- Take 0.1 mL dose daily until the next appointment in 2-4 weeks.

Day Five: 40 mg/mL solution date: _____

Dose 1: 0.15 mL = 2.76 mg protein per dose, **observe 20 minutes** Time given: _____

Dose 2: 0.25 mL = 4.6 mg protein per dose, **observe 45 minutes** Time given: _____

SLIT Escalation Protocols - Examples

Chicago Family Asthma & Allergy:

Second option slower, similar to Kim protocol:

Kim, et al. “Long-term sublingual immunotherapy for peanut allergy in children: Clinical and immunologic evidence of desensitization.” JACI 2019.

- 1 to 11 yrs old, **peanut SLIT 2 mg/d for up to 5 years.**
- DBPCFC up to 5000 mg of peanut protein on SLIT, then SU after 2 to 4 weeks without peanut exposure.
- Thirty-seven of 48 subjects completed 3 to 5 years of SLIT
- **67% ok with 750 mg or more**
- **25% passed 5000 mg, 10 of these 12 SU**
- Side effects 4.8% of doses, OP itch
- Antihistamine tx 0.21%
- No epinephrine was administered.

Table 3 **Peanut SLIT dosing instructions***

Dose No.	Peanut Dilution	Pumps	Dose of Peanut Protein, µg	Interval, week	% Increase	In-Clinic Observed Dosing
1	1:100	1	2.5		—	Yes
2	1:100	2	5	1	100	
3	1:100	4	10	1	100	
4	1:100	8	20	1	100	
5	1:10	1	25	1	25	Yes
6	1:10	2	50	1	100	
7	1:10	4	100	1	100	
8	1:10	8	200	1	100	
9	1:1	1	250	2	25	Yes
10	1:1	2	500	2	100	
11	1:1	4	1000	2	100	Yes
12	1:1	8	2000	2	100	
13	1:1	12	3000	2	50	Yes
14	1:1	16	4000	2	33	

SLIT = Sublingual immunotherapy.
**From the 2011(Ref. 15) 2019 (Ref. 16) studies: included 1:1000 dilution and all dose escalations were in clinic.*

08

Other OIT Concepts and Deviations

Slow OIT - SmaChO (Small Children Oral Immunotherapy)

SmaChO Protocol First Year

- **3 years** of peanut OIT **1-3 yrs old**
- **Up-dosing every 4 weeks**
- **Maintenance dose 285 mg**
- **Followed by 4–6 weeks of peanut-free diet for SU.**

- A cumulative dose of **750 mg peanut protein after 1 year** was tolerated by **72%** (36 of 50 children) in the OIT group compared with 4% (1 of 25) in the avoidance group (P < .001).

- Median tolerated cumulative dose was 2,750 mg peanut protein in the OIT group.

- Home doses 1.4% resulted in adverse events
  - 79% were mild
  - Three doses of epinephrine were given at home to two individuals.

SmaChO Protocol Three Years

- On OIT, **84%** (42 of 50) tolerated **≥750 mg** peanut protein, compared with 3 of 25 children (12%) without treatment.
- Median cumulative tolerated dose after treatment was 5000 mg peanut protein.
- **82%** (41 of 50) **achieved SU to a cumulative dose of ≥750 mg** peanut protein.

Dose nr	Amount of peanut protein, mg	Amount of peanut flour 10%* in mg (4.6% peanut protein)	Amount of peanut, mg (one peanut approx. 800 mg)	Pieces of Bamba (≈700 mg/piece, peanut protein content ≈95 mg/piece)	Interval, weeks	% increase
4	3	65	11		4	100
5	6	130	22		4	100
6	12	260	44		4	100
7	24	521	88		4	100
8	32	695	120	1/3	4	33
9	48	1040	180	1/2	4	50
10	95	2060	350	1	4	100
11	143	3130	530	1.5	4	50
12	190	4130	700	2	4	33
13	238	5170	880	2.5	4	25
14	285	6200	1050	3	4	20

Other OIT Protocols

Very Low-Dose Multi-Nut OIT - VLOIT - 2025

- 18 children age 3-9 yrs old, **allergies 2-5 nuts**
- Started 4 mg protein per nut
- Increasing doses **every 2 months x three visits**
- **Maintenance 30 mg protein per nut x 12 mo**
- Baseline median tolerance 10 mg protein/nut; **67% tolerated dose final 1000 mg OFC dose or cumulative 2040 mg protein**
- **78% achieved >/= 5-fold higher doses or at least 300 mg**

Upton, et al. Safety and Efficacy of Very Low-Dose Multi-Nut Oral Immunotherapy in Children.
Clin Transl Allergy. 2025 Dec;15(12):e7012.

Peanut OIT Using 30 mg and 300 mg

- 51 children peanut allergy
- **Group 30mg: build-up q 2 weeks x 5 visits**
- Group 300mg: build-up q 2 weeks x 11 visits
- Challenge one year
- By intention to treat, 17 patients:
  - **Group 30 mg**
    - 76% tolerated >/= 443 mg
    - 41% tolerated >/= 1,043 mg
  - **Group 300 mg**
    - 59% tolerated >/= 443 mg
    - 47% tolerated >/= 1,043 mg
- Specific IgE, specific IgG4, BAT changes similar between Group 30 mg and Group 300 mg
- **Systemic adverse events fewer in Group 30 mg** compared with Group 300 mg.

Upton, et al. Peanut Oral Immunotherapy Using 30 and 300 mg Maintenance Doses. JACIP 2026;14:223-32

Other OIT Protocols

High Threshold Peanut Allergy Kids - CAFETERIA trial

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High Dose, Home Measured Peanut OIT in Children with High Threshold Peanut Allergy

- 4 to 14 years of age **reacting to challenge between 443 mg and 5043 mg of peanut protein cumulatively**.
- Peanut avoidance vs. peanut butter OIT home-measured
- Started ⅛ tsp, ¼ tsp, ⅜ tsp, or 1 tsp based on challenge
- Every 8 weeks up-dose: ⅛ tsp - ¼ - ⅜ - ½ - ¾ - 1 - 1.5 - 2 - 3
  or equivalent Bamba or candy ⅜ tsp or above
- Thirty-two of 38 participants in the OIT group (84.2%) and 30 of 35 in the avoidance group (85.7%) underwent food challenge 9043 mg (~ 36 peanuts).
- **Two-fold threshold improvement: 100% success for ingestion vs 21% for avoidance.**
- **Passed 9043 mg challenge eight weeks after goal or 72 weeks treatment: 100% success OIT vs. 10% avoidance.**
- **SU (8 weeks) in 68.4% on OIT vs 8.6% tolerating 9043 mg among those avoiding.**
- No dosing reactions greater than grade 1 severity.

Sicherer, et al. NEJM Evid. 2025 Mar;4(3):EVIDoa2400306

Three Egg OIT Protocols - CHOP

- OIT with low-dose egg, high-dose egg, and baked egg
- 96 kids with egg allergy, *25 d/c or lost to f/u:* 71 patients completed egg OIT, up-dosing about **every 2 weeks**.
- **Baked egg**: 10 doses to reach cake goal 1 g egg protein, hold 3 mos, pancake 1g protein 3-6 mos, then high-dose liquid “native” egg white (LEW) protocol.
- **High-dose** LEW: updosed from 3.3mg to 4g (¾ egg).
- **Low-dose** LEW: updosed from 1.6mg to 3g (⅔ egg).
- Pts on **baked egg OIT more likely to stop**: 44% vs 19%
- **Epi use** for high-dose 30%, low-dose 10%, baked egg 7%. All epi with low-dose were given during IDE (3 doses).
- OIT success:
  - **Freely eat baked egg plus at least 3g of LEW**: **low-dose OIT 94%** (17/18) vs. **69% other** (54/78)
  - **Pass 12g (~2 whole egg) OFC**: **low-dose 78%, high-dose 61%, baked egg 44%**

Buckey, et al. Safety and efficacy of three office-based egg oral immunotherapy protocols.
Ann Allergy Asthma Immunol. 2026 Jun 1:S1081-1206(26)00240-1

Three Egg OIT Protocols

Table 1A: Baked egg OIT protocol (followed by native protocol)

Dose Number	Protein Content	Preparation
1	40 mg	½ cookie
2	80 mg	1 cookie
3	120 mg	1 and ½ cookie
4	160 mg	2 cookie
5	200 mg	2 and ½ cookie
6	320 mg	4 cookie
7	333.3 mg	1 piece of cake
8	500 mg	1.5 pieces of cake
9	666.6 mg	2 pieces of cake
10	999.9 mg	3 pieces of cake

Table 3: Low-dose native egg OIT protocol

Dose Number	Protein Content	Preparation
1	1.6 mg	Egg beaters 1: 100=1 mL (Mix 3 ml egg beater with 100 ml water) Dose: give 0.5 ml
2	3.3 mg	Egg beaters 1: 100=1 mL (Mix 3 ml egg beater with 100 ml water) Dose: give 1 ml
3	6.6 mg	Egg beaters 1: 100=1 mL (Mix 3 ml egg beater with 100 ml water) Dose: give 2 ml
4	11.1 mg	0.1 mL (no dilution)
5	33.3 mg	0.3 mL (no dilution)
6	66.6 mg	0.6 mL (no dilution)
7	111.1 mg	1 mL (no dilution)
8	222.2 mg	2 mL (no dilution)
9	333.3 mg	3 mL (no dilution)
10	666.6 mg	6 mL (no dilution)
11	999.9 mg	9 mL (no dilution)
Remain on 9mL for 3 months. After 3 months, resume updose every 2 weeks.		
11	1.5 g	13.5 mL
12	2 g	18 mL
13	3 g	27 mL
Remain on 3g dose for 6 months; Liberalize baked egg in diet when reached 3g		

- After one month on 3g, reduce exercise restrictions and observation by 30 minutes.
- After 3 months on 3g, reduce exercise restrictions and observation to 30 minutes before and 1 hour after dosing
- After 6 months of daily 3 g, decrease the observation period at this time to 30 minutes before and 30 minutes after dosing. Offer full OFC for native egg.

Buckey, et al. Safety and efficacy of three office-based egg oral immunotherapy protocols.
Ann Allergy Asthma Immunol. 2026 Jun 1:S1081-1206(26)00240-1

Microspoons - creative, simple

Home Multifood Oral Immunotherapy Microdosing with Dartmouth Spoon Sheets. Shaker, et al. JACIP 2025 Jan;13(1):244-246

TABLE E1. Example DSS dosing strategy

Using PB2 peanut butter powder (protein content 46% of weight) mix well (and fresh daily) in 3-oz (18 tsp) single serving Motts apple sauce

Stage	Measure PB2 & add to 3 oz apple sauce	Apple sauce (tsp)	Apple sauce equiv	Protein (mg)	
1	Black Spoon	1		0.16	
2		2		0.32	
3		3		0.48	
4		4		0.64	
5		5		0.80	
6		6	1 oz	0.96	
7		7	1 oz, 1 tsp	1.12	
8		8	1 oz, 2 tsp	1.28	
9		9	1 oz, 3 tsp	1.44	
10		10	1 oz, 4 tsp	1.60	
11		11	1 oz, 5 tsp	1.76	
12		12	2 oz	1.92	
13		13	2 oz, 1 tsp	2.08	
14		14	2 oz, 2 tsp	2.24	
15		15	2 oz, 3 tsp	2.40	
16		16	1 oz, 4 tsp	2.56	
17		17	1 oz, 5 tsp	2.72	
18		18	3 oz	2.88	*Continue this dose for 2 wk
25	Red Spoon	1		0.22	
26		2		0.44	

ORIGINAL ARTICLE

Developing a Standardised National Model of Care for Treatment of Peanut Allergy in Infants: The ADAPT Peanut Oral Immunotherapy Program

3.6 | Program Overview

The ADAPT OIT Program comprised five stages over a 38-month period: *Up-dose*, *Maintenance*, *Avoid*, *Assessment*, and *Follow-up* (Figure 2):

TABLE 2 | Escalation OFC doses and time intervals.

Time	Dose of peanut flour (PB2)	Volume of peanut protein
0	Red microspoon	3 mg
20 min	Gold microspoon	10 mg
40 min	1/64th tsp	15 mg
Total		28 mg

Note: Microspoon: standardised set volume spoons (Red: 0.01 mL and Gold: 0.005 mL) [36].
Abbreviations: OFC, oral food challenge; PB2, commercial peanut butter flour product; tsp, teaspoon.

TABLE 3 | *Up-dosing stage* doses. Start dose for each patient determined at threshold OFC or escalation OFC.

Dose	Dose of peanut flour (PB2)	Volume of peanut protein
1	Red microspoon	3 mg
2	Gold microspoon	10 mg
3	1/64th tsp	15 mg
4	1/32nd tsp	30 mg
5	1/16th tsp	60 mg
6	1/8th tsp	120 mg
7	1/4 tsp	260 mg
8	1/2 tsp	650 mg

Abbreviations: OFC, oral food challenge; PB2, commercial peanut butter flour product; tsp, teaspoon.

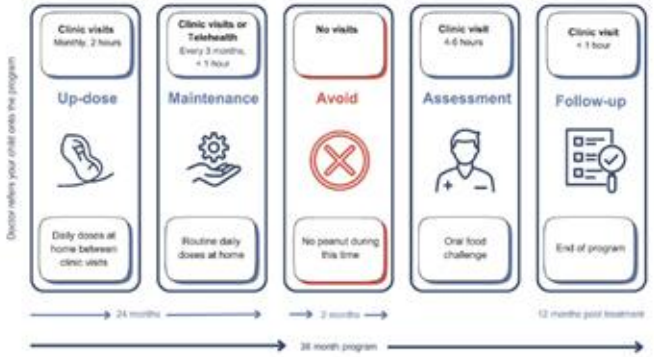

FIGURE 2 | The ADAPT OIT program stages.

09

Omalizumab escalation strategies

Omalizumab Strategies with Food Immunotherapy

OIT from the Start: Faster, Safer

- Less risk from accidents sooner due to oma effect
- Faster up-dosing: frequency and doses
- Reduced adverse IT reactions
- Not clearly immunomodulatory when stopped
- Worth the $$$?

SLIT Start from Single Dose?

- Reduced adverse reactions?
- Reduced up-dosing

OIT and Challenges

- OUTMATCH: no OIT, eat what you tolerate
- Start OIT at higher doses
- Choose your target: low, medium, full serving

When to Stop Omalizumab?

- How long on OIT/SLIT/free-eating?
- Change food dosing when stop oma?

***FAST 2026 Survey: 68% providers use oma rarely, 29% use occasionally, 3% often.**

Final Thoughts

- Match OIT and SLIT protocols with/without omalizumab to patient risk profile and treatment goals.
- ED05 acceptable for standard escalations. Consider ED01 for high-risk patients.
- Challenge-based protocols may shorten time to target when appropriate.
- Food form, increment size, and visit frequency must balance safety vs efficiency.
- Updose setting options expanding, match with protocol and patient readiness/risk.
- SLIT requires less frequent escalation visits with lower systemic risk. More research needed!
- OIT options continue to unfold.

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