PROTOCOL CODE: SMILALD

DOCTOR'S ORDERS

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

No routine lab tests required before each treatment

PREMEDICATIONS:

acetaminophen 325 mg PO 30 to 60 minutes prior to treatment

☐ Other:

**** Have Spill Kit and Protocol Available****

TREATMENT:

aldesleukin 5 million units/mL for intralesional injection(s) – approximately 0.1 to 0.2 mL (0.5 to 1 million units) injected into each lesion (maximum 4.4 mL or 22 million units per cycle).

For administration by ordering provider.

First treatment: routine vital signs pre- and post- treatment. Observe for 30 minutes post-treatment (not required after first treatment with no reaction).

Dispense 8 x 0.55 mL (supplied in 1 mL luer lock syringes).

RETURN APPOINTMENT ORDERS

☐ Return in _____ week(s) for Doctor and Treatment # _____.

☐ Last Treatment. Return in _____ week(s).

☐ **Tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: