PROTOCOL CSP-032

A SINGLE CENTER EXPLORATORY STUDY TO EVALUATE THE USE OF THE RXSIGHT LIGHT ADJUSTABLE LENS (LAL) AND THE LIGHT DELIVERY DEVICE (LDD) TO IMPROVE VISUAL OUTCOMES

Sponsor: RxSight, Inc.
100 Columbia, Suite 120
Aliso Viejo, CA 92656

April 09, 2019
Version 06

I have read and agree to follow the procedures as outlined in this protocol.

This protocol contains confidential proprietary information with respect to RxSight products and clinical trials. I agree to hold this information in confidence and not to disclose it to any third parties for a period of five years from the date of this agreement, or until this information becomes a matter of public knowledge through no action or failure on my part to maintain its confidentiality.

_____
Site Name

_____ _____
Principal Investigator's Signature *Date*

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RXSIGHT, INC.

PROTOCOL NO. CSP-032

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1 STUDY SYNOPSIS

STUDY OBJECTIVE

The objective of this study is to evaluate, for the visual correction of aphakia, whether the RxSight Light Adjustable Lens (LAL) and Light Delivery Device (LDD) can be used to improve visual outcomes after performing adjustments of the LAL with the LDD. This is an exploratory study. No primary effectiveness endpoints will be identified.

STUDY POPULATION

The study population will consist of up to 200 eyes in up to 200 subjects (one or two eyes per subject).

STUDY DESIGN

A prospective, controlled, single center, exploratory clinical study will be conducted. Subjects will be followed until the completion of a Postop Month 3 or later visit. Subjects who were enrolled under protocol version 05 will be reconsented prior to undergoing a Postop Month 3 or later visit. Subjects who were enrolled under protocol version 05 and exited from the study after their Postop Months 1-2 visit will be reconsented prior to undergoing the Postop Month 3 or later visit.

Patients who require cataract extraction and intraocular lens implantation will be screened for eligibility. If one or both eyes meet inclusion/exclusion criteria, study staff will explain the study purpose, procedures, risks/benefits and subject responsibilities to the potential participant. Written informed consent will be obtained prior to any study specific testing. The patient is enrolled upon signing the informed consent. If both eyes of the subject are enrolled for study participation, each eye will be scheduled for surgery within a timeframe of the investigator's choice but on separate days.

Commencing at the Postop Week 3 visit, all eyes will receive two to three adjustments and one to two lock-in treatments. Each light treatment will be separated by 3 to 7 days. [redacted] ostoperatively, all subjects will undergo complete ophthalmic examinations at regular intervals.

For subjects that receive only spherical/sphero-cylindrical adjustments, distance visual acuities will be presented and summarized. For subjects that receive a presbyopia adjustment, distance, intermediate, and near visual acuities and depth of focus (DOF) curves will be

presented and summarized. Additional analyses may be performed. Safety for all study eyes will be evaluated per ISO 11979-7.

DURATION OF STUDY

Each subject will participate in the study for 3-9 months. Time of participation is dependent on the date of the Postop Month 3 or later visit. The recruitment phase is expected to last approximately 12 months. The complete study period is expected to be 14 months.

STUDY SITE

The study will be performed in an ophthalmology clinic. The investigator will be an ophthalmic surgeon, specializing in cataract surgery with implantation of intraocular lenses. Study responsibilities will be registered in a delegation log that will be kept at the investigational site. The overall responsibility at the study clinic remains with the investigator.

Both eyes of all subjects should be screened for eligibility. If at any time during the screening, an eye does not meet inclusion or exclusion criteria, screening for that eye will be discontinued.

REQUIRED INCLUSION CRITERIA

- Must sign a written Informed Consent form and be willing to undergo cataract surgery for unilateral or bilateral implantation of the LAL.
- Between the ages of 40 and 80 inclusive on the day the cataract surgery is performed.
- Study eye must have preoperative keratometric cylinder ≤ 3.50 D.
- Study eye must have a cataract causing reduction in best corrected distance visual acuity (BCDVA) to a level of 20/32 or worse with or without a glare source.
- Study eye must have BCDVA projected (by clinical estimate based upon past ocular history or retinal exam) to be 20/20 or better after cataract removal and IOL implantation.
- If only one eye of a subject is enrolled, the non-study eye must have the potential for BCDVA of 20/40 or better.
- Study eye has clear intraocular media other than cataract.
- Willing and able to comply with the requirements for study specific procedures and visits.
- Study eye has a dilated pupil diameter of ≥7.0 mm.
- Study eye has an undilated distance viewing pupil diameter >2.5 mm.
- Study eye requires an IOL power within the range available for the LAL.

OPTIONAL INCLUSION CRITERIA

- Study eye was previously enrolled within clinical study CSP-026 sponsored by RxSight, Inc.

REQUIRED EXCLUSION CRITERIA

- Serious co-morbid conditions that in the judgment of the investigator makes inclusion in the study not in the best interest of the subject.
- Study eye with pseudoexfoliation.
- Study eye with diabetes with any evidence of retinopathy.
- Study eye with evidence of glaucomatous optic neuropathy.
- Study eye with history of uveitis.
- Study eye with significant anterior segment pathology, such as rubeosis iridis, aniridia, or iris coloboma.
- Study eye with corneal pathology or corneal dystrophy that is either progressive or sufficient to reduce BCDVA to worse than 20/20.
- Study eye with clinically significant dry eye syndrome (DES).
- Study eye with keratoconus or suspected of having keratoconus.
- Study eye with prior history of Intacs, Radial keratotomy (RK), Conductive keratoplasty (CK), Astigmatic keratotomy (AK), Phakic Implantable Collamer Lens (ICL), Corneal Inlay, intraocular surgery, or with previous pterygium excision unless the pterygium did not extend more than 2mm onto the cornea from the limbus.
- Subjects taking systemic medication that may increase sensitivity to UV light such as tetracycline, doxycycline, psoralens, amiodarone, phenothiazines, chloroquine, hydrochlorothiazide, hypericin, ketoprofen, piroxicam, lomefloxacin, and methoxsalen. LDD treatment in patients taking such medications may lead to irreversible phototoxic damage to the eye. This is only a partial list of photosensitizing medications. Please evaluate all medications that the patient is taking for this effect prior to consideration for implantation.
- Subjects taking a systemic medication that is considered toxic to the retina such as tamoxifen.
- Study eye with irregular astigmatism.
- Study eye with a history of ocular herpes simplex virus.
- Subjects who the doctor believes will be unable to maintain steady fixation that is necessary for centration of the LDD light treatment.
- Study eye with previous trauma or developmental defects in which appropriate support of the intraocular lens (IOL) is not possible.
- Study eye with current vitreoretinal disease or are at a high risk for future vitreoretinal disease that may require silicone oil as part of therapy.

OUTCOME PARAMETERS

The following visual performance parameters will be collected and summarized for subjects that received only spherical/sphero-cylindrical adjustments.

- % of eyes with UCDVA of 20/20 or better at Postop Month 1-2 and the Postop Month 3 or later visit

The following visual performance parameters will be collected and summarized for subjects that were bilaterally implanted with the LAL and received a presbyopia adjustment.

- Proportion of subjects simultaneously with (1) Binocular UCDVA of 20/20 or better and (2) Binocular UCIVA of 20/25 or better and (3) Binocular UCNVA of 20/40 or better at Postop Month 1-2 and the Postop Month 3 or later visit
- Change in pseudoaccommodation (D) at Postop Month 1-2 and the Postop Month 3 or later visit from pre-light adjustment at Postop Week 3

Additional analyses may be performed. Clinical data for subjects receiving only spherical/sphero-cylindrical adjustments and subjects receiving a presbyopia adjustment will be summarized and analyzed separately.

Safety Parameters:

- Incidence of cumulative ocular serious adverse events defined per ISO 11979-7.

The incidence of all other adverse events will also be presented.

Subjects who agree to participate in the study will return for the listed follow-up examinations for each study eye:

Examination Schedule:

Evaluation	
Preoperative	Day -60 to Day -1
Operative	Day 0, day of surgery
Postop Day 1	Days 1 to 2 postop
Postop Week 3	Days 17 to 24 postop: Adjustment #1
Adjustment #2, if needed	3 to 7 days post Adjustment #1
Adjustment #3, if needed	3 to 7 days post Adjustment #2
Lock-in #1	3 to 7 days post final adjustment
Lock-in #2, if needed	3 to 7 days post lock-in #1
Postop Month 1-2	7 to 14 days post final lock-In
Postop Month 3 or later	≥90 days postop

Unscheduled visits falling outside the designated ranges for scheduled visits will be considered "interim" visits for data recording purposes and a report form will be completed.

Clinical Parameters:

[redacted]

2. Demographics
3. Ocular history including medications
4. Subjective symptoms/complaints (subject reported)
5. Compliance with UV spectacles
6. Ocular Biometry: ACD and axial length (Optical biometry)
7. Corneal Topography
8. Autorefraction
9. Corneal Keratometry
10. Vision Quality Measurement
11. Undilated Distance Viewing Pupil Diameter
12. Binocular UCDVA
13. Monocular uncorrected distance visual acuity (UCDVA)
14. Manifest Refraction
15. Monocular best corrected distance visual acuity (BCDVA)
16. Ocular Dominance Test
17. Pseudo accommodation testing
18. Mesopic binocular distance corrected contrast sensitivity testing
19. Mesopic monocular distance corrected contrast sensitivity testing
20. Photopic binocular distance corrected contrast sensitivity testing
21. Photopic monocular distance corrected contrast sensitivity testing
22. Monocular distance corrected 10% low contrast intermediate visual acuity (photopic only)
23. Monocular distance corrected intermediate visual acuity (DCIVA)
24. Monocular distance corrected intermediate visual acuity (DCIVA) with +1.50 D add
25. Monocular uncorrected intermediate visual acuity (UCIVA)
26. Binocular UCIVA
27. Undilated Intermediate Viewing Pupil Diameter
28. Monocular distance corrected 10% low contrast near visual acuity (photopic only)
29. Monocular distance corrected near visual acuity (DCNVA)
30. Monocular distance corrected near visual acuity (DCNVA) with a +2.50 D add
31. Monocular uncorrected near visual acuity (UCNVA)
32. Binocular UCNVA
33. Undilated Near Viewing Pupil Diameter

[redacted]

35. Intraocular pressure
36. Slit Lamp Examination
37. Fundus Exam
38. Aberrometry
39. Dilated pupil diameter
40. Adverse Events

ABBREVIATIONS AND DEFINITION OF TERMS

ACD	Anterior Chamber Depth
ADE	Adverse Device Effect
AE	Adverse Event
BCDVA	Best Corrected Distance Visual Acuity
CCC	Continuous Circular Capsulorhexis
CDRH	Center for Devices and Radiological Health
CFR	Code of Federal Regulations
CRF	Case Report Form
CRO	Contract Research Organization
CSP	Clinical Study Protocol
D	Diopter
DCIVA	Distance Corrected Intermediate Visual Acuity
DCNVA	Distance Corrected Near Visual Acuity
DD	Device Deficiency
DES	Dry Eye Syndrome
DOF	Depth of Focus
EC	Ethics Committee
EDC	Electronic Data Capture
ETDRS	Early Treatment Diabetic Retinopathy Study
FDA	Food and Drug Administration
GCP	Good Clinical Practice
IDE	Investigational Device Exemption
IOL	Intraocular Lens
IOP	Intraocular Pressure
IRB	Institutional Review Board
ISO	International Organization for Standardization
LAL	RxSight Light Adjustable Lens
LDD	Light Delivery Device
MR	Manifest Refraction
MRSE	Manifest Refraction Spherical Equivalent
PCO	Posterior Capsular Opacity
PMA	Premarket Application
PMMA	Polymethylmethacrylate
PPC	Precision Pulse Capsulotomy
[redacted]	[redacted]
SAE	Serious Adverse Event
SE	Spherical Equivalent

SPK	Superficial Punctate Keratitis
SSI	Secondary Surgical Intervention
UADE	Unanticipated Adverse Device Effect
UCDVA	Uncorrected Distance Visual Acuity
UCIVA	Uncorrected Intermediate Visual Acuity
UCNVA	Uncorrected Near Visual Acuity
UP	Unanticipated Problem
UV	Ultraviolet

2 INTRODUCTION AND RATIONALE

Cataract surgery is the most commonly performed procedure by the ophthalmic surgeon. It is estimated that more than 26 million cataract operations with intraocular lens (IOL) implantation were to be performed worldwide in 2017.[1] The average age of cataract patients is reported to be 65 to 70 years old, with a small percentage of cataract surgeries being performed on patients as young as in their early 40's.[2,3] While key cataract technology advancements have resulted in important reductions in residual refractive error and improved uncorrected visual acuity, significant postoperative residual refractive error remains the most frequent cataract surgery complication. RxSight's Light Adjustable Lens (LAL) addresses the problems of residual refractive error by allowing adjustment of the spherical and cylindrical power postoperatively. The Center for Devices and Radiological Health (CDRH) of the Food and Drug Administration (FDA) approved RxSight's premarket approval (PMA) application for the LAL and Light Delivery Device (LDD) system on November 22, 2017. The system is indicated for the reduction of residual astigmatism to improve uncorrected visual acuity after removal of the cataractous natural lens by phacoemulsification and implantation of the intraocular lens in the capsular bag; in adult patients:

- With pre-existing corneal astigmatism of ≥ 0.75 diopters
- Without pre-existing macular disease

The system also reduces the likelihood of clinically significant residual spherical refractive errors.

Presbyopia, which will affect approximately 2.1 billion people by 2020, is the irreversible loss of the accommodative ability of the eye that occurs due to aging.[4] Accommodation refers to the ability of the eye to increase the refractive power of its crystalline lens in order to focus near objects on the retina.[5] Presbyopia typically occurs in people over 40 years of age and can cause a considerable decrease in the quality of life for many of those affected.[6] Without correction, presbyopia results in difficulty performing tasks at a customary working distance. Because most patients have daily activities that require them to read and work at near and with the increasing importance of intermediate vision to clearly see cell phones and computer monitors, patients are seeking treatment options to mitigate the effects of their presbyopia.

[1] Eyewiretoday. Steady Growth in Cataract Surgical Procedures is Expected Over the Next 5 Years, July 27, 2017.
[2] Cummings A. The Influence of Age on Refractive Cataract Surgery. CRSTEurope. Feb 2011.
[3] Gollogly H, Hodge D, St. Sauver J, Erie J. Increasing incidence of cataract surgery: Population –based study. J Cataract Refract Surg 2013; 39:1383-1389.
[4] Arlt EM, Krall EM, Moussa S, Grabner G, Dexl A. Implantable inlay devices for presbyopia: the evidence to date. Clin Ophthalmol. 2015 Jan 14;9:129-137.
[5] American Optometric Association. Care of the patient with presbyopia. St. Louis (MO): American Optometric Association; 2010.
[6] McDonnell PJ, Lee P, Spritzer K, Lindblad AS, Hays RD. Association of presbyopia with vision-targeted health-related quality of life. Arch Ophthalmol. 2003;121(11):1577-1581.

The vast majority of cataract surgery patients are presbyopic preoperatively and all patients will experience presbyopia after cataract surgery. Cataract surgery presents patients with an opportunity to not only remove the cataractous lens, but also to have presbyopia mitigated through the implantation of specific IOLs. Current techniques include the use of pseudophakic monovision and multifocal IOLs.

Pseudophakic monovision is a concept in which 1 eye (usually dominant) is targeted for distance vision and the other eye is targeted for near vision after IOL implantation. Depending on the technique, target refraction of the non-dominant eye ranges from 1.00 to 2.50 diopters (D) of myopia.[7] Obtaining a pre-determined magnitude of anisometropia (i.e. refractive accuracy of the IOL implantation) between eyes is critical to achieving patient satisfaction as any inaccuracy could lead to inadequate distance or near vision or patient non-adaptation to the amount of anisometropia.

Multifocal IOLs can be refractive, diffractive, or hybrid diffractive-refractive. Diffractive multifocal IOLs use light diffraction to produce 2 focal points, one for distance vision and one for near vision. In refractive multifocal IOLs, refractive power changes from the center to the periphery of the IOL, thus producing many focal points. Recent studies of multifocal IOLs report good results for both near and distance vision in terms of spectacle independence, but these IOLs are frequently associated with a number of visual adverse effects, such as dysphotopsia, visual disturbances at night, halos, and glare.[7]

[7] Labiris G, Giarmoukakis A, Patsiamanidi M, et al. Mini-monovision versus multifocal intraocular lens implantation. J Cataract Refract Surg 2015; 41:53-57.

2.1 CLINICAL STUDIES PERFORMED WITH THE LIGHT ADJUSTABLE LENS AND LIGHT DELIVERY DEVICE

US Phase III Study Conducted Under IDE G100240

A 600 eye prospective, randomized, controlled, multi-center clinical trial of the LAL and LDD designed to evaluate safety and effectiveness over a 12-month period was conducted at 17 sites. In addition to the visual correction of aphakia, reduction in residual spherocylindrical refractive error and improvement in uncorrected visual acuity were evaluated following LAL implantation and subsequent refractive adjustment of the LAL by the LDD.

Eyes with ≥0.75 and ≤2.5 diopters (D) of keratometric cylinder were randomly assigned to receive either the LAL or a commercially available, posterior chamber, non-accommodating, control monofocal IOL. Six hundred eyes were implanted with 403 eyes randomized to the LAL group and 197 eyes to the Control group.

Co-primary effectiveness endpoints included percent reduction in manifest cylinder, percent mean absolute reduction in manifest refraction spherical equivalent (MRSE), and rotation of the LAL. All primary effectiveness endpoints compared pre-adjustment (LAL) or 17-21 days (Control) to 6 months postoperatively and the first two endpoints compared results between the LAL and Control groups. All three co-primary effectiveness endpoints were met with a p-value <0.0001. The difference in means for percent reduction in manifest cylinder was 54.7%, with a p-value <0.0001. The difference in means for percent reduction in absolute MRSE was 41.1% with a p-value <0.0001. Rotation of the LAL of ≤5 degrees was observed in 96.1% of LAL implanted eyes with both the upper and lower bound of the 95% confidence interval exceeding the requirement of 90%.

100% of eyes in both the LAL and Control groups had BSCVA of 20/40 or better, exceeding the historic grid rate of 92.5% (ISO 11979-7). The incidence of sight-threatening complications and adverse events for the LAL and Control groups were also below the threshold rates calculated from the 1-year historical grid for intraocular lenses (ISO 11979-7, Ophthalmic implants- Intraocular lenses- Part 7: Clinical investigations) except for the category of Secondary Surgical Interventions (SSI), which was significantly higher than the historical rate (p<.05).

On November 22, 2017, the Center for Devices and Radiological Health (CDRH) of the Food and Drug Administration (FDA) approved RxSight's premarket approval application (PMA) for the Light Adjustable Lens (LAL) and Light Delivery Device (LDD) system. This system is indicated for the reduction of residual astigmatism to improve uncorrected visual acuity after removal of the cataractous natural lens by phacoemulsification and implantation of the intraocular lens in the capsular bag; in adult patients:

- With pre-existing corneal astigmatism of ≥ 0.75 diopters
- Without pre-existing macular disease

The system also reduces the likelihood of clinically significant residual spherical refractive errors.

[redacted]

[redacted]

[redacted]

[8] Hengerer FH, Bocker J, Dick BH, Conrad-Hengerer I. Light adjustable lens. New options for customized correction of presbyopia. Ophthalmologe. 2012 Jul; 109(7): 676-82.

3 STUDY OBJECTIVE

The objective of this study is to evaluate, for the visual correction of aphakia, whether the RxSight Light Adjustable Lens (LAL) and Light Delivery Device (LDD) can be used to improve visual outcomes after performing adjustments of the LAL with the LDD. This is an exploratory study. No primary effectiveness endpoints will be identified.

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A prospective, controlled, single center, exploratory clinical study will be conducted. Subjects will be followed until the completion of a Postop Month 3 or later visit. Subjects who were enrolled under protocol version 05 will be reconsented prior to undergoing a Postop Month 3 or later visit. Subjects who were enrolled under protocol version 05 and exited from the study after their Postop Months 1-2 visit will be reconsented prior to undergoing the Postop Month 3 or later visit.

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Postoperatively, all subjects will undergo complete ophthalmic examinations at regular intervals.

For subjects that receive only spherical/sphero-cylindrical adjustments, distance visual acuities will be presented and summarized. For subjects that receive a presbyopia adjustment, distance, intermediate, and near visual acuities and depth of focus (DOF) curves will be presented and summarized. Additional analyses may be performed. Safety for all study eyes will be evaluated per ISO 11979-7.

DURATION OF STUDY

Each subject will participate in the study for 3-9 months. Time of participation is dependent on the date of the Postop Month 3 or later visit. [redacted]

STUDY SITE

The study will be performed in an ophthalmology clinic. The investigator will be an ophthalmic surgeon, specializing in cataract surgery with implantation of intraocular lenses.

Study responsibilities will be registered in a delegation log that will be kept at the investigational site. The overall responsibility at the study clinic remains with the investigator.

5 OUTCOME PARAMETERS

The following visual performance parameters will be collected and summarized for subjects that received only spherical/sphero-cylindrical adjustments.

- % of eyes with UCDVA of 20/20 or better at Postop Month 1-2 and the Postop Month 3 or later visit.

The following visual performance parameters will be collected and summarized for subjects that were bilaterally implanted with the LAL and received a presbyopia adjustment.

- Proportion of subjects simultaneously with (1) Binocular UCDVA of 20/20 or better and (2) Binocular UCIVA of 20/25 or better and (3) Binocular UCNVA of 20/40 or better at Postop Month 1-2 and the Postop Month 3 or later visit.
- Change in pseudoaccommodation (D) at Postop Month 1-2 and the Postop Month 3 or later visit from pre-light adjustment at Postop Week 3

Additional analyses may be performed. Clinical data for subjects receiving only spherical/sphero-cylindrical adjustments and subjects receiving a presbyopia adjustment will be summarized and analyzed separately.

SAFETY PARAMETERS

- Incidence of cumulative ocular serious adverse events defined per ISO 11979-7.

The incidence of all other adverse events will also be presented.

6 STUDY POPULATION

The study population will consist of up to 200 eyes in up to 200 subjects (one or two eyes per subject).

Both eyes of all subjects should be screened for eligibility. If at any time during the screening, an eye does not meet inclusion or exclusion criteria, screening for that eye will be discontinued.

6.1 REQUIRED INCLUSION CRITERIA

- Must sign a written Informed Consent form and be willing to undergo cataract surgery for unilateral or bilateral implantation of the LAL.
- Between the ages of 40 and 80 inclusive on the day the cataract surgery is performed.
- Study eye must have preoperative keratometric cylinder ≤ 3.50 D.
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- If only one eye of a subject is enrolled, the non-study eye must have the potential for BCVDA of 20/40 or better.
- Study eye has clear intraocular media other than cataract.
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- Study eye has a dilated pupil diameter of ≥7.0 mm.
- Study eye has an undilated distance viewing pupil diameter >2.5 mm.
- Study eye requires an IOL power within the range available for the LAL.

6.2 OPTIONAL INCLUSION CRITERIA

- Study eye was previously enrolled within clinical study CSP-026 sponsored by RxSight, Inc.

6.3 REQUIRED EXCLUSION CRITERIA

- Serious co-morbid conditions that in the judgment of the investigator makes inclusion in the study not in the best interest of the subject.
- Study eye with pseudoexfoliation.
- Study eye with diabetes with any evidence of retinopathy.
- Study eye with evidence of glaucomatous optic neuropathy.
- Study eye with history of uveitis.
- Study eye with significant anterior segment pathology, such as rubeosis iridis, aniridia, or iris coloboma.

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- Study eye with previous trauma or developmental defects in which appropriate support of the intraocular lens (IOL) is not possible.
- Study eye with current vitreoretinal disease or are at a high risk for future vitreoretinal disease that may require silicone oil as part of therapy.

7 STUDY MATERIALS AND METHODS

7.1 DEVICE DESCRIPTION

RxSight's Light Adjustable Lens (LAL) is a silicone intraocular lens whose shape and focusing characteristics can be modified after implantation using an office-based UV light source, the RxSight Light Delivery Device (LDD), to improve uncorrected visual acuity.

7.1.1 RXSIGHT LIGHT ADJUSTABLE INTRAOCULAR LENS

The RxSight Light Adjustable Lens (LAL) is a foldable posterior chamber, UV filtering, three-piece photoreactive silicone lens with blue PMMA (polymethylmethacrylate) modified-C haptics, a 6.0 mm optic with squared posterior edge, and an overall diameter of 13.0 mm. The LAL optic design also features a UV filtering posterior surface layer, to further enhance the UV absorbing properties of the LAL lens and limit retinal exposure.

The LAL silicone material is designed to respond to a narrowband UV light by incorporating photoreactive components in the cross-linked silicone lens matrix. Post implantation, the LAL shape may be altered non-invasively by photoinitiation using a select spatial intensity

profile. The silicone material contains photoreactive additive, which is selectively photo-polymerized in targeted areas upon exposure to the near UV light to alter the lens shape thus modifying spherical and spherocylindrical power of the LAL or extending depth of focus or creating multifocality. The change in the shape becomes permanent when the remaining photoreactive additive is consumed following application of a non-profiled beam of the same ultraviolet light.

7.1.2 LIGHT DELIVERY DEVICE (LDD)

RxSight's Light Delivery Device (LDD) is a UV light projection system (Figure 1) used to induce a predictable change in the LAL after implantation. RxSight's LDD consists of an anterior segment biomicroscope with the addition of an optical projection system, electronic control circuitry, and a UV source. The LDD delivers light profiles with adequate intensity and duration to induce polymerization of photoreactive additive leading to a change of the implanted LAL. Because this procedure is performed after implantation, residual refractive errors can be minimized and/or a patient's depth of focus can be extended, reducing the need for spectacles, corneal refractive procedures, or additional IOL procedures to optimize a patient's vision.

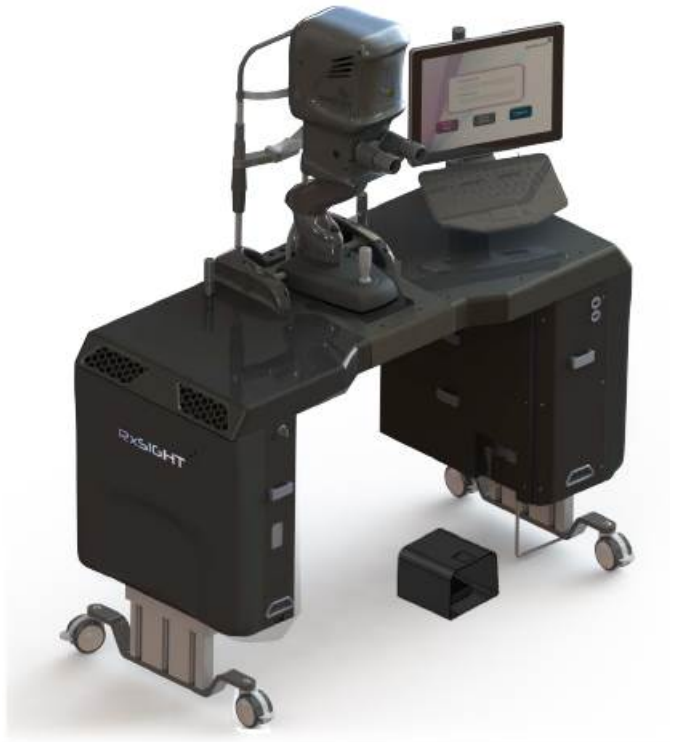

FIGURE 1: RXSIGHT LIGHT DELIVERY DEVICE (LDD)

7.1.3 DEVICE MANUFACTURER

The LAL and LDD are manufactured by RxSight, Inc. located in Aliso Viejo, California (FDA Establishment Registration No. 3012712027). RxSight, Inc. has an established Quality Management System that is in conformance with the following standards:

- 21 C.F.R. Part 820 (Quality System Regulation)
- EN ISO 13485:2016 (Quality Management System with scope: design, manufacture, distribution and service of therapeutic, surgical and diagnostic devices and instruments especially for ophthalmology), and the Medical Device Directive 93/42/EEC.

The Sponsor will keep records to document the physical location of all investigational devices from shipment to the investigational sites until use, return or disposal. Traceability for both the LAL and LDD will be achieved by use of device serial numbers.

The principal investigator or an authorized designee shall keep records documenting the receipt, use, return, and disposal of the investigational devices, which shall include:

- The date of receipt
- Identification of each investigational device (batch number/serial number or unique code),
- The expiry date, if applicable,
- The date or dates of use,
- Subject identification
- Date on which the investigational device was returned/explanted from subject, if applicable, and
- The date of return of unused, expired or malfunctioning investigational devices, if applicable.

7.1.4 RXSIGHT INSERTION DEVICE

The LAL can be inserted into the eye using the RxSight Insertion Device, which is comprised of a re-usable titanium injector and a single-use, non-preloaded polypropylene cartridge with lubricating coating.

7.1.5 INDICATIONS FOR USE

The RxSight Light Adjustable Lens (LAL) is an intraocular lens intended for primary implantation in the capsular bag for the visual correction of aphakia in adult patients with or without presbyopia in whom a cataractous lens has been removed. The Light Delivery Device (LDD) is used to improve uncorrected visual acuity by adjusting the LAL power to correct residual postoperative refractive error including -2.0 to +2.0 diopters of sphere and 0.50 to 3 diopters of cylinder and by changing lens curvature to introduce controlled amounts of spherical aberration (± 1 micron) and center near add (up to 2 diopters).

7.2 SUBJECT ENTRY

Patients who require cataract extraction and intraocular lens implantation will have both eyes screened for eligibility. If one or both eyes meet inclusion/exclusion criteria, study staff will explain the study purpose, procedures, risk/benefits and subject responsibilities to the potential participant. Written informed consent will be obtained prior to any study specific testing. The patient is enrolled upon signing the informed consent. The subject will sign and date the informed consent form in the presence of the person conducting the consent process. The investigator and/or the person conducting the consent process will also sign and date the consent form. During the study, the subject will be provided with any new information that is received that could affect their health status or change their willingness to continue to participate in the study. The preoperative examination will be performed no more than 60 days prior to surgery. If the 60-day time period elapses, it is acceptable for patients to be re-screened by undergoing a complete preoperative examination. Ocular dominance testing will be performed as part of the preoperative evaluation to determine eye dominance. If both eyes of the subject are enrolled for study participation, each eye will be scheduled for surgery within a timeframe of the investigator's choice but on separate days.

Only subjects meeting all inclusion/exclusion criteria will be implanted. Those subjects who do not meet the inclusion/exclusion requirements will be considered screen failures. Unique identification numbers will be assigned to each subject.

The implant lens power for the LAL will be calculated based upon the ocular biometry data and a lens power formula of the surgeon's choice. A postoperative spherical equivalent (SE) outcome of the physician's choice will be targeted.

7.3 LAL IMPLANTATION AND REFRACTIVE ADJUSTMENT

7.3.1 SURGICAL PROCEDURE

The LAL will be implanted on Day 0 of the study using standard microsurgical techniques.

No additional refractive procedures are allowed until after the Postop Month 3 or later visit.

The surgical procedure will be performed as follows:

1. Prepare and drape the eye for surgery in accordance with standard surgical procedures.
2. A temporal clear corneal incision will be made using the surgeon's standard instrumentation and techniques.
3. Use viscoelastic to fill the anterior chamber through the incision opening.
4. Perform an anterior circular capsulorhexis of a maximum of 5.2 mm in diameter using standard technique. The capsulorhexis should be well-centered with a 360° overlapping capsular edge to minimize IOL tilt and decentration and longitudinal IOL shift. The capsulorhexis and/or nuclear fragmentation can be performed with a femtosecond laser. Precision pulse capsulotomy (PPC) can also be used to perform the capsulorhexis.
5. The surgeon will extract the cataract by phacoemulsification.
6. In the event of an intraoperative complication prior to implantation of the LAL, including posterior capsule rupture, zonular rupture, radial capsulorhexis tear, vitreous

loss, iris trauma, corneal complications or any intraoperative abnormality that may affect the postoperative pupillary dilation, or the centration or tilt of the intraocular lens, do not implant the LAL.

7. The LAL can be introduced into the eye using any of the following systems:
    a. The RxSight Insertion Device through a clear temporal corneal incision up to 3.2 mm
    b. Nichamin III Foldable Lens Inserter (Rhein Medical 05-2349) with the Nichamin II Foldable Lens Insertion Forceps (Rhein Medical 05-2348) through a temporal clear corneal incision of 3.5-3.8 mm
    c. An insertion system of the investigator's choice through a clear temporal corneal incision

    The LAL is placed into the capsular bag. If utilizing additional surgical instruments near the incision upon insertion, precaution should be taken not to contact the LAL optic with this additional instrument.
8. Verify proper orientation of the LAL
9. Aspirate any residual viscoelastic from the eye using a preferred technique.
10. The wound may close without suturing. If the unsutured wound is not watertight, close it with a either a suture using standard technique or an ocular sealant (ReSure Sealant).
11. After completion of the surgery, ocular anti-inflammatory and/or antibiotic drops may be applied in accordance with standard clinical practice.
12. The subject will be provided with two pairs of RxSight approved UV protective spectacles (one clear and one tinted) to protect the implanted LAL from extraneous sources of UV light. It is important to direct the subject to follow all instructions that are provided with the UV protective spectacles.

    If a patch was used at the conclusion of surgery, the subject will wait for the surgeon to remove the patch. Once removed, the subject will begin wear of the UV protective eyewear as instructed.

7.3.2 LIGHT TREATMENT PROCEDURE

Seventeen (17) to 24 days after surgery, the subject will return for the Postop Week 3 evaluation and a 1st adjustment treatment of the LAL. Subsequent second and third adjustment treatments, if necessary, will all be separated by 3-7 days. The subject will receive the 1st lock-in treatment 3-7 days after the final adjustment treatment. If necessary, lock-in #2 may be performed 3-7 days after lock-in #1. Depending on the adjustment(s) performed, all eyes will receive two to three adjustments and one or two lock-in treatments.

7.3.2.1 Postponement of Light Treatment Procedure(s)

LDD treatment should be delayed if any of the following new symptoms or changes in performance are noted;

[redacted]

- Best Corrected Distance Visual Acuity: With any loss of BCDVA (unless the cause is known to be non-retinal) of 10 letters or more on an ETDRS (logMAR) chart compared to the Postop Week 3 BCDVA, treatment should be delayed.

[redacted]

- If sutures were utilized at the time of surgery to close the incision wound, light treatments should not commence on the study eye until a minimum of 4 weeks after suture removal.[9]
- A study eye with an ocular adverse event that could be negatively impacted by light treatment or negatively impact the effectiveness or safety of a light treatment should have light treatments delayed until after the adverse event has subsided. This includes corneal edema and superficial punctate keratitis (SPK) (Grade 3 (moderate) or more severe)), retinal conditions including diabetic retinopathy and cystoid macular edema, epithelial defect, and endophthalmitis.
- If a study eye is discovered with evidence of premature photopolymerization as evidenced as a zone on the lens surface, the investigator should contact the Sponsor for further instructions. (see [redacted] for additional details regarding premature photopolymerization).
- Any study eye possessing clinically significant posterior capsular (PC) haze should undergo a YAG capsulotomy procedure prior to the adjustment. A minimum of 48 hours should separate the YAG treatment from the corresponding refraction and LDD adjustment.

7.3.2.2 Additional Clinical Testing

[redacted]

- Monocular and/or binocular contrast sensitivity (photopic/mesopic) at the Postop Month 1-2 visit and Postop Month 3 or later visit.
- Monocular and binocular intermediate and near visual acuity measurements at the Adjustment #2 and Adjustment #3 visits

7.3.2.3 Procedure Preparation

[redacted]

[9] Azar D, Stark W, Dodick J, et al. Prospective, randomized vector analysis of astigmatism after three-, one-, and no-suture phacoemulsification. J Cataract Refract Surg 1997; 23:1164-1173.

[redacted]

If dilation is required:

The study eye will be dilated using any of the following pupil dilation drops [redacted] or pupil dilation gel [redacted]. After waiting an appropriate amount of time for dilation to occur, the study eye will be examined to ensure that adequate dilation (enough of the edge of the LAL optic can be visualized to allow for centration during LDD light treatment) has been obtained. If adequate dilation has not been obtained, additional dilating drops with manual punctal occlusion or a sponge soaked in mydriatic medication and applied to the ocular surface can be utilized to try and gain further dilation. If adequate pupil dilation is still not achieved with the methods described above, the treatment will be rescheduled and the dilation attempted at another visit or another dilation method is used.

Once adequate pupil dilation is achieved, patch the subject's opposite eye and position the subject comfortably in front of the LDD with chin in the chinrest and forehead against the support bar. Ask the subject to grasp the handles on the LDD table for support. Inform the subject to concentrate on the green fixation light presented in front of them and to try and minimize eye movement.

If no dilation is required:

The subject's fellow eye will be patched and the subject will be comfortably positioned in front of the LDD with chin in the chinrest and forehead against the support bar. The subject is asked to grasp the handles on the LDD for support and is asked to look straight ahead and concentrate on the green fixation light presented in front of them and to try and minimize eye movement.

7.3.2.4 Adjustment Procedure(s)

Refer to the LDD Operator's manual for instructions on LDD start up and instructions for the daily alignment test to be performed prior to the first treatment of the day to ensure the UV beam is aligned to the reticle. If the UV beam is not aligned to the reticle within the specifications detailed in the LDD Operator's manual, do not perform treatments and call RxSight customer service immediately.

1. All adjustment procedure(s) will be recorded.

2. Within the Patient ID and Patient Data screens, follow the touchscreen prompts to enter requested information. Press the "Proceed" button once information has been entered respectively for each screen.
3. Within the Confirmation screen, review all information and press the "Confirm" button.
4. Verify that the LDD ring lights and reticle target are activated.
5. Apply topical anesthetic.
6. Position the RxSight supplied contact lens [redacted] on the cornea using [redacted] as the coupling medium.

   Note: The RxSight contact lens is similar to those used in other ophthalmic procedures in which customized magnification is required. To ensure correct magnification for treatment, use only the RxSight designated contact lens.
7. Instruct the subject to focus straight ahead on the LDD fixation light with the study eye.
8. Using the microscope, focus on the cornea and verify that there are no trapped bubbles present. Confirm alignment of the contact lens by approximately aligning the Purkinje images to the inner circle of the reticle target.
9. For dilated pupil light treatments, using the microscope, focus on the LAL haptics and align the reticle target with the periphery of the LAL. Press the "Ready" button. Initiate the UV exposure as prompted by the LDD display using the trigger. Use the joystick to keep the LAL centered in the alignment reticle. Perform micro adjustments to keep the reticle target centered to the LAL and to keep the LAL in focus. In the case of subject movement, loss of alignment, or loss of focus, pause the treatment, quickly refocus, realign the lens with respect to the reticle beam, and immediately resume treatment to limit the duration of any pauses once the light treatment has been initiated.

   Note: Always maintain the LAL in focus by focusing at the haptics. Never focus onto the CCC (capsulotomy) or Purkinje images.
10. [redacted]
11. If the event of an aborted Adjustment Treatment, do not initiate a new treatment sequence; instead; instruct the subject to return 3-7 days later for refractive evaluation to assess whether an adjustment treatment is required or to proceed directly to a lock-in treatment.
12. Following the light adjustment, the subject will continue to wear their UV protective eyewear as instructed until exactly 24 hours after the final lock-in treatment has been completed.
13. The subject will return 3 to 7 days following the power adjustment treatment for another light treatment. The subject may receive up to 3 adjustment treatments before receiving the 1st lock-in treatment.

7.3.2.5 Lock-In Procedure(s)

Refer to the LDD Operator's manual for instructions on LDD start up and instructions for the daily alignment test to be performed prior to the first treatment of the day to ensure the UV beam is aligned to the reticle. If the UV beam is not aligned to the reticle within the specifications detailed in the LDD Operator's manual, do not perform treatments and call RxSight customer service immediately.

1. All lock-in procedure(s) will be recorded.
2. Within the Patient ID screen, utilize the pop-out menu within the Patient ID field to select the appropriate subject identification with eye to be treated. Reconfirm information displayed on screen and follow the touch screen prompts to enter in newly requested information. Press the "Proceed" button.
3. Within the Confirmation screen, review all information and press the "Confirm" button.
4. Verify that the LDD ring lights and reticle target are activated.
5. Apply topical anesthetic.
6. Position the RxSight supplied contact lens [redacted] on the cornea using [redacted] as the coupling medium

   Note: The RxSight contact lens is similar to those used in other ophthalmic procedures in which customized magnification is required. To ensure correct magnification for treatment, use only the RxSight designated contact lens.
7. Instruct the subject to focus straight ahead on the LDD fixation light with the study eye.
8. Using the microscope, focus on the cornea and verify that there are no trapped bubbles present. Confirm alignment of the contact lens by approximately aligning the Purkinje images to the inner circle of the reticle target.
9. Using the microscope, focus on the LAL haptics and align the reticle target with the periphery of the LAL.
10. Press the "Ready" button
11. Initiate the irradiation delivery as prompted by the LDD display using the joystick or foot pedal to keep the LAL centered in the alignment reticle.
12. Perform micro adjustments to keep the reticle target centered to the LAL and to keep the LAL in focus. In the case of subject movement, loss of alignment, or loss of focus, pause the treatment, quickly refocus, realign the lens with respect to the reticle beam, and immediately resume treatment to limit the duration of any pauses once the light treatment has been initiated.

    Note: Always maintain the LAL in focus by focusing at the haptics. Never focus onto the CCC (capsulotomy) or Purkinje images.
13. If the lock-in treatment is aborted before completion, contact the Sponsor for technical assistance.

14. Upon completion of the lock-in #1 treatment, a notification may appear that informs the user that a lock-in #2 treatment is not required for the subject. If this notification appears, proceed to step #16. If no notification appears, then the subject will require a lock-in #2 treatment and proceed to step #15.
15. The subject will return for the second lock-in treatment 3 to 7 days after the first lock-in treatment.
16. The subject will be permitted to discontinue wear of the UV protective eyewear exactly 24 hours after the final lock-in treatment has been completed.

7.4 EXAMINATION SCHEDULE

Subjects who agree to participate in the study will return for the listed follow-up examinations for each study eye:

Evaluation	
Preoperative	Day -60 to Day -1
Operative	Day 0, day of surgery
Postop Day 1	Days 1 to 2 postop
Postop Week 3	Days 17 to 24 postop: Adjustment #1
Adjustment #2, if needed	3 to 7 days post Adjustment #1
Adjustment #3, if needed	3 to 7 days post Adjustment #2
Lock-in #1	3 to 7 days post final adjustment
Lock-in #2, if needed	3 to 7 days post lock-in #1
Postop Month 1-2	7 to 14 days post final lock-in
Postop Month 3 or later visit	≥90 days postop

Unscheduled visits falling outside the designated ranges for scheduled visits will be considered "interim" visits for data recording purposes and a report form will be completed.

7.5 CLINICAL PARAMETERS

[redacted]

42. Demographics
43. Ocular history including medications
44. Subjective symptoms/complaints (subject reported)
45. Compliance with UV spectacles
46. Ocular Biometry: ACD and axial length (Optical biometry)
47. Corneal Topography
48. Autorefraction
49. Corneal Keratometry
50. Vision Quality Measurement
51. Undilated Distance Viewing Pupil Diameter
52. Binocular UCDVA
53. Monocular uncorrected distance visual acuity (UCDVA)
54. Manifest Refraction
55. Monocular best corrected distance visual acuity (BCDVA)
56. Ocular Dominance Test
57. Pseudo accommodation testing
58. Mesopic binocular distance corrected contrast sensitivity testing
59. Mesopic monocular distance corrected contrast sensitivity testing
60. Photopic binocular distance corrected contrast sensitivity testing
61. Photopic monocular distance corrected contrast sensitivity testing
62. Monocular distance corrected 10% low contrast intermediate visual acuity (photopic only)
63. Monocular distance corrected intermediate visual acuity (DCIVA)
64. Monocular distance corrected intermediate visual acuity (DCIVA) with +1.50 D add
65. Monocular uncorrected intermediate visual acuity (UCIVA)
66. Binocular UCIVA
67. Undilated Intermediate Viewing Pupil Diameter
68. Monocular distance corrected 10% low contrast near visual acuity (photopic only)
69. Monocular distance corrected near visual acuity (DCNVA)
70. Monocular distance corrected near visual acuity (DCNVA) with a +2.50 D add
71. Monocular uncorrected near visual acuity (UCNVA)
72. Binocular UCNVA
73. Undilated Near Viewing Pupil Diameter

[redacted]

75. Intraocular pressure
76. Slit Lamp Examination
77. Fundus Exam
78. Aberrometry
79. Dilated pupil diameter
80. Adverse Events

Table 1. Schedule of Visits and Clinical Parameters

Visits	Preop	Operative	Postop Day 1	Postop Week 3	Adjustment #2 (if needed)	Adjustment #3 (if needed)	Lock-in #1	Lock-in #2 (if needed)	Postop Month 1-2	Postop Month 3 or later Visit	Unscheduled Visit[3]
[redacted]				X			X		X	X	
Demographics	X										
Ocular History Including Medications	X	X	X	X	X	X	X	X	X	X	
Subjective Symptoms/Complaints (Subject reported)			X	X	X	X	X	X	X	X	X
Compliance with UV Spectacles			X	X	X	X	X	X			
Ocular Biometry (ACD + Axial length)	X								X	X	
Corneal Topography	X			X							
Autorefraction				X	X	X	X	X	X	X	
Corneal Keratometry	X			X					X	X	
Vision Quality Measurement (HD Analyzer)				X			X		X	X	
Undilated Distance Viewing Pupil Diameter	X			X					X	X	
Binocular UCDVA				X[1]					X[1]	X[1]	
Monocular uncorrected distance visual acuity (UCDVA)	X		X	X	X	X	X	X	X	X	X
Manifest Refraction	X			X	X	X	X	X	X	X	
Monocular best corrected distance visual acuity (BCDVA)	X			X	X	X	X	X	X	X	
Ocular Dominance Test	X			X							
Pseudo Accommodation Testing				X			X[2]		X[2]	X[2]	
Mesopic binocular distance corrected contrast sensitivity testing				X					X[4]	X[4]	
Mesopic monocular distance corrected contrast sensitivity testing				X					X[4]	X[4]	
Photopic binocular distance corrected contrast sensitivity testing				X					X[4]	X[4]	
Photopic monocular distance corrected contrast sensitivity testing				X					X[4]	X[4]	
Monocular distance corrected 10% low contrast intermediate visual acuity (photopic)				X					X[2]	X[2]	
Monocular distance corrected intermediate visual acuity (DCIVA)				X	X[2,4]	X[2,4]	X[2]		X[2]	X[2]	
Monocular distance corrected intermediate visual acuity (DCIVA) with +1.50 D add				X	X[2,4]	X[2,4]	X[2]		X[2]	X[2]	

Visits	Preop	Operative	Postop Day 1	Postop Week 3	Adjustment #2 (if needed)	Adjustment #3 (if needed)	Lock-in #1	Lock-in #2 (if needed)	Postop Month 1-2	Postop Month 3 or later Visit	Unscheduled Visit[3]
Monocular uncorrected intermediate visual acuity (UCIVA)				X	X[2, 4]	X[2, 4]	X[2]		X[2]	X[2]	
Binocular UCIVA				X[1]	X[1,2, 4]	X[1,2, 4]	X[1,2]		X[1,2]	X[1,2]	
Undilated Intermediate Viewing Pupil Diameter				X	X[2,4]	X[2,4]			X[2]	X[2]	
Monocular distance corrected 10% low contrast near visual acuity (photopic)				X					X[2]	X[2]	
Monocular distance corrected near visual acuity (DCNVA)				X	X[2,4]	X[2,4]	X[2]		X[2]	X[2]	
Monocular distance corrected near visual acuity (DCNVA) with +2.50 D add				X	X[2,4]	X[2,4]	X[2]		X[2]	X[2]	
Monocular uncorrected near visual acuity (UCNVA)				X	X[2,4]	X[2,4]	X[2]		X[2]	X[2]	
Binocular UCNVA				X[1]	X[1,2,4]	X[1,2,4]	X[1,2]		X[1,2]	X[1,2]	
Undilated Near Viewing Pupil Diameter				X	X[2,4]	X[2,4]	X[2]		X[2]	X[2]	
[redacted]											
Intraocular Pressure	X		X	X	X	X	X	X	X	X	
Slit Lamp Exam	X		X	X	X	X	X	X	X	X	X
Fundus Exam	X			X							
Aberrometry				X	X	X	X		X	X	
Dilated Pupil Diameter	X			X	X	X	X	X			
Adverse Events		X	X	X	X	X	X	X	X	X	X

[1] Only performed on subjects with both eyes enrolled and successfully implanted.
[2] Only performed on subjects receiving a presbyopia treatment.
3 Tests indicated with an "X" must be performed at each unscheduled visit. Other tests may be conducted based on the investigator's assessment of the subject.
[4] May be performed if the events described in section 7.3.2.2 of the protocol occur.

7.6 DATA REPORTING

All study data will be recorded onto case report forms (electronic or paper) designed for the study. CRFs can be signed by the investigator either by paper signature or by electronic signature. The CRF may be the source document for some data and each site will document this with a note to file describing in which cases source data will be recorded directly onto the CRF. If paper CRFs are used, all CRFs will be completed in a legible manner in black/blue ink.

Any corrections to the CRFs will be made by drawing a single line through the incorrect entry, recording the correct information, and initialing and dating the change. The CRFs and/or data entered in the EDC system will be reviewed by the Study Monitor.

All clinical data generated in the study will be submitted to RxSight or designated CRO for quality assurance review and statistical analysis. All CRFs and/or data entered into the EDC system will be reviewed for completeness and evident recording errors will be rectified by contact with the appropriate clinical site. Computerized data checks will be used to identify unusual data entries for verification prior to statistical analysis.

To minimize the amount of missing data, investigators will be trained on the deleterious effect that missing data have on trial integrity and credibility and that missing data could diminish the scientific value of all subjects' altruistic contributions.

7.7 STUDY COMPLETION PROCEDURES

A study Exit Form must be completed for all subjects enrolled in the study upon subject completion, withdrawal or discontinuation.

7.7.1 SUBJECT COMPLETION

Subjects are considered to have completed the study if they have completed the Postop Month 3 or later visit.

Subjects with ocular serious adverse events or adverse device effects that are unresolved at study exit should continue to be followed until resolution of the event or until they are stable per the investigator’s evaluation.

7.7.2 SUBJECT WITHDRAWAL PRIOR TO IMPLANTATION

Subjects may be withdrawn from the study prior to implantation if they do not meet all inclusion/exclusion criteria (screen failures) or decide not to participate in the study.

7.7.3 SUBJECT WITHDRAWAL DUE TO INTRAOPERATIVE COMPLICATIONS PRIOR TO IMPLANTATION

Subjects that meet all inclusion/exclusion criteria but do not undergo implantation of the LAL due to intraoperative complications prior to introduction of the LAL will be followed to resolution of any adverse events and then exited from the study.

7.7.4 SUBJECT DISCONTINUATION AFTER IMPLANTATION

After implantation, subjects may not be withdrawn from the study unless the study lens has been explanted. In the case of an explant, the investigator should continue follow-up for a period that ensures no adverse consequences have resulted. When possible, all necessary clinical assessments will be performed prior to the Subject exiting the study even if the assessment was not scheduled at that particular visit.

Subjects may be discontinued from the study only when the study lens has been explanted or subject has deceased. The reason for discontinuation will be recorded on the appropriate study worksheet. Subjects who are discontinued from the study will still be a part of the study analyses up until the point they are exited.

7.7.5 LOST TO FOLLOW-UP

Subjects for which the final post-operative case report form is overdue and who refuse to be followed, or have difficulty being followed, or cannot be contacted despite extensive written and telephone follow-ups to determine the final clinical outcome, will be considered lost to follow-up. Sites must make a minimum of three documented attempts via telephone, email, or regular mail to contact the subject. If the subject does not reply to any of these attempts, the site must send a letter by certified mail (with a request for notification of receipt of delivery) to the subject. If a subject is non-responsive to these follow-up attempts, the subject will be considered to be lost to follow-up.

7.7.6 STUDY TERMINATION

The study may be stopped at any time by the Sponsor(s) for reasonable cause with appropriate notification. Conditions that may warrant study termination include, but are not limited to the following:

- Safety concerns. Clinical data from the study will be monitored to assure the safety of enrolled subjects.

If the clinical study is prematurely terminated, the Sponsor will inform the Investigator, Ethics Committee, and other appropriate regulatory bodies. If the Sponsor terminates the study for safety reasons, it will immediately notify the Investigator, Ethics Committee, and other appropriate regulatory bodies and provide an explanation of the reasons for termination. The Investigator will be provided with instructions for study termination and applicable subject follow-up. The Sponsor will continue to provide resources to fulfill the Clinical Study Plan obligations for follow-up of the subjects enrolled in the study.

8 STATISTICAL METHODS

8.1 POPULATIONS FOR ANALYSIS

Exploratory effectiveness analyses will be performed on all eyes as specified.

Safety analyses will be performed on observed data for all eyes of subjects who sign the informed consent and the procedure was attempted which is defined as the point at which the LAL makes contact with the eye. No imputation will be performed.

8.1.1 EXPLORATORY EFFECTIVENESS PARAMETERS

UCDVA
Monocular and binocular UCDVA will be presented with the number and percent of eyes that fall into each category of visual acuity performance (e.g. 20/20 or better, 20/25 or better, 20/32 or better, etc.) at each visit tested. Number and percent of eyes for subjects that only received spherical/sphero-cylindrical adjustments and for subjects that received a presbyopia adjustment will be presented separately.

UCIVA, UCNVA, DCIVA, and DCNVA
Monocular and/or binocular UCIVA, UCNVA, DCIVA, and DCNVA for subjects that received a presbyopia adjustment will be presented with the number and percent of eyes that fall into each category of visual acuity performance (e.g. 20/20 or better, 20/25 or better, 20/32 or better, etc.) at each visit tested.

Pseudo Accommodation
The mean acuity across all subjects that received a presbyopia adjustment will be calculated and plotted separately. The mean, standard deviation, and confidence intervals for each point on the curve will be reported.

[redacted]

8.2 SAFETY PARAMETERS

- Incidence of cumulative ocular serious adverse events defined per ISO 11979-7.

The incidence of all other adverse events will also be presented.

[redacted]

8.2.1 ADDITIONAL SAFETY ANALYSES

The safety outcomes will be summarized descriptively for all eyes that have the procedure attempted.

BCDVA
Monocular BCDVA will be presented with the number and percent of eyes who fall into each category of BCDVA at each visit (e.g. 20/20 or better, 20/25 or better, 20/32 or better, etc.). The mean BCVDA letter score will be calculated for each visit. Change in BCVDA from Postop Week 3 or from Preoperative will be presented at each visit as categorical outcomes of "Increase in 15 letters or more", "Increase in 10-14 letters", "Increase in 5-9 letters", "No change", "Decrease in 5-9 letters", "Decrease in 10-14 letters", and "Decrease in 15 letters or more".

[redacted]

Intraocular Pressure (IOP)
The IOP and change in IOP from preoperative will be summarized by mean, standard deviation, median, minimum and maximum. The number and percent of eyes reported with IOP $\geq$ 25 mmHg or an IOP increase of $\geq$ 10 mmHg from preop will be provided at each visit.

Slit Lamp Examination and Fundus Examination Findings
The outcomes will be summarized descriptively by count and percent of eyes with each possible finding category.

9 SEQUENCE OF PLANNED ANALYSES

9.1 INTERIM ANALYSES

An interim analysis may be performed. Since there are no statistically based hypothesis driven endpoints or associated sample size, no multiplicity adjustment is needed.

9.2 FINAL REPORT

When all enrolled study eyes have completed the Postop Month 3 or later visit or have been discontinued from the study, the data will be analyzed for a final study report.

10 ADVERSE EVENTS

Throughout the study, adverse events are to be documented and reported on Adverse Event Forms (AE Forms) that are included in the study documentation. If an adverse event (AE) occurs, the first concern will be the safety and welfare of the subject; treatment should be provided as appropriate for the event. During the study, the Investigator should appropriately treat and follow each AE until it resolves, stabilizes, or it is determined that further improvement is not expected.

10.1 ADVERSE EVENT (AE) DEFINITIONS

An adverse event is any untoward medical occurrence, unintended disease or injury, or untoward clinical signs (including abnormal laboratory findings) in subjects, users, or other persons, whether or not related to the investigational medical device.

Note 1 to entry: This definition includes events related to the investigational medical device or the comparator.

Note 2 to entry: This definition includes events related to the procedures involved.

Note 3 to entry: For users or other persons, this definition is restricted to events related to investigational medical devices.

The specific event should be reported as an AE:

- An [redacted] at any time after Postop Week 3.

10.2 ADVERSE DEVICE EFFECT (ADE) DEFINITION

Adverse event related to the use of an investigational medical device.

Note 1: This definition includes adverse events resulting from insufficient or inadequate instructions for use, deployment, implantation, installation, or operation, or any malfunction of the investigational medical device.

Note 2: This definition includes any event resulting from use error or from intentional misuse of the investigational medical device.

10.3 DEVICE DEFICIENCY (DD) DEFINITION

Inadequacy of a medical device with respect to its identity, quality, durability, reliability, safety or performance. Note: Device deficiencies include malfunctions, use errors, and inadequate labeling.

10.4 SERIOUS ADVERSE EVENT (SAE) DEFINITION

Serious Adverse Events are AEs that lead to:

- death
- a serious deterioration in the health of the subject that:

  - results in a life-threatening illness or injury
  - results in a permanent impairment of a body structure or function (e.g., blindness)
  - requires in-subject hospitalization or prolongation of existing hospitalization
  - results in medical or surgical intervention to prevent permanent impairment to a body structure or a body function
- fetal distress, fetal death, or a congenital abnormality or birth defect
- a potentially sight-threatening condition
- or is another important medical event.

10.4.1 IDENTIFICATION AND COLLECTION

All AEs that occur during the study must be recorded in English on the adverse event Case Report Form. Each event must be on a separate form, regardless of whether one event may be secondary to another or from a single cause. Identification and collection of an AE begins after informed consent has been obtained and documented. Standard sources of identifying AEs include:

- direct observation by the Investigator or study team member
- asking the study participant a specific question (e.g., "Since your last visit, have you experienced any problems with your eyes or vision?")
- unsolicited volunteering of information by the study participant (e.g., "Doctor, I have had numerous headaches since I started using this lens.")

Ocular AEs and SAEs and systemic SAEs observed or elicited by the Investigator, reported by the subject, or resulting from a test result, etc., occurring during the clinical investigation must be documented. AE Forms are to be completed at the time of the event regardless of all data being available.

During the study, the Investigator should treat the study subject as appropriate to ensure his/her safety and welfare. Refer to Section 7.7.1 for additional information pertaining to ongoing AEs at subject exit.

Pre-existing conditions will not be considered AE/SAEs but will be collected at the Preoperative Visit as medical history. A worsening of a pre-existing condition during the study should be documented as an AE and evaluated accordingly.

Hospitalization is a criterion for assessment of seriousness. Hospitalization in the absence of a medical AE is not in itself an AE. For example, the following reports of hospitalization without a medical AE should not be considered either an SAE or an AE:

- Planned hospitalization for a pre-existing condition without serious deterioration in health (e.g., planned knee replacement surgery)
- Social admission (e.g., subject has no place to sleep)
- Administrative admission (e.g., for yearly physical exam or elective procedures not related to the study)

- Optional admission not associated with a precipitation medical AE (e.g., for elective cosmetic surgery)

10.4.2 EVALUATIONS

When evaluating AEs, the Investigator must determine if the event is serious, assess the severity of symptoms, the relationship of the event to the device or study protocol, using the following guidelines:

1. **Severity**

   Mild: subject awareness of a sign or symptom that is easily tolerated, requires no treatment, and does not interfere with subject's daily activities

   Moderate: subject awareness of a sign or symptom which may be a low level of concern to the subject and may interfere with daily activities, but can be relieved by simple therapeutic care

   Severe: a sign or symptom that interrupts the subject's daily activity and requires systemic therapy or other treatment

2. **Relationship (Causality) to Study Device or Study Protocol**

   Related: There is at least a reasonable possibility that the AE/SAE is related to the study device or study protocol. Reasonable possibility means that there is evidence to suggest a causal relationship between the study device or study protocol and the AE.

   Unrelated: There is little or no reasonable possibility that the AE/SAE is related to the study device or study protocol. This assessment implies that the AE/SAE has little or no temporal relationship to the study device and/or a more likely or certain alternative etiology exists.

10.4.3 SAE/UNANTICIPATED ADVERSE DEVICE EFFECT (UADE)/UNANTICIPATED SERIOUS ADVERSE DEVICE EFFECT (USADE) REPORTING

The site should report any event to the Sponsor and its representative in an expedited manner if it meets the criteria for an SAE and/or is an IOL explant from a study eye. Expedited reporting is calling or e-mailing the Sponsor and its representative within 48 hours of becoming aware of the event. Contact details are as follows:

Email: [redacted]
Tele: [redacted]

When reporting an SAE to the Sponsor and/or its representative, the site should forward any supporting documents along with the SAE Report Form to the Sponsor and its designee within 5 days of the initial communication. Sites must also report the SAE to the reviewing Ethics Committee per its reporting procedures.

An investigator shall submit to the Sponsor and to the reviewing IRB/EC a report of any Unanticipated Adverse Device Effect (UADE) occurring during an investigation as soon as

possible, but in no event later than 10 working days after the investigator first learns of the effect or in accordance with National Regulations. As soon as notification of a potential UADE is received by the Sponsor, an investigation will be initiated to determine if the event is a UADE. If the event is confirmed to be a UADE, the regulatory authorities, all other participating Investigators and each reviewing IRB/EC must be notified within 10 working days of the initial report from the site, as applicable or in accordance with National Regulations. If it is determined that the UADE represents an unreasonable risk to study subjects, the study must be terminated within 5 working days following the decision, and no later than 15 working days after first learning of the UADE or in accordance with National Regulations.

10.4.4 DEVICE DEFICIENCY (DD) REPORTING

All device deficiencies (DDs) should be reported to the Sponsor without unjustified delay. The Investigator is responsible for notifying the regulatory authorities and IRB/EC of DDs that could have led to a Serious Adverse Device Effect (SADE), if required by the national regulations or by the IRB/EC per each body's reporting procedures. In the case of DDs that could have led to a SADE, the Sponsor will determine whether the risk analysis needs to be updated and assess whether corrective or preventative action is required.

10.5 PREGNANCY

During the study, all female subjects of childbearing potential should be instructed to contact the investigator immediately if they suspect they might be pregnant (e.g., missed or late menstrual period). Female subjects who become pregnant during the study will be followed until completion of pregnancy. Every effort will be made to obtain the health status of the mother and infant or fetus (in cases of miscarriage or therapeutic abortion) at term. Pregnancy itself is not considered an AE.

All confirmed pregnancies must be immediately reported to the Sponsor within 48 hours of the investigator's awareness of the pregnancy.

10.6 POTENTIAL ADVERSE EVENTS

The following have been identified as potential adverse events for all cataract surgeries including the LAL. Please notify the Sponsor regarding any events that may be occurring more frequently than your customary rates, or more frequently than expected at your site.

Infection, inflammation, hypopyon, endophthalmitis, infectious keratitis, hyphema, retinal detachment or other retinal problems including cystoid macular edema and epiretinal membranes, toxic anterior segment syndrome, glaucoma, corneal endothelial damage, vitritis, corneal edema which may require correction with a corneal transplant, lens dislocation out of the posterior chamber, pupillary block, striation on the lens with or without visual sequelae, iritis, synechiae, ptosis, wound leak, flat anterior chamber, increased astigmatism, rupture of the capsule, iris prolapse, vitreous in the anterior chamber, and retained pieces of the lens in the eye. These adverse events may result in total loss of vision or the loss of an eye.

Secondary surgery may be required after the cataract surgery to treat surgical complications. Additionally, a posterior capsulotomy may be required to treat posterior capsular haze after the cataract surgery. Visual problems after cataract surgery may include halos, glare, ghost images, and/or double vision. These and other complications may result in permanent poor vision.

Additional specific risks of the LAL include:

The LAL must be implanted following specific surgical procedures. If these procedures are not followed by the surgeon, the lens may become scratched or improperly placed in the eye and may need to be explanted prior to light treatments. In order to perform the lens adjustment or the lens lock-in procedures, the subject's pupil needs to be adequately dilated. If this cannot be accomplished for any reason, additional eye drops, injections into the eye, or surgery may need to be utilized to adequately dilate the pupil. If the pupil cannot be adequately dilated after these types of treatments, the LAL may need to be explanted. An unpredicted change in vision can occur resulting from ocular exposure to daylight or any other UV source before the LAL is locked-in. The light treatments may not improve vision and/or manifest refraction, and the adjustment/lock-in procedure may make vision worse, such that it may be necessary to remove and replace the LAL. Vision loss may be permanent and may not be improved by replacing the LAL. There is a potential risk for UV-induced damage to the eye, including the cornea and retina, which may be permanent. UV light can sometimes cause a reactivation of previous herpes virus infection in the eye. A reactivation of herpes virus can cause scarring of the cornea, blurred vision, eye pain, extreme light sensitivity, permanent loss of vision, and possible need for corneal transplant. Temporary or persistent erythropsia and/or temporary or persistent color vision deficiency may occur. Corneal dryness and corneal abrasions from the lens used for adjustment and lock-in can occur. After the lens adjustment(s) or after the lens lock-in procedures, discomfort, itching and light sensitivity may occur. In cases where a spherocylinder adjustment is performed, it is possible that visual disturbances may occur if the IOL rotates or if the correction is not performed on the correct axis of astigmatism.

10.7 POTENTIAL BENEFITS

The subject's benefit from taking part in this study is the correction of the loss of vision from the natural cataract lens potentially without the need of glasses, contact lenses, or secondary surgical procedures for optimal distance or optimatl distance, intermediate, and near vision.

11 STUDY MONITORING

RxSight clinical personnel or designated CRO will monitor all clinical studies in a manner consistent with any applicable health authority regulations and the clinical research standards adopted by RxSight. Study monitoring will involve the following elements:

- Member(s) of RxSight's Clinical Affairs Department or designated CRO may meet with investigators prior to the initiation of the study in order to review the adequacy of the subject population, facilities, and equipment with respect to the needs of the study, and to familiarize the investigator with the study protocol.
- A member of RxSight's Clinical Affairs Department or designated CRO may meet with the investigator(s) at the time study subjects begin to be enrolled in order to ensure that subjects are being properly selected and that study data are being correctly recorded.
- A member of RxSight or designated CRO may visit the clinical site at any time during the study to review study CRFs and/or data entered in the EDC system.
- Interim monitoring visits and telephone consultations will occur as necessary during the course of the study to ensure the proper progress and documentation of the study findings.
- RxSight clinical personnel may visit the site at any time during the course of the study to observe implantation of the LAL and the adjustment and lock-in treatments to ensure that the procedures described in the protocol are being followed.
- RxSight clinical personnel may also observe examination techniques used by study personnel to ensure that the procedures being utilized are the procedures described in [redacted] of the protocol.

12 ETHICAL AND REGULATORY CONSIDERATIONS

12.1 SUBJECT INFORMATION AND CONSENT

It is the responsibility of the Principal Investigator or authorized designee to give each subject prior to inclusion in the study full and adequate verbal and written information regarding the objective and procedures of the study and the possible risks involved. The subjects will be informed about their right to refuse to participate in the study. The written consent form will be given to each subject before enrollment. It is the responsibility of the Principal Investigator to obtain a signed informed consent form and to ensure the subject is given a copy.

The Principal Investigator or authorized designee needs to file the informed consent forms for review by RxSight study monitors. The Investigator or authorized designee will acknowledge the receipt of the informed consent form from each subject by signing the appropriate pages of these documents.

12.2 DECLARATION OF HELSINKI

The study will be performed in accordance with the relevant recommendations guiding physicians in biomedical research involving human subjects adopted by the 18th World Medical Assembly, Helsinki, Finland, 1964 and later revisions, as well as applicable U.S. Food and Drug Administration regulations (21 CFR Parts 50, 56, and 812).

It is the responsibility of the Principal Investigator to obtain Institutional Review Board approval of the Study Protocol and to keep the IRB informed of serious side effects or adverse events and any amendments to the protocol.

12.3 ISO 14155:2011 CLINICAL INVESTIGATION OF MEDICAL DEVICES FOR HUMAN SUBJECTS- GOOD CLINICAL PRACTICE

This study will be performed in compliance with ISO 14155:2011.

12.4 ADDITIONAL REGULATORY CONSIDERATIONS

The proposed study is subject to all applicable governmental rules and regulations concerning the conduct of clinical trials on human subjects. This includes, but is not necessarily limited to, the approval of an Ethics Committee; obtaining prospective informed consent; monitoring of the conduct of the study, the completeness of the study CRFs, and/or accuracy of data entered into the EDC system, as may be employed, by the Sponsor or its designee(s); and record retention by the Sponsor in accordance with Good Clinical Practice.

12.5 STUDY INITATION/CONDUCT

The study will not commence until approval is obtained from the Ethics Committee. Any additional requirements imposed by the Ethics Committee shall be followed.

12.6 COMPLIANCE WITH THE CLINCIAL STUDY PROTOCOL

The Investigator shall conduct this clinical investigation in accordance with the signed agreement with the Sponsor, the investigational plan, and the applicable regulations. The Investigator shall avoid improper influence on or inducement of the subject, Sponsor, Monitor, other Investigator(s) or other parties participating in or contributing to the clinical investigation.

12.7 PROTOCOL DEVIATIONS (PDS)

Protocol deviations should be avoided. Any deviation from the protocol will be recorded on a Case Report Form together with an explanation for the deviation. Deviations should be reported to the Sponsor, who is responsible for analyzing them and assessing their significance.

Deviations should be reviewed to determine the need to amend the protocol or to terminate the investigation.

NOTE: When relevant, Ethics Committees and Competent Authorities or the appropriate regulatory bodies will be informed of protocol deviations.

12.8 PROTOCOL AMENDMENTS

Modification of the protocol is prohibited without prior written agreement in the form of a protocol amendment. All amendments will be created by the Sponsor and must be approved by the Ethics Committee or other regulatory bodies as needed prior to implementation except when required to mitigate immediate safety risks or when the changes involve only logistical or administrative revisions. All protocol amendments must be clearly summarized to outline the changes that were made.

12.9 PUBLICATION POLICY

The final report of the study will be available to the ethics committee and the investigator as requested. The study results may be submitted for publication in peer-reviewed journals as well as presented at scientific meetings and congresses where all identifiable data will be anonymized.

12.10 INSURANCE AND INDEMNITY

The Sponsor shall ensure that acceptable insurance and indemnification is in place prior to enrollment of the first study subject.

13 REFERENCES

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