Clinical Study Protocol
Johnson & Johnson Vision Care, Inc.

Visual Performance of Soft Contact Lenses with Myopia Control Optics

Protocol CR-6457

Version: 4.0

Date: 29 March 2022

Investigational Products:

Run-in:
- 1 Day Acuvue Moist

Test:
- EMO-114
- EMO-118

Control:
- MiSight 1 Day

Keywords: myopia, senofilcon A, etafilcon A, omafilcon A, daily wear, daily replacement, logMAR distance visual acuity, logMAR near visual acuity, patient-reported outcomes

Statement of Compliance to protocol, GCP and applicable regulatory guidelines:
This trial will be conducted in compliance with the protocol, ISO 14155:2020,[1] the International Council for Harmonization Good Clinical Practice E6(R2) (ICH GCP),[2] the Declaration of Helsinki,[3] and all applicable regulatory requirements.

Confidentiality Statement:

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PROTOCOL TITLE, NUMBER, VERSION AND DATE

Title: Visual Performance of Soft Contact Lenses with Myopia Control Optics
Protocol Number: CR-6457
Version: 4.0
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SPONSOR NAME AND ADDRESS

Johnson & Johnson Vision Care, Inc. (JJVC)
7500 Centurion Parkway
Jacksonville, FL 32256

MEDICAL MONITOR

The Medical Monitor must be notified by the clinical institution/site by e-mail or telephone within 24 hours of learning of a Serious Adverse Event. The Medical Monitor may be contacted during business hours for adverse event questions. General study related questions should be directed towards your assigned clinical research associate.

The Medical Monitoring Plan is maintained as a separate document and included in the Trial Master File.

AUTHORIZED SIGNATURES

The signatures below constitutes the approval of this protocol and the attachments and provide the necessary assurances that this trial will be conducted according to all stipulations of the protocol, including all statements regarding confidentiality, and according to local legal and regulatory requirements and applicable U.S. federal regulations,[4] ISO 14155:2020,[2] ICH guidelines,[2] and the Declaration of Helsinki.[3]

Author	*See Electronic Signature* [redacted]	DATE
Clinical Operations Manager	*See Electronic Signature* [redacted]	DATE
Biostatistician	*See Electronic Signature* [redacted]	DATE
Biostatistician Reviewer	*See Electronic Signature* [redacted]	DATE
Data Management	*See Electronic Signature* [redacted]	DATE
Medical Safety Officer	*See Electronic Signature* [redacted]	DATE
Reviewer	*See Electronic Signature* [redacted]	DATE
Approver	*See Electronic Signature* [redacted]	DATE

CHANGE HISTORY

Version	Originator	Description of Change(s) and Section Number(s) Affected	Justification for Change	Date
1.0	[redacted]	Original Protocol	N/A	10AUG2021

2.0	[redacted]	1. Section 2.2: Number (n, %) of subjects and eyes with contact lens related (i.e., related and possibly related) serious and significant ocular adverse events (AEs), including best corrected logMAR loss > 0.20 logMAR (10 letters).. 2. Section 3.1: Clarified the refractive error for anticipated study population to be best sphere refraction for level of myopia. 3. Section 7: Added logMAR BCVA assessment at baseline and during each study visit. 4. Section 6.2 and 7: Updated the chart number for high contrast near logMAR VA to be 2106C. 5. Unscheduled visit procedures were updated to allow over-refraction, lens modification, and the logMAR VA with spherocylindrical correction. 6. Primary safety endpoint added to section 14.5, "Primary Analysis." 7. Section 7: Clarified that general health questionnaire would also be completed during PRO follow-up. 8. Attached lens power modification guide for all 3 test lenses. The run-in lens modification is already described within the study procedures. 9. Added assigned lens codes to section 6 to connect the lens design with the		07OCT2021

Version	Originator	Description of Change(s) and Section Number(s) Affected	Justification for Change	Date
		appropriate power modification instructions.		
3.0	[redacted]	1. Section 7: Moved logMAR VA with spherocylindrical correction procedure from the exit evaluation to end of V5. 2. Section 14: Included reference to standalone SAP which will be developed and finalized prior to database lock.		10/19/2021
4.0	[redacted]	1. Updated the designated Clinical Operations Manager on the signature page due to a personnel change. 2. Corrected the primary safety endpoint in the Synopsis and Section 2.2 to read 'best corrected logMAR loss ≥ 0.20 logMAR,' not '> 0.20 logMAR.' 3. Removed 'Treatment 2,' a typo, from the header of visit 5 in Table 3, Section 7.1.	1-3: Administrative changes to ensure the accuracy of the protocol and clarify roles/responsibilities.	29MAR2022

SYNOPSIS

Protocol Title	Visual Performance of Soft Contact Lenses with Myopia Control Optics
Sponsor	JJVC, 7500 Centurion Parkway, Jacksonville, FL 32256
Clinical Phase	Clinical trial phase: Confirmatory* Design control phase: • EMO-118: Phase 3 • EMO-114: Phase 0 *This is a research study but will be assigned the confirmatory clinical trial phase due to the advanced development stage of the EMO-118 investigational product.

Trial Registration	This study will be registered on ClinicalTrials.gov by the sponsor because this study is in the confirmatory clinical trial phase.
Test Article(s)	Investigational Products: Daily disposable soft contact lenses (SCL) made in senofilcon A material with the same parameters but differing optical designs • EMO-118 (Test 1) • EMO-114 (Test 2) Approved Products: • MiSight® 1 day, a SCL made in omafilcon A material approved by the US-FDA for slowing the progression of myopia in children (Control) • 1-Day Acuvue® Moist Brand Contact Lenses manufactured in etafilcon A material (Run-in period)
Wear and Replacement Schedules	Wear Schedule: Daily wear Replacement Schedule: Daily disposable
Objectives	**Primary Objective** The primary objective is to evaluate the logMAR visual performance of soft contact lenses featuring myopia control optical designs. **Exploratory Objectives** The exploratory objectives of the study are to assess: • logMAR visual performance at 4 m under varying luminance and contrast conditions • logMAR visual performance at 40 cm under high and low contrast conditions • Patient-reported outcomes at fitting and follow-up • Assess safety through adverse events, slit lamp findings, and subject-reported ocular symptoms • Number of power modifications and over-refraction with first trial lens at fitting • Over-refraction at follow-up • Lens fitting characteristics
Study Endpoints	Primary endpoint(s): • Binocular distance (4 m) high luminance high contrast (HLHC) logMAR visual acuity, measured per [redacted]

	Primary safety endpoint: • Number (n, %) of subjects and eyes with contact lens related (i.e., related and possibly related) serious and significant ocular adverse events (AEs), including best corrected logMAR loss ≥ 0.20 logMAR (10 letters). Other exploratory endpoints: • Monocular HLHC logMAR visual acuity at 4 m • Binocular high luminance low contrast (HLLC) logMAR visual acuity at 4 m • Monocular HLLC logMAR visual acuity at 4 m • Binocular low luminance high contrast (LLHC) logMAR visual acuity at 4 m • Monocular LLHC logMAR visual acuity at 4 m • Binocular HLHC logMAR visual acuity at 40 cm • Binocular HLLC logMAR visual acuity at 40 cm • Subjective vision, comfort, and ease of handling • Non-significant AEs and non-ocular AEs • Slit lamp findings per the ISO 11980 grading scale • Subject-reported ocular symptoms • Number of contact lens insertion attempts per eye at fitting • Subjective best sphere over-refraction with the first trial lens • Subjective best sphere over-refraction at follow-up • Number of power modifications at fitting • Lens fitting characteristics
Study Design	This is a multi-site, bilateral, dispensing, randomized, controlled, single-masked, 3x3 crossover study with a run-in period. Following the run-in period, each subject will be bilaterally fitted with one of the three study contact lenses test articles in each of the three periods. There will be a total of 5 planned visits: Visit 1: Screening, baseline evaluation, run-in lens fit and application/removal training Visit 2: Run-in follow-up and treatment #1 fit Visit 3: Treatment #1 follow-up and Treatment #2 fit Visit 4: Treatment #2 follow-up and Treatment #3 fit Visit 5: Treatment #3 follow-up and study exit

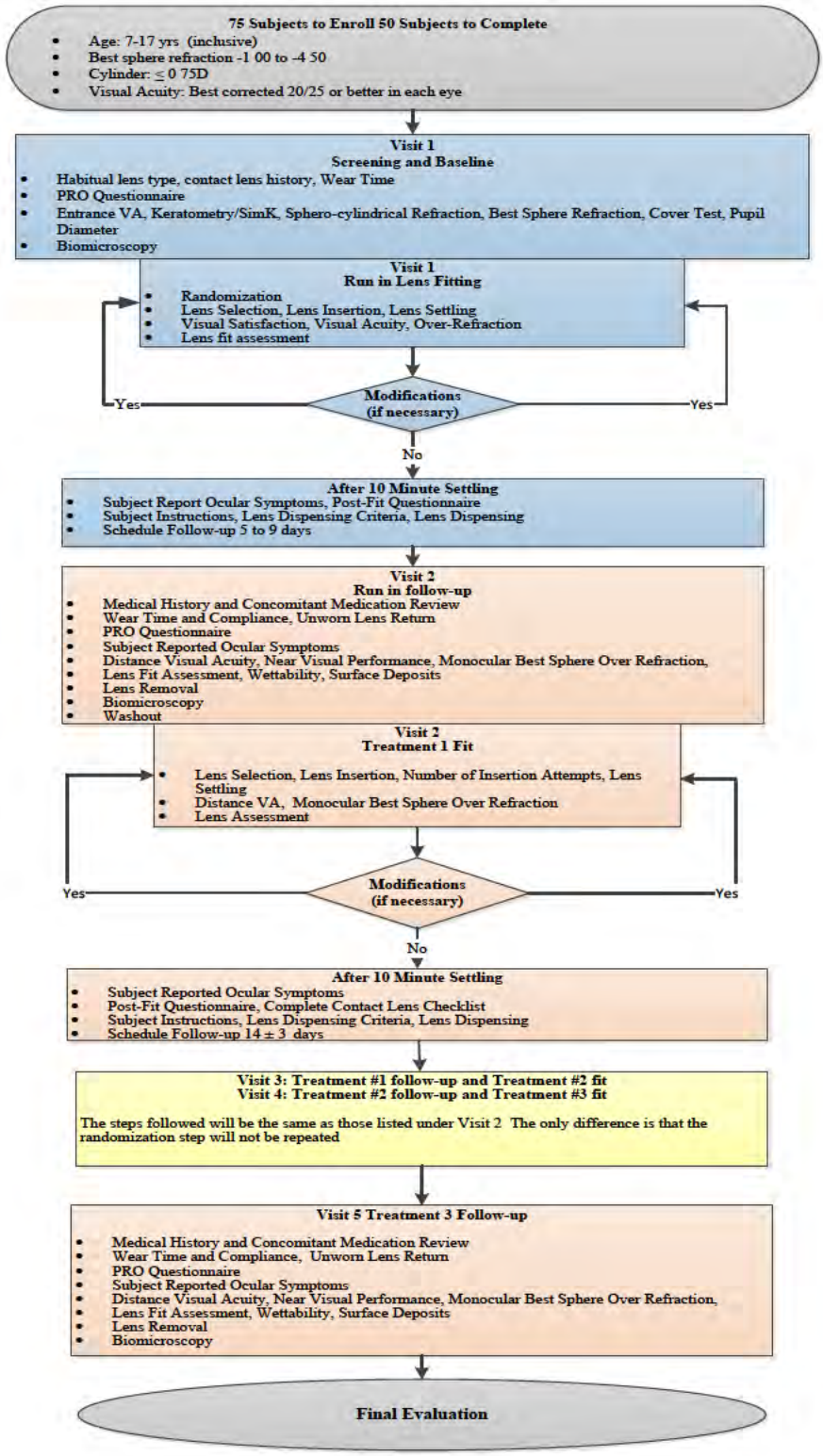
	See the flow chart at the end of the synopsis table for the schematic of the study visits and procedures of main observations (Figure 1).
Sample Size	The goal is to enroll approximately 75 eligible subjects and complete 50. Up to 6 sites are expected to enroll approximately 15 subjects each.
Study Duration	There will be 5 visits in total per subject (not including application and removal training). Total study duration including the enrollment period is expected to be approximately 4 months, with an expected enrollment period of 2 months.
Anticipated Study Population	Healthy male and female subjects between 7 and 17 years old with best sphere refraction from -1.00 to -4.50 D (inclusive) and 0.75 D or less astigmatism will be recruited. The goal is to have the number of 7-12 year old subjects approximately equal to the number of 13-17 year old subjects. Potential subjects can be spectacle lens wearers, current soft lens wearers, or symptomatic myopes (e.g., with complaints of blurry vision) currently without correction. There are no restrictions regarding race/ethnicity of the subjects.
Eligibility Criteria - Inclusion	Potential subjects must satisfy all of the following criteria to be enrolled in the study: Inclusion Criteria following Screening The subject must: 1. Read (or be read to) and sign the CHILDREN'S ASSENT (Information and Assent Form) and receive a fully executed copy of the form. 2. Have parents or legal guardians who must read, understand, and sign the STATEMENT OF INFORMED CONSENT (Parental Permission Form and Authorization to Use and Disclose Medical Information). 3. Appear able and willing to adhere to the instructions set forth in this clinical protocol. 4. Be between 7 and 17 (inclusive) years of age at the time of screening. 5. By self-report, habitually wear soft contact lenses or be a current non-contact lens wearer interested in soft lens wear. Inclusion Criteria following Baseline Evaluation

	6. The non-vertex corrected best sphere distance refraction must be between -1.00 D and -4.50 D (inclusive) in each eye. 7. The magnitude of the cylindrical component of the subject's vertex-corrected distance refraction must be less than or equal to 0.75 D (inclusive) in each eye with any degree of axis. 8. The distance visual acuity with best sphere distance correction must be 20/25 or better in each eye. 9. Have ≤ 1.50 D difference in subjective best-sphere refraction between the two eyes. 10. Have 20/40 or better vision in each eye with wearable spectacles or uncorrected.
Eligibility Criteria – Exclusion	Potential subjects who meet any of the following criteria will be excluded from participating in the study: Exclusion Criteria following Screening The subject must not: 1. Be currently pregnant or lactating. 2. Be diabetic. 3. Be currently using any ocular medications. Lubricants (artificial tears) eyedrops are allowed. 4. Have any current ocular infection of any type. 5. Have any systemic disease (e.g., Sjogren's Syndrome), allergies, infectious disease (e.g., hepatitis, tuberculosis), contagious immunosuppressive diseases (e.g., HIV), autoimmune disease (e.g., rheumatoid arthritis), any underlying medical condition that makes subjects at risk of severe COVID complications, a history of serious mental illness or seizures, or other diseases, by parent or legal guardian's self-report, which are known to interfere with contact lens wear and/or participation in the study. 6. Use of systemic medication (e.g., chronic steroid use) that are known to interfere with contact lens wear and/or participation in the study. See section 9.1 for additional details regarding excluded systemic medications. 7. Have habitually worn rigid gas permeable (RGP) lenses, orthokeratology lenses, or hybrid lenses (e.g. SynergEyes, SoftPerm) within the past 30 days. 8. Be currently wearing lenses in an extended wear modality.

	9. Be currently wearing soft contact lenses for astigmatism in either eye. 10. Have participated in a contact lens or lens care product clinical trial within 7 days prior to study enrollment. 11. Be an employee (e.g., Investigator, Coordinator, Technician) or immediate family member of an employee (including partner, child, parent, grandparent, grandchild or sibling of the employee or their spouse) of the clinical site. 12. Children who are wards of the State or any other agency, institution, or entity. Exclusion Criteria following Baseline Evaluation The subject must not: 13. Have any ocular allergies, infections, or other ocular abnormalities that are known to interfere with contact lens wear and/or participation in the study. This may include, but is not limited to, entropion, ectropion, chalazia, recurrent styes, glaucoma, history of recurrent corneal erosions, aphakia, moderate or above corneal distortion, herpetic keratitis. 14. Have grade 3 or greater palpebral conjunctival observations or any other grade 2 slit lamp findings on the ISO 11980 classification scale. 15. Have strabismus (intermittent or constant) or amblyopia. 16. Have a history or signs of a contact lens-related corneal inflammatory event (e.g., past peripheral ulcer or round peripheral scar). 17. Have any central corneal scar. 18. Have a pupil diameter under bright illumination of less than 2 mm in either eye.
Disallowed Medications/Interventions	See section 9.1 for details regarding disallowed systemic medications.
Measurements and Procedures	Primary endpoint: logMAR Visual Acuity at distance (4 m)
Microbiology or Other Laboratory Testing	None

Study Termination	The occurrence of an Unanticipated Adverse Device Effect (UADE) or Serious Adverse Event (SAE) for which a causal relationship to a test article cannot be ruled out, will result in stopping further dispensing investigational product. In the event of a UADE or SAE, the Sponsor Medical Monitor may unmask the treatment regimen of subject(s) and may discuss this with the Principal Investigator before any further subjects are enrolled. See section 11 for additional study-specific stopping rules.
Ancillary Supplies/ Study-Specific Materials	The following supplies may be provided to the clinical sites as needed: • Lens cases • Fluorescein strips (either 0.6 mg or 1.0 mg) • Precision Vision distance (4 m) high and low contrast ETDRS logMAR visual acuity charts • Precision Vision near (40 cm) high and low contrast ETDRS logMAR visual acuity charts • Precision Vision LED Illuminator Cabinet • Precision Vision large mesopic filter for ETDRS Illuminator Cabinet • Sekonic light meter
Principal Investigator(s) and Study Institution(s)/Site(s)	A full list of Principal Investigators, clinical sites, and institutions is kept separately from the Study Protocol and is included in the study Trial Master File.

Figure 1: Study Flowchart



COMMONLY USED ABBREVIATIONS, ACRONYMS AND DEFINITIONS OF TERMS

ADE	Adverse Device Effect
ADHD	Attention Deficit Hyperactivity Disorder
AE	Adverse Event/Adverse Experience
BSCVA	Best Spectacle Corrected Visual Acuity
CFR	Code of Federal Regulations
CLUE	Contact Lens User Experience
COM	Clinical Operations Manager
COVID-19	Coronavirus Disease 2019
CRA	Clinical Research Associate
CRF	Case Report Form
CRO	Contract Research Organization
[redacted]	[redacted]
D	Diopter
DMC	Data Monitoring Committee
eCRF	Electronic Case Report Form
EDC	Electronic Data Capture
ETDRS	Early Treatment Diabetic Retinopathy Study
FDA	Food and Drug Administration
GCP	Good Clinical Practice
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
IB	Investigator's Brochure
ICH	International Council for Harmonization
IDE	Investigational Device Exemption
IEC	Independent Ethics Committee
IRB	Institutional Review Board
ISO	International Organization for Standardization
ITT	Intent-to-Treat
JJVC	Johnson & Johnson Vision Care, Inc.
LASIK	Laser-Assisted in Situ Keratomileusis
LogMAR	Logarithm of Minimal Angle of Resolution
OD	Right Eye
OS	Left Eye
OU	Both Eyes
PIG	Patient Instruction Guide
PQC	Product Quality Complaint
PRK	Photorefractive Keratectomy
PRO	Patient Reported Outcome
QA	Quality Assurance
SAE	Serious Adverse Event/Serious Adverse Experience
SAP	Statistical Analysis Plan
SAS	Statistical Analysis System
SD	Standard Deviation

UADE	Unanticipated Adverse Device Effect
USADE	Unanticipated Serious Adverse Device Effect
VA	Visual Acuity

1. INTRODUCTION AND BACKGROUND

The MiSight® 1 day is the only current soft contact lens with a US-FDA indication to slow the progression of myopia (nearsightedness) in children between the ages of 8 and 12 years old at the initiation of treatment. Johnson and Johnson Vision Care (JJVC) has developed a series of soft contact lens prototypes with novel optical designs that aim to maximize myopia control efficacy while minimizing potential visual impact. The EMO-118 design was efficacious in slowing refractive error progression and axial elongation in children between 7 and 12 years of age after 6 months of wear ([redacted]) and is being confirmed in a longer-term myopia control clinical trial ([redacted]). The EMO-114 design was efficacious in slowing axial elongation and performed similarly to EMO-116, a dual focus myopia control design, but did not demonstrate a statistically significant reduction in refractive error progression at 6 months ([redacted]).[5,6] EMO-114 did, however, minimize the potential visual impact and provided objective and subjective visual performance that approached a control lens with conventional optics. This study will assess the visual performance of these EMO-118 and EMO-114 in neophyte and habitual soft contact lens wearers compared to a marketed control indicated to slow the progression of myopia.

1.1. Name and Descriptions of Investigational Products

One commercially available marketed product with conventional optics (1-DAY ACUVUE® MOIST) will be used during the study run-in period for neophyte and existing soft contact lens wearers.

This study will test two senofilcon A-C3 design prototypes with varying myopia control optical designs (Test 1 and Test 2) and one commercially available marketed product for myopia control (Control). Both Test lenses are senofilcon A-C3 prototypes and use the same manufacturing process as the ACUVUE OASYS® Brand Contact Lenses with HydraLuxe™ Technology (AO1D; cleared by FDA under K042275). The Test lenses have a smaller lens diameter and a steeper base curve compared to the AO1D to facilitate lens application while maintaining a well-centered fit in children. While both Test lenses have myopia control optical designs, the EMO-114 lens has a larger optical zone, no central myopic defocus dot and reduced dioptric power within the myopia control zones. The Control lens is manufactured in omafilcon A material and features two concentric zones to create myopic defocus.

Further details about the test articles are found in section 6 of this protocol. For detailed information regarding the investigational products, refer to the latest version of the Investigator's Brochure for EMO Design Family Lenses and the package insert of the marketed products.[7]

1.2. Intended Use of Investigational Products

The intended use of the investigational products is for correcting myopia and slowing the progression of myopia in children. For this study, however, slowing the progression of myopia is not a study endpoint and the duration of test article wear may not produce a lasting effect. During the study, each test article will be worn bilaterally in daily wear, daily disposable

modality for at least 8 hours per day. The subject will wear each investigational product for one wearing period.

1.3. Summary of Findings from Nonclinical Studies

All previous pre-clinical findings were deemed satisfactory prior to proceeding with clinical trials on humans. For the most comprehensive nonclinical information regarding EMO-114 and EMO-118 refer to the latest version of the Investigator's Brochure for EMO Design Family Lenses.[7]

1.4. Summary of Known Risks and Benefits to Human Subjects

The anticipated clinical benefit of the investigational lenses during this study will be the correction of refractive error. While the Test and Control lenses feature myopia control optical designs, the duration of wear during the study is may not be sufficient to produce a lasting reduction in a subject's axial length and myopia control efficacy is not an endpoint of this study. Other potential benefits are that soft contact lenses (conventional and myopia control) have shown better subjective performance versus glasses regarding appearance, satisfaction, social self-perception, and willingness to try new activities.[8]

The anticipated risks associated with the use of the investigational lenses are considered to be the same as those for any other soft contact lens worn in the same modality (i.e. daily disposable wear) and within the same population.

While the target population for this study is children (<18 years), not adults, clinical research has generally supported that younger children can successfully and safely wear soft contact lenses .[9-12] While contact lens wear is less common in children than adults, studies assessing adverse event rates have concluded that the adverse event rates in children are similar to established rates among adults wearing soft contact lenses .[9,10] A thorough review of the risks and benefits of myopia control concluded that the incidence of corneal infiltrative events and microbial keratitis in children 12 years of age and younger is no higher than that observed in adults, and may be lower.[9] Furthermore, all investigational lenses used in this study will be used in a daily wear, daily disposable modality, which reduces lens care burden and avoids potential contamination from the storage case, a known risk factor for microbial keratitis.[13,14]

Another known risk is that the optical design of myopia control soft contact lenses may not provide equivalent vision quality to a conventional spherical lens design. While minimal difference has been measured between optical designs using high contrast visual acuity, reductions in low contrast and/or low luminance conditions have been reported.[15] While the visual experience with a soft myopia control contact lens may be different, children using MiSight 1 Day have subjectively rated their overall vision similarly to a parallel control group using single vision spectacles after 12 and 24 months of wear .[8] To manage this risk, the protocol is designed to ensure that each subject meets a minimum visual acuity and reports acceptable subjective vision prior to study contact lens dispense.

No additional risks associated with participation in this investigation are anticipated.

For the most comprehensive risk and benefit information regarding the EMO lenses refer to the latest version of the Investigator's Brochure for EMO Design Family Lenses and the package insert of the marketed products.

1.5. Relevant Literature References and Prior Clinical Data Relevant to Proposed Clinical Study

The review of the scientific literature examined the current state of published information of contact lens safety and myopia control with soft contact lenses. Potential applicable literature was identified through a literature search on PubMed.org dated since 1980's, as well as through examination of review articles published on the subject. A list of relevant literature references is provided in latest version of the Investigator's Brochure for EMO Design Family Lenses.

To date, there have been five clinical studies completed involving the EMO-118 or EMO-114 lenses ( ) and there is one additional study that is ongoing ( ). (adult) and (pediatric) were both non-dispensing pilot studies with a primary objective of evaluating the visual performance of multiple EMO lens design prototypes. was a non-dispensing study including pediatric and young adult subjects assessing the accommodative response with multiple EMO optical designs. and (ongoing) were myopia control efficacy clinical trials in 7-12 year old children with lenses dispensed for 6-months and, at a minimum, 3 years, respectively. While included both EMO-118 and EMO-114, only EMO-118 was included in . Lastly, is an ongoing pediatric non-dispensing clinical study evaluating the vision performance and lens fit acceptance.[5,6,16-19]

For detailed information regarding prior clinical data refer to the latest version of the Investigator's Brochure for EMO Design Family Lenses and the package insert of the marketed products.[7]

2. STUDY OBJECTIVES, ENDPOINTS AND HYPOTHESES

2.1. Objectives

Primary Objective

The primary objective is to evaluate the logMAR visual performance of soft contact lenses featuring myopia control optical designs.

Exploratory Objectives

The exploratory objectives of the study are to assess:

- logMAR visual performance at 4 m under varying luminance and contrast conditions
- logMAR visual performance at 40 cm under high and low contrast conditions
- Patient-reported outcomes at fitting and follow-up
- Assess safety through adverse events, slit lamp findings, and subject-reported ocular symptoms
- Number of power modifications and over-refraction with first trial lens at fitting

- Over-refraction at follow-up
- Lens fitting characteristics

2.2. Endpoints

Primary efficacy endpoint:

- Binocular distance (4 m) high luminance high contrast (HLHC) logMAR visual acuity, measured per [redacted]

Primary safety endpoint:

- Number (n, %) of subjects and eyes with contact lens related (i.e., related and possibly related) serious and significant ocular adverse events (AEs), including best corrected logMAR loss ≥ 0.20 logMAR (10 letters).

Other exploratory endpoints:

- Monocular HLHC logMAR visual acuity at 4 m
- Binocular high luminance low contrast (HLLC) logMAR visual acuity at 4 m
- Monocular HLLC logMAR visual acuity at 4 m
- Binocular low luminance high contrast (LLHC) logMAR visual acuity at 4 m
- Monocular LLHC logMAR visual acuity at 4 m
- Binocular HLHC logMAR visual acuity at 40 cm
- Binocular HLLC logMAR visual acuity at 40 cm
- Subjective vision, comfort, and ease of handling
- Non-significant AEs and non-ocular AEs
- Slit lamp findings per the ISO 11980 grading scale
- Subject-reported ocular symptoms
- Number of contact lens insertion attempts per eye at fitting
- Subjective best sphere over-refraction with the first trial lens
- Subjective best sphere over-refraction at follow-up
- Number of power modifications at fitting
- Lens fitting characteristics

2.3. Hypotheses

The primary hypothesis must be met to satisfy the objective of the study.

Primary Hypothesis

1. The distance (4 m) binocular high luminance high contrast visual acuity (in logMAR) with EMO-118 will be non-inferior to that of MiSight at follow-up visit. A non-inferiority margin of 0.05 logMAR will be used.

Other Exploratory Hypotheses

1. The distance (4 m) binocular high luminance high contrast visual acuity (in logMAR) with EMO-114 will be superior to that of EMO-118 at follow-up visit.
2. The distance (4 m) binocular high luminance high contrast visual acuity (in logMAR) with EMO-114 will be superior to that of MiSight at follow-up visit.

3. TARGETED STUDY POPULATION

3.1. General Characteristics

Healthy male and female subjects between 7 and 17 years old with best sphere refraction from -1.00 to -4.50 D (inclusive) and 0.75 D or less astigmatism will be recruited. The goal is to have the number of 7-12 year old subjects approximately equal to the number of 13-17 year old subjects, which will be stratified per site. Potential subjects can be spectacle lens wearers, current soft lens wearers, or symptomatic myopes (e.g., with complaints of blurry vision) currently without correction. There are no restrictions regarding race/ethnicity of the subjects.

3.2. Inclusion Criteria

Potential subjects must satisfy all of the following criteria to be enrolled in the study:

Inclusion Criteria following Screening
The subject must:

1. Read (or be read to) and sign the CHILDREN'S ASSENT (Information and Assent Form) and receive a fully executed copy of the form.
2. Have parents or legal guardians who must read, understand, and sign the STATEMENT OF INFORMED CONSENT (Parental Permission Form and Authorization to Use and Disclose Medical Information).
3. Appear able and willing to adhere to the instructions set forth in this clinical protocol.
4. Be between 7 and 17 (inclusive) years of age at the time of screening.
5. By self-report, habitually wear soft contact lenses or be a current non-contact lens wearer interested in soft lens wear.

Inclusion Criteria following Baseline Evaluation

6. The non-vertex corrected best sphere distance refraction must be between -1.00 D and -4.50 D (inclusive) in each eye.
7. The magnitude of the cylindrical component of the subject's vertex-corrected distance refraction must be less than or equal to 0.75 D (inclusive) in each eye with any degree of axis.
8. The distance visual acuity with best sphere distance correction must be 20/25 or better in each eye.
9. Have ≤ 1.50 D difference in subjective best-sphere refraction between the two eyes.
10. Have 20/40 or better vision in each eye with wearable spectacles or uncorrected.

3.3. Exclusion Criteria

Potential subjects who meet any of the following criteria will be excluded from participating in the study:

Exclusion Criteria following Screening
The subject must not:

1. Be currently pregnant or lactating.
2. Be diabetic.
3. Be currently using any ocular medications. Lubricants (artificial tears) eyedrops are allowed.
4. Have any current ocular infection of any type.
5. Have any systemic disease (e.g., Sjogren's Syndrome), allergies, infectious disease (e.g., hepatitis, tuberculosis), contagious immunosuppressive diseases (e.g., HIV), autoimmune disease (e.g., rheumatoid arthritis), any underlying medical condition that makes subjects at risk of severe COVID complications, a history of serious mental illness or seizures, or other diseases, by parent or legal guardian's self-report, which are known to interfere with contact lens wear and/or participation in the study.
6. Use of systemic medication (e.g., chronic steroid use) that are known to interfere with contact lens wear and/or participation in the study. See section 9.1 for additional details regarding excluded systemic medications.
7. Have habitually worn rigid gas permeable (RGP) lenses, orthokeratology lenses, or hybrid lenses (e.g. SynergEyes, SoftPerm) within the past 30 days.
8. Be currently wearing lenses in an extended wear modality.
9. Be currently wearing soft contact lenses for astigmatism in either eye.
10. Have participated in a contact lens or lens care product clinical trial within 7 days prior to study enrollment.
11. Be an employee (e.g., Investigator, Coordinator, Technician) or immediate family member of an employee (including partner, child, parent, grandparent, grandchild or sibling of the employee or their spouse) of the clinical site.
12. Children who are wards of the State or any other agency, institution, or entity.

Exclusion Criteria following Baseline Evaluation

The subject must not:

13. Have any ocular allergies, infections, or other ocular abnormalities that are known to interfere with contact lens wear and/or participation in the study. This may include, but is not limited to, entropion, ectropion, chalazia, recurrent styes, glaucoma, history of recurrent corneal erosions, aphakia, moderate or above corneal distortion, herpetic keratitis.
14. Have grade 3 or greater palpebral conjunctival observations or any other grade 2 slit lamp findings on the ISO 11980 classification scale.
15. Have strabismus (intermittent or constant) or amblyopia.
16. Have a history or signs of a contact lens-related corneal inflammatory event (e.g., past peripheral ulcer or round peripheral scar).

17. Have any central corneal scar.
18. Have a pupil diameter under bright illumination of less than 2 mm in either eye.

3.4. Enrollment Strategy

Study subjects will be recruited from the Institution/clinical site's subject database and/or utilizing Independent Ethics Committee (IEC) or Institutional Review Board (IRB) approved materials.

The goal is to enroll approximately 75 eligible subjects and complete 50. Up to 6 sites are expected to enroll approximately 15 subjects each. The preferred ratio for the number of subjects in the two age groups (7 -12 years and 13- 17 years) is 1:1 within each site.

4. STUDY DESIGN AND RATIONALE

4.1. Description of Study Design

This is a multi-center, randomized, subject-masked, bilateral, 3x3 crossover dispensing study including a run-in period. Once the subjects complete the run-in period, they will be randomized to one of six lens wear sequences. Subjects will be bilaterally fitted with one of the three test articles in each of the three study periods. Investigational lenses should be worn for a minimum of 10 days and 8 hours per day. Subjects will not have access to the test articles at study closure.

At Visit 1 if subjects meet all eligibility criteria, then they will be fitted with the run-in lens. Application and removal training must be completed and the other requirements met before lenses are dispensed, either at V1 or at a subsequent unscheduled visit. The visit window for visit 2 will be calculated from the date of the run-in contact lens dispense.

At Visit 2, after undergoing all the assessments for the run-in lens follow-up, the run-in lens will be removed, and subjects will be randomized to one of six lens wear sequences. Subjects will be fitted in a bilateral fashion in their first study lens per the randomization scheme. Follow-up evaluation on the first lens will be after approximately 2 weeks of lens wear. After undergoing all follow-up assessments, the study lens will be removed, and subjects will be fit with the next lens per the randomization schedule.

This process will be repeated until the subjects have worn all three test articles.

4.2. Study Design Rationale

This study is to evaluate logMAR visual performance of three soft contact lenses featuring myopia control optical designs using a 3×3 crossover design. Crossover designs are well-established and expose subjects to multiple treatments during different time periods. This design is cost effective and efficient since it eliminates between-subject variability from the treatment comparisons. A limitation of crossover design is the potential for carryover effects between treatments. Since the primary endpoint of logMAR visual acuity is an objective measure, a carryover effect is less concerning. All subjects will begin with a run-in period

using a single vision contact lens design to allow both new and existing contact lens wearers to enter the study and acclimate to a similar contact lens design.

4.3. Enrollment Target and Study Duration

Approximately 75 subjects will be enrolled in the study with a minimum of 50 subjects targeted to complete the study. The study will be conducted at up to six clinical sites, where the enrollment target for each site will be approximately 15 subjects with a minimum of 10 subjects completing the study. The point of study enrollment is defined as the execution of the informed consent and assent at Visit 1. Subjects will be stratified at each site by age so that the number of children from 7-12 years old is approximately equal to those 13-17 years old.

There will be 5 visits in total per subject (not including application and removal training). Total study duration including the enrollment period is expected to be approximately 4 months, with an expected enrollment period of 2 months. Subjects who are discontinued prior to the final evaluation will not be replaced. The investigation will end at the time that the study data is hard locked.

5. TEST ARTICLE ALLOCATION AND MASKING

5.1. Test Article Allocation

The three study lenses (Test1, Test2, and Control) will be worn in a bilateral and random fashion using a 3×3 crossover design with 3 lens types and 3 periods. Use of the test articles will be randomized using a lens fitting schedule supplied by the study biostatistician. The clinical site will follow the lens fitting schedule provided and will complete enrollment according to the randomization list and will not pre-select or pre-assign subjects.

Randomly-permuted block randomization will be used to avoid bias in the assignment of subjects to treatment and to enhance the validity of statistical comparisons across treatment groups. Each subject will begin with a run-in period using a single vision contact lens design (run-in lens: 1 Day Acuvue Moist) and then will be randomly assigned to one of six unique sequences of the three lens types (Test1/Test2/Control, Test1/Control /Test2, Test2/Test1/Control, Test2/Control /Test1, Control/Test1/Test2, Control/Test2/Test1) using a 3×3 Williams design which is balanced for first-order carryover effects. Each block will contain these six different lens trial sequences.[20] The randomization will be stratified by site and age (7 – 12 years old and 13- 17 years old). The preferred ratio for the number of subjects in the two age groups is 1:1 within each site. The randomization scheme will be generated using the PROC PLAN procedure in Statistical Analysis System (SAS) Software Version 9.4 or higher (SAS Institute, Cary, NC, USA).[21]

Randomization will be performed at visit 1. The following must have occurred prior to randomization:

- Informed consent must have been obtained.

- The subject must have met all eligibility criteria.
- The subject's screening and baseline information must have been collected.

When dispensing test articles, the following steps should be followed to maintain randomization codes:

1. Investigator or designee (documented on the Delegation Log) will consult the lens fitting schedule to obtain the test article assignment for that subject prior to dispensing.
2. Investigator or designee will record the subject's number on the appropriate line of the lens fitting schedule.
3. Investigator or designee will pull the appropriate test articles from the study supply. All test articles that are opened, whether dispensed (placed/fit on eye or dispensed outside the clinical site) or not, must be recorded on the Test Article Accountability Log in the "Dispensed" section.

5.2. Masking

This is a single-masked study with the subjects being masked. The subjects will not be told any information regarding the optical designs of the lenses beyond that they are intended to correct for their refractive error and feature myopia control optics. The investigators cannot be completely masked to the identity of the investigational lenses because there will be more than one fitting guide used and the fitting guide is specific to the lens design.

5.3. Procedures for Maintaining and Breaking the Masking

The identity of the study lenses will be masked by having the blister packs labeled with the study number, lot number, sphere power, expiration date and the randomization codes. The medical monitor will have access to the decode information in case breaking the mask is necessary for the urgent medical treatment of a subject.

Under normal circumstances, the mask should not be broken until all subjects have completed the study and the database is finalized. Otherwise, the mask should be broken only if specific emergency treatment/course of action would be dictated by knowing the treatment status of the subject. In such cases, the investigator may, in an emergency, contact the medical monitor. In the event the mask is broken, the sponsor must be informed as soon as possible. The date, time, and reason for the unmasking must be documented in the subject record. The investigator is also advised not to reveal the study treatment assignment to the clinical site or sponsor personnel.

Subjects who have had their treatment assignment unmasked are expected to return for all remaining scheduled evaluations. Subjects who are discontinued will not be replaced.

6. STUDY INTERVENTION

6.1. Identity of Test Articles

The following contact lenses will be used in this study:

Table 1: Test Articles

	Run-in	Test 1	Test 2	Control
Test Article Form	Soft contact lens			
Design / Description	1 Day Acuvue Moist	EMO-118	EMO-114	MiSight 1 Day
Assigned Lens Code	A	K	H	P
Manufacturer	Johnson & Johnson Vision Care, Inc.			CooperVision
Packaging Form	Blister packaging in sterile packing solution			
Packing Solution	Optimized Borate Buffer (OBB) solution			Buffered isotonic saline solution
Lens Material	Etafilcon A	senofilcon A (C3)	senofilcon A (C3)	Omafilcon A
Sphere Powers (DS)	-1.00 to -5.00 in 0.25 steps			
Nominal Base Curve (mm)	8.5	7.9	7.9	8.7
Nominal Lens Diameter (mm)	14.2	13.8	13.8	14.2
Dk (Fatt method, boundary corrected, edge corrected, $\times 10^{-11}$ [cm^2 /sec] [ml O_2/ml × mm Hg] at 35°C)	28	103	103	26
Optical design	Single vision	Myopia control	Myopia control	Myopia control
Wear Modality in Current Study	Daily wear			
Replacement Frequency	Daily disposable			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Each subject will wear approximately 7 lenses per eye of the run-in lens over approximately 1 week. Each subject will wear approximately 14 lenses per test article per eye over approximately 2 weeks of daily disposable wear. For a total enrollment of 75 subjects and 4 test articles (including the run-in lens), approximately 7350 lenses will be used.

6.2. Ancillary Supplies/Products

The following solutions may be used in this study:

Table 2: Ancillary Supplies

	Non-Preserved Rewetting Drops		
Solution Name/Description	Single use Eye-Cept® Rewetting Drops	LacriPure Saline Solution	ScleralFil Preservative Free Saline Solution
Manufacturer	Optics Laboratory	Menicon	Bausch & Lomb
Preservative	None	None	None

The following supplies may be provided to the clinical sites as needed:

- Lens cases
- Fluorescein strips (either 0.6 mg or 1.0 mg)
- Precision Vision distance (4 m) high and low contrast ETDRS logMAR visual acuity charts
  - HC-1 (2214), HC-2 (2214-A), HC-3 (2114B), HC-4 (2114C)
  - LC-1 (2164), LC-2 (2164A)
- Precision Vision near (40 cm) high and low contrast ETDRS logMAR visual acuity charts
  - HC-1 (2106C)
  - LC-1 (2118)
- Precision Vision LED Illuminator Cabinet
- Precision Vision large mesopic filter for ETDRS Illuminator Cabinet
- Sekonic light meter
- Neuroptics VIP 300 pupillometer

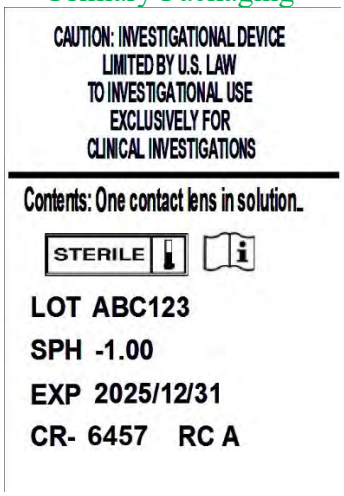
6.3. Administration of Test Articles

Test articles will be dispensed to subjects meeting all eligibility requirements, including any dispensing requirements set forth in this clinical protocol. Subjects will be dispensed an adequate supply of test articles to complete the study. Lost or damaged test articles may be replaced at the discretion of the investigator and/or the sponsor.

6.4. Packaging and Labeling

The test articles will be packaged in blisters as the primary packaging. The test article will be over-labeled to mask the subject and investigators to the identity of the lens. The test articles will be in plastic bags as the secondary packaging form. The sample study label is shown below:

Primary Packaging



Secondary Packaging

6.5. Storage Conditions

Test articles will be maintained at ambient temperatures at the clinical site. Test articles must be kept under secure conditions.

6.6. Collection and Storage of Samples

No samples will be collected as part of the study procedures. When possible, any lens or test article associated with an Adverse Event and/or a Product Quality Complaint must be retained and stored in a glass vial with moderate solution pending directions from the sponsor for potential return to JJVC.

6.7. Accountability of Test Articles

JJVC will provide the Investigator with sufficient quantities of study articles and supplies to complete the investigation. The Investigator is asked to retain all lens shipment documentation for the test article accountability records.

Test articles must be kept in a locked storage cabinet, accessible only to those assigned by the Investigator for dispensing. The Investigator may delegate this activity to authorized study site personnel listed on the Site Delegation Log. All test articles must be accounted. This includes:

1. What was dispensed for the subject for trial fitting, to wear out of the office, or issued for the subject to replace appropriately between visits.
2. What was returned to the Investigator unused, including expired or malfunctioning product.
3. The number and reason for unplanned replacements.

The Investigator will collect all unused test articles from the subjects at the end of the subject's participation. Subject returned unused test articles must be separated from the clinical study inventory of un-dispensed test articles and must be labeled with the subject number and date of return. Following final reconciliation of test articles by the monitor, the Investigator or monitor will return all unused test articles to JJVC.

If there is a discrepancy between the shipment documents and the contents, contact the study monitor immediately.

[redacted]

7. STUDY EVALUATIONS

7.1. Time and Event Schedule

Table 3: Time and Events

Visit Information	Visit 1 Screening, Baseline, Fit Run-in lens	Visit 2 Follow-up and new lens fit	Visits 3-4 Follow-up and new lens fit	Visit 5 Follow-up, Final Evaluation
Time Point	Day 0	7 ± 2 days following run-in lens dispense	14 ± 3 days following prior visit	14 ± 3 days following Visit 4
Minimum lens wear time immediately prior to visit	Not applicable	1 hour	1 hour	1 hour
Estimated Visit Duration	2.5 hours	1.5 hours	1.5 hours	1.0 hours
Statement of Informed Consent	X			
Demographics	X			
Medical History/Concomitant Medications	X	X	X	X
Habitual Contact Lens Information	X			
Eligibility Following Screening	X			
Lens wear compliance and unworn lens return		X	X	X
Baseline Questionnaires	X			
Follow-up Questionnaires		X	X	X
Subject-reported ocular symptoms		X	X	X
Entrance Visual Acuity	X			
Distance logMAR VA		X	X	X
Near logMAR VA		X	X	X
Keratometry/SimKs	X			

Visit Information	Visit 1 Screening, Baseline, Fit Run-in lens	Visit 2 Follow-up and new lens fit	Visits 3-4 Follow-up and new lens fit	Visit 5 Follow-up, Final Evaluation
Time Point	Day 0	7 ± 2 days following run-in lens dispense	14 ± 3 days following prior visit	14 ± 3 days following Visit 4
Minimum lens wear time immediately prior to visit	Not applicable	1 hour	1 hour	1 hour
Estimated Visit Duration	2.5 hours	1.5 hours	1.5 hours	1.0 hours
Subjective Sphero-Cylindrical Refraction and best-corrected VA	X			
Subjective Best Sphere Refraction	X			
Distance spherocylindrical logMAR VA	X	X	X	X
Cover test	X			
Pupil diameter	X			
General Lens Fit Assessment	X	X	X	X
Wettability Characteristics		X	X	X
Surface Deposits		X	X	X
Lens Removal		X	X	X
Slit Lamp Biomicroscopy	X	X	X	X
Eligibility Following Baseline Evaluation	X			
Lens Selection	X	X	X	
Lens Insertion & Settling	X	X	X	
Visual Acuity and Over Refraction	X	2X	2X	X
Lens fit assessment		X	X	
Lens Power Modification (if applicable)	X	X	X	
Subject Reported Ocular Symptoms	X	2X	X	X
Post Fit Questionnaires	X	X	X	
Dispense Patient Instruction Guide	X			
Dispense Test Article	X	X	X	
Study Completion				X

7.2. Detailed Study Procedures

VISIT 1

Subjects should bring spectacles with them to Visit 1, if applicable. The subjects must present to Visit 1 wearing spectacles or uncorrected, not having worn contact lenses on the day of the visit.

Visit 1: Screening			
Step	Procedure	Details	[redacted]
1.1	Statement of Informed Consent & Children's Assent	Each subject's parent or legal guardian must read, understand, and sign the Statement of Informed Consent (Parental Permission Form and Authorization to Use and Disclose Medical Information), and each subject must read (or be read to), understand and sign the Information and Assent Form before the subject is enrolled into the study. The Principal Investigator or his/her designee conducting the informed consent discussion must also sign the Consent and Assent forms. ***Note:*** *The subject and parent (legal guardian) must be provided a signed copy of both documents.*	
1.2	Demographics	Record the subject's year of birth, age, gender, race and ethnicity.	
1.3	Medical History and Concomitant Medications	Record the subject's medical history and concomitant medications.	
1.4	Habitual Contact Lenses (if applicable)	Record the subject's habitual lens type, parameters, lens care solution (if applicable), wear modality and approximate prescription date.	
1.5	Habitual Lens Wear Time (if applicable)	Record the subject's duration of lens wear in years and months, minimum days worn per week, and average daily wear time for their habitual lenses.	

Visit 1: Screening			
Step	Procedure	Details	[redacted]
1.6	Eligibility after Screening	All responses to Screening Inclusion Criteria questions must be answered "yes" and all responses to Exclusion Criteria must be answered "no" for the subject to be considered eligible. ***Note:*** *If subject is deemed to be ineligible after screening, proceed to Final Evaluation and complete Subject Disposition. Refraction and Biomicroscopy forms are not required.*	

Visit 1: Baseline			
Step	Procedure	Details	[redacted]
1.7	PRO Questionnaire (PROMIS PGH7 only)	Subjects will complete a PRO questionnaire.	
1.8	Entrance Visual Acuity	Record the monocular distance Snellen visual acuity for each eye (OD, OS) to the nearest letter with the subject's habitual eyeglasses or uncorrected. Subjects must continue until at least 50% of the letters on a line are read incorrectly. *Note: Subject must have 20/40 or better vision in each eye with habitual spectacles or uncorrected.*	[redacted]
1.9	Keratometry/SimK	Record the keratometry or SimK readings OD and OS in diopters.	
1.10	Subjective Sphero-cylindrical Refraction	Complete subjective spherocylindrical refraction and record the resultant distance visual acuity (OD, OS) to the nearest letter.	[redacted]
1.11	Subjective Best Sphere Refraction	Perform subjective best sphere refraction with a phoropter (adopt the maximum plus to maximum visual acuity (MPMVA) approach and record the best corrected distance visual acuity (OD, OS) to the nearest letter.	[redacted]

<table>
<tr><th colspan="4">Visit 1: Baseline</th></tr>
<tr><th>Step</th><th>Procedure</th><th>Details</th><th>[redacted]</th></tr>
<tr><td>1.12</td><td>Distance logMAR VA with spherocylindrical prescription</td><td>Measure distance ETDRS logMAR visual acuity at a 4 meter (m) distance with spherocylindrical prescription in a trial frame using the conditions and charts shown in the table below:

<table><tr><td>Distance</td><td>4 m</td><td>4 m</td></tr><tr><td>Condition</td><td>HLHC</td><td>HLHC</td></tr><tr><td>Room illumination</td><td>686-788 lux</td><td>686-788 lux</td></tr><tr><td>Chart luminance</td><td>181-208 cd/m^2</td><td>181-208 cd/m^2</td></tr><tr><td>Eye</td><td>OD</td><td>OS</td></tr><tr><td>Charts (Numbers)</td><td>HC-3 (2114B)</td><td>HC-4 (2114C)</td></tr></table></td><td>[redacted]</td></tr>
<tr><td>1.13</td><td>Cover Test</td><td>Perform distance and near cover-uncover test to rule out the presence of strabismus. Subject must be wearing distance vision correction during cover test assessment.</td><td>[redacted]</td></tr>
<tr><td>1.14</td><td>Pupil Diameter</td><td>Measure pupil diameter (one measurement per eye per condition) under the following two lighting conditions:

• dim illumination (1.4-1.6 lux, or -0.8 to -0.6 EV), 4 meters away from a low luminance (2.5-2.8 cd/m2 , or 4.3-4.5 EV), high contrast chart (LLHC, with a mesopic filter)
• bright illumination (686-788 lux, or 8.1-8.3 EV), 4 meters away from a high luminance (181-208 cd/m2 , or 10.5-10.7 EV), high contrast chart (HLHC)

Note: Subjects with pupil diameter less than 2mm under the bright illumination in either eye will be discontinued from the study</td><td></td></tr>
</table>

Visit 1: Baseline			
Step	Procedure	Details	[redacted]
1.15	Slit Lamp Biomicroscopy	Slit Lamp Classification Scale per ISO 11980 will be used to grade the findings. If the clearance of the fluorescein needs to be expedited, preservative-free rewetting drops or saline may be instilled. ***Note:*** *Except for subjects with Grade 2 palpebral conjunctival observations that are eligible to be enrolled, if any other slit lamp finding (per ISO 11980) is graded as 2 or worse, the subject may not continue at this time, but may return up to one additional time to determine eligibility. If the subject is discontinued from the study, Final Evaluation must be completed.* *If the clearance of the fluorescein needs to be expedited, preservative-free rewetting drops or saline may be instilled.*	
1.16	Eligibility after Baseline	All responses to Inclusion Criteria questions must be answered "yes" and all responses to Exclusion Criteria questions must be answered "no" for the subject to be considered eligible. ***Note:*** *If subject is deemed to be ineligible after baseline, proceed to Final Evaluation and complete Subject Disposition. Refraction and Biomicroscopy forms do not need to be completed as part of Final Evaluation.*	

Visit 1: Run-in Lens Fitting			
Step	Procedure	Details	[redacted]
1.17	Randomization	Record the randomization ID.	
1.18	Lens Selection	Select the appropriate power of the run-in lens based on subjective best sphere refraction and adjust for vertex distance to the corneal plane if needed (< -4.00 D).	

Visit 1: Run-in Lens Fitting			
Step	Procedure	Details	[redacted]
1.19	Lens Insertion	The Investigator applies the study lenses. If a lens is uncomfortable, inspect for damage and remove, reinsert or replace as necessary. Check for lens damage under the slit lamp before proceeding with lens settling. Replace damaged lenses if applicable. Record the time of lens insertion. Ensure the subject is given a Patient Instruction Guide.	
1.20	Lens Settling	Allow the study lenses to settle for a minimum of 10 minutes.	
1.21	Lens-on-eye Distance VA	Record the distance Snellen visual acuity (OD, OS) to the nearest letter with the study lenses in place. Subjects must read the smallest line until at least 50% of the letters are read incorrectly.	[redacted]
1.22	Monocular Subjective Best Sphere Over Refraction	Perform monocular subjective best sphere refraction over the study lenses with a phoropter. • Reduce minus (add plus) in 0.25 D steps if there is no decrease in visual acuity and no subjective vision reduction. • Increase minus in 0.25 D steps if it significantly improves distance vision. • Record the spherical power and the resultant distance visual acuity to the nearest letter (OD, OS).	[redacted]
1.23	General Lens Fit Assessment	Evaluate lens centration, movement on blink, and push-up test for each eye. An unacceptable fit is deemed by one of the following criteria: • limbal exposure at primary gaze or with extreme eye movement. • edge lift.	[redacted]

Visit 1: Run-in Lens Fitting			
Step	Procedure	Details	[redacted]
		• excessive movement in primary and up gaze. • insufficient movement in all three of the following conditions: primary gaze, up gaze, and push-up test. *Note: if lens fit is unacceptable for either eye, the subject will be discontinued from the study.*	
1.24	Lens Power Modification (if applicable)	Adjust the lens power if the monocular best sphere over-refraction is not plano (0.00 D) and the modification improves vision (objectively or subjectively). For each power modification, select the new lens power as appropriate and repeat the steps beginning with right lens insertion. A maximum of 2 lens modifications are allowed per eye. If, for either eye, the fit is not successful after 2 modifications, the subject will be discontinued (proceed to final evaluation.	
1.25	Subject Reported Ocular Symptoms	Subjects will respond to a verbal open-ended symptoms questionnaire.	[redacted]
1.26	Post-Fit Questionnaire	Subjects will complete a PRO questionnaire regarding the initial comfort and handling of the study lenses.	
1.27	I/R Training and Contact Lens Checklist	Instruct and teach contact lens insertion, removal and safe lens wear practices. Review the training material(s) including training video, if applicable. The subject's parent or legal guardian must be present during I/R training. I/R training will be deemed successful only if the subject and/or the parent can successfully insert the study contact lenses, and the subject	[redacted]

Visit 1: Run-in Lens Fitting			
Step	Procedure	Details	[redacted]
		him/herself can remove the lenses without any assistance. Investigator will observe and record if lens insertion and removal is successful by the parent or by the subject. If I/R training is successful, ask the subject to complete the Contact Lens Checklist (repeat until the subject can answer all the questions correctly) and continue with lens dispensing; If I/R training is NOT successful, measure exit visual acuity and schedule the subject and parent to return for additional I/R training visits without dispensing the study lenses. Application and removal training must be completed within 2 weeks from visit 1. Subjects can return for up to 2 additional application and removal training visits.	
1.28	Continuance (Lens Dispensing Criteria)	For the subject to continue in the study, they must meet all five of the following criteria: 1. The subject's distance visual acuity with the test article must be equal to or better than 20/25 in each eye. 2. The subject indicates that the comfort and vision with the study lenses is acceptable. 3. The lens fit is acceptable in both eyes. 4. Investigator approval. If the Investigator does not approve the dispensing of the study lens, then the study is terminated for that subject. The subject has successfully completed the I/R training and answered all questions in the Contact Lens Checklist correctly.	
1.29	Lens Dispense	The lenses will be dispensed for a wearing period of 5 to 9 days. The lenses will be worn as daily wear/daily disposable only.	

Visit 1: Run-in Lens Fitting			
Step	Procedure	Details	[redacted]
		At the investigator's discretion, provide the subject with rewetting drops approved in local markets. No disinfecting or storage solutions will be given to the subject. Study contact lens dispensing instruction checklist: 1. Habitual contact lens wearers should wear the study lenses at least 8 hours a day, 5 days a week (recommend 10 hours or more a day, 7 days a week) until the next visit. 2. Neophytes may wear the study lenses 4 hours today, 6 hours the next day and at least 8 hours a day every day afterwards until the next visit. 3. Never sleep in the lenses. 4. Always throw away any lens that is taken out of the eye and use only the new lens with each lens insertion. 5. Always have eyeglasses at hand while wearing the study contact lenses. 6. When not wearing the study contact lenses, only the habitual spectacles (no contact lenses) should be worn. 7. Provide the subject with a copy of the parent instruction guide, the instruction pamphlet, and the lens insertion/removal information cards. 8. Schedule the subject for Visit 2 (1-week follow up, 5 to 9 days from Visit 1 or the day the subject completes the initial lens dispensing). 9. Instruct the subject to wear study lenses to the next visit. ***Note:*** *In the event a lens is lost or damaged, the subject will use a new lens from the most recently dispensed lenses. As much as reasonably possible, a damaged lens and packaging should be returned to the clinical*	

Visit 1: Run-in Lens Fitting			
Step	Procedure	Details	[redacted]
		site (wet, if possible) and then returned to the Sponsor. If lens damage is present, site staff will complete the Product Quality Complaint Form. The lens will be stored in labeled vial with saline, and clearly differentiated from the other worn lenses that may be returned to the Sponsor, if any.	
1.30	Schedule next visit	Schedule the follow-up visit to occur in 5 to 9 days (counting the day of this visit as day 0, the subject may return on day 5 through 9). Ensure the subject is instructed to wear the study lenses for at least 1 hour(s) immediately prior to attending the follow-up visit.	

VISIT 2

The subjects must present to Visit 2 wearing the study lenses and having worn them continuously for at least 1 hour on the day of the visit immediately prior to attending the visit.

Visit 2: CL Follow-Up			
Step	Procedure	Details	[redacted]
2.1	Change of Medical History (Adverse Events) and Concomitant Medications / Therapies Review	Record any adverse events or medical history changes from the previous study visit with the subject/parents. Review the subject's concomitant medications/therapies and record any changes from the previous study visit.	
2.2	Contact Lens Wearing Time and Compliance	Record the average wearing time and confirm compliance with the prescribed wear schedule. The subjects will be asked the time of the day they typically apply the study lenses in the morning and take off in the evening, the number of days per week lenses were worn, and the number of consecutive days the subject didn't wear the study lenses (if applicable), etc.	

<table>
<tr><th colspan="4">Visit 2: CL Follow-Up</th></tr>
<tr><th>Step</th><th>Procedure</th><th>Details</th><th>[redacted]</th></tr>
<tr><td>2.3</td><td>Unworn lens return</td><td>Subject to return any unworn investigational lenses.</td><td></td></tr>
<tr><td>2.4</td><td>PRO Follow-up and PROMIS PGH7 Questionnaires</td><td>The subject will complete a PRO questionnaire to assess their experience with the study lenses and a general health questionnaire.</td><td>[redacted]</td></tr>
<tr><td>2.5</td><td>Subject Reported Ocular Symptoms</td><td>Subjects will respond to a verbal open-ended symptoms questionnaire.</td><td>[redacted]</td></tr>
<tr><td>2.6</td><td>Distance Visual Performance</td><td>Measure distance ETDRS logMAR visual acuity at a 4 meter (m) distance with the subject wearing the study lenses using the conditions and charts shown in the table below:

For low luminance measures, the mesopic filter should be used to reduce luminance to the range specified below. Allow subjects to adapt to dim illumination for at least 3 minutes before testing the LLHC condition.

<table>
<tr><td>Distance</td><td colspan="6">4 m</td></tr>
<tr><td>Condition</td><td colspan="2">HLHC</td><td colspan="2">HLLC</td><td colspan="2">LLHC</td></tr>
<tr><td>Room illumination</td><td colspan="2">686-788 lux</td><td colspan="2">686-788 lux</td><td colspan="2">1.4-1.6 lux</td></tr>
<tr><td>Chart luminance</td><td colspan="4">181-208 cd/m²</td><td colspan="2">2.5-2.8 cd/m²</td></tr>
<tr><td>Eye</td><td>OU</td><td>OD</td><td>OU</td><td>OD</td><td>OU</td><td>OD</td></tr>
<tr><td>Charts (Numbers)</td><td>HC-1 (2214)</td><td>HC-2 (2214A)</td><td>LC-1 (2164)</td><td>LC-2 (2164A)</td><td>HC-3 (2114B)</td><td>HC-4 (2114C)</td></tr>
</table></td><td></td></tr>
</table>

<table>
<tr><th colspan="4">Visit 2: CL Follow-Up</th></tr>
<tr><th>Step</th><th>Procedure</th><th>Details</th><th>[redacted]</th></tr>
<tr><td>2.7</td><td>Near Visual Performance</td><td>Measure near ETDRS logMAR visual acuity at a 40 centimeter (cm) distance with the subject wearing the study lenses using the conditions shown in the table below:

<table><tr><td>Distance</td><td>40 cm</td><td>40 cm</td></tr><tr><td>Condition</td><td>HLHC</td><td>HLLC</td></tr><tr><td>Room illumination</td><td>686-788 lux</td><td>686-788 lux</td></tr><tr><td>Chart luminance</td><td>225 - 275 cd/m^2</td><td>225 - 275 cd/m^2</td></tr><tr><td>Eye</td><td>OU</td><td>OU</td></tr><tr><td>Charts (Numbers)</td><td>HC-1 (2106C)</td><td>LC-1 (2118)</td></tr></table></td><td>[redacted]</td></tr>
<tr><td>2.8</td><td>Monocular Subjective Best Sphere Over Refraction</td><td>Perform monocular subjective best sphere refraction over the study lenses with a phoropter.
Reduce minus (add plus) in 0.25 D steps if there is no decrease in visual acuity and no subjective vision reduction.
Increase minus in 0.25 D steps if it significantly improves distance vision.
Record the spherical power and the resultant distance visual acuity to the nearest letter (OD, OS).</td><td>[redacted]</td></tr>
</table>

Visit 2: CL Follow-Up			
Step	Procedure	Details	[redacted]
2.9	General Lens Fit Assessment	Evaluate lens centration, movement on blink, and push-up test for each eye. An unacceptable fit is deemed by one of the following criteria: • limbal exposure at primary gaze or with extreme eye movement. • edge lift. • excessive movement in primary and up gaze. • insufficient movement in <u>all three</u> of the following conditions: primary gaze, up gaze, and push-up test. **Note:** if lens fit is unacceptable for either eye, the subject will be discontinued from the study.	[redacted]
2.10	Wettability Characteristics	Record the white light lens wettability of both lenses.	[redacted]
2.11	Surface Deposits	Record any front and back surface lens deposits.	[redacted]
2.12	Lens Removal	Remove the study contact lenses. If either removed lens is associated with a PQC or adverse event, add solution to the lens vial for storage prior to return shipment to JJVC. If no adverse event or PQC is associated with the lenses they can be properly disposed.	
2.13	Slit Lamp Biomicroscopy	Slit Lamp Classification Scale per ISO 11980 will be used to grade the findings. If the clearance of the fluorescein needs to be expedited, preservative-free rewetting drops or saline may be instilled. *Note: If any slit lamp finding is graded as 2 (except for subjects with Grade 2 baseline palpebral conjunctival observations) or worse, it may warrant classification of an adverse event, and shall be followed accordingly. A subject with significant slit lamp findings (e.g., Grade 3 corneal staining, Grade 2 corneal vascularization, anterior segment inflammation, and corneal infiltrate, etc.) may not be dispensed with the study contact lens at this time, and an adverse event form must be filled.*	[redacted]

Visit 2: CL Follow-Up			
Step	Procedure	Details	[redacted]
		The subject must be followed until slit lamp findings are resolved and the investigator deems it's appropriate for the subject to continue with the study before study lens dispensing. If the subject is discontinued from the study, Final Evaluation must be completed. *If the clearance of the fluorescein needs to be expedited, preservative-free rewetting drops or saline may be instilled.*	
2.14	Washout	Wait 10 minutes from lens removal before proceeding with the next lens fit.	

Visit 2: CL Fit			
Step	Procedure	Details	[redacted]
2.15	Distance logMAR VA with spherocylindrical prescription	Measure distance ETDRS logMAR visual acuity at a 4 meter (m) distance with the spherocylindrical prescription measured at V1 in a trial frame using the conditions and charts shown in the table below: **Distance**: 4 m | 4 m **Condition**: HLHC | HLHC **Room illumination**: 686-788 lux | 686-788 lux **Chart luminance**: 181-208 cd/m^2 | 181-208 cd/m^2 **Eye**: OD | OS **Charts (Numbers)**: HC-3 (2114B) | HC-4 (2114C) *Note: If logMAR VA measures more than 0.15 logMAR worse than at baseline, the measurement should be repeated. If the visual acuity reduction is confirmed, an adverse event will be filed. The subject will be followed until visual acuity is no more than 0.15 logMAR worse than baseline or is stabilized before being discontinued.*	

Visit 2: CL Fit			
Step	Procedure	Details	[redacted]
		Note 2: per ISO 11980, a loss of two or more lines (0.20 logMAR) of best corrected visual acuity for greater than or equal to 2 weeks is considered a significant or serious adverse event depending on the duration.	
2.16	Lens Selection	Assign the study lenses based on the randomization schedule. Select the appropriate power of the contact lenses based on subjective best sphere refraction (completed at V1) and adjust for vertex distance to the corneal plane if needed (< -4.00 D). Record the lens parameters.	
2.17	Lens Insertion	The subject applies the study lenses. If a lens is uncomfortable, inspect for damage and remove, reinsert or replace as necessary. Check for lens damage under the slit lamp before proceeding with lens settling. Replace damaged lenses if applicable. Record the time of lens insertion.	
2.18	Right eye number insertion attempts	Record the number of attempts that were necessary to successfully insert the lens into the right eye. If more than 1 insertion attempt was necessary, or the patient otherwise experienced significant difficulty inserting the lens, record the primary reason for difficulty with the lens insertion: • Lens did not leave finger • Lens folded on finger • Lens inverted on finger • Lens touched eyelid/eyelashes as it moved towards eye • Lens did not settle on eye or was blinked out • Other (specify reason)	

Visit 2: CL Fit			
Step	Procedure	Details	[redacted]
2.19	Left eye number insertion attempts	Record the number of attempts that were necessary to successfully insert the lens into the right eye. If more than 1 insertion attempt was necessary, or the patient otherwise experienced significant difficulty inserting the lens, record the primary reason for difficulty with the lens insertion: • Lens did not leave finger • Lens folded on finger • Lens inverted on finger • Lens touched eyelid/eyelashes as it moved towards eye • Lens did not settle on eye or was blinked out • Other (specify reason)	
2.20	Lens Settling	Allow the study lenses to settle for a minimum of 10 minutes.	
2.21	Lens-on-eye Distance VA	Record the distance Snellen visual acuity (OD, OS) to the nearest letter with the study lenses in place. Subjects must read the smallest line until at least 50% of the letters are read incorrectly.	[redacted]
2.22	Monocular Subjective Best Sphere Over Refraction	Perform monocular subjective best sphere refraction over the study lenses with a phoropter. • Reduce minus (add plus) in 0.25 D steps if there is no decrease in visual acuity and no subjective vision reduction. • Increase minus in 0.25 D steps if it significantly improves distance vision. • Record the spherical power and the resultant distance visual acuity to the nearest letter (OD, OS).	[redacted]

Visit 2: CL Fit			
Step	Procedure	Details	[redacted]
2.23	General Lens Fit Assessment	Evaluate lens centration, movement on blink, and push-up test for each eye. An unacceptable fit is deemed by one of the following criteria: • limbal exposure at primary gaze or with extreme eye movement. • edge lift. • excessive movement in primary and up gaze. • insufficient movement in <u>all three</u> of the following conditions: primary gaze, up gaze, and push-up test. **Note:** if lens fit is unacceptable for either eye, the subject will be discontinued from the study.	[redacted]
2.24	Lens Power Modification (if applicable)	Refer to the respective fitting guide to determine whether a lens power modification is needed. For each power modification, select the new lens power as appropriate and repeat the steps beginning with right lens insertion. A maximum of 2 lens modifications are allowed per eye. If, for either eye, the fit is not successful after 2 modifications, the subject will be discontinued proceed to final evaluation.	Appendix G
2.25	Subject Reported Ocular Symptoms	Subjects will respond to a verbal open-ended symptoms questionnaire.	[redacted]
2.26	Post-Fit Questionnaire	Subjects will complete a PRO questionnaire regarding the initial comfort and handling of the study lenses.	
2.27	Contact Lens Checklist	Ask the subject to complete the Contact Lens Checklist (repeat until the subject can answer all the questions correctly) and continue with lens dispensing.	[redacted]

Visit 2: CL Fit			
Step	Procedure	Details	[redacted]
2.28	Continuance (Lens Dispensing Criteria)	For the subject to continue in the study, they must meet all five of the following criteria: 1. The subject's distance visual acuity with the test article must be equal to or better than 20/25 in each eye. 2. The subject indicates that the comfort and vision with the study lenses is acceptable. 3. The lens fit is acceptable in both eyes. 4. Investigator approval. If the Investigator does not approve the dispensing of the study lens, then the study is terminated for that subject. 5. The subject has successfully answered all questions in the Contact Lens Checklist correctly.	
2.29	Lens Dispense	The lenses will be dispensed for a wearing period of 11 to 17 days. The lenses will be worn as daily wear/daily disposable only. At the investigator's discretion, provide the subject with rewetting drops approved in local markets. No disinfecting or storage solutions will be given to the subject. Study contact lens dispensing instruction checklist: 1. Habitual contact lens wearers should wear the study lenses at least 8 hours a day, 5 days a week (recommend 10 hours or more a day, 7 days a week) until the next visit. 2. Never sleep in the lenses. 3. Always throw away any lens that is taken out of the eye and use only the new lens with each lens insertion. 4. Always have eyeglasses at hand while wearing the study contact lenses. 5. When not wearing the study contact lenses, only the habitual spectacles (no contact lenses) should be worn.	

Visit 2: CL Fit			
Step	Procedure	Details	[redacted]
		6. Schedule the subject for the next visit (11 to 17 days from Visit 2). 7. Instruct the subject to wear study lenses to the next visit. ***Note:*** *In the event a lens is lost or damaged, the subject will use a new lens from the most recently dispensed lenses. As much as reasonably possible, a damaged lens and packaging should be returned to the clinical site (wet, if possible) and then returned to the Sponsor. If lens damage is present, site staff will complete the Product Quality Complaint Form. The lens will be stored in labeled vial with saline, and clearly differentiated from the other worn lenses that may be returned to the Sponsor, if any.*	
2.30	Schedule next visit	Schedule the follow-up visit to occur in 14 ± 3 days (counting the day of this visit as day 0, the subject may return on day 11 through 17). Ensure the subject is instructed to wear the study lenses for at least 1 hour(s) immediately prior to attending the follow-up visit.	

VISIT 3

The subjects must present to Visit 3 wearing the study lenses and having worn them continuously for at least 1 hour on the day of the visit immediately prior to attending the visit.

Visit 3: CL Follow-Up

The steps followed will be the same as those listed under Visit 2: CL Follow-Up. The only difference is that the randomization step will not be repeated.

Visit 3: CL Fit

The steps followed will be the same as those listed under Visit 2: CL Fit.

VISIT 4

The subjects must present to Visit 4 wearing the study lenses and having worn them continuously for at least 1 hour on the day of the visit immediately prior to attending the visit.

Visit 4: CL Follow-Up

The steps followed will be the same as those listed under Visit 2: CL Follow-Up. The only difference is that the randomization step will not be repeated.

Visit 4: CL Fit

The steps followed will be the same as those listed under Visit 2: CL Fit.

VISIT 5

The subjects must present to Visit 5 wearing the study lenses and having worn them continuously for at least 1 hour on the day of the visit immediately prior to attending the visit.

Visit 5: Follow-Up			
Step	Procedure	Details	[redacted]
5.1	Change of Medical History (Adverse Events) and Concomitant Medications / Therapies Review	Record any adverse events or medical history changes from the previous study visit with the subject/parents. Review the subject's concomitant medications/therapies and record any changes from the previous study visit.	
5.2	Contact Lens Wearing Time and Compliance	Record the average wearing time and confirm compliance with the prescribed wear schedule. The subjects will be asked the time of the day they typically apply the study lenses in the morning and take off in the evening, the number of days per week lenses were worn, and the number of consecutive days the subject didn't wear the study lenses (if applicable), etc.	
5.3	Compliance	Confirm compliance with the prescribed wear schedule.	
5.4	Unworn lens return	Subject to return any unworn investigational lenses.	

<table>
<tr><th colspan="4">Visit 5: Follow-Up</th></tr>
<tr><th>Step</th><th>Procedure</th><th>Details</th><th>[redacted]</th></tr>
<tr><td>5.5</td><td>PRO Follow-up and PROMIS PGH7 Questionnaires</td><td>The subject will complete a PRO questionnaire to assess their experience with the study lenses and a general health questionnaire.</td><td>[redacted]</td></tr>
<tr><td>5.6</td><td>Subject Reported Ocular Symptoms</td><td>Subjects will respond to a verbal open-ended symptoms questionnaire.</td><td>[redacted]</td></tr>
<tr><td>5.7</td><td>Distance Visual Performance</td><td>Measure distance ETDRS logMAR visual acuity at a 4 meter (m) distance with the subject wearing the study lenses using the conditions and charts shown in the table below:

For low luminance measures, the mesopic filter should be used to reduce luminance to the range specified below. Allow subjects to adapt to dim illumination for at least 3 minutes before testing the LLHC condition.

<table>
<tr><td>Distance</td><td colspan="6">4 m</td></tr>
<tr><td>Condition</td><td colspan="2">HLHC</td><td colspan="2">HLLC</td><td colspan="2">LLHC</td></tr>
<tr><td>Room illumination</td><td colspan="2">686-788 lux</td><td colspan="2">686-788 lux</td><td colspan="2">1.4-1.6 lux</td></tr>
<tr><td>Chart luminance</td><td colspan="4">181-208 cd/m²</td><td colspan="2">2.5-2.8 cd/m²</td></tr>
<tr><td>Eye</td><td>OU</td><td>OD</td><td>OU</td><td>OD</td><td>OU</td><td>OD</td></tr>
<tr><td>Charts (Numbers)</td><td>HC-1 (2214)</td><td>HC-2 (2214A)</td><td>LC-1 (2164)</td><td>LC-2 (2164A)</td><td>HC-3 (2114B)</td><td>HC-4 (2114C)</td></tr>
</table></td><td>[redacted]</td></tr>
<tr><td>5.8</td><td>Near Visual Performance</td><td>Measure near ETDRS logMAR visual acuity at a 40 centimeter distance with the subject wearing the study lenses using the conditions shown in the table below:

<table>
<tr><td>Distance</td><td>40 cm</td><td>40 cm</td></tr>
<tr><td>Condition</td><td>HLHC</td><td>HLLC</td></tr>
<tr><td>Room illumination</td><td>686-788 lux</td><td>686-788 lux</td></tr>
<tr><td>Chart luminance</td><td>225 - 275 cd/m²</td><td>225 - 275 cd/m²</td></tr>
<tr><td>Eye</td><td>OU</td><td>OU</td></tr>
</table></td><td>[redacted]</td></tr>
</table>

Visit 5: Follow-Up			
Step	Procedure	Details	[redacted]
		Charts (Numbers) HC-1 (2106C) LC-1 (2118)	
5.9	Monocular Subjective Best Sphere Over Refraction	Perform monocular subjective best sphere refraction over the study lenses with a phoropter. • Reduce minus (add plus) in 0.25 D steps if there is no decrease in visual acuity and no subjective vision reduction. • Increase minus in 0.25 D steps if it significantly improves distance vision. • Record the spherical power and the resultant distance visual acuity to the nearest letter (OD, OS).	[redacted]
5.10	General Lens Fit Assessment	Evaluate lens centration, movement on blink, and push-up test for each eye. An unacceptable fit is deemed by one of the following criteria: • limbal exposure at primary gaze or with extreme eye movement. • edge lift. • excessive movement in primary and up gaze. • insufficient movement in all three of the following conditions: primary gaze, up gaze, and push-up test. **Note:** if lens fit is unacceptable for either eye, the subject will be discontinued from the study.	[redacted]
5.11	Wettability Characteristics	Record the white light lens wettability of both lenses.	[redacted]
5.12	Surface Deposits	Record any front and back surface lens deposits.	[redacted]
5.13	Lens Removal	Remove the study contact lenses. If either removed lens is associated with a PQC or adverse event, add solution to the lens vial for storage prior to return shipment to JJVC. If no adverse event or PQC is associated with the lenses they can be properly disposed.	

<table>
<tr><th colspan="4">Visit 5: Follow-Up</th></tr>
<tr><th>Step</th><th>Procedure</th><th>Details</th><th>[redacted]</th></tr>
<tr><td>5.14</td><td>Slit Lamp Biomicroscopy</td><td>Slit Lamp Classification Scale per ISO 11980 will be used to grade the findings. If the clearance of the fluorescein needs to be expedited, preservative-free rewetting drops or saline may be instilled.

Note: If any slit lamp finding is graded as 2 (except for subjects with Grade 2 baseline palpebral conjunctival observations) or worse, it may warrant classification of an adverse event, and shall be followed accordingly. A subject with significant slit lamp findings (e.g., Grade 3 corneal staining, Grade 2 corneal neovascularization, anterior segment inflammation, and corneal infiltrate, etc.) an adverse event form must be completed. The subject must be followed until slit lamp findings are resolved.</td><td></td></tr>
<tr><td>5.15</td><td>Distance logMAR VA with spherocylindrical prescription</td><td>Measure distance ETDRS logMAR visual acuity at a 4 meter (m) distance with spherocylindrical prescription in a trial frame using the conditions and charts shown in the table below:

<table>
<tr><td>Distance</td><td>4 m</td><td>4 m</td></tr>
<tr><td>Condition</td><td>HLHC</td><td>HLHC</td></tr>
<tr><td>Room illumination</td><td>686-788 lux</td><td>686-788 lux</td></tr>
<tr><td>Chart luminance</td><td>181-208 cd/m^2</td><td>181-208 cd/m^2</td></tr>
<tr><td>Eye</td><td>OD</td><td>OS</td></tr>
<tr><td>Charts (Numbers)</td><td>HC-3 (2114B)</td><td>HC-4 (2114C)</td></tr>
</table>

Note: If logMAR VA measures more than 0.15 logMAR worse than at baseline, the measurement should be repeated. If the visual acuity reduction is confirmed, an adverse event will be filed. The subject will be followed until visual acuity is no more than 0.15 logMAR worse than baseline or is stabilized before being discontinued.</td><td></td></tr>
</table>

Visit 5: Follow-Up			
Step	Procedure	Details	[redacted]
		Note 2: per ISO 11980, a loss of two or more lines (0.20 logMAR) of best corrected visual acuity for greater than or equal to 2 weeks is considered a significant or serious adverse event depending on the duration.	

FINAL EVALUATION

The final evaluation will ordinarily take place immediately following the last scheduled follow-up visit per the study protocol. It may also take place at any point the subject discontinues the study or is terminated from the study.

Final Evaluation			
Step	Procedure	Details	[redacted]
F.1	Final Exam Form	Indicate if the subject completed the study successfully. If subject discontinued from the study, indicate the reason.	
F.2	Exit Refraction	Perform bare-eye subjective spherocylindrical refraction with a phoropter and record the best-corrected distance visual acuity (OD and OS) to the nearest letter. **Note**: This step is not necessary if the subject was exited due to screen failure.	[redacted]
F.3	Exit Slit Lamp Biomicroscopy (for subjects that are discontinued early)	Slit Lamp Classification Scale per ISO 11980 will be used to grade the findings. If the clearance of the fluorescein needs to be expedited, preservative-free rewetting drops or saline may be instilled. ***Note:*** *If any slit lamp finding is graded as 2 (except for subjects with Grade 2 baseline palpebral conjunctival observations) or worse, it may warrant classification of an adverse event, and shall be followed accordingly. A subject with significant slit lamp findings (e.g., Grade 3 corneal staining, Grade 2 corneal neovascularization, anterior segment inflammation, and corneal infiltrate, etc.) requires an adverse event form to be*	[redacted]

Final Evaluation			
Step	Procedure	Details	[redacted]
		completed. The subject must be followed until slit lamp findings are resolved.	

7.3. Unscheduled Visits

If, during the investigation, a subject requires an unscheduled visit to the clinical site, the following information will be collected, as appropriate:

- Chief complaint prompting the visit. If the reason is an adverse event, the applicable eCRF for the adverse event must be completed and subject record completed as appropriate.
- Date and time of the visit and all procedures completed at the unscheduled visit.
- Review of adverse event and concomitant medications.
- Documentation of any test article dispensed or collected from the subject, if applicable.
- Slit lamp findings (using the Slit Lamp Classification Scale).

If the Investigator withdraws a subject from the study, the final study visit case report forms must be completed indicating the reason(s) why the subject was withdrawn. The subject record must be completed documenting the date and primary reason for withdrawal and the study CRA notified.

Any ocular and non-ocular Adverse Events that are ongoing at the time of the study visit will be followed by the Investigator, within licensure, until they have resolved, returned to pre-treatment status, stabilized, or been satisfactorily explained. If further treatment i.e., beyond licensure is required, the subject will be referred to the appropriate health care provider.

The following information will be collected, if applicable, during an unscheduled visit.

Unscheduled Visit			
Step	Procedure	Details	[redacted]
U.1	Reason for unscheduled visit	Indicate if the only reason for the visit is that the subject requires additional test articles. If the reason is other than resupply of previously dispensed lenses, specify the reason for the visit.	
U.2	Chief Complaints (if applicable)	Record the subject's chief complaints for reasons for the unscheduled visit.	
U.3	Adverse Events and Concomitant Medications Review (if applicable)	Review any changes to the subject's medical history or concomitant medications from the previous study visit. Record any changes, and any adverse events.	

Unscheduled Visit			
Step	Procedure	Details	[redacted]
U.4	Entrance VA (if applicable)	Record the entrance distance visual acuity (OD, OS) to the nearest letter with habitual correction or uncorrected.	
U.5	Monocular Subjective Best Sphere Over Refraction (if subject's chief complaint is blurry vision with study contact lens(es))	Perform monocular subjective best sphere refraction over the study lenses with a phoropter. • Reduce minus (add plus) in 0.25 D steps if there is no decrease in visual acuity and no subjective vision reduction. • Increase minus in 0.25 D steps if it significantly improves distance vision. • Record the spherical power and the resultant distance visual acuity to the nearest letter (OD, OS).	
U.6	Lens Power Modification (if applicable)	Refer to the respective fitting guide to determine whether a lens power modification is needed. For each power modification, select the new lens power as appropriate and repeat the steps beginning with right lens insertion. A maximum of 2 lens modifications are allowed per eye. If, for either eye, the fit is not successful after 2 modifications, the subject will be discontinued (proceed to final evaluation).	Appendix G
U.7	Subjective Sphero-cylindrical Refraction (if applicable)	Perform bare-eye subjective spherocylindrical refraction with a phoropter (adopt the maximum plus to maximum visual acuity (MPMVA) approach and use the duo-chrome test for binocular balancing) and record the best corrected distance visual acuity to the nearest letter (OD, OS).	

<table>
<tr><th colspan="4">Unscheduled Visit</th></tr>
<tr><th>Step</th><th>Procedure</th><th>Details</th><th>[redacted]</th></tr>
<tr><td>U.8</td><td>Distance logMAR VA with spherocylindrical prescription</td><td>Measure distance ETDRS logMAR visual acuity at a 4 meter (m) distance with spherocylindrical prescription in a trial frame using the conditions and charts shown in the table below:

<table>
<tr><td>Distance</td><td>4 m</td><td>4 m</td></tr>
<tr><td>Condition</td><td>HLHC</td><td>HLHC</td></tr>
<tr><td>Room illumination</td><td>686-788 lux</td><td>686-788 lux</td></tr>
<tr><td>Chart luminance</td><td>181-208 cd/m^2</td><td>181-208 cd/m^2</td></tr>
<tr><td>Eye</td><td>OD</td><td>OS</td></tr>
<tr><td>Charts (Numbers)</td><td>HC-3 (2114B)</td><td>HC-4 (2114C)</td></tr>
</table>

Note: If logMAR VA measures more than 0.15 logMAR worse than at baseline, the measurement should be repeated. If the visual acuity reduction is confirmed, an adverse event will be filed. The subject will be followed until visual acuity is no more than 0.15 logMAR worse than baseline or is stabilized before being discontinued.

Note 2: per ISO 11980, a loss of two or more lines (0.20 logMAR) of best corrected visual acuity for greater than or equal to 2 weeks is considered a significant or serious adverse event depending on the duration.</td><td></td></tr>
<tr><td>U.9</td><td>Slit Lamp Biomicroscopy (if applicable)</td><td>Slit Lamp Classification Scale per ISO 11980 will be used to grade the findings. If the clearance of the fluorescein needs to be expedited, preservative-free rewetting drops or saline may be instilled.

Note: If any slit lamp finding is graded as 2 (except for subjects with Grade 2 baseline palpebral conjunctival observations) or worse, it may warrant classification of an adverse event, and shall be followed</td><td></td></tr>
</table>

Unscheduled Visit			
Step	Procedure	Details	[redacted]
		accordingly. A subject with significant slit lamp findings (e.g., Grade 3 corneal staining, Grade 2 corneal neovascularization, anterior segment inflammation, and corneal infiltrate, etc.) may not be dispensed study contact lenses at this time and an adverse event form must be completed. The subject must be followed until slit lamp findings are resolved and the investigator deems it's appropriate for the subject to continue with the study before contact lens dispensing. If the subject is discontinued from the study, the Final Evaluation must be completed.	
U.10	Dispensing (if applicable)	If the subject requires additional lenses to complete the wear period and is eligible to do so, provide additional lenses per the dispensing instructions given in the detailed study procedures.	
U.11	Exit Visual Acuity (if applicable)	Record the subject's exit distance visual acuity (OD, OS) to the nearest letter.	[redacted]

NOTE: If the only reason for the unscheduled visit is that the subject requires additional test articles, only the dispensing information needs to be recorded.

7.4. Laboratory Procedures

Not applicable.

8. SUBJECTS COMPLETION/WITHDRAWAL

8.1. Completion Criteria

Subjects are considered to have completed the study if they:

- provided informed consent.
- they are eligible.
- have not withdrawn/discontinued from the study for any reason described in section 8.2.
- completed all visits through the final visit (visit 5).
- If all visits were completed but an additional visit is considered necessary for subject care, follow the requirements for unscheduled visits in section 7.3.

8.2. Withdrawal/Discontinuation from the Study

A subject will be withdrawn from the study for any of the following reasons:

- Subject withdrawal of consent.
- Subject not compliant to protocol (e.g., refusing any protocol specified procedure)
- Subject lost to follow-up.
- Subject no longer meets eligibility criteria (e.g. the subject becomes pregnant).
- Subject develops significant or serious adverse events necessitating discontinuation of study lens wear
- Subjects who have experienced a Corneal Infiltrative Event (CIE).
- Investigator's clinical judgment regarding the subject safety reasons (that it is in the best interest of the subject to stop treatment).
- Subject not compliant with study lens wear schedule
- Subject not successfully dispensed due to lack of efficacy and safety including poor vision, poor comfort or unacceptable fit.

For discontinued subjects, the Investigator will:

- Complete the current visit (scheduled or unscheduled).
- Complete the Final Evaluation, indicating the reason that the subject was discontinued from the study.
- Record the spherocylindrical refraction with best corrected distance visual acuity.
- Collect used test article(s) (worn or brought to the visit) from the subject and discard them, unless otherwise stated in section 7.2
- Collect all unused test article(s) from the subject.
- Make arrangements for subject care, if needed, due to their study participation

Additional subjects will not be enrolled if a subject discontinues from the study prematurely.

In cases where a subject is lost to follow-up, every possible effort must be made to contact the subject and determine the reason for discontinuation/withdrawal. The measures taken to follow up must be documented including two written attempts and a certified letter (or equivalent) as the final attempt.

9. PRE-STUDY AND CONCOMITANT INTERVENTION/MEDICATION

Concomitant medications will be documented during screening and updated during the study. Disallowed medications for this study include:

1. Any medication or therapy that would normally contraindicate contact lens wear or have ocular side effects that would affect vision assessment.
2. Topical atropine or other medications that may temporarily impact pupil size

Concomitant therapies that are disallowed include:

1. Orthokeratology
2. Vision therapy/orthoptics/patching

3. Any therapies that the investigator feels would be contraindicated in contact lens wear or would affect vision assessment

9.1. Systemic Medications

Certain systemic medications are known to have a higher likelihood to interfere with contact lens wear, chiefly by disrupting the tear film.

A summary of disallowed systemic medications is shown in Table 4. Subjects with a history of taking these medications will be allowed to enroll only if:

- The medications have been taken on a continual, routine basis for at least 1 month, and
- The subject has demonstrated successful contact lens wear during this time.

Or:

- The subject was taking the medication on a temporary basis and ceased taking that medication at least 2 weeks prior to signing the informed consent (this is considered sufficient time for the medication to have left the body prior to enrollment).

Or:

- The subject is a neophyte. Based on the investigator's assessment, the use of the medication(s) will not interfere with the subject's participation in the study or with their ability to successfully wear soft contact lenses.

Subjects with a history of taking medications listed in Table 4 on a long-term, routine basis for less than 6 months will not be allowed to participate in the study.

Table 4: Disallowed systemic medications

Class of Drug	Common Indication(s)	Common Examples
Estrogens (not including contraceptive medication)	Menopause, osteoporosis, vaginitis	Vagifem, Estrace, Climara, Vivelle-Dot, Premarin, Minivelle, etc.
Anticholinergics	Irritable bowel syndrome, Parkinson's disease, peptic ulcer, cystitis, nasal congestion, cold symptoms, overactive bladder, COPD	Bentyl, Spiriva, Atrovent, Hyosyne, Levsin, Symax Fastab, Symax SL, Homax SL, Cogentin, Transderm Scop, etc.
Beta-blockers	Hypertension, angina, heart attack, migraine, artrial fibrillation, andrenal cancer, essential tumor, glaucoma	Toprol XL, Lopressor, Tenormin, Propranolol, Timoptic, Trandate, Inderal LA, etc.
Psychotropics	Antipsychotic (schizophrenia, mania), antidepression, antiobsessive, antianxiety, mood stabilizer, stimulants (ADHD)	Zoloft, Celexa, Prozac, Lexapro, Effexor, Cymbalta, Ativan, Xanax, Desyrel, Wellbutrin, etc.

Class of Drug	Common Indication(s)	Common Examples
Vitamin A analogs	Cystic acne	Isotretinoin

Examples of disallowed systemic antihistamines are given in Table 5. Subjects with a history of taking systemic antihistamines will be allowed to enroll only if:

- They have taken antihistamines continuously for at least 2 weeks, and
- They have demonstrated successful wear while taking the medication

Or:

- They stopped taking the medication for at least 2 weeks prior to enrollment.

Or:

- The subject is a neophyte. Based on the investigator's assessment, the use of the medication(s) will not interfere with the subject's participation in the study or with their ability to successfully wear soft contact lenses.

Table 5: Disallowed systemic antihistamines

Class of Drug	Common Indication(s)	Common Examples
Antihistamines	Allergic rhinitis, sedation, hives, allergic conjunctivitis, skin allergy, itching, motion sickness	Hydroxyzine, Promethagan, Phenadoz, Vistaril, Claritin, Zyrtec, Astepro, Astelin, Optivar, Allegra, Benedryl, etc.

10. DEVIATIONS FROM THE PROTOCOL

Investigator will notify study sponsor upon identification of a protocol deviation. Protocol deviations must be reported to the sponsor within 24 hours after discovery of the protocol deviation. The Investigator will report deviations per IRB/IEC requirements. All deviations will be tracked, and corrective actions implemented as appropriate.

If it becomes necessary for the Investigator to implement a deviation in order to eliminate an immediate hazard to the trial subject, the Investigator may implement the deviation immediately without notification to the sponsor. Within 24 hours after the implemented deviation, the Investigator must notify and provide the rationale to the Sponsor and, as required, the IEC/IRB.

If the deviation potentially impacts the safety of patient or changes the technical integrity of the study, then it must be reported to IEC/IRB. This is a "Major Deviation". Deviations that contradict the information contained in the Informed Consent/Assent forms will be considered Major Deviations.

Minor deviations have no substantive effect on patient safety or technical integrity of the study. They are often logistical in nature.

Protocol waivers are prohibited.

Table 6 lists examples of deviations that will constitute major and minor protocol deviations for this study.

Table 6: Examples of major and minor protocol deviations

Deviation category	Major deviation	Minor deviation
Out-of-window visit	Visit attended 2-4 days out of visit window defined in study procedures if subject did not meet per protocol wear time. Visit attended more than 4 days out of visit window defined in study procedures regardless of wear time compliance.	Visit attended 2 or fewer days out of visit window defined in study procedures. Visit attended up to 4 days out of visit window and subject has met wear time compliance.
Unanswered PRO questions	Not applicable.	For questionnaires where data where any PRO questions are unanswered (i.e., left blank).
Insufficient wear of study lenses	Not applicable.	Subject does not wear study lenses for at least 1 hour prior to attending a follow-up visit or subject does not wear study lenses for at least 8 hours on at least 10 days of a study lens wear period.

In the case of a major protocol deviation, the decision of whether or not the subject will be excluded from the Per-Protocol analysis population will be made at the time of cohort review.

11. STUDY TERMINATION

The occurrence of one or more Unanticipated Serious Adverse Device Effect (USADE), or any SAE where the relationship to study agent cannot be ruled out, may result in stopping

further dispensing of test article. In the event of a USADE or SAE, the Sponsor may unmask the treatment regimen for the subject(s) and will discuss this with the Investigator before any further subjects are enrolled.

The Sponsor will determine when a study will be stopped. The Principal Investigator always has the discretion to initiate stopping the study based on patient safety or if information indicates the study's results are compromised.

JJVC reserves the right to terminate the study at any time for any reason. Additionally, the IEC/IRB reserves the right to terminate the study if an unreasonable risk is determined. The study can be terminated by the Principal Investigator at the individual clinical site due to specific clinical observations, if in their opinion, after a discussion with JJVC, it is determined that it would be unwise to continue at the clinical site.

JJVC (and the IEC/IRB and DMC, if applicable) will evaluate all adverse events. If it is determined that an adverse event presents an unreasonable risk, the investigation, or that part of the investigation presenting the risk, will be terminated as soon as possible.

Should the study be terminated (either prematurely or as scheduled), the Investigator will notify the IEC/IRB and Regulatory Authority as required by local regulatory requirements.

12. PROCEDURE FOR HANDLING PRODUCT QUALITY COMPLAINTS

A Product Quality Complaint (PQC) refers to any written, electronic, or oral communication that alleges deficiencies related to the identity, quality, durability, reliability, safety, effectiveness or performance of test articles after they have been released for clinical trial use.

Potential complaints may come from a variety of sources including but not limited to subjects, clinical research associates (CRA), clinical operations managers (COM), medical monitors, and site personnel, etc. The following are not considered product quality complaints:

- Subject satisfaction inquiries reported via "Subjective Questionnaires" and "Patient Reported Outcomes (PRO)."
- Clinical test articles that are stored improperly or damaged after receipt at the investigational site.
- Lens replacements that occur due to drops/fall-outs.
- Damage deemed by clinicians or clinical staff to be caused by handling by the user, and not indicative of a quality deficiency (i.e. tears, rips, etc.), only in situations where there is no deficiency alleged by the subject.

Within 24 hours of site personnel becoming aware that a PQC has occurred, the PQC must be recorded in the EDC system, which will trigger an automatic email notification to the appropriate COM/CRA and Clinical QA representative. In cases where the EDC system in use is not configured to send automatic notifications or when an EDC system is not used, the COM/CRA is responsible for notifying Clinical QA upon discovery that a PQC has occurred.

Upon receipt of the EDC notification, the COM/CRA will contact the study site to collect additional information which will include:

- Date the complaint was received/recorded in the EDC System (Date of Sponsor Awareness).
- Who received the complaint.
- Study number.
- Clinical site information (contact name, site ID, telephone number).
- Lot number(s).
- Unique Subject Identifier(s).
- Indication of who first observed complaint (site personnel or subject).
- OD/OS indication, along with whether the lens was inserted.
- Any related AE number if applicable.
- Detailed complaint description (scheduled/unscheduled visit, wear time, symptoms, resolution of symptoms, etc.).
- Eye Care Provider objective (slit lamp) findings if applicable.
- Confirmation of product availability for return (and tracking information, if available), or rationale if product is not available for return [redacted]

Once a complaint is received, it will be assessed by the COM, CRA, or trained site personnel to determine if it is an Adverse Event/Serious Adverse Event (AE/SAE). If the complaint results in an AE/SAE, the COM/CRA, or trained site personnel will follow section 13 of this protocol. If the AE/SAE was potentially the result of a product quality related deficiency, these procedures also apply and will be executed in parallel.

In some cases, a PQC form may be generated in EDC by the site in error. In this event, the PQC forms will be marked “Intentionally Left Blank” or “ILB”. Justification for ILB must be documented.

13. ADVERSE EVENTS

13.1. Definitions and Classifications

Adverse Event (AE) – An AE 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: This definition includes events related to the investigational medical device or the comparator, and to the procedures involved. For users or other persons, this definition is restricted to events related to investigational medical devices.[1]

An AE includes any condition (including a pre-existing condition) that:

a) Was not present prior to the study, but appeared or reappeared following initiation of the study.

b) Was present prior to the study but worsened during the study. This would include any condition resulting from concomitant illnesses, reactions to concomitant medications, or progression of disease states.
c) Pregnancy must be documented as an adverse event and must be reported to the clinical monitor and to the Sponsor immediately upon learning of the event.

Serious Adverse Event (SAE) – An SAE is any adverse event that led to any of the following:

- Death
- Serious deterioration in the health of the subject that resulted in any of the following:
  - Life-threatening illness or injury
  - Permanent or persistent impairment of a body structure or a body function
  - Hospitalization or prolongation of patient hospitalization
  - Medical or surgical intervention to prevent life-threatening illness or injury or permanent impairment to a body structure or a body function.
  - Chronic disease
  - Fetal distress, fetal death or a congenital physical or mental impairment of birth defect.

Per ISO 11980, Serious adverse events are those events that result in, or have potential to cause, either permanent impairment of an ocular function or damage to an ocular structure, and may necessitate medical or surgical intervention.

Serious adverse events may include any hazardous, sight-threatening conditions occurring after exposure to test article, including but not limited to the following.

a) A presumed infectious ulcer (defined as a progressive erosion of the corneal tissue). Signs may include irregular focal infiltrates (> 1 mm); active lesions with raised edges; significant diffuse infiltration; anterior corneal to mid-stromal involvement; erosion with overlying staining; conjunctival and lid edema; anterior chamber reaction (iritis); severe bulbar and limbal redness. Symptoms associated with a presumed infectious ulcer (microbial keratitis) may include pain of rapid onset; severe redness; purulent or mucopurulent discharge; tearing; photophobia. For the purposes of reporting, a corneal ulcer which has *any* of the following characteristics should be considered in this category:
   1) central or paracentral location;
   2) penetration of Bowman’ s membrane;
   3) infiltrate > 2 mm diameter;
   4) associated with iritis ≥ grade 2;
   5) associated with any increase in intraocular pressure;
   6) culture positive for microorganisms;
   7) increasing size or severity at subsequent visits.
b) Any central or paracentral corneal event (such as vascularization) that results in permanent opacification.
c) Any serious adverse ophthalmic events including hypopyon and hyphema.
d) Any neovascularization within the central 6 mm of the cornea.
e) The loss of two or more lines of visual acuity that fail to resolve.

f) All cases of iritis.

Diagnoses and conditions that are considered Ocular Serious Adverse Events include, but not limited to:

- Microbial Keratitis (MK)
- Iritis (including cells in the anterior chamber)
- Permanent decrease in best spectacle corrected visual acuity equivalent to 2 acuity lines or greater
- Central Corneal Opacity
- Central Corneal Neovascularization
- Uveitis
- Endophthalmitis
- Hypopyon
- Hyphemia
- Penetration of Bowman's Membrane
- Persistent Epithelial Defect
- Limbal cell Damage leading to Conjunctivalization

Significant Adverse Events – are defined as events that are symptomatic and warrant discontinuation (temporary or permanent) of the contact lens wear or require medical treatment to maintain normal ocular health.

Per ISO 11980, significant but non-serious adverse events should include, but not be limited to:

a) peripheral non-progressive non-infectious ulcers;
b) all symptomatic corneal infiltrative events;
c) all cases of corneal staining greater than or equal to grade 3;
d) a temporary loss of two or more lines of best corrected visual acuity (for greater than or equal to 2 weeks);
a) cases greater than or equal to grade 2 neovascularization;
b) any ocular event that necessitates temporary lens discontinuation of greater than or equal to 2 weeks.

Diagnoses and conditions that are considered Ocular Significant Adverse Events that may occur during the study include, but not limited to the following:

a) Contact Lens Induced Peripheral Ulcer (CLPU)
b) Significant Infiltrative Events (SIE)
c) Superior Epithelial Arcuate Lesions (SEALs)
d) Other grade 3 or higher corneal findings, such as abrasions or edema
e) Non-contact lens related corneal events - e.g., Epidemic Keratoconjunctivitis (EKC)
f) Asymptomatic Corneal Scar

In addition to above identified serious and significant adverse events, below are examples of other diagnoses and conditions that may occur during the study. The classification of these adverse events should be based on the above-specified definitions.

a) Non-significant Infiltrative Event (NSIE), if it is < Grade 2, non-symptomatic, and does not require medication
b) Contact Lens Papillary Conjunctivitis (CLPC)
c) Superficial Punctate Keratitis (SPK)
d) Conjunctivitis: Bacterial, Viral, Allergic
e) Blepharitis
f) Meibomianitis
g) Contact Dermatitis
h) Localized Allergic Reactions

Adverse Device Effect (ADE) – An ADE is an "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.[1]

Unanticipated Adverse Device Effect (UADE) – Any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, the test article, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan, Investigator's Brochure or protocol, or any other unanticipated serious problem associated with the test article that relates to the rights, safety and welfare of subjects.

13.2. Assessing Adverse Events

In conjunction with the medical monitor, the Investigator will evaluate adverse events to ensure the events are categorized correctly. Elements of categorization will include:

- Seriousness/Classifications (see definition in section 13.1).
- Causality or Relatedness – i.e. the relationship between the test article, study treatment or study procedures and the adverse event (not related, unlikely related, possibly related, or related - see definition in section 13.2.1).
- Adverse Event Severity – Adverse event severity is used to assess the degree of intensity of the adverse event (mild, moderate, or severe - see definition in section13.2.2).
- Outcome – not recovered or not resolved, recovering or resolving, recovered or resolved with sequelae, recovered or resolved, death related to adverse event, or unknown.
- Actions Taken – none, temporarily discontinued, permanently discontinued, or other.

13.2.1. Causality Assessment

Causality Assessment – A determination of the relationship between an adverse event and the test article. The test article relationship for each adverse event should be determined by the investigator using these explanations:

- Not Related- An adverse event that is not related to the use of the test article, study treatment or study procedures.
- Unlikely Related – An adverse event for which an alternative explanation is more likely, e.g. concomitant treatment, concomitant disease(s), or the relationship of time suggests that a causal relationship is not likely.
- Possibly Related – An adverse event that might be due to the use of the test article, or to the study treatment or study procedures. An alternative explanation, e.g. concomitant treatment, concomitant disease(s), is inconclusive. The relationship in time is reasonable. Therefore, the causal relationship cannot be excluded.
- Related – An adverse event that is listed as a possible adverse effect (device) or adverse reaction (drug) and cannot be reasonably explained by an alternative explanation, e.g. concomitant treatment of concomitant disease(s). The relationship in time is very suggestive, e.g. it is confirmed by de-challenge and re-challenge.

13.2.2. Severity Assessment

Severity Assessment – A qualitative assessment of the degree of intensity of an adverse event as determined by the Investigator or reported to him/her by the subject. The assessment of severity is made irrespective of test article, study treatment or study procedure relationship or seriousness of the event and should be evaluated according to the following scale:

- Mild – Event is noticeable to the subject but is easily tolerated and does not interfere with the subject's daily activities.
- Moderate – Event is bothersome, possible requiring additional therapy, and may interfere with the subject's daily activities.
- Severe – Event is intolerable, necessitates additional therapy or alteration of therapy and interferes with the subject's daily activities.

13.3. Documentation and Follow-Up of Adverse Events

The recording and documenting of adverse events (ocular and non-ocular) begin when the subjects are exposed to the test article, study treatment or study procedure. Adverse events reported before the use of test article, start of study treatment, or study procedures will be recorded as medical history. However, if the condition deteriorates at any time during the study it will be recorded and reported as an AE. Untoward medical events reported after the subject's exit from the study will be recorded as adverse events at the discretion of the Investigator.

Upon finding an adverse event, the Principal Investigator will document the condition in the subject record and in the eCRFs and complete the Adverse Event eCRF.

Complete descriptions of all adverse events must be available in the subject record. All Adverse Events including local and systemic reactions not meeting the criteria for "serious adverse events" shall be captured on the appropriate case report form or electronic data system.

All adverse events occurring while the subject is enrolled in the study must be documented appropriately regardless of relationship.

It is the Investigator's responsibility to maintain documentation of each reported adverse event. All adverse events will be followed in accordance with applicable licensing requirements. Such documentation will include the following:

- Adverse event (diagnosis not symptom).
- Drawings or photographs (where appropriate) that detail the finding (e.g., size, location, and depth, etc.).
- Date the clinical site was notified.
- Date and time of onset.
- Date and time of resolution.
- Adverse event classification, severity, and relationship to test articles, as applicable.
- Treatment regimen instituted (where appropriate), including concomitant medications prescribed, in accordance with applicable licensing requirements.
- Any referral to another health care provider if needed.
- Outcome, ocular damage (if any).
- Likely etiology.
- Best corrected visual acuity at the discovery of the event and upon conclusion of the event, if the AE is related to the visual system.

Upon discovery of an AE that is deemed 'possibly related' or 'related' to the test article or study procedures (whether related to the visual system or not), an AE review form [redacted] must be completed. Additional dated and initialed entries should be made at follow-up evaluations. Separate forms must be completed for each eye if the AE is bilateral.

In addition, if an infiltrate(s) is present, he/she will complete the Corneal Infiltrate Assessment eCRF. Where necessary, a culture of the corneal lesion will be collected to determine if the infection is microbial in nature. If cultures are collected, the date of culture collection and laboratory utilized will be recorded.

Changes in the severity of an AE shall be documented to allow an assessment of the duration of the event at each level of intensity to be performed. Adverse events characterized as intermittent require documentation of the onset and duration of each episode. Changes in the assessment of relationship to the Test Article shall also be clearly documented.

Subjects who present with an adverse event shall be followed by the Investigator, within licensure, until all signs and symptoms have returned to pre-treatment status, stabilized, or been satisfactorily resolved. If further treatment beyond licensure is required, the patient will be referred to the appropriate health care provider. The Investigator will use his/her clinical judgment as to whether a subject reporting with an adverse event will continue in the study. If a subject is discontinued from the study, it will be the responsibility of the Investigator to record the reason for discontinuation. The Investigator will also document the adverse event appropriately and complete the Adverse Event eCRF. Any subjects with ongoing adverse events related to the test article, study treatment or study procedures, as of the final study visit

date, should be followed to resolution of the adverse event or until referral to an appropriate health care provider, as recommended by the Investigator. Non-ocular adverse events that are not related to the test article, study treatment, or study procedures may be recorded as "ongoing" without further follow-up.

13.4. Reporting Adverse Events

The Investigator will notify the Sponsor of an adverse event by e-mail, facsimile, or telephone as soon as possible and no later than 24 hours from discovery for any serious /significant adverse events, and 2 days from discovery for any non-significant adverse event. In addition, a written report will be submitted by the Principal Investigator to the IEC/IRB according to their requirements (section 13.4.2). The report will comment whether the adverse event was considered to be related to the test article, study treatment or study procedures.

13.4.1. Reporting Adverse Events to Sponsor

Serious/Significant Adverse Events
The Investigator will inform the sponsor of all serious/significant adverse events occurring during the study period as soon as possible by e-mail or telephone, but no later than 24 hours following discovery of the event. The Investigator is obligated to pursue and obtain information requested by the Sponsor in addition to that information reported on the eCRF. All subjects experiencing a serious/significant adverse event must be followed up and all outcomes must be reported.

When medically necessary, the Investigator may break the randomization code to determine the identity of the treatment that the subject received. The Sponsor and study monitor should be notified prior to unmasking the test articles.

In the event of a serious/significant adverse event, the Investigator must:

- Notify the Sponsor immediately.
- Obtain and maintain in the subject's records all pertinent medical information and medical judgment for colleagues who assisted in the treatment and follow-up of the subject.
- Provide the Sponsor with a complete case history which includes a statement as to whether the event was or was not related to the use of the test article.
- Notify the IEC/IRB as required by the IEC/IRB reporting procedure according to national regulations.

Unanticipated (Serious) Adverse Device Effect (UADE)
In the event of an Unanticipated (Serious) Adverse Device Effect (UADE), the Investigator will submit a report of the UADE to the Sponsor and IEC/IRB as soon as possible, but no later than 24 hours after the Investigator first learns of the effect. This report is in addition to the immediate notification mentioned above.

The Sponsor must conduct an evaluation of the UADE and must report the results of the evaluation to FDA, the IEC/IRB and participating Investigators within 10 working days after the Sponsor first receives notification of the effect.

Non-Serious Adverse Events
All non-serious adverse events, including non-serious adverse device effects, will be reported to the sponsor by the Investigator no later than 2 days from discovery.

13.4.2. Reporting Adverse Events to the Responsible IEC/IRB and Health Authorities

Adverse events that meet the IEC/IRB requirements for reporting must be reported within the IEC/IRB's written guidelines. Each clinical site will refer to and follow any guidelines set forth by their Approving IEC/IRB. Each clinical site will refer to and follow any guidelines set forth by their local governing Health Authorities.

The Sponsor will report applicable Adverse Events to the local health authorities according the written guidelines, including reporting timelines.

13.5. Event of Special Interest

13.5.1. Specific Requirements for Recording and Diagnosing Possible Microbial Keratitis

The signs of a presumed infectious ulcer (defined as progressive erosion of the corneal tissue) may include irregular focal infiltrates (>1 mm); active lesions with raised edges; significant diffuse infiltration; anterior corneal to mid-stromal involvement; erosion with overlying staining; conjunctival and lid edema; anterior chamber reaction (iritis); severe bulbar and limbal redness. Symptoms associated with a presumed infectious ulcer (microbial keratitis, MK) may include pain of rapid onset; severe redness; purulent or mucopurulent discharge; tearing; photophobia. For the purpose of reporting, per the ISO 11980, a presumed corneal ulcer which has any of the following characteristics should be reported as a serious adverse event:[48]

1) Central (6 mm) or paracentral (8 mm) location;
2) Penetration of Bowman's membrane;
3) Infiltrate> 2 mm diameter
4) Associated with iritis ≥ Grade 2;
5) Associated with any increase in intraocular pressure;
6) Culture positive for microorganisms
7) Increasing size of severity at subsequent visits.

In the event of any case of possible microbial keratitis (e.g., presence of an infiltrative lesion), the investigators shall provide complete descriptions of the event. A comprehensive description of diagnostic procedures is provided in [redacted].

The investigator shall record the following in the CRF:

- Presence and severity of pain;
- Presence and type of discharge;
- Presence of lid edema;
- Presence of chemosis;
- Pattern and grading of redness (bulbar/limbal);

- Characterization of infiltrates (size, shape, location, depth) on the Infiltrate Assessment Form;
- Characterization of the epithelial defect (size/depth);
- Involvement of surrounding cornea;
- Endothelial involvement;
- Grading of anterior chamber cell and flare

The investigator shall record the diagnosis and specific treatment on the Adverse Event Form. Where necessary, a culture of the corneal lesion will be collected to determine if the infection is microbial in nature. For example, if an overlying epithelial defect is present and any one of the conditions listed below is present when the infiltrate is first evaluated, the infiltrate must be cultured.

- Diameter greater than 1 mm
- Location within the central (6 mm) optical zone
- Purulent discharge
- Pain
- Photophobia
- Iris/Anterior chamber inflammation

Any corneal lesions meeting the criteria set forth above must be cultured as outlined in the Premarket Notification (510[k]) Guidance Document for Daily Wear Contact Lenses (Revised May 1994).[22] Cultures will be collected with the Sponsor approved culture kits and sent to a study designated laboratory for analysis. The results will be communicated to the Investigator and the Sponsor. See [redacted] for specific procedures that should be followed for culturing of possible cases of infectious keratitis.

For other infiltrative events that do not meet the criteria as specified above, the investigators may culture the lesion when deemed appropriate. If cultures are collected, a source document note should be completed specifying the date of culture collection and laboratory utilized. An eCRF documenting this should be completed.

The following definitions will be used to classify whether the case is definite MK, probable MK, probably not MK, definitely not MK, or MK unrelated to contact lens wear.[23]

- **Definite MK:** one or more central (6 mm) or paracentral (8 mm) corneal stromal infiltrates greater than 2 mm in size with pain rated more than mild, and one of the following:
  - anterior chamber reaction (iritis) Grade 2 or higher
  - mucopurulent discharge
  - positive corneal culture
- **Probable MK:** One or more corneal stromal infiltrates greater than 1 mm, with overlying epithelial defect, with pain more than mild, and at least one of the following additional criteria:
  - anterior chamber reaction;
  - mucopurulent discharge;
  - positive corneal culture;

  - aggressive treatment consistent with standard of care for MK in North America (choice of medication, high frequency dosing of long duration to resolution).
- **Probably not MK:** not meeting any of the above specified MK definitions.
- **Definitely not MK:** not meeting any of the above specified MK definitions and with significant evidence that suggests non-infectious etiology (e.g., reduction in severity without pharmacologic treatment).
- **MK unrelated to contact lens wear:** cases such as *Herpes simplex* keratitis or *Staphylococcal* marginal keratitis, where, in the judgment of the panel, the etiology is unrelated to the wear of contact lenses.

13.5.2. Loss of Best Sphero-cylindrical Corrected Visual Acuity without Physical Cause

At the final study visit, if it is found that best sphero-cylindrical corrected visual acuity (BSCVA) of a subject is less than 20/25 (0.1 logMAR) in either eye and is more than 1.5 lines worse than that was measured at baseline without any physical cause (confirmed through up to 3 repeated independent measures to rule out potential measurement errors or variations), an adverse event will be filed. The subject will be followed until the best corrected visual acuity is no more than 1.5 lines worse than baseline or is stabilized before being discontinued from the study. A decrease of more than 1.5 lines of BSCVA is considered a significant change. This criterion is established based on the 95% limits of agreement of repeated measures of visual acuity in children.[24] It is not anticipated that development of amblyopia (defined as a reduction of BSCVA to 20/30 or worse or a two-line difference between the two eyes, in the absence of pathology[25-27]) will occur while wearing the investigational soft contact lens. Upon identifying the first confirmed case of amblyopia during the course of the study, the event will be investigated and followed according to procedures specified for an Unanticipated Adverse Device Effect (section 11 and section 13.1).

13.6. Reporting of Pregnancy

Subjects reporting pregnancy (by self-report) during the study will be discontinued after the event is recorded as an Adverse Event. Once discontinued, pregnant participants and their fetuses will not be monitored for study related purposes. Pregnant participants are not discontinued from contact lens or solution related studies for safety concerns, but due to general concerns relating to pregnancy and contact lens use. Specifically, pregnant women are discontinued due to fluctuations in refractive error and/or visual acuity that occur secondary to systemic hormonal changes, and not due to unforeseen health risks to the mother or fetus.

14. STATISTICAL METHODS

14.1. General Considerations

Statistical Analysis will be undertaken by the sponsor or under the authority of the sponsor. A general description of the statistical methods to be implemented in this clinical trial is outlined below. More details will be included in the stand-alone Statistical Analysis Plan (SAP). The SAP will be developed and finalized prior to database lock.

All data summaries and statistical analyses will be performed using the SAS software Version 9.4 or higher (SAS Institute, Cary, NC).[21] Throughout the analysis of data, the results for each subject/eye will be used when available for summarization and statistical analysis. Unscheduled visits will be summarized separately and will be excluded from the statistical analysis.

Summary tables (descriptive statistics and/or frequency tables) will be provided for all baseline variables, efficacy variables and safety variables as appropriate. Continuous variables will be summarized with descriptive statistics (n, mean, standard deviation (SD), median, minimum and maximum). Frequency count and percentage of subjects or eyes within each category will be provided for categorical data.

14.2. Sample Size Justification

The plan is to enroll approximately 75 eligible subjects with a minimum of 50 subjects targeted to compete the study. Given no historical data is available for the Control lens (MiSight 1 Day), a power analysis for the primary endpoint was conducted to estimate statistical power based on historical data for the Test lens (EMO-118) under various scenarios with different assumptions and sample sizes.

EMO-118 and EMO-114 lenses were evaluated in a historical study ([redacted]) with a parallel group design. Table 7 below presents the descriptive statistics of distance binocular logMAR VA under bright HLHC at 1-week follow-up observed from [redacted]

Table 7: Descriptive Summaries of Binocular LogMAR Visual Acuity at 1-week Follow-up from [redacted] – Per Protocol Subjects

	EMO-114	EMO-118
Number of subjects	42	41
Mean (SD)	-0.12 (0.083)	-0.08 (0.084)

SD = standard deviation

Considering different number of subjects to complete the study (i.e., 40, 50, or 60), a power analysis was conducted for the primary hypothesis based on the assumptions for correlation between repeated measures, standard deviation for the Control lens, and effect size (i.e., mean difference between the Test and the Control). It was assumed that the standard deviation of MiSight is the same EMO-118 with respect to distance binocular HLHC logMAR VA. Power was estimated using a paired sample *t*-test with a 2-sided type I error rate of 5% and non-inferiority margin of 0.05. The calculation was performed using the POWER procedure in SAS Version 9.4. Table 8 below shows the estimated statistical power under different scenarios. Given time and resource constraints, fifty subjects have been considered as the optimal number which demonstrated an acceptable level of statistical power under most assessed scenarios. Therefore, the plan is to enroll approximately 75 eligible subjects with a minimum of 50 subjects targeted to compete the study.

Table 8: Power Analysis for the Primary Hypothesis

Endpoint	Standard Deviation	Mean Difference (EMO-118 - MiSight)	Correlation	Completed Subjects	Power
Distance Binocular HLHC LogMAR VA	0.084	0	0.3	40	87.3%
				50	93.7%
				60	96.9%
			0.5	40	95.6%
				50	98.5%
				60	99.5%
		0.01	0.3	40	69.9%
				50	79.7%
				60	86.6%
			0.5	40	83.6%
				50	91.0%
				60	95.2%

14.3. Analysis Populations

The following analysis populations will be defined and used in the analysis and presentation of the data.

Safety Population:
All subjects who are administered any test article excluding subjects who drop out prior to administering any test article. At least one observation should be recorded. Subjects will be analyzed as per treatment received.

Per-Protocol Population:
All subjects who successfully complete all visits and do not substantially deviate from the protocol as determined by the trial cohort review committee prior to database hard lock. Justification for the exclusion of subjects with protocol deviations from the per-protocol population set will be documented in a memo to file. See section 10 for definition and examples of major deviations.

Intent-to-Treat (ITT) Population:
All randomized subjects regardless of actual treatment and subsequent withdrawal from the study or deviation from the protocol. At least one observation should be recorded. Subjects will be analyzed as per randomized treatment.

14.4. Level of Statistical Significance

The planned primary analysis for this study will be conducted with a two-sided type I error rate of 5%. Each exploratory analysis will be conducted with a two-sided type I error rate of 5%.

14.5. Primary Analysis

Primary Efficacy Endpoint

Binocular Distance (4m) logMAR Visual Acuity (VA)
Non-inferiority of the EMO-118 compared to the MiSight lens with respect to the primary endpoint of distance binocular HLHC logMAR visual acuity will be assessed on the Per-protocol population (PP).

The distance binocular logMAR VA under HLHC will be analyzed using a linear mixed model at the follow-up evaluation. The model will include lens type, lens sequence, period, and first-order carryover as fixed effects and interaction between lens type and period will be evaluate. Other subject characteristics such as age, gender and race will be included as fixed covariates when appropriate. Site will be included in the model as a random effect (G-side). The covariance of residuals between measurements from different periods within the same subject (R-side) will be modeled using Unstructured (UN) covariance structure. If the model does not converge, the compound Symmetry (CS) covariance structure will be considered. The Kenward and Roger method will be used for the denominator degree of freedom.[28]

Hypothesis Testing
The null and alternative hypotheses for testing non-inferiority of the EMO-118 lens relative to the MiSight lens with respect to logMAR visual acuity are as follows:

$$H_0\colon\ \mu_{EMO118} - \mu_{MiSight} \geq 0.05$$
$$H_A\colon \mu_{EMO118} - \mu_{MiSight} < 0.05$$

Where, μ_{EMO118} represents the mean logMAR VA score for the EMO-118 lens and $\mu_{MiSight}$ represents the mean logMAR VA score for the MiSight lens. Non-inferiority will be declared if the upper bound of the 2-sided 95% confidence interval (CI) of the mean difference (EMO-118 – MiSight) is less than 0.05.

Primary Safety Endpoint
Primary safety endpoint will be evaluated by tabulations of contact lens related (i.e., related and possibly related) serious and significant ocular adverse events and will be summarized by treatment across all visits. The tables will present the number and percentage of eyes and subjects by diagnosis and sorted by decreasing frequency based on the total number of reports.

Additionally, all ocular and non-ocular adverse events will be summarized by seriousness (i.e., ocular AEs by serious, significant and all other ocular AEs, and non-ocular AEs by serious and non-serious), relatedness, severity and diagnosis. A listing of all adverse events including all

information of an event (e.g., diagnosis, duration, treatment and resolution status) will be provided.

14.6. Secondary Analysis

Not applicable.

14.7. Other Exploratory Analysis

Exploratory hypotheses on distance binocular HLHC logMAR VA will be assessed using the same model as the primary analysis. Comparisons between EMO-114 and the other two study lenses will be conducted based on the 2-sided 95% CIs constructed for the mean differences between EMO-114 and EMO-118 (EMO-114 – EMO-118) and between EMO-114 and MiSight (EMO-114 – MiSight). Superiority of EMO-114 lens relative to EMO-118 lens will be declared if the upper bound of the 95% CI for the mean difference is less than 0. Superiority of EMO-114 lens relative to MiSight lens will be declared if the upper bound of the corresponding 95% CI is less than 0.

Patient-reported outcome (PRO) items will be used to measure subjective vision, comfort, and ease of handling, with descriptive summaries tabulated by lens type. Exploratory analysis will be conducted to evaluate the psychometric properties of these PRO measures.

Descriptive data summaries will be tabulated by lens type for all other exploratory endpoints. A by-subject listing of all adverse events (ocular and non-ocular AEs) will be provided.

As supplementary analyses to support the primary analysis, two sensitivity analyses may be considered. (1) If non-inferiority for the primary endpoint is met with subjects in the per-protocol population, a sensitivity analysis using ITT population may be considered. (2) To evaluate the impact of missing data, a sensitivity analysis using ITT population with missing data imputed may be conducted using multiple imputation methods if the proportion of subject dropout is greater than the 15%. The SAS/STAT procedures PROC MI and PROC MIANALYZE will be utilized with a parametric regression method using the fully conditional method (FCS) to make at least 50 imputations.[21]

14.8. Interim Analysis

Not applicable.

14.9. Procedure for Handling Missing Data and Drop-Outs

Subject dropout is expected to be one of the main reasons of missing data in this clinical trial. Past clinical trials don't provide the evidence that subject dropout is systematic or not-at-random. Missing or spurious values will not be imputed. The count of missing values will be included in the summary tables and listings.

14.10. Procedure for Reporting Deviations from Statistical Plan

The analysis will be conducted according to that specified in above sections. There are no known reasons for which it is planned to deviate from these analysis methods. If for any reason a change is made, the change will be documented in the study report along with a justification for the change.

15. DATA HANDLING AND RECORD KEEPING/ARCHIVING

15.1. Electronic Case Report Form/Data Collection

The data for this study will be captured on electronic case report forms (eCRFs) using the BioClinica EDC system. An authorized data originator will enter study data into the eCRFs using the EDC system. Data collected on equipment that is not captured in EDC will be formatted to the specification of the JJVC database manager and sent to JJVC for analysis.

External data sources for this study include: Not Applicable

The clinical data will be recorded on dedicated eCRFs specifically designed to match the study procedures for each visit. Only specifically delegated staff can enter data on a CRF. Once completed, the eCRFs will be reviewed for accuracy and completeness and signed by the Investigator. The sponsor or sponsor's representatives will be authorized to gain access to the subject recordation for the purposes of monitoring and auditing the study.

Edit checks, electronic queries, and audit trails are built into the system to ensure accurate and complete data collection. Data will be transmitted from the clinical site to a secure central database as forms are completed or updated, ensuring information accuracy, security, and confidentiality. After the final database lock, the Investigator will be provided with Individual Patient Profiles (IPP) including the full audit trail on electronic media in PDF format for all of the study data. The IPP must be retained in the study files as a certified copy of the source data for the study.

The content and structure of the eCRFs are compliant with ISO14155:2011.[1]

15.2. Subject Record

At a minimum, subject record should be available for the following:

- subject identification
- eligibility
- study identification
- study discussion
- provision of and date of informed consent
- visit dates
- results of safety and efficacy parameters as required by the protocol
- a record of all adverse events
- follow-up of adverse events

- medical history and concomitant medication
- test article receipt/dispensing/return records
- date of study completion
- reason for early discontinuation of test article or withdrawal from the study, if applicable

The subject record is the eCRF or an external record. The author of an entry in the subject record must be identifiable. The first point of entry is considered to be the source record.

Adverse event notes must be reviewed and initialed by the Investigator.

15.3. Trial Registration on ClinicalTrials.gov

This study will be registered on ClinicalTrials.gov by the Sponsor because this study is in the confirmatory clinical trial phase.

16. DATA MANAGEMENT

16.1. Access to Source Data/Document

The Investigator/Institution will permit trial-related monitoring, audits, IEC/IRB review and regulatory inspection(s) by providing direct access to source data/documents. Should the clinical site be contacted for an audit by an IEC/IRB or regulatory authority, JJVC must be contacted and notified in writing within 24 hours.

16.2. Confidentiality of Information

Information concerning the investigational product and patent application processes, scientific data or other pertinent information is confidential and remains the property of JJVC. The Investigator may use this information for the purposes of the study only. It is understood by the Investigator that JJVC will use information developed in this clinical study in connection with the development of the investigational product and therefore may disclose it as required to other clinical investigators and to regulatory agencies. In order to allow the use of the information derived from this clinical study, the Investigator understands that he/she has an obligation to provide complete test results and all data developed during this study to the Sponsor.

16.3. Data Quality Assurance

Steps will be taken to ensure the accuracy and reliability of data, include the selection of qualified investigators and appropriate clinical sites and review of protocol procedures with the Principal Investigator. The Principal Investigator, in turn, must ensure that all Sub-Investigators and clinical site personnel are familiar with the protocol and all study-specific procedures and have appropriate knowledge of the study article.

Training on case report form completion will be provided to clinical site personnel before the start of the study. The Sponsor will review case report forms for accuracy and completeness remotely during the conduct of the study, during monitoring visits, and after transmission to data management. Any data discrepancies will be resolved with the Investigator or designee, as appropriate.

Quality Assurance representatives from JJVC may visit clinical sites to review data produced during the study and to access compliance with applicable regulations pertaining to the conduct of clinical trials. The clinical sites will provide direct access to study-related source data/documents and reports for the purpose of monitoring and auditing by JJVC and for inspection by local and regulatory authorities.

16.4. Data Monitoring Committee (DMC)

Not applicable.

17. CLINICAL MONITORING

The study monitors will maintain close contact with the Principal Investigator and the Investigator's designated clinical site personnel. The monitor's responsibilities will include:

- Ensuring that the investigation is being conducted according to the protocol, any subsequent versions, and regulatory requirements are maintained.
- Ensuring the rights and wellbeing of subjects are protected.
- Ensuring adequate resources, including facilities, laboratories, equipment, and qualified clinical site personnel.
- Ensuring that protocol deviations are documented with corrective action plans, as applicable.
- Ensuring that the clinical site has sufficient test article and supplies.
- Clarifying questions regarding the study.
- Resolving study issues or problems that may arise.
- Reviewing of study records and source documentation verification in accordance with the monitoring plan.

18. ETHICAL AND REGULATORY ASPECTS

18.1. Study-Specific Design Considerations

Potential subjects and their parents/legal guardians will be fully informed of the risks and requirements of the study and, during the study, subjects and their parents/legal guardians will be given any new information that may affect their decision to continue participation. Subjects and their parents/legal guardians will be told that their consent to participate in the study is voluntary and may be withdrawn at any time with no reason given and without penalty or loss of benefits to which they would otherwise be entitled. Subjects will only be enrolled if the subject's parents/legal guardians are fully able to understand the risks, benefits, and potential adverse events of the study and provide their consent voluntarily, and, the subject provides their assent voluntarily.

18.2. Investigator Responsibility

The Principal Investigator is responsible for ensuring that the clinical study is performed in accordance with the signed agreement, the investigational plan, section 4 of the ICH E6(R2) guidelines on Good Clinical Practice (GCP),[2] and applicable regulatory requirements. GCP is an international ethical and scientific quality standard for designing, conducting, recording, and reporting studies that involve the participation of human subjects. Compliance with this standard provides public assurance that the rights, safety, and well-being of study subjects are protected, consistent with the principles of the Declaration of Helsinki 64th WMA General Assembly 2013[3] and that the clinical study data are credible. The Investigator must maintain clinical study files in accordance with section 8 of the ICH E6(R2) guidelines on Good Clinical Practice (GCP),[2] and applicable regulatory requirements.

18.3. Independent Ethics Committee or Institutional Review Board (IEC/IRB)

Before the start of the study, the Investigator (or Sponsor when applicable) will provide the IEC/IRB with current and complete copies of the following documents (where applicable):

- Final protocol.
- Sponsor-approved informed consent form (and any other written materials to be provided to the subjects)
- Investigator's Brochure (or equivalent information).
- Sponsor-approved subject recruitment materials.
- Information on compensation for study-related injuries or payment to subjects for participation in the study.
- Investigator's curriculum vitae, clinical licenses, or equivalent information (unless not required, as documented by IEC/IRB).
- Information regarding funding, name of the Sponsor, institutional affiliations, other potential conflicts of interest, and incentives for subjects.
- Any other documents that the IEC/IRB requests to fulfill its obligation.

This study will be undertaken only after IEC/IRB has given full approval of the final protocol, the informed consent form, applicable recruiting materials, and subject compensation programs, and the Sponsor has received a copy of this approval. This approval letter must be dated and must clearly identify the documents being approved.

During the study, the Investigator (or Sponsor when applicable) will send the following documents to the IEC/IRB for their review and approval, where appropriate:

- Protocol revisions
- Revision(s) to informed consent form and any other written materials to be provided to subjects
- If applicable, new or revised subject recruitment materials approved by the Sponsor
- Revisions to compensation for study-related injuries or payment to subjects for participation in the study
- Investigator's Brochure revisions
- Summaries of the status of the study (at least annually or at intervals stipulated in guidelines of the IEC/IRB)

- Reports of adverse events that are serious, unanticipated, and associated with the test articles, according to the IRB's requirements
- New information that may adversely affect the safety of the subjects or the conduct of the study
- Major protocol deviations as required by the IEC/IRB
- Report of deaths of subjects under the Investigator's care
- Notification if a new Investigator is responsible for the study at the clinical site
- Any other requirements of the IEC/IRB

For protocol revisions that increase subject risk, the revisions and applicable informed consent form revisions must be submitted promptly to the IEC/IRB for review and approval before implementation of the change(s).

At least once a year, the IEC/IRB will review and reapprove this clinical study. This request should be documented in writing.

At the end of the study, the Investigator (or Sponsor where required) will notify the IEC/IRB about the study completion. Documentation of this notification must be retained at the clinical site and a copy provided to the CRO or Sponsor as applicable.

18.4. Informed Consent

Each subject must give written assent and their parents (legal guardians) must give written consent according to local requirements after the nature of the study has been fully explained. The consent and assent forms must be signed before performance of any study-related activity. The consent and assent forms that are used must be approved by both the Sponsor and by the reviewing IEC/IRB. The informed consent and assent are in accordance with principles that originated in the Declaration of Helsinki,[3] current ICH GCP[2] and ISO 14155[1] guidelines, applicable regulatory requirements, and Sponsor Policy.

Before entry into the study, the Investigator or an authorized member of the clinical site personnel must explain to potential subject and the parent (legal guardian) the aims, methods, reasonably anticipated benefits, and potential hazards of the study, and any discomfort it may entail. Subjects and their parents (legal guardians) will be informed that their participation is voluntary and that they may withdraw consent to participate at any time.

The subject and parent (legal guardian) will be given sufficient time to read the Information and Assent form and the informed consent form (Parental Permission Form and Authorization to Use and Disclose Medical Information), respectively, and the opportunity to ask questions. After this explanation and before entry into the study, assent and consent should be appropriately recorded by means of the subject's and parent/legal guardian's dated signatures. After having obtained the consent and assent, a copy of the informed consent and assent forms must be given to the subject.

18.5. Privacy of Personal Data

The collection, processing and disclosure of personal data and medical information related to the Study Subject, and personal data related to Principal Investigator and any clinical site personnel (e.g., name, clinic address and phone number, curriculum vitae) is subject to compliance with the Health Information Portability and Accountability Act (HIPAA) in the United States[29] and other applicable personal data protection and security laws and regulations. Appropriate measures will be employed to safeguard these data, to maintain the confidentiality of the person's related health and medical information, to properly inform the concerned persons about the collection and processing of their personal data, to grant them reasonable access to their personal data and to prevent access by unauthorized persons.

All information obtained during the course of the investigation will be regarded as confidential. All personal data gathered in this trial will be treated in strictest confidence by Investigators, monitors, Sponsor's personnel and IEC/IRB. No data will be disclosed to any third party without the express permission of the subject concerned, with the exception of Sponsor personnel (monitor, auditor), IEC/IRB and regulatory organizations in the context of their investigation related activities that, as part of the investigation will have access to the CRFs and subject records.

The collection and processing of personal data from subjects enrolled in this study will be limited to those data that are necessary to investigate the efficacy, safety, quality, and utility of the investigational product(s) used in this study.

These data must be collected and processed with adequate precautions to ensure confidentiality and compliance with applicable data privacy protection laws and regulations.
The Sponsor ensures that the personal data will be:

- processed fairly and lawfully.
- collected for specified, explicit, and legitimate purposes and not further processed in a way incompatible with these purposes.
- adequate, relevant, and not excessive in relation to said purposes.
- accurate and, where necessary, kept current.

Explicit consent for the processing of personal data will be obtained from the participating subject before collection of data. Such consent should also address the transfer of the data to other entities and to other countries.

The subject has the right to request through the Investigator access to his personal data and the right to request rectification of any data that are not correct or complete. Reasonable steps should be taken to respond to such a request, taking into consideration the nature of the request, the conditions of the study, and the applicable laws and regulations.

Appropriate technical and organizational measures to protect the personal data against unauthorized disclosures or access, accidental or unlawful destruction, or accidental loss or alteration must be put in place. Sponsor personnel whose responsibilities require access to personal data agree to keep the identity of study subjects confidential.

19. STUDY RECORD RETENTION

In compliance with the ICH GCP guidelines,[2] the Investigator/Institution will maintain all CRFs and all subject records that support the data collected from each subject, as well as all study documents as specified in ICH GCP[2] and all study documents as specified by the applicable regulatory requirement(s). The Investigator/Institution will take measures to prevent accidental or premature destruction of these documents.

Essential documents must be retained until at least two (2) years after the last approval of a marketing application in an ICH region and until there are no pending or contemplated marketing applications in an ICH region or until at least two (2) years have elapsed since the formal discontinuation of clinical development of the investigational product. These documents will be retained for a longer period if required by the applicable regulatory requirements or instructed by the Sponsor. It is the responsibility of the Sponsor to inform the Investigator/Institution as to when these documents no longer need to be retained.

If the responsible Investigator retires, relocates, or for other reasons withdraws from the responsibility of keeping the study records, custody must be transferred to a person who will accept the responsibility. The Sponsor must be notified in writing of the name and address of the new custodian. Under no circumstance shall the Investigator relocate or dispose of any study documents before having obtained written approval from the Sponsor.

If it becomes necessary for the Sponsor or the appropriate regulatory authority to review any documentation relating to this study, the Investigator must permit access to such reports.
If the Investigator has a question regarding retention of study records, he/she should contact JJVC.

20. FINANCIAL CONSIDERATIONS

Remuneration for study services and expenses will be set forth in detail in the Clinical Research Agreement. The Research Agreement will be signed by the Principal Investigator and a JJVC management representative prior to study initiation.

JJVC reserves the right to withhold remuneration for costs associated with protocol violations such as:

- Continuing an ineligible subject in the study.
- Scheduling a study visit outside the subject's acceptable visit range.

JJVC reserves the right to withhold final remuneration until all study related activities have been completed, such as:

- Query resolution.
- Case Report Form signature.
- Completion of any follow-up action items.

21. PUBLICATION

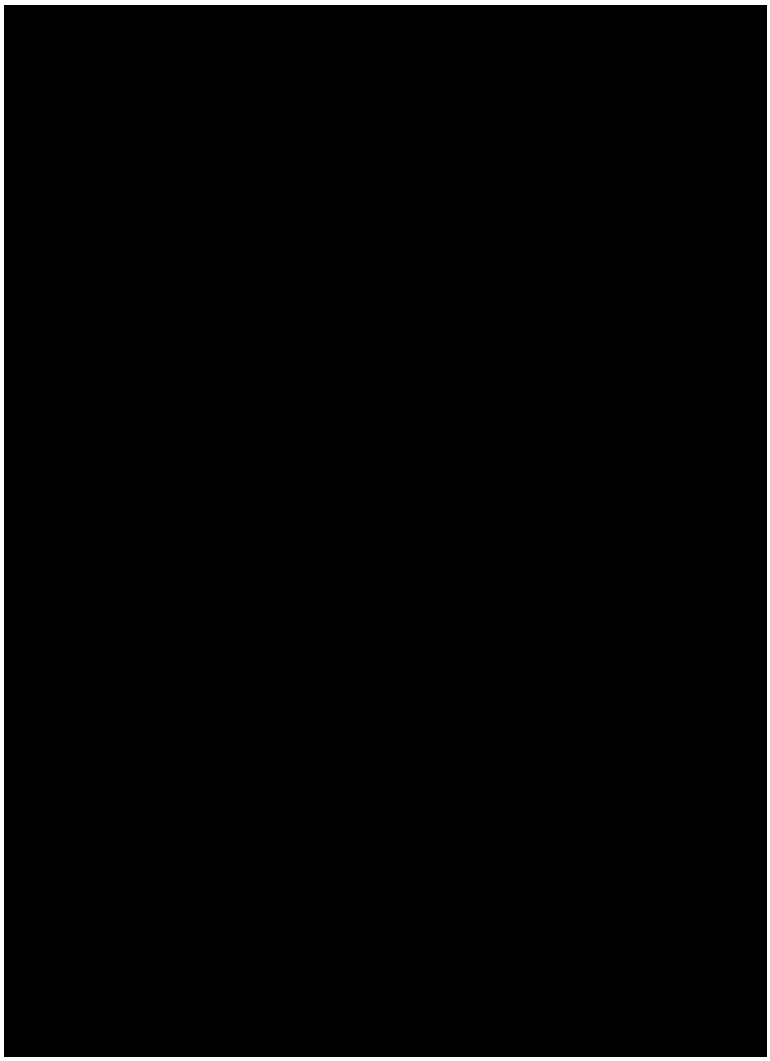
There is no plan to publish this outcome of this investigation.

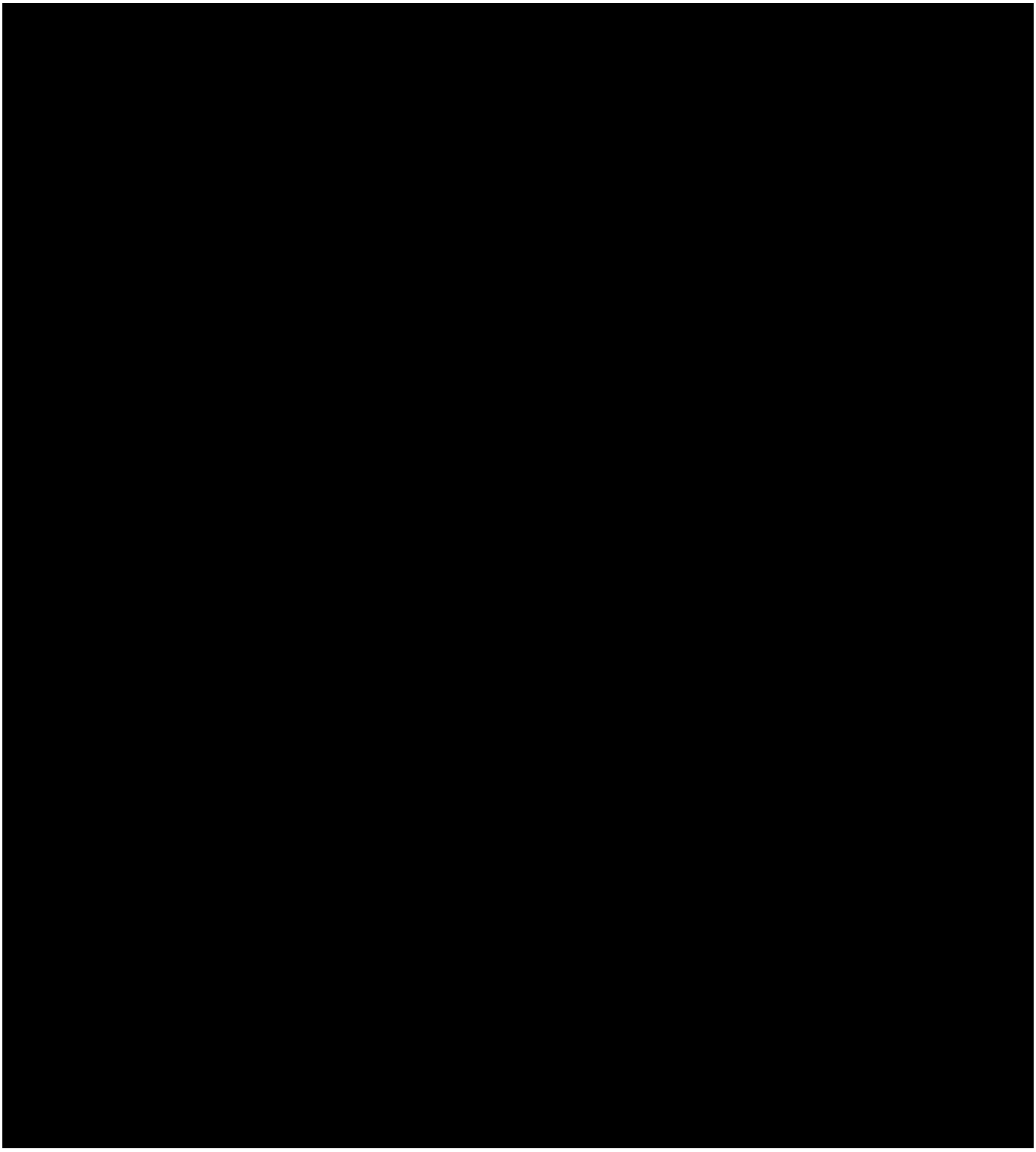
22. REFERENCES

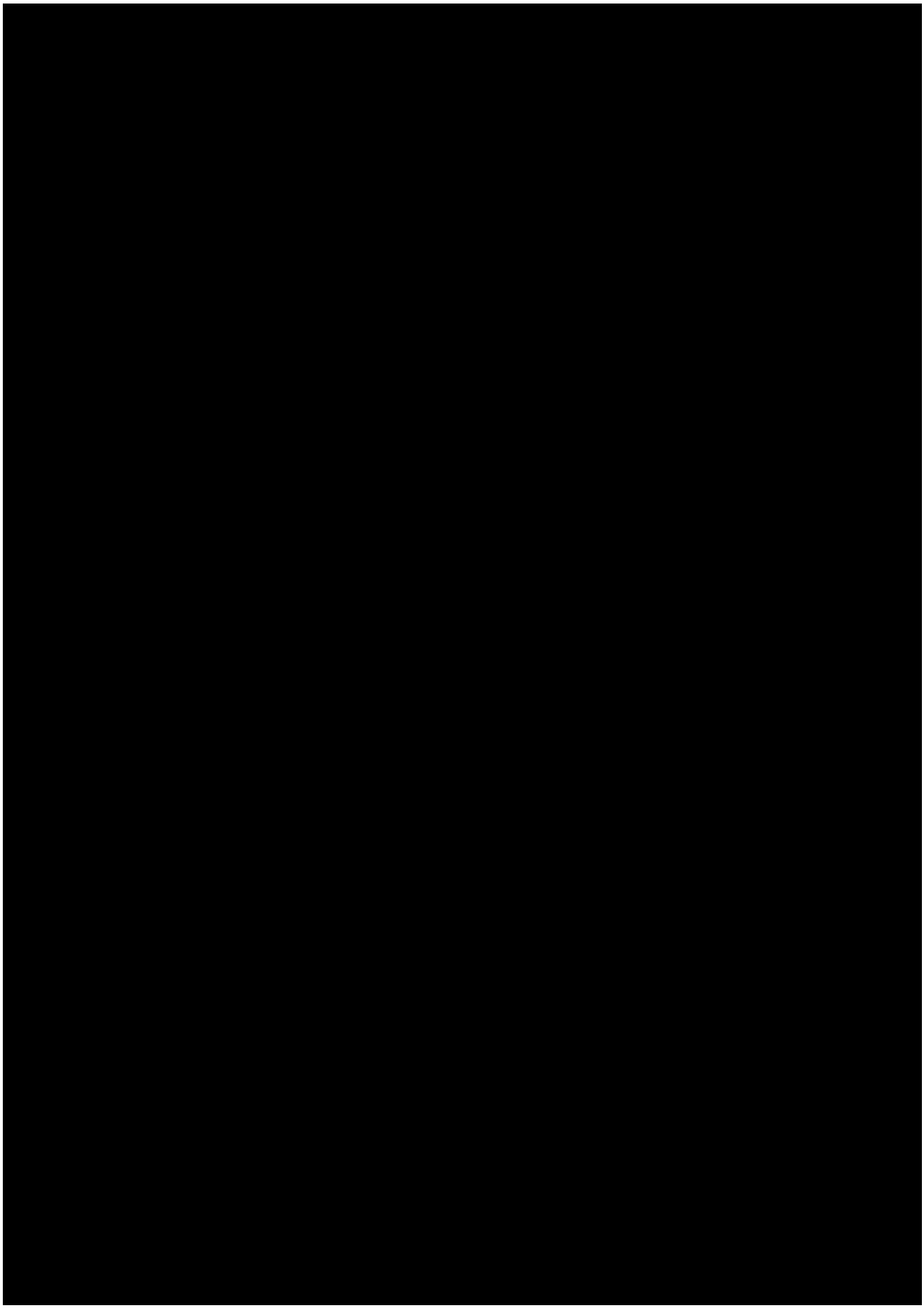
1. ISO 14155:2020: Clinical Investigation of Medical Devices for Human Subjects — Good Clinical Practice. Available at https://www.iso.org/standard/45557.html
2. International Conference on Harmonization Good Clinical Practice E6 (ICH-GCP). Available at http://www.ich.org/products/guidelines/efficacy/article/efficacy-guidelines.html
3. Declaration of Helsinki - Ethical principles for Medical Research Involving Human Subjects. Available at https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/
4. United States (US) Code of Federal Regulations (CFR). . Available at https://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR
5. Cheng X. Clinical Study Report [redacted] *Evaluating Soft Contact Lens Prototypes for Myopia Control*. October 25, 2019
6. Cheng X. Clinical Study Protocol [redacted] *Evaluating a soft contact lens for myopia control*. August 07, 2020
7. Cheng X. Investigator Brochure [redacted] *EMO Design Family Lenses*. May 2021
8. Pomeda AR, Pérez-Sánchez B, Cañadas Suárez MdP, Prieto Garrido FL, Gutiérrez-Ortega R, Villa-Collar C. MiSight Assessment Study Spain. *Eye & Contact Lens: Science & Clinical Practice.* 2018;44:S99-S104.
9. Bullimore M. The Safety of Soft Contact Lenses in Children. *Optom Vis Sci.* 2017;94(6):638-646.
10. Chalmers RL, McNally JJ, Chamberlain P, Keay L. Adverse event rates in the retrospective cohort study of safety of paediatric soft contact lens wear: the ReCSS study. *Ophthalmic and Physiological Optics.* 2020;41(1):84-92.
11. Cheng X, Brennan NA, Toubouti Y, Greenaway NL. Safety of soft contact lenses in children: retrospective review of six randomized controlled trials of myopia control. *Acta Ophthalmologica.* 2019;98(3).
12. Walline JJ, Jones LA, Rah MJ, et al. Contact Lenses in Pediatrics (CLIP) Study: Chair Time and Ocular Health. *Optometry and Vision Science.* 2007;84(9):896-902.
13. Chalmers RL, Hickson-Curran SB, Keay L, Gleason WJ, Albright R. Rates of Adverse Events With Hydrogel and Silicone Hydrogel Daily Disposable Lenses in a Large Postmarket Surveillance Registry: The TEMPO Registry. *Investigative Ophthalmology & Visual Science.* 2015;56(1):654-663.
14. Stapleton F, Edwards K, Keay L, et al. Risk Factors for Moderate and Severe Microbial Keratitis in Daily Wear Contact Lens Users. *Ophthalmology.* 2012;119(8):1516-1521.
15. Richdale K, Cox I, Kollbaum P, et al. CLEAR – Contact lens optics. *Contact Lens and Anterior Eye.* 2021;44(2):220-239.
16. Cheng X. Clinical Study Report [redacted] *Evaluation of Visual Performances of Soft Contact Lens Prototypes for Myopia Control*. December 08, 2017

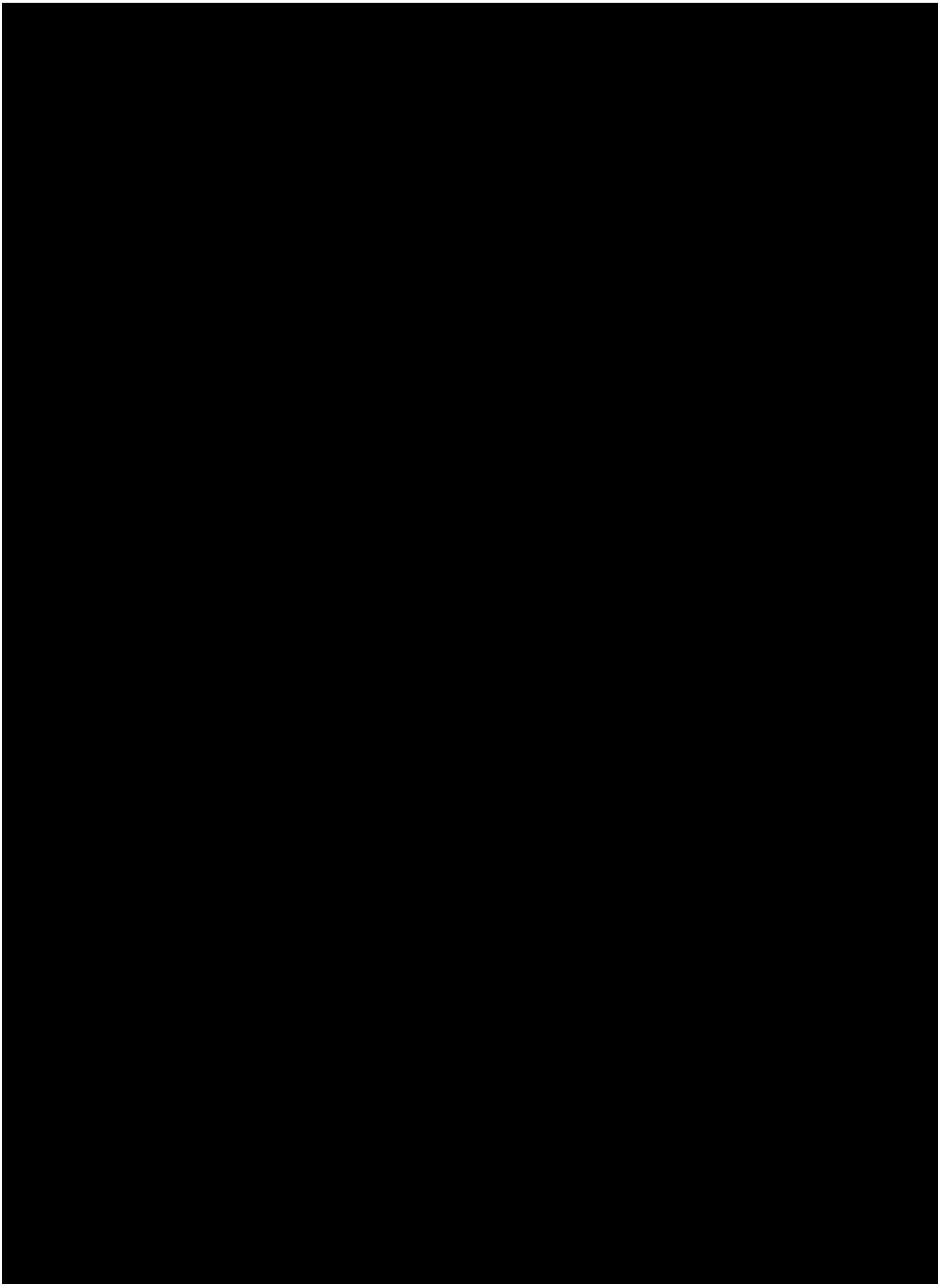
17. Cheng X. Clinical Study Protocol [redacted] *Evaluating Accommodative Responses of Soft Contact Lenses for Myopia Control*. March 27, 2018
18. Nixon A. Clinical Study Report [redacted] *Evaluation of Vision and Fit Performance of a Soft Contact Lens for Myopia Control*. May 29, 2020
19. Cheng X. Clinical Study Protocol [redacted] *Evaluating visual acuity and initial fit performance of two soft contact lenses*. May 06, 2021
20. Williams EJ. Experimental Designs Balanced for the Estimation of Residual Effects of Treatments. *Australian Journal of Chemistry.* 1949;2(2):149.
21. SAS Institute Inc. 2016 SAS/STAT® 14.3 User's Guide. Cary, NC: SAS Institute Inc.
22. FDA Premarket Notification [510(k)] Guidance Document for Daily Wear Contact Lens [May 1994].
23. Bullimore MA, Sinnott LT, Jones-Jordan LA. The Risk of Microbial Keratitis With Overnight Corneal Reshaping Lenses. *Optometry and Vision Science.* 2013;90(9):937-944.
24. Manny RE, Hussein M, Gwiazda J, Marsh-Tootle W. Repeatability of ETDRS Visual Acuity in Children. *Investigative Opthalmology & Visual Science.* 2003;44(8):3294.
25. Attebo K, Mitchell P, Cumming R, Smith W, Jolly N, Sparkes R. Prevalence and causes of amblyopia in an adult population. *Ophthalmology.* 1998;105(1):154-159.
26. Chua B, Mitchell P. Consequences of amblyopia on education, occupation, and long term vision loss. *Br J Ophthalmol.* 2004;88(9):1119-1121.
27. Scheiman M, Wick B. Clinical Management of Binocular Vision- Heterophoric, Accommodative, & Eye Movement Disorders, 4th edn (Wolter Kluwer Health/Lippincott, Williams & Wilkins). 2008;34(6):678-679.
28. Kenward MG, Roger JH. Small Sample Inference for Fixed Effects from Restricted Maximum Likelihood. *Biometrics.* 1997;53(3):983.
29. Health Information Portability and Accountability Act (HIPAA). Available at https://www.hhs.gov/hipaa/for-professionals/privacy/index.html

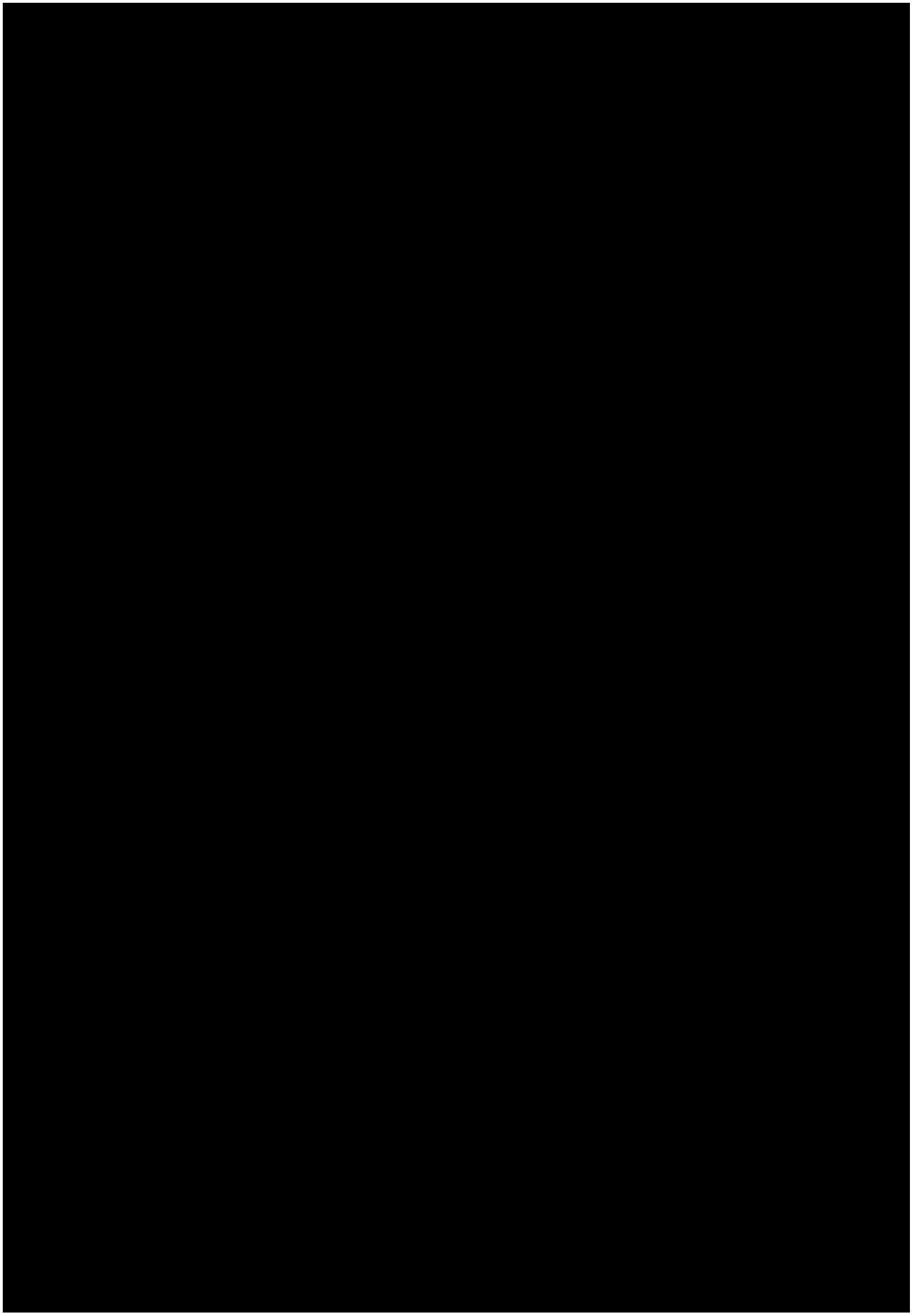
APPENDIX A: PATIENT REPORTED OUTCOMES (STUDY QUESTIONNAIRES)

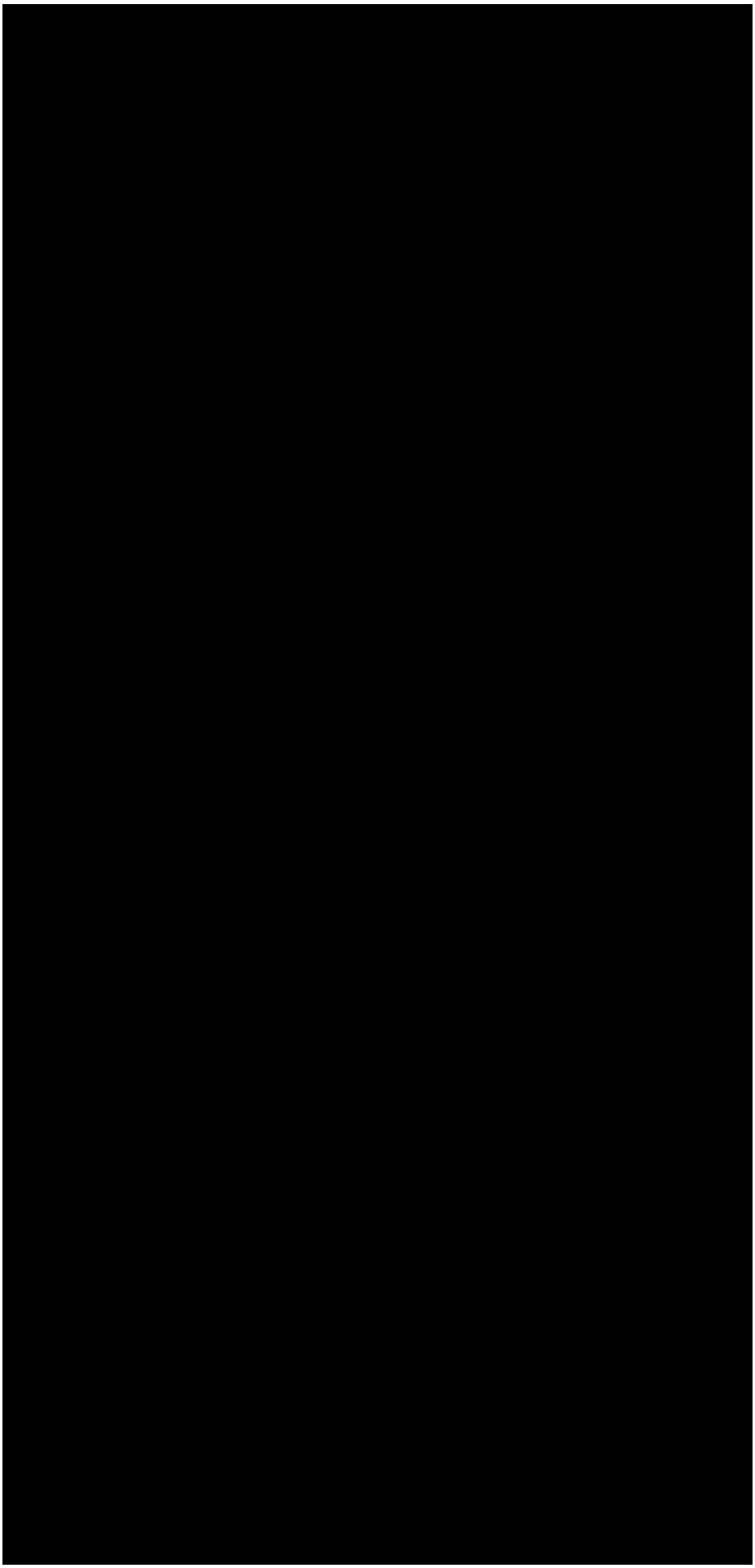












APPENDIX B: PATIENT INSTRUCTION GUIDE

This will be provided separately

APPENDIX C: PACKAGE INSERT (APPROVED PRODUCT)

1-Day Acuvue® Moist Brand Contact Lenses

IMPORTANT: Please read carefully and keep this information for future use.

This Package Insert and Fitting Instruction Guide is intended for the Eye Care Professional, but should be made available to patients upon request.

The Eye Care Professional should provide the patient with the appropriate instructions that pertain to the patient's prescribed lenses. Copies are available for download at www.acuvue.com.

1-DAY ACUVUE® MOIST BRAND CONTACT LENSES

1-DAY ACUVUE® MOIST Brand Contact Lenses

1-DAY ACUVUE® MOIST Brand Contact Lenses for ASTIGMATISM

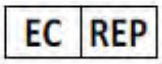
1-DAY ACUVUE® MOIST Brand MULTIFOCAL Contact Lenses

etafilcon A Soft (hydrophilic) Contact Lenses
Visibility Tinted with UV Blocker
for Daily Disposable Wear

℞ Only CAUTION: U.S. Federal law restricts this device to sale by or on the order of a licensed practitioner.

SYMBOLS KEY

The following symbols may appear on the label or packaging:

SYMBOL	DEFINITION
	Consult Instructions for Use
	Manufacturer
	Date of Manufacture
	Use By Date (expiration date)
	Batch Code
	Sterilized Using Steam Heat
	Do Not Re-Use (Single Use)
	Lens Orientation Correct
	Lens Orientation Incorrect (Lens Inside Out)
	Quality System Certification Symbol
	Fee Paid for Waste Management
	Authorized Representative in the European Community

Visit www.acuvue.com/guides for additional information about symbols.

DESCRIPTION

1-DAY ACUVUE® MOIST Brand Contact Lenses, 1-DAY ACUVUE® MOIST Brand Contact Lenses for ASTIGMATISM, and 1-DAY ACUVUE® MOIST Brand MULTIFOCAL Contact Lenses are soft (hydrophilic) contact lenses available as spherical, toric, or multifocal lenses, and include LACREON® Technology.

The lens material (etafilcon A) is a copolymer of 2-hydroxyethyl methacrylate and methacrylic acid cross-linked with 1, 1, 1-trimethylol propane trimethacrylate and ethylene glycol dimethacrylate.

The lenses are tinted blue using Reactive Blue Dye #4 to make the lenses more visible for handling. A benzotriazole UV absorbing monomer is used to block UV radiation.

Lens Properties:

The physical/optical properties of the lens are:

- Specific Gravity (calculated): 0.98 – 1.12
- Refractive Index: 1.40
- Light Transmittance: 85% minimum
- Surface Character: Hydrophilic
- Water Content: 58%
- Oxygen Permeability (D/k):

VALUE	METHOD
21.4 x 10^{-11} (cm^2/sec) (ml O_2/ml x mm Hg) @ 35°C	Fatt (boundary corrected, edge corrected)
28.0 x 10^{-11} (cm^2/sec) (ml O_2/ml x mm Hg) @ 35°C	Fatt (boundary corrected, non-edge corrected)

Lens Parameters Ranges:

- Diameter (DIA): 12.0 mm to 15.0 mm
- Center Thickness: Varies with power
- Base Curve (BC): 7.85 mm to 10.00 mm
- Spherical Power (D): -20.00D to +20.00D
- Cylinder Power (CYL): -0.25D to -10.00D
- Axis (AXIS): 2.5° to 180°
- ADD Powers: +0.25D to +4.00D

AVAILABLE LENS PARAMETERS

1-DAY ACUVUE® MOIST Brand Contact Lenses are hemispherical shells of the following dimensions:

Diameter (DIA): 14.2 mm

Center Thickness: 0.084 mm to 0.230 mm (varies with power)

Base Curve (BC):	8.5 mm, 9.0 mm
Powers (D):	-0.50D to -6.00D (in 0.25D increments) -6.50D to -12.00D (in 0.50D increments) +0.50D to +6.00D (in 0.25D increments)

1-DAY ACUVUE® MOIST Brand Contact Lenses for ASTIGMATISM are hemitoric shells of the following dimensions:

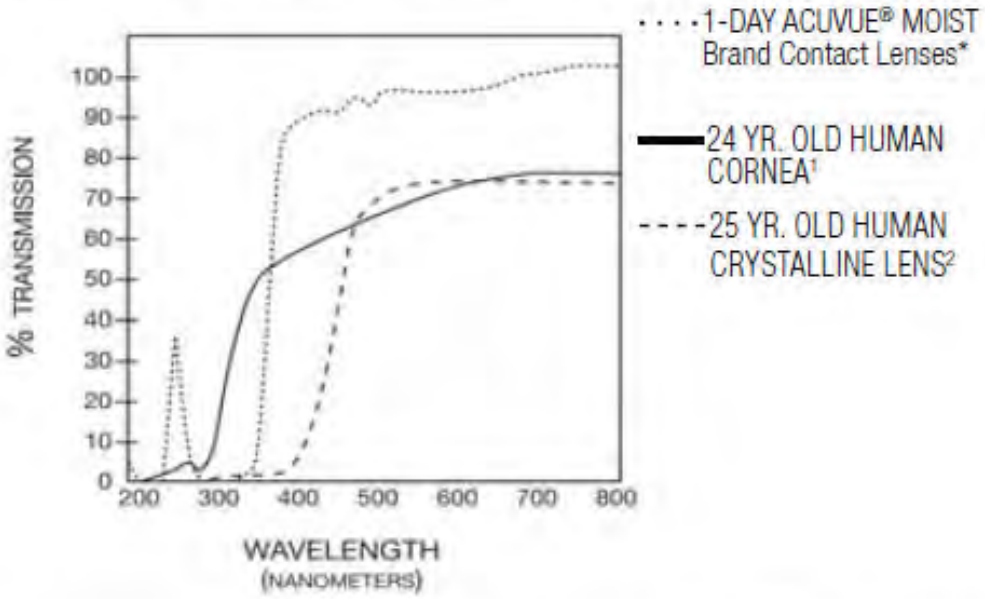
Diameter (DIA):	14.5 mm
Center Thickness:	0.090 mm to 0.189 mm (varies with power)
Base Curve (BC):	8.5 mm
Powers (D):	+0.00 to -6.00D (in 0.25D increments) Cylinders (CYL): -0.75D, -1.25D, -1.75D, -2.25D* Axis (AXIS): 10° to 180° in 10° increments *-2.25D cylinder is available in 10°, 20°, 70°, 80°, 90°, 100°, 110°, 160°, 170°, 180° axes only -6.50D to -9.00D (in 0.50D increments) Cylinders (CYL): -0.75D, -1.25D, -1.75D, -2.25D* Axis (AXIS): 10°, 20°, 60°, 70°, 80°, 90°, 100°, 110°, 120°, 160°, 170°, 180° *-2.25D cylinder is available in 20°, 90°, 160°, 180° axes only +0.25D to +4.00D (in 0.25D increments) Cylinders (CYL): -0.75D, -1.25D, -1.75D Axis (AXIS): 10°, 20°, 70°, 80°, 90°, 100°, 110°, 160°, 170°, 180°

1-DAY ACUVUE® MOIST Brand MULTIFOCAL Contact Lenses are hemispherical shells of the following dimensions:

Diameter (DIA):	14.3 mm
Center Thickness:	0.084 mm to 0.207 mm (varies with power)
Base Curve (BC):	8.4 mm
Powers (D):	+6.00D to -9.00D (in 0.25D increments)
Near ADD Powers (MAX ADD):	Low Near ADD (LOW): +1.25D Medium Near ADD (MID): +1.75D High Near ADD (HGH): +2.50D

TRANSMITTANCE CURVES

1-DAY ACUVUE® MOIST Brand Contact Lenses (etafilcon A) Visibility Tinted with UV Blocker vs. 24 yr. old human cornea and 25 yr. old human crystalline lens.



*The data are representative measurements taken through the central 3-5 mm portion for the thinnest marketed lens (-3.00D lens, 0.084 mm center thickness).

[1] Lerman, S., Radiant Energy and the Eye, MacMillan, New York, 1980, p. 58, figure 2-21

[2] Waxler, M., Hitchins, V.M., Optical Radiation and Visual Health, CRC Press, Boca Raton, Florida, 1986, p. 19, figure 5

WARNING: UV absorbing contact lenses are NOT substitutes for protective UV absorbing eyewear, such as UV absorbing goggles or sunglasses because they do not completely cover the eye and surrounding area. The patient should continue to use UV absorbing eyewear as directed.

ACTIONS

In its hydrated state, the contact lens, when placed on the cornea, acts as a refracting medium to focus light rays on the retina.

The UV Blocking for these lenses averages 97% in the UVB range of 280 nm to 315 nm and 82% in the UVA range of 316 nm to 380 nm for the entire power range.

NOTE: Long-term exposure to UV radiation is one of the risk factors associated with cataracts. Exposure is based on a number of factors such as environmental conditions (altitude, geography, cloud cover) and personal factors (extent and nature of outdoor activities). UV-Blocking contact lenses help provide protection against harmful UV radiation. However, clinical studies have not been done to demonstrate that wearing UV-Blocking contact lenses reduces the risk of developing cataracts or other eye disorders. The Eye Care Professional should be consulted for more information.

INDICATIONS (USES)

1-DAY ACUVUE® MOIST Brand Contact Lenses are indicated for daily disposable wear for the optical correction of refractive ametropia (myopia and hyperopia) in phakic or aphakic persons with non-diseased eyes who may have 1.00D or less of astigmatism.

1-DAY ACUVUE® MOIST Brand Contact Lenses for ASTIGMATISM are indicated for daily disposable wear for the optical correction of refractive ametropia (myopia and hyperopia) in phakic or aphakic persons with non-diseased eyes who may have 0.50D to 3.00D of astigmatism.

1-DAY ACUVUE® MOIST Brand MULTIFOCAL Contact Lenses are indicated for daily disposable wear for the optical correction of distance and near vision in presbyopic phakic or aphakic persons with non-diseased eyes who may have 4.00D of ADD power or less and 0.75D or less of astigmatism.

The lenses contain a UV Blocker to help protect against transmission of harmful UV radiation to the cornea and into the eye.

When prescribed for daily disposable use, no cleaning or disinfection is required. Lenses should be discarded upon removal.

CONTRAINDICATIONS (REASONS NOT TO USE)

DO NOT USE these lenses when any of the following conditions exist:

- Acute or subacute inflammation or infection of the anterior chamber of the eye.
- Any eye disease, injury, or abnormality that affects the cornea, conjunctiva, or eyelids.
- Severe insufficiency of lacrimal secretion (dry eye).
- Corneal hypoesthesia (reduced corneal sensitivity).

- Any systemic disease that may affect the eye or be exaggerated by wearing contact lenses.
- Allergic reactions of ocular surfaces or adnexa that may be induced or exaggerated by wearing contact lenses or use of contact lens solutions.
- Ocular irritation due to allergic reactions which may be caused by use of contact lens solutions (i.e., rewetting drops) that contain chemicals or preservatives (such as mercury, Thimerosal, etc.) to which some people may develop an allergic response.
- Any active corneal infection (bacterial, fungal, protozoal, or viral).
- If eyes become red or irritated.

WARNINGS

Patients should be advised of the following warnings pertaining to contact lens wear:

EYE PROBLEMS, INCLUDING CORNEAL ULCERS, CAN DEVELOP RAPIDLY AND LEAD TO LOSS OF VISION. IF THE PATIENT EXPERIENCES:

- **Eye Discomfort,**
- **Excessive Tearing,**
- **Vision Changes,**
- **Loss of Vision,**
- **Eye Redness, or**
- **Other Eye Problems,**

THE PATIENT SHOULD BE INSTRUCTED TO IMMEDIATELY REMOVE THE LENSES AND PROMPTLY CONTACT THE EYE CARE PROFESSIONAL.

- When prescribed for daily wear, patients should be instructed not to wear their lenses while sleeping. Clinical studies have shown that when lenses are worn overnight, the risk of ulcerative keratitis is greater than among those who do not wear them overnight.[3]
- Studies have shown that contact lens wearers who are smokers have a higher incidence of adverse reactions than nonsmokers.
- Problems with contact lenses or lens care products could result in serious injury to the eye. Patients should be cautioned that proper use and care of contact lenses and lens care products are essential for the safe use of these products.

- The overall risk of ulcerative keratitis may be reduced by carefully following directions for lens care.

[3] New England Journal of Medicine, September 21, 1989; 321 (12), pp. 773-783

Specific Instructions for Use and Warnings:

- **Water Activity**
  Instruction for Use
  Do not expose contact lenses to water while wearing them.

  WARNING:
  Water can harbor microorganisms that can lead to severe infection, vision loss, or blindness. If lenses have been submersed in water when participating in water sports or swimming in pools, hot tubs, lakes, or oceans, the patient should be instructed to discard them and replace them with a new pair. The Eye Care Professional should be consulted for recommendations regarding wearing lenses during any activity involving water.

PRECAUTIONS

Special Precautions for Eye Care Professionals:

- Due to the small number of patients enrolled in clinical investigation of lenses, all refractive powers, design configurations, or lens parameters available in the lens material are not evaluated in significant numbers. Consequently, when selecting an appropriate lens design and parameters, the Eye Care Professional should consider all characteristics of the lens that can affect lens performance and ocular health, including oxygen permeability, wettability, central and peripheral thickness, and optic zone diameter.

  The potential impact of these factors on the patient's ocular health should be carefully weighed against the patient's need for refractive correction; therefore, the continuing ocular health of the patient and lens performance on the eye should be carefully monitored by the prescribing Eye Care Professional.

- Patients who wear these lenses to correct presbyopia using monovision (or modified monovision using 1-DAY ACUVUE® MOIST Brand MULTIFOCAL) may not achieve the best corrected visual acuity for either far or near vision. Visual requirements vary with the individual and should be considered when selecting the most appropriate type of lens for each patient.

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- Fluorescein, a yellow dye, should not be used while the lenses are on the eyes. The lenses absorb this dye and become discolored. Whenever fluorescein is used in eyes, the eyes should be flushed with a sterile saline solution that is recommended for in-eye use.
- Eye Care Professionals should instruct the patient to remove lenses immediately if the eyes become red or irritated.

Eye Care Professionals should carefully instruct patients about the following care regimen and safety precautions.

Handling Precautions:

- Before leaving the Eye Care Professional's office, the patient should be able to promptly remove the lenses or should have someone else available who can remove the lenses for him or her.
- DO NOT use if the sterile blister package is opened or damaged.
- Always wash and rinse hands before handling lenses. Do not get cosmetics, lotions, soaps, creams, deodorants, or sprays in the eyes or on the lenses. It is best to put on lenses before putting on makeup.
- DO NOT touch contact lenses with the fingers or hands if the hands are not free of foreign materials, as microscopic scratches of the lenses may occur, causing distorted vision and/or injury to the eye.
- Carefully follow the handling, insertion, removal, and wearing instructions in the Patient Instruction Guide for these lenses and those prescribed by the Eye Care Professional.
- Always handle lenses carefully and avoid dropping them.
- Never use tweezers or other tools to remove lenses from the lens container. Slide the lens up the side of the bowl until it is free of the container.
- Do not touch the lens with fingernails.

Lens Wearing Precautions:

- If the lens sticks (stops moving) on the eye, follow the recommended directions in "Care for Sticking (Non-Moving) Lenses." The lens should move freely on the eye for the continued health of the eye. If non-movement of the lens continues, the patient should be instructed to immediately consult his or her Eye Care Professional.
- Never wear lenses beyond the period recommended by the Eye Care Professional.

- The patient should be advised to never allow anyone else to wear their lenses. They have been prescribed to fit their eyes and to correct their vision to the degree necessary. Sharing lenses greatly increases the chance of eye infections.
- If aerosol products, such as hairspray, are used while wearing lenses, exercise caution and keep eyes closed until the spray has settled.
- Avoid all harmful or irritating vapors and fumes while wearing lenses.

Lens Care Precautions:

- The patient should be informed that no cleaning or disinfection is needed when lenses are worn for daily disposable wear. Patients should always dispose of lenses when removed and have spare lenses or spectacles available.

Other Topics to Discuss with Patients:

- Always contact the Eye Care Professional before using any medicine in the eyes.
- Certain medications, such as antihistamines, decongestants, diuretics, muscle relaxants, tranquilizers, and those for motion sickness may cause dryness of the eye, increased lens awareness, or blurred vision. Should such conditions exist, proper remedial measures should be prescribed.
- Oral contraceptive users could develop visual changes or changes in lens tolerance when using contact lenses. Patients should be cautioned accordingly.
- As with any contact lens, follow-up visits are necessary to assure the continuing health of the patient's eyes. The patient should be instructed as to a recommended follow-up schedule.

Who Should Know That the Patient is Wearing Contact Lenses?

- Patients should inform all doctors (Health Care Professionals) about being a contact lens wearer.
- Patients should always inform their employer of being a contact lens wearer. Some jobs may require use of eye protection equipment or may require that the patient not wear contact lenses.

ADVERSE REACTIONS

The patient should be informed that the following problems may occur when wearing contact lenses:

- The eye may burn, sting, and/or itch.
- There may be less comfort than when the lens was first placed on the eye.
- There may be a feeling of something in the eye (foreign body, scratched area).
- There may be the potential for some temporary impairment due to peripheral infiltrates, peripheral corneal ulcers, or corneal erosion. There may be the potential for other physiological observations, such as local or generalized edema, corneal neovascularization, corneal staining, injection, tarsal abnormalities, iritis, and conjunctivitis, some of which are clinically acceptable in low amounts.
- There may be excessive watering, unusual eye secretions, or redness of the eye.
- Poor visual acuity, blurred vision, rainbows or halos around objects, photophobia, or dry eyes may also occur if the lenses are worn continuously or for too long a time.

The patient should be instructed to conduct a simple 3-part self-examination at least once a day. They should ask themselves:

- How do the lenses feel on my eyes?
- How do my eyes look?
- Have I noticed a change in my vision?

If the patient reports any problems, he or she should be instructed to IMMEDIATELY REMOVE THE LENS. If the problem or discomfort stops, the patient should discard the lens and place a new fresh lens on the eye.

If after inserting the new lens, the problem continues, the patient should be directed to IMMEDIATELY REMOVE THE LENS AND CONTACT HIS OR HER EYE CARE PROFESSIONAL.

The patient should be advised that when any of the above symptoms occur, a serious condition such as infection, corneal ulcer, neovascularization, or iritis may be present. He or she should be instructed to seek immediate professional identification of the problem and prompt treatment to avoid serious eye damage.

GENERAL FITTING GUIDELINES

A. Patient Selection

Patients selected to wear these lenses should be chosen based on:

- Motivation to wear lenses
- Ability to follow instructions regarding lens wear
- General health
- Ability to adequately handle and care for the lenses
- Ability to understand the risks and benefits of lens wear

Patients who do not meet the above criteria should not be provided with contact lenses.

B. Pre-fitting Examination

Initial evaluation of the patient should begin with a thorough case history to determine if there are any contraindications to contact lens wear. During the case history, the patient's visual needs and expectations should be determined as well as an assessment of their overall ocular, physical, and mental health.

Preceding the initial selection of trial contact lenses, a comprehensive ocular evaluation should be performed that includes, but is not limited to, the measurement of distance and near visual acuity, distance and near refractive prescription (including determining the preferred reading distance for presbyopes), keratometry, and biomicroscopic evaluation.

Based on this evaluation, if it is determined that the patient is eligible to wear these lenses, the Eye Care Professional should proceed to the lens fitting instructions as outlined below.

C. Initial Power Determination

A spectacle refraction should be performed to establish the patient's baseline refractive status and to guide in the selection of the appropriate lens power. Remember to compensate for vertex distance if the refraction is greater than ±4.00D.

D. Base Curve Selection (Trial Lens Fitting)

The following trial lenses should be selected for patients regardless of keratometry readings. However, corneal curvature measurements should be performed to establish the patient's baseline ocular status.

- 1-DAY ACUVUE® MOIST: 8.5 mm/14.2 mm
- 1-DAY ACUVUE® MOIST for ASTIGMATISM: 8.5 mm/14.5 mm
- 1-DAY ACUVUE® MOIST MULTIFOCAL: 8.4 mm/14.3 mm

The trial lens should be placed on each of the patient's eyes and evaluated after the patient has adjusted to the lenses.

1. Criteria of a Properly Fit Lens

   A properly fit lens will center and completely cover the cornea (i.e., no limbal exposure), have sufficient movement to provide tear exchange under the contact lens with the blink, and be comfortable. The lens should move freely when manipulated digitally with the lower lid, and then return to its properly centered position when released.

2. Criteria of a Flat Fitting Lens

   A flat fitting lens may exhibit one or more of the following characteristics: decentration, incomplete corneal coverage (i.e., limbal exposure), excessive movement with the blink and/or edge standoff. If the lens is judged to be flat fitting, it should not be dispensed to the patient.

3. Criteria of a Steep Fitting Lens

   A steep fitting lens may exhibit one or more of the following characteristics: insufficient movement with the blink, conjunctival indentation, and resistance when pushing the lens up digitally with the lower lid. If the lens is judged to be steep fitting, it should not be dispensed to the patient.

If the initial trial base curve is judged to be flat or steep fitting, the alternate base curve, if available, should be trial fit and evaluated after the patient has adjusted to the lens. The lens should move freely when manipulated digitally with the lower lid, and then return to a properly centered position when released. If resistance is encountered when pushing the lens up, the lens is fitting tightly and should not be dispensed to the patient.

E. Final Lens Power (Spherical)

A spherical over-refraction should be performed to determine the final lens power after the lens fit is judged acceptable. The spherical over-refraction should be combined with the trial lens power to determine the final lens prescription. The patient should experience good visual acuity with the correct lens power unless there is excessive residual astigmatism.

Example 1	
Diagnostic lens:	-2.00D
Spherical over-refraction:	-0.25D
Final lens power:	-2.25D

Example 2	
Diagnostic lens:	-2.00D
Spherical over-refraction:	+0.25D
Final lens power:	-1.75D

If vision is acceptable, perform a slit lamp examination to assess adequate fit (centration and movement). If the fit is acceptable, dispense the lenses and instruct the patient to return in one week for reassessment (see **PATIENT MANAGEMENT** section).

All patients should be supplied with a copy of the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

TORIC FITTING GUIDELINES

Although most aspects of the fitting procedure are identical for all types of soft contact lenses, including toric lenses, there are some additional steps and/or rules to follow to assure the proper fit of toric lenses.

The only new steps you must follow in prescribing 1-DAY ACUVUE® MOIST for ASTIGMATISM are that you must determine the stability, repeatability, and drift angle of the lens axis so that you can prescribe the correct lens axis for the patient.

A. How to Determine Lens Cylinder and Axis Orientation

1. Locate the Orientation Marks

To help determine the proper orientation of the toric lens, you'll find two primary marks approximately 1 mm from the lens edge representing the vertical position on opposite ends of the lens at 6 and 12 o'clock (Fig. 1). Because of the lens' ballasting system, either mark can represent the vertical position – there is no "top" and "bottom" as in a prism-ballasted lens. You don't need to view both marks to assess orientation; simply look for the 6 o'clock mark as you would with a prism-ballasted lens.

Figure 1

You'll need a slit lamp biomicroscope with a 1 to 2 mm parallelepiped beam to highlight the marks when the lens is fitted to the eye. There are a number of techniques you can use to improve the visibility of the 6 o'clock mark. Using a parallelepiped beam and medium magnification (10x or 15x), slowly pan down the lens, looking just below the direct illumination at the retroilluminated area. Backlighting the mark this way should make it more visible. Sometimes manipulating the lower lid may be necessary to uncover the mark.

2. Observe Lens Rotation and Stability

Observe the position and stability of the "bottom" mark. It usually stabilizes at the 6 o'clock position. If it does, calculation of the lens power will be straightforward. The 6 o'clock position is not a "must"; however, the absolute requirement is that the axis position be stable and repeatable.

The mark may stabilize somewhat left or right (drift) of the vertical meridian and still enable you to fit a toric lens for that eye, as long as the lens always returns to the same "drift axis" position after settling. The deviation can be compensated for in the final prescription. Your objective is to ensure that whatever position the initial lens assumes near 6 o'clock, this position must be stable and repeatable. With full eye movement or heavy blink, you may see the marks swing away, but they must return quickly to the original stable position. If the lens does not return quickly, you may need to select a different lens.

3. Assessing Rotation

Imagine the eye as a clock dial and every hour represents a 30° interval. If the orientation mark of the initial lens stabilizes somewhat left or right of the vertical position, the final lens will orient on the eye with the same deviation. You can use an axis reticule in the slit lamp or use a line-scribed lens in a spectacle trial frame to measure or estimate the "drift angle" of the cylinder axis.

To compensate for this "drift," measure or estimate the "drift," then add or subtract it from the refractive axis to determine the correct cylinder axis. Use the LARS (Left Add, Right Subtract) method to determine which direction to compensate.

B. Final Lens Power

When the diagnostic lens has its axis aligned in the same meridian as the patient's refractive axis, a spherocylindrical over-refraction may be performed and visual acuity determined. However, in the case of crossed axes, such as when the diagnostic lens axis is different from the spectacle cylinder axis, it is not advisable to perform a full spherocylindrical over-refraction because of the difficulty in computing the resultant power. A spherical over-refraction without cylinder refraction may be performed.

If the required cylinder correction falls between two available cylinder powers, it is recommended to prescribe the lower cylinder power lens. See below for instructions on how to determine the final lens power.

1. For the Sphere

If sphere alone or combined sphere and cylinder Rx > 4.00D, compensate for vertex distance. If sphere alone or combined sphere and cylinder Rx $\leq$ ±4.00D, vertex compensation is not necessary.

2. For the Cylinder

Adjust the axis by the drift angle using the LARS method. Choose a cylinder that is ≤ 0.50D from the refractive cylinder.

3. Case Examples

Example 1

Manifest (spectacle) refraction:

O.D. -2.50D / -1.25D x 180° 20/20
O.S. -2.00D / -1.00D x 180° 20/20

Choose a diagnostic lens for each eye with axis 180°. Place the lens on each eye and allow a minimum of 3 minutes for it to equilibrate, based on the patient's initial response to the lens. If the lens has not yet stabilized, recheck until stable.

Check the orientation of the axis mark. If the bottom axis mark is in the 6 o'clock position on both eyes, choose the appropriate cylinder as listed previously. If the lens has not yet stabilized, recheck until stable.

Here is the Rx prescribed:

O.D. -2.50D / -1.25D x 180°
O.S. -2.00D / -0.75D x 180°

Example 2

Manifest (spectacle) refraction:

O.D. -3.00D / -1.00D x 90° 20/20
O.S. -4.75D / -2.00D x 90° 20/20

Choose diagnostic lenses of -3.00D / -0.75D x 90° for the right eye and -4.50D / -1.75D x 90° for the left eye, the nearest lenses available to the spherical power and axis needed. For the left eye, since the manifest refraction called for -4.75D, compensating for vertex distance the sphere is reduced by 0.25D to -4.50D. The cylinder power will be -1.75D. Place the lens on each eye and allow a minimum of 3 minutes for it to equilibrate, based on the patient's initial response to the lens. If the lens has not yet stabilized, recheck until stable.

Right Eye

The orientation mark on the right lens rotates left from the 6 o'clock position by 10° and remains stable in this position. Compensation for this rotation should be done as follows:

Compensate the 10° axis drift by adding it to the manifest refraction axis.

Here is the Rx prescribed:
O.D. -3.00D / -0.75D x 100°

Left Eye

The orientation mark on the left lens rotates right from the 6 o'clock position by 10° and remains stable in this position. Compensation for this rotation should be done as follows:

Compensate for the 10° axis drift by subtracting it from the manifest refraction axis.

Here is the Rx prescribed:
O.S. -4.50D / -1.75D x 80°

If vision is acceptable, perform a slit lamp examination to assess adequate fit (centration and movement). If fit is acceptable, dispense the lenses instructing the patient to return in one week for reassessment (see **PATIENT MANAGEMENT** section).

All patients should be supplied with a copy of the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

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MULTIFOCAL FITTING GUIDELINES

A. Presbyopic Needs Assessment & Patient Education

Multifocal contact lenses may produce compromise to vision under certain circumstances and the patient should understand that they might not find their vision acceptable in specific situations (i.e., reading a menu in a dim restaurant, driving at night in rainy/foggy conditions, etc.). Therefore, caution should be exercised when the patient is wearing the correction for the first time until they are familiar with the vision provided in visually challenging environments. Occupational and environmental visual demands should be considered. If the patient requires critical visual acuity and stereopsis, it should be determined by trial whether this patient can function adequately with 1-DAY ACUVUE® MOIST MULTIFOCAL. Wearing these lenses may not be optimal for activities such as:

- Visually demanding situations such as operating potentially dangerous machinery or performing other potentially hazardous activities; and
- Driving automobiles (e.g., driving at night). Patients who cannot meet their state driver's license requirements with the 1-DAY ACUVUE® MOIST MULTIFOCAL should be advised to not drive with this correction, OR may require that additional over-correction be prescribed.

1-DAY ACUVUE® MOIST MULTIFOCAL is not recommended for patients who have -1.00D or greater of refractive cylinder as this level of uncorrected cylinder may lead to additional visual compromise. These lenses are available in the following ADD powers:

- Lens "LOW" = low near ADD lens (Max ADD +1.25)
- Lens "MID" = medium near ADD lens (Max ADD +1.75)
- Lens "HGH" = high near ADD lens (Max ADD +2.50)

B. Initial Power Determination

A spectacle refraction should be performed to establish the patient's baseline refractive status and to guide in the selection of the appropriate lens power. Remember to compensate for vertex distance if the refraction is greater than ±4.00D. Determine the spherical equivalent distance prescription for a multifocal patient. Determine the eye dominance using one of the methods below:

Method 1 Determine which eye is the "sighting eye." Have the patient point to an object at the far end of the room. Cover one eye. If the patient is still pointing directly at the object, the eye being used is the dominant (sighting) eye.

Method 2 Determine which eye does not accept added plus power. Place a +1.00D hand-held trial lens in front of one eye and then the other while the distance refractive error correction is in place for both eyes while the patient is viewing the distance visual acuity chart. The eye with the plus over it that the patient notices the greatest reduction in vision is determined to be the dominant eye.

C. Select the Initial Trial Lens

1. For each eye, select the trial lens distance power that is closest to the patient's distance spherical equivalent. Remember to compensate for vertex distance if the refraction is greater than ±4.00D.
2. Select the near power of the lens based on the patients ADD range as follows:
   - ADD: +0.75D to +1.25D use a low near ADD (LOW) lens on each eye
   - ADD: +1.50D to +1.75D use a medium near ADD (MID) lens on each eye
   - ADD: +2.00D to +2.50D use a medium near ADD (MID) on the dominant eye and a high near ADD (HGH) lens on the non-dominant eye
3. Allow the lenses to settle for a minimum of 10 minutes.
4. Assess distance and near vision binocularly and monocularly.
5. Demonstrate the vision under various lighting conditions (normal and decreased illumination) and at distance, intermediate, and near.
6. Make adjustments in power as necessary based on the distance over-refraction. The use of hand-held trial lenses is recommended. Check the impact on distance and near vision.
7. If vision is still unacceptable, make adjustments in power as necessary (see "Multifocal Troubleshooting" below). If distance and near vision are acceptable, perform a slit lamp examination to assess adequate fit (centration and movement). If fit is acceptable, dispense the lenses instructing the patient to return in one week for reassessment (see **PATIENT MANAGEMENT** section).

D. Multifocal Troubleshooting

Unacceptable Near Vision

If it has been determined that no change is required based on the over-refraction, then add +0.25D to the spherical power of the non-dominant eye.

Unacceptable Distance Vision

If it has been determined that no change is required based on the over-refraction, then make the changes as listed below:

- If the patient is wearing two "LOW" ADD lenses, change the dominant eye to a 1-DAY ACUVUE® MOIST sphere lens with a power equal to the spherical equivalent distance prescription.
- If the patient is wearing two "MID" ADD lenses, change the ADD power in the dominant eye to the "LOW" ADD power.
- If the patient is wearing a "MID" ADD lens in the dominant eye and a "HGH" ADD lens in the non-dominant eye, change the non-dominant eye to a "MID" ADD lens and add +0.25D to the distance power.

E. Adaptation

Visually demanding situations should be avoided during the initial wearing period. A patient may at first experience some mild blurred vision, dizziness, headaches and a feeling of slight imbalance. You should explain the adaptational symptoms to the patient. These symptoms may last for a brief minute or for several weeks. The longer these symptoms persist, the poorer the prognosis for successful adaptation.

To help in the adaptation process, the patient can be advised to first use the lenses in a comfortable, familiar environment such as in the home.

Some patients feel that automobile driving performance may not be optimal during the adaptation process. This is particularly true when driving at night. Before driving a motor vehicle, it may be recommended that the patient be a passenger first to make sure that their vision is satisfactory for operating an automobile. During the first several weeks of wear (when adaptation is occurring), it may be advisable for the patient to only drive during optimal driving conditions. After adaptation and success with these activities, the patient should be able to drive under other conditions with caution.

All patients should be supplied with a copy of the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

MONOVISION FITTING GUIDELINES

A. Patient Selection

1. Monovision Needs Assessment

For a good prognosis, the patient should have adequately corrected distance and near visual acuity in each eye. The amblyopic patient or the patient with significant astigmatism (greater than 1.00D) in one eye may not be a good candidate for monovision correction with these lenses.

Occupational and environmental visual demands should be considered. If the patient requires critical vision (visual acuity and stereopsis), it should be determined by trial whether this patient can function adequately with monovision correction. Monovision contact lens wear may not be optimal for activities such as:

- Visually demanding situations such as operating potentially dangerous machinery or performing other potentially hazardous activities; and
- Driving automobiles (e.g., driving at night). Patients who cannot meet their state driver's license requirements with monovision correction should be advised to not drive with this correction, OR may require that additional over-correction be prescribed.

2. Patient Education

All patients do not function equally well with monovision correction. Patients may not perform as well for certain tasks with this correction as they have with spectacles (multifocal, bifocal, trifocal, readers, progressives). Each patient should understand that monovision, as well as other presbyopic alternatives, can create a vision compromise that may reduce visual acuity and depth perception for distance and near tasks. Therefore, caution should be exercised when the patient is wearing the correction for the first time until they are familiar with the vision provided in visually challenging environments (e.g., reading a menu in a dimly lit restaurant, driving at night in rainy/foggy conditions, etc.). During the fitting process, it is necessary for the patient to realize the disadvantages as well as the advantages of clear near vision, and straight ahead and upward gaze that monovision contact lenses provide.

B. Eye Selection

1. Ocular Preference Determination Methods

Generally, the non-dominant eye is corrected for near vision. The following two methods for eye dominance can be used.

Method 1 Determine which eye is the "sighting eye." Have the patient point to an object at the far end of the room. Cover one eye. If the patient is still pointing directly at the object, the eye being used is the dominant (sighting) eye.

Method 2 Determine which eye will accept the added power with the least reduction in vision. Place a hand-held trial lens equal to the spectacle near ADD in front of one eye and then the other while the distance refractive error correction is in place for both eyes. Determine whether the patient functions best with the near ADD lens over the right or left eye.

2. Other Eye Selection Methods

Other methods include the "Refractive Error Method" and the "Visual Demands Method."

Refractive Error Method

For anisometropic correction, it is generally best to fit the more hyperopic (less myopic) eye for distance and the more myopic (less hyperopic) eye for near.

Visual Demands Method

Consider the patient's occupation during the eye selection process to determine the critical vision requirements. If a patient's gaze for near tasks is usually in one direction, correct the eye on that side for near.

Example: A secretary who places copy to the left side of the desk will function best with the near lens on the left eye.

C. Special Fitting Characteristics

1. Unilateral Vision Correction

There are circumstances where only one contact lens is required. As an example, an emmetropic patient would only require a near lens, whereas a bilateral myope would require corrective lenses on both eyes.

Examples:

A presbyopic emmetropic patient who requires a +1.75D ADD would have a +1.75D lens on the near eye and the other eye left without correction.

A presbyopic patient requiring a +1.50D ADD who is -2.50D myopic in the right eye and -1.50D myopic in the left eye may have the right eye corrected for distance and the left eye uncorrected for near.

2. **Near ADD Determination**

Always prescribe the lens power for the near eye that provides optimal near acuity at the midpoint of the patient's habitual reading distance. However, when more than one power provides optimal reading performance, prescribe the least plus (most minus) of the powers.

3. **Trial Lens Fitting**

A trial fitting is performed in the office to allow the patient to experience monovision correction. Lenses are fit according to the **GENERAL FITTING GUIDELINES** for base curve selection described in this Package Insert.

Case history and a standard clinical evaluation procedure should be used to determine the prognosis. Determine the distance correction and the near correction. Next, determine the near ADD. With trial lenses of the proper power in place, observe the reaction to this mode of correction.

Allow the lenses to settle for about 20 minutes with the correct power lenses in place. Walk across the room and have the patient look at you. Assess the patient's reaction to distance vision under these circumstances. Then have the patient look at familiar near objects such as a watch face or fingernails. Again assess the reaction. As the patient continues to look around the room at both near and distance objects, observe the reactions. Only after these vision tests are completed, should the patient be asked to read print. Evaluate the patient's reaction to large print (e.g., typewritten copy) at first and then graduate to newsprint and finally smaller type sizes.

After the patient's performance under the above conditions is completed, tests of visual acuity and reading ability under conditions of moderately dim illumination should be attempted.

An initial unfavorable response in the office, while indicative of a guarded prognosis, should not immediately rule out a more extensive trial under the usual conditions in which a patient functions.

4. Adaptation

Visually demanding situations should be avoided during the initial wearing period. A patient may at first experience some mild blurred vision, dizziness, headaches, and a feeling of slight imbalance. You should explain the adaptational symptoms to the patient. These symptoms may last for a brief minute or for several weeks. The longer these symptoms persist, the poorer the prognosis for successful adaptation.

To help in the adaptation process, the patient can be advised to first use the lenses in a comfortable, familiar environment such as in the home.

Some patients feel that automobile driving performance may not be optimal during the adaptation process. This is particularly true when driving at night. Before driving a motor vehicle, it may be recommended that the patient be a passenger first to make sure that their vision is satisfactory for operating an automobile. During the first several weeks of wear (when adaptation is occurring), it may be advisable for the patient to only drive during optimal driving conditions. After adaptation and success with these activities, the patient should be able to drive under other conditions with caution.

D. Other Suggestions

The success of the monovision technique may be further improved by having your patient follow the suggestions below:

- Have a third contact lens (distance power) to use when critical distance viewing is needed.
- Have a third contact lens (near power) to use when critical near viewing is needed.
- Have supplemental spectacles to wear over the monovision contact lenses for specific visual tasks may improve the success of monovision correction. This is particularly applicable for those patients who cannot meet state driver's licensing requirements with monovision correction.
- Make use of proper illumination when carrying out visual tasks.

Monovision fitting success can be improved by the following suggestions:

- Reverse the distance and near eyes if a patient is having trouble adapting.
- Refine the lens powers if there is trouble with adaptation. Accurate lens power is critical for presbyopic patients.
- Emphasize the benefits of clear near vision, and straight ahead and upward gaze with monovision.

The decision to fit a patient with monovision correction is most appropriately left to the Eye Care Professional in conjunction with the patient after carefully considering the patient's needs.

All patients should be supplied with a copy of the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

PATIENT MANAGEMENT

- Follow the accepted standard of care in fitting and following up with your patient, e.g., American Optometric Association standard of care.
- Schedule the appropriate follow-up examination.
- Preferably, at the follow-up visits, lenses should have been worn for at least six hours.
- Provide the patient with a copy of the PATIENT INSTRUCTION GUIDE for these lenses, which can be found at www.acuvue.com. REVIEW THESE INSTRUCTIONS WITH THE PATIENT SO THAT HE OR SHE CLEARLY UNDERSTANDS THE PRESCRIBED WEARING AND REPLACEMENT SCHEDULES.

WEARING SCHEDULE

The wearing schedule should be determined by the Eye Care Professional. Regular checkups, as determined by the Eye Care Professional, are also extremely important.

Patients tend to over wear the lenses initially. The Eye Care Professional should emphasize the importance of adhering to the initial maximum wearing schedule. Maximum wearing time should be determined by the Eye Care Professional based upon the patient's physiological eye condition, because individual response to contact lenses varies.

The maximum suggested wearing time for these lenses is:

DAY	HOURS
1	6-8
2	8-10
3	10-12
4	12-14
5 and after	all waking hours

REPLACEMENT SCHEDULE

These lenses are indicated for daily disposable wear and should be discarded upon removal.

When disposed of after a single daily use, these lenses may reduce the risk of developing giant papillary conjunctivitis.[4]

When worn as a daily disposable lens, these lenses may provide improved comfort for many patients who experience mild discomfort and itching associated with allergies during contact lens wear, compared to lenses replaced at intervals of greater than 2 weeks.

Clinical research has shown that when worn on a daily disposable basis, these lenses may provide improved comfort for 2 out of 3 patients who reported suffering from discomfort associated with allergies during contact lens wear.

[4]The CLAO Journal, July 1999, Volume 25, Number 3

LENS CARE DIRECTIONS

The Eye Care Professional should review with patients that no cleaning or disinfection is needed with daily disposable lenses. Patients should always dispose of lenses when they are removed and have replacement lenses or spectacles available.

For complete information concerning contact lens handling and care, refer to the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

Care for Sticking (Non-Moving) Lenses

During removal, if the lens sticks to the eye, the patient should be instructed to apply a few drops of the recommended lubricating or rewetting solution

directly to the eye and wait until the lens begins to move freely on the eye before removing it. If non-movement of the lens continues after a few minutes, the patient should **immediately** consult the Eye Care Professional.

EMERGENCIES

The patient should be informed that if chemicals of any kind (household products, gardening solutions, laboratory chemicals, etc.) are splashed into the eyes, the patient should: FLUSH EYES IMMEDIATELY WITH TAP WATER AND IMMEDIATELY CONTACT THE EYE CARE PROFESSIONAL OR VISIT A HOSPITAL EMERGENCY ROOM WITHOUT DELAY.

HOW SUPPLIED

Each UV-absorbing sterile lens is supplied in a foil-sealed plastic package containing buffered saline solution with povidone. The plastic package is marked with the following:

- **1-DAY ACUVUE® MOIST**: base curve, power, diameter, lot number, and expiration date
- **1-DAY ACUVUE® MOIST for ASTIGMATISM:** base curve, power, diameter, cylinder, axis, lot number, and expiration date
- **1-DAY ACUVUE® MOIST MULTIFOCAL**: base curve, power, diameter, ADD power, lot number, and expiration date

REPORTING OF ADVERSE REACTIONS

All serious adverse experiences and adverse reactions observed in patients wearing these lenses or experienced with these lenses should be reported to:

Johnson & Johnson Vision Care, Inc.
7500 Centurion Parkway
Jacksonville, FL 32256
USA
Tel: 1-800-843-2020
www.acuvue.com

Johnson & Johnson Vision Care, Inc.
7500 Centurion Parkway
Jacksonville, FL 32256
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Tel: 1-800-843-2020
www.acuvue.com

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Revision number: M-07-17-02

PACKAGE INSERT (APPROVED PRODUCT)
MiSight® 1 day

MiSight 1 Day (omafilcon A) Soft (Hydrophilic) Contact Lenses For Daily Wear

IMPORTANT: Please read carefully and keep this information for future use. This package insert is intended for the eye care practitioner, but should be made available to patients upon request. The eye care practitioner should provide the patient with the patient instructions that pertain to the patient's prescribed lens.

SYMBOLS KEY

The following symbols may appear on the label or carton.

SYMBOL	DEFINITION	Reference
Rx ONLY	Caution: Federal (USA) law restricts this device to sale by or on the order of a licensed practitioner	81 FR 38911
	Caution / See Instructions for Wearers	BS EN ISO 15223-1 Table 1, Symbol 5.4.4
	Use by Date (expiration date)	BS EN ISO 15223-1 Table 1, Symbol 5.1.4
LOT	Batch Code	BS EN ISO 15223-1 Table 1, Symbol 5.1.5
STERILE	Sterile using Steam Heat	BS EN ISO 15223-1 Table 1, Symbol 5.2.5
	Manufacturer	BS EN ISO 15223-1 Table 1, Symbol 5.1.1
EC REP	Authorized representative in the European Community	BS EN ISO 15223-1 Table 1, Symbol 5.1.2
	Do not use if package is damaged	BS EN ISO 15223-1 Table 1, Symbol 5.2.8
	Consult instructions for use / consult electronic instructions for use	BS EN ISO 15223-1 Table 1, Symbol 5.4.3
	Do not re-use	BS EN ISO 15223-1 Table 1, Symbol 5.4.2
	Date of manufacture	BS EN ISO 15223-1 Table 1, Symbol 5.1.3

CAUTION: FEDERAL LAW RESTRICTS THIS DEVICE TO SALE BY OR ON THE ORDER OF A LICENSED PRACTITIONER.

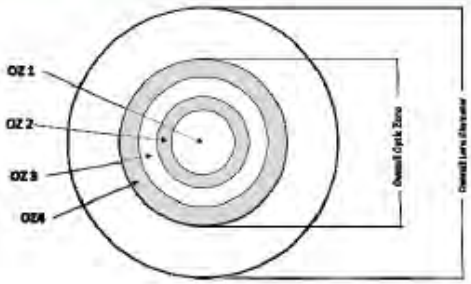
DESCRIPTION

MISight (omafilcon A) daily wear single use contact lenses are made from a material containing 60% water and 40% omafilcon A, consisting of 2-hydroxy-ethylmethacrylate and 2-methacryloyloxyethyl phosphorycholine polymers cross-linked with ethyleneglycol dimethacrylate. The lens material has a permanently fixed tint using Vat Blue 6, which is added to make the lens more visible for handling.

MISight daily wear single use contact lenses parameters:

- Diameter: 13.00 mm to 15.5 mm
- Basic Curve: 8.00 mm to 9.50 mm
- Center Thickness: 0.08 mm to 0.14 mm (dependent on power)
- Powers: -0.50D to -7.00D in 0.25 steps

The optic zone design is a concentric ring design with alternating vision correction zones and treatment zones (shaded in diagram). Zones 1 and 3 are vision correction zones and the label power of the contact lens. Zones 2 and 4 are treatment zones with 2 diopters of defocus to slow the progression of myopia.



The physical/optical properties of the lens are:

- Refractive Index: 1.395 ± 0.005
- Light Transmittance: > 90%
- Water Content: 60% ± 2%
- Oxygen Permeability: 25 x10^{-11} (cm^2/sec)(ml O_2/ml x mmHg) (Polarographic FATT Method)

ACTIONS

When placed on the cornea in its hydrated state, the **MISight** daily wear single use (omafilcon A) Soft (Hydrophilic) Contact Lens acts as a refracting medium to focus light rays on the retina and to simultaneously provide an optical stimulus to slow the progression of myopia.

INDICATIONS FOR USE

MISight 1 Day (omafilcon A) Soft (Hydrophilic) Contact Lenses for Daily Wear are indicated for the correction of myopic ametropia and for slowing the progression of myopia in children with non-diseased eyes, who at the initiation of treatment are 8-12 years of age and have a refraction of -0.75 to -4.00 diopters (spherical equivalent) with ≤ 0.75 diopters of astigmatism. The lens is to be discarded after each removal.

CONTRAINDICATIONS

Do not use the **MISight daily wear single use** lens when any of the following conditions exist:

- Acute and subacute inflammation or infection of the anterior chamber of the eye.
- Any eye disease, injury, or abnormality that affects the cornea, conjunctiva, or eyelids.
- Severe insufficiency of lacrimal secretion (dry eyes).
- Corneal hypoesthesia (reduced corneal sensitivity), if not aphakic.
- Any systemic disease that may affect the eye or be exaggerated by wearing contact lenses.
- Allergic reactions of ocular surfaces or adnexa that may be induced or exaggerated by wearing contact lenses or use of contact lens solutions.
- Any active corneal infection (bacterial, fungal, or viral).
- If eyes become red or irritated.
- The patient is unable to follow lens handling and wear regimen or unable to obtain assistance to do so.

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Revision: C

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WARNINGS

Patients should be advised of the following warnings pertaining to contact lens wear:

- **PROBLEMS WITH CONTACT LENSES COULD RESULT IN SERIOUS INJURY TO THE EYE.** It is essential that patients follow their eye care practitioner's directions and all labeling instructions for proper use of lens. Eye problems, including corneal ulcers, can develop rapidly and lead to loss of vision. If a patient experiences eye discomfort, excessive tearing, vision changes, or redness of the eye, the patient should be instructed to immediately remove lenses and promptly contact his or her eyecare practitioner.
- **WATER ACTIVITY**
  - Do not expose the contact lenses to water while wearing them.
  - Water can harbor microorganisms that can lead to severe infection, vision loss or blindness. If the lenses have been submersed when swimming in pools, lakes, or oceans, discard them and replace them with a new pair.
  - Ask eye care practitioner (professional) for recommendations about wearing the lenses during any activity involving water.
- **EYE PROBLEMS, INCLUDING CORNEAL ULCERS, CAN DEVELOP RAPIDLY AND LEAD TO LOSS OF VISION; IF THE FOLLOWING IS EXPERIENCED:**
  - Eye Discomfort,
  - Excessive Tearing,
  - Vision Changes;
  - Loss of Vision,
  - Eye Redness
  - Or Other Eye Problems

  PATIENTS SHOULD BE INSTRUCTED TO IMMEDIATELY REMOVE THE LENSES, AND PROMPTLY CONTACT THE EYE CARE PRACTITIONER.
- Daily wear lenses are not indicated for overnight wear, and patients should be instructed not to wear lenses while sleeping. Clinical studies have shown that risk of serious adverse reactions is increased when these lenses are worn overnight.
- Single Use, Daily Disposable lenses are not intended for cleaning or re-use, and on removal should be discarded and a fresh pair used each day.
- Studies have shown that contact lens wearers who are smokers have a higher incidence of adverse reactions than nonsmokers.
- MISight lenses provide an optical correction that simultaneously presents one image "in-focus" and a second image "out-of-focus." Under certain circumstances (such as low light levels), this optical design can cause the following visual symptoms for some patients:
  - Reduced image contrast;
  - A ghost image (double image, with a mild second image seen);
  - Halos around bright lights; and glare around lights.

  Not all patients function equally well with this type of correction. This type of correction can create a vision compromise that may cause difficulties with certain visually-demanding tasks. Patients should exercise extra care if performing potentially hazardous activities.

PRECAUTIONS

Special Precautions for Eye Care Practitioners

- When selecting an appropriate lens design and parameters, the eye care practitioner should consider all characteristics of the lens that can affect lens performance and ocular health, including oxygen permeability, wettability, central and peripheral thickness, and optic zone diameter.
- The potential impact of these factors on the patient's ocular health should be carefully weighed against the patient's need for refractive correction; therefore, the continuing ocular health of the patient and lens performance on the eye should be carefully monitored by the prescribing eye care practitioner.
- Fluorescein, a yellow dye, should not be used while the lenses are on the eyes. The lenses absorb the dye and become discolored. Whenever fluorescein is used in the eyes, the eyes should be flushed with a sterile saline solution that is recommended for in-eye use.
- Before leaving the eye care practitioner's office, the patient should be able to promptly remove the lenses or should have someone else available who can remove the lenses for him or her.
- Eye care practitioners should instruct the patient to remove the lenses immediately if the eye becomes red or irritated.

Eye care practitioners should carefully instruct patients about the following safety precautions:

- Lenses prescribed on a daily wear single use wearing schedule should always be discarded when removed at the end of the wearing day.
- The compatibility of the lens with lens care regimens has not been evaluated.
- Do not use saliva or anything other than the recommended solutions for lubricating or wetting lenses.
- If the lens sticks (stops moving) on the eye, follow the recommended directions on Care for a Sticking Lens. The lens should move freely on the eye for the continued health of the eye. If non-movement of the lens continues, the patient should be instructed to **immediately** consult his or her eye care practitioner.
- Always wash and rinse hands before handling lenses. Do not get cosmetics, lotions, soaps, creams, deodorant, or sprays in the eyes or on the lenses. It is best to put on lenses before putting on makeup. Water-based cosmetics are less likely to damage lenses than oil-based products.
- Do not touch the contact lenses with the finger or hands if the hands are not free of foreign materials, as lens damage may occur.
- Carefully follow the handling, insertion, removal, and wearing instructions in the Patient Instructions for MISight contact lenses and those prescribed by the eye care practitioner.
- Never wear lenses beyond the period recommended by the eye care practitioner.
- If aerosol products such as hairspray are used while wearing lenses, exercise caution and keep eyes closed until the spray has settled.
- Always handle lenses gently and avoid dropping them.
- Avoid all harmful or irritating vapors and fumes while wearing lenses.
- Ask the eye care practitioner about wearing the lenses during sporting activities.
- Inform the doctor (health care practitioner) about being a contact lens wearer.
- Never use tweezers or other tools to remove lenses from the lens container unless specifically indicated for that use. Pour the lens into your hand.
- Do not touch the lens with fingernails.
- Always contact the eye care practitioner before using any medicine in the eyes.
- Always inform the employer of being a contact lens wearer. Some jobs may require use of eye protection equipment or may require that the patient not wear contact lenses.
- As with any contact lens, follow-up visits are necessary to assure the continuing health of the patient's eyes. The patient should be instructed as to a recommended follow-up schedule.
- Although the clinical study demonstrated decreased progression

in myopia during its three-year duration with the MiSight lenses, any potential benefits beyond the three-year study, specifically with regard to the further slowing of myopic progression or the prevention of future retinal disease have not been determined.

- Several inclusion/exclusion criteria restricted participating subjects in the MiSight pivotal study to those in whom contact lens wear might pose greater risks, and to those with characteristics that might reduce the effectiveness of the treatment. Thus, the safety and effectiveness of the use of the device in these types of patients is not known. Patients with the following characteristics were not studied:
  - Best corrected visual acuity worse than 20/25;
  - Younger than 8 or older than age 12 at initiation of treatment (no patient was seen in any year of the study who was older than age 15);
  - Spherical equivalent refractive error lower than -0.75 D or higher than -4.00 D at initiation of treatment
  - Astigmatism > 0.75 D at initiation of treatment
  - Anisometropia ≥ 1.00 D at initiation of treatment
  - Exhibiting poor personal hygiene;
  - Born earlier than 30 weeks or weighed less than 1500g (3.3lb) at birth;
  - Regularly using of ocular medications (prescription or over-the-counter), artificial tears, or wetting agents;
  - Currently using systemic medications which may significantly affect contact lens wear, tear film production, pupil size, accommodation or refractive state. Such as, but not limited to: long term use of nasal decongestants (for example, pseudoephedrine, phenylephrine), antihistamines (for example, chlorpheniramine, diphenhydramine), prednisolone or Ritalin (methylphenidate).
  - With a history of corneal hypoesthesia (reduced corneal sensitivity), corneal ulcer, corneal infiltrates, ocular viral or fungal infections or other recurrent ocular infections.
  - Showing strabismus by cover test;
  - Having known ocular or systemic disease such as, but not limited to: anterior uveitis or iritis, episcleritis or scleritis, glaucoma, Sjögren's syndrome, lupus erythematosus, scleroderma, or diabetes;
  - Having known ocular or systemic or neuro-developmental conditions that could influence refractive development. Such as, but not limited to: persistent pupillary membrane, vitreous hemorrhage, cataract, corneal scarring, ptosis eyelid hemangiomas, Marfan's syndrome, Down's syndrome, Ehler's-Danlos syndrome, Stickler's syndrome, ocular albinism, retinopathy of prematurity;
  - Having keratoconus or an irregular cornea;
  - Showing biomicroscope findings that would contraindicate contact lens wear including, but not limited to: neovascularization; active anterior segment ocular disease, grade 3 or 4 abnormalities

ADVERSE REACTIONS

The patient should be informed that the following problems may occur when wearing contact lenses:

- Eyes stinging, burning, or itching (irritation), or other eye pain.
- Comfort is less than when the lens was first placed on the eye.
- Feeling that something is in the eye such as a foreign body or a scratched area.
- Excessive watering (tearing) of the eyes.
- Unusual eye secretions.
- Redness of the eyes.
- Reduced sharpness of vision (poor visual acuity).
- Sensitivity to light (photophobia).
- Dry eyes.

When any of the above problems occur, it may be a symptom of a serious condition such as corneal infection, corneal ulceriopacity, infiltrative keratitis, corneal abrasion, corneal edema, neovascularization, or iritis. Some of these adverse events can cause permanent or temporary loss of vision.

If the patient notices any of the above, he or she should be instructed to:

- **Immediately remove the lenses.**
- If the discomfort or the problem stops, then look closely at the lens. If the lens is in some way damaged, **do not** put the lens back on the eye. If the problem continues, **do not** put the lens back on your eye; **immediately remove the lenses and consult the eye care practitioner.**

Other adverse effects potentially associated with daily wear contact lenses are: conjunctivitis, giant papillary conjunctivitis, blepharitis/meibomianitis, tarsal hyperemia/lid irritation, hyperemia of the bulbar conjunctiva, superficial punctate keratitis, subconjunctival hemorrhage, and mild pannus.

Due to the optical design of the MiSight lenses, containing two focal points, under certain circumstances (e.g., low light conditions) some wearers may notice reduced image contrast, halos or glare around bright lights or ghost images (double images).

CLINICAL STUDIES

Two clinical studies were completed to support FDA approval. These studies are summarized here:

MISIGHT RANDOMIZED, CONTROLLED STUDY
Study Description:

The MiSight (omafilcon a) study was a three-year parallel-group, randomized, controlled, double-masked clinical trial at four investigative sites. The control lens was Proclear 1 Day (omafilcon A). The lenses were identical in overall geometry with the exception of the front surface optical zone. The primary effectiveness endpoints were the change in cycloplegic spherical equivalent refractive error and the change in axial length over three years. The primary safety endpoint was the comparison of biomicroscopy findings and adverse events.

One-hundred-forty-four (144) subjects met the eligibility criteria and were randomized to the MiSight or Control group. Subjects were eligible for the study if they were 8 to 12 years of age inclusive at the baseline examination and had cycloplegic Spherical Equivalent Refractive Error (SERE) between -0.75 and -4.00 D inclusive, astigmatism ≤ -0.75 D and anisometropia < 1.00 D. Sixty-five subjects were dispensed the MiSight lens and 70 subjects were dispensed the control soft contact lens.

The randomized groups were comparable in terms of age, gender, ethnicity, baseline refractive error and axial length. The average age was 10.1 year-of-age in each group. The mean baseline cycloplegic spherical equivalent refractive error was -2.02 D in the MiSight group and -2.19 D in the Control group. The mean baseline axial length was 24.4 mm in the MiSight group and 24.5 mm in the Control group. Fifty- three (53) MiSight subjects and 56 Control subjects completed the 3- year study.

Effectiveness Endpoint

The primary statistical analyses for effectiveness were the mean changes in cycloplegic SERE and axial length. These were compared between the two groups using a linear mixed model, statistically adjusting for possible baseline imbalances in age, sex, ethnicity, or baseline refractive error. The least-squares-mean cycloplegic refractive error and axial length change over 3-years are shown below.

3-Year Myopic Progression from Baseline
(LS Mean - All Available Eyes)

	LS Mean	Std. Err	95% Confidence Interval	p-value
Refractive Error (SERE)				
MiSight	-0.65 D	0.07	-0.50 to -0.79	
Control	-1.31 D	0.08	-1.16 to -1.46	
Difference	0.67 D	0.09	0.49 to 0.84	<0.0001
Axial Length				
MiSight	0.34 mm	0.03	0.27 to 0.41	
Control	0.62 mm	0.03	0.56 to 0.69	
Difference	-0.28 mm	0.04	-0.20 to -0.36	<0.0001

The difference between the groups for both refractive error and axial length were statistically significant. The change in axial length was highly correlated with the change in refractive error.

The mean contact lens visual acuity was 20/20 or better for the MiSight group and the Control group at all visits over three years. The mean wearing times were 11-12 hours per day for at least 6 days per week and were similar for both groups.

Additional Analysis

Additional analyses were performed to further characterize the myopia progression in the two groups. The table below shows the percentage of subjects in each group at various levels of myopic increase.

3-Year Cycloplegic SERE Change from Baseline
(All Available Eyes)

Change from Baseline	Control		MiSight	
	n	%	n	%
-0.25 D or less	4	3.6%	43	41.3%
-0.50 D or less	11	9.8%	57	54.8%
-0.75 D or less	30	26.8%	70	67.3%
-1.00 D or less	43	38.4%	85	81.7%
More than -1.00D	69	61.6%	19	18.3%

% = n/N(100)

The year-by-year change in refractive error is shown in the following table. This table shows the unadjusted mean change for all eyes with data within the interval as well as stratification by age at enrollment. In all age groups, the first year of use showed the greatest difference in myopia progression between test and control groups with continued accumulation of effect over the 3-year study period.

Year-to-Year Cycloplegic SERE Change
(Unadjusted Mean - All Available Eyes)

	0-12M		12-24M		24-36M		0-36M	
	P1D	MS	P1D	MS	P1D	MS	P1D	MS
All Eyes								
N	120	116	118	108	112	102	112	104
Mean (D)	-0.58	-0.18	-0.33	-0.19	-0.30	-0.17	-1.24	-0.51
Difference (D)	+0.40		+0.15		+0.13		+0.73	
% Control	69%		45%		44%		59%	
8 years old at Enrollment								
N	20	8	20	8	20	8	20	8
Mean (D)	-0.70	-0.38	-0.30	-0.17	-0.39	-0.21	-1.39	-0.76
Difference (D)	+0.32		+0.14		+0.18		+0.64	
9 years old at Enrollment								
N	28	34	28	30	28	28	28	30
Mean (D)	-0.77	-0.26	-0.25	-0.25	-0.29	-0.23	-1.44	-0.72
Difference (D)	+0.51		0.00		+0.06		+0.71	
10 years old at Enrollment								
N	14	24	14	22	14	22	14	22
Mean (D)	-0.57	-0.13	-0.23	-0.17	-0.32	-0.13	-1.12	-0.39
Difference (D)	+0.44		+0.07		+0.19		+0.73	
11 years old at Enrollment								
N	30	28	28	24	28	24	28	24
Mean (D)	-0.51	-0.18	-0.45	-0.21	-0.26	-0.09	-1.20	-0.47
Difference (D)	+0.33		+0.24		+0.17		+0.73	
12 years old at Enrollment								
N	28	24	28	24	24	20	24	20
Mean (D)	-0.40	-0.06	-0.38	-0.11	-0.25	-0.18	-0.98	-0.28
Difference (D)	+0.35		+0.27		+0.08		+0.71	

% Control=Difference/P1D Mean (D) X100

The year-to-year change in axial length showed a pattern of progression similar to that of the refractive error progression. The following table shows the unadjusted mean change for all eyes with data within the interval.

Year-to-Year Axial Length Change
(Unadjusted Mean - All Available Eyes)

	0-12M		12-24M		24-36M		0-36M	
	P1D	MS	P1D	MS	P1D	MS	P1D	MS
All Eyes								
N	120	116	118	108	112	102	112	104
Mean (mm)	+0.24	+0.09	+0.21	+0.12	+0.17	+0.11	+0.62	+0.30
Difference (mm)	-0.15		-0.10		-0.06		-0.32	
% Control	63%		46%		34%		52%	

% Control=Difference/P1D Mean (mm) X100

Safety Endpoint

The incidence of adverse events was similar between the MiSight and Control groups. This would be expected due to the similarity of lens geometry and lens material. None of the ocular adverse events were considered as Serious Adverse Events. The table below shows the adverse events for all eyes randomized to wear lenses.

Eyes with Adverse Events (Eyes of All Dispensed Subjects)
(All Available Eyes)

	Control (N = 140 eyes)		MISight (N =130 eyes)	
	n	%	n	%
Infiltrative Keratitis	3	2.1	1	0.8
Corneal opacity	1	0.7	0	0.0
Conjunctivitis	3	2.1	2	1.5
Blepharitis / Meibomianitis	0	0.0	4	3.1
Tarsal hyperemia / Lid irritation	1	0.7	3	2.3
Foreign body	0	0.0	1	0.8
Superficial Punctate Keratitis	1	0.7	3	2.3
Subconjunctival hemorrhage	1	0.7	1	0.8
Mild pannus	0	0.0	1	0.8
Other: headache, asthenopia, dryness	2	1.4	2	1.5

% = n/N(100)

There were 2 cases of temporary reduction in visual acuity of two lines measured at one visit only. These were not related to any observation of significant eye problems and resolved without treatment.

Overall, there were very few visits with Grade 2 or greater biomicroscopy findings. There were no Grade 4 findings and very few visits with Grade 3 findings (0.4% MISight; 0.1% Control).

RETROSPECTIVE COHORT STUDY OF SOFT LENS WEAR IN CHILDREN

Study Description:

A retrospective cohort study was performed to estimate a rate of microbial keratitis and other adverse events in conventional daily wear soft contact lenses in children initially fit between the ages of 8-12 years of age.

Data was obtained by a medical record audit of children fitted with commercial soft contact lens in seven US eye care practices. The lenses were various commercially available soft contact lenses. MISight lenses were not included in this audit as they were not yet available in the US.

Clinical records from 782 children fit in eye care practices and followed for an average of 2.7 years-of-wear were collected and evaluated. In total, this represents 2,134 patient-years of observation of children wearing soft contact lenses. Current status (last visit within 9 months) was obtained for 93% of the patients. The age distribution of the cohort studied is shown below.

Study Cohort

Age @ Fit	Subjects n (%)
8 years	54 (7%)
9 years	107 (14%)
10 years	162 (21%)
11 years	220 (28%)
12 years	239 (30%)
Total	782 (100%)

Redacted clinical records were reviewed by an independent expert adjudication committee and a consensus diagnosis was determined for each case. Two cases were adjudicated as microbial keratitis from the eye care practices. Both cases resolved with 20/20 vision and the patients returned to contact lens wear. A mild scar remained in one case.

Based upon this data, the estimated annualized rate of microbial keratitis is estimated at 2/2134 patient-years (0.094%) or 9.4/10,000 patient-years (95% C.I = 2.3 to 37.7).

Estimated Annual Incidence of Microbial Keratitis in Soft Contact Lenses
(Total Patient-Years of Observation = 2134)

	Number of Cases	Annualized Rate/10,000	2-sided 95%CI
Microbial Keratitis	2	9.4	2.3 to 37.7

The rate of non-infectious infiltrative adverse events is summarized in the following table. Fourteen (14) non-infectious infiltrates were observed, four (4) of which were adjudicated as peripheral ulcers.

Estimated Annual Incidence of Non-Infectious Infiltrative Events
(Total Patient-Years of Observation = 2134)

Adverse Events	Number of Cases	Annualized Rate	2-sided 95%CI
All Non-Infectious Infiltrative Events	14	0.66%	0.36 - 1.10%
Peripheral Ulcer	4	0.19%	0.05 - 0.50%

Limitations of this type of observational study may include selection bias, since there is no randomization to treatment; missing information, since medical records may not contain information pertinent to the study; and loss to follow-up, since patients may seek medical care at locations other than the participating eye care practice.

FITTING

Conventional methods of fitting contact lenses apply to all **MISight** contact lenses. For a detailed description of the fitting techniques, refer to the **MISight** Professional Fitting and Information Guide, copies of which are available from:

CooperVision, Inc.
711 North Road
Scottsville, New York 14546
1-800-341-2020
www.coopervision.com

WEARING SCHEDULE

For best results, it is recommended that the patient wears the lens for a minimum of 10 hours per day for at least 6 days per week. Daily wear lenses are not indicated for overnight wear, and patients should be instructed not to wear lenses while sleeping.

All **MISight** lenses should be discarded and replaced with a new lens on a daily basis.

LENS CARE DIRECTIONS

The MISight (omafilcon A) Soft (Hydrophilic) Contact Lenses are indicated for daily wear single use only. The lenses are to be discarded upon removal; therefore, no cleaning or disinfection is required.

For MISight contact lenses prescribed for daily wear single use only: The Eye Care Professional should review with patients that no cleaning or disinfection is needed. Patients should always dispose of lenses when they are removed and have replacement lenses or spectacles available.

- The patient should always have a spare pair of lenses at all times.
- Always wash, rinse, and dry hands before handling contact lenses.
- Do not use saliva. Do not put lenses in the mouth.
- Eye care practitioners may recommend a lubricating/rewetting solution which can be used to wet (lubricate) lenses while they are being worn to make them more comfortable.

CARE FOR A DRIED OUT (DEHYDRATED) LENS

If any **MISight** lens is exposed to air while off the eye, it may become dry and brittle. In this event, simply dispose of the lens and replace with a fresh one.

CARE FOR A STICKING (NONMOVING) LENS

If the lens sticks (stops moving or cannot be removed), the patient should be instructed to apply 2 to 3 drops of the recommended lubricating or rewetting solution directly to the eye and wait until the lens begins to move freely on the eye before removing it. If non- movement of the lens continues more than 5 minutes, the patient should immediately consult the eye care practitioner.

EMERGENCIES

The patient should be informed that if chemicals of any kind (household products, gardening solutions, laboratory chemicals, etc.) are splashed into the eyes, the patient should: FLUSH THE EYES IMMEDIATELY WITH TAP WATER AND IMMEDIATELY CONTACT THE EYE CARE PRACTITIONER OR VISIT A HOSPITAL EMERGENCY ROOM WITHOUT DELAY.

HOW SUPPLIED

Each lens is supplied sterile in a blister containing buffered isotonic saline solution. The blister is labeled with the base curve, diameter, dioptric power, manufacturing lot number, and expiration date of the lens.

DO NOT USE IF THE MISIGHT LENS IS BROKEN OR THE SEAL HAS BEEN DAMAGED

REPORTING OF ADVERSE REACTIONS

All serious adverse experiences and adverse reactions observed in patients wearing any **MISight** contact lens or experienced with the lenses should be reported to:

CooperVision

Attn: Product Services
711 North Road
Scottsville, New York 14546
(800) 341-2020
www.coopervision.com

Part Number: PI01082
Revision: C

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Revision Date: April 9, 2020

APPENDIX D: [redacted]

- [redacted] Near LogMAR Visual Acuity Measurement Procedure
- [redacted] Lens Fitting Characteristics
- [redacted] Subject Reported Ocular Symptoms/Problems
- [redacted] Front and Back Surface Lens Deposit Grading Procedure
- [redacted] Determination of Distance Spherocylindrical Refractions
- [redacted] Distance and Near Snellen Visual Acuity Evaluation
- [redacted] Distance LogMAR Visual Acuity Measurement Procedure
- [redacted] Patient Reported Outcomes
- [redacted] White Light Lens Surface Wettability
- [redacted] Cover-Uncover Test
- [redacted] ISO Biomicroscopy Scale
- [redacted] Visual Acuity Chart Luminance and Room Illumination Testing

[redacted] NEAR LOGMAR VISUAL ACUITY MEASUREMENT PROCEDURE

Title: Near LogMAR Visual Acuity Measurement Procedure

Document Type: [redacted]

Document Number: [redacted] **Revision Number:** 9

[redacted]

[redacted]

[redacted] LENS FITTING CHARACTERISTICS

Title: Lens Fitting Characteristics

Document Type: [redacted]

Document Number: [redacted] **Revision Number: 6**

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted] SUBJECT REPORTED OCULAR SYMPTOMS/PROBLEMS

Title: Subject Reported Ocular Symptoms/Problems

Document Type: [redacted]

Document Number: [redacted] **Revision Number: 4**

[redacted]

[redacted] FRONT AND BACK SURFACE LENS DEPOSIT GRADING PROCEDURE

Title: Front and Back Surface Lens Deposit Grading Procedure

Document Type: [redacted]

Document Number: [redacted] **Revision Number: 4**

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted] DETERMINATION OF DISTANCE SPHEROCYLINDRICAL REFRACTIONS

Title: Determination of Distance Spherocylindrical Refractive Error

Document Type: [redacted]

Document Number: [redacted] **Revision Number: 5**

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted] DISTANCE AND NEAR SNELLEN VISUAL ACUITY EVALUATION

Title: Distance and Near Snellen Visual Acuity Evaluation

Document Type: [redacted]

Document Number: [redacted] **Revision Number: 5**

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted] DISTANCE LOGMAR VISUAL ACUITY MEASUREMENT PROCEDURE

Title:	Distance LogMAR Visual Acuity Measurement Procedure
Document Type:	[redacted]
Document Number:	[redacted] Revision Number: 5

[redacted]

[redacted]

[redacted]

[redacted]

Title:	Distance LogMAR Visual Acuity Measurement Procedure
Document Type:	[redacted]
Document Number:	[redacted] Revision Number: 5

[redacted]

Title:	**Distance LogMAR Visual Acuity Measurement Procedure**
Document Type:	[redacted]
Document Number:	[redacted] **Revision Number: 5**

[redacted]

[redacted]

[redacted]

[redacted]

[redacted] **PATIENT REPORTED OUTCOMES**

Title: Patient Reported Outcomes
Document Type: [redacted]
Document Number: [redacted] **Revision Number:** 3

[redacted]

[redacted] WHITE LIGHT LENS SURFACE WETTABILITY

Title: White Light Lens Surface Wettability
Document Type: [redacted]
Document Number: [redacted] **Revision Number:** 2

[redacted] [redacted]

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[redacted] [redacted]

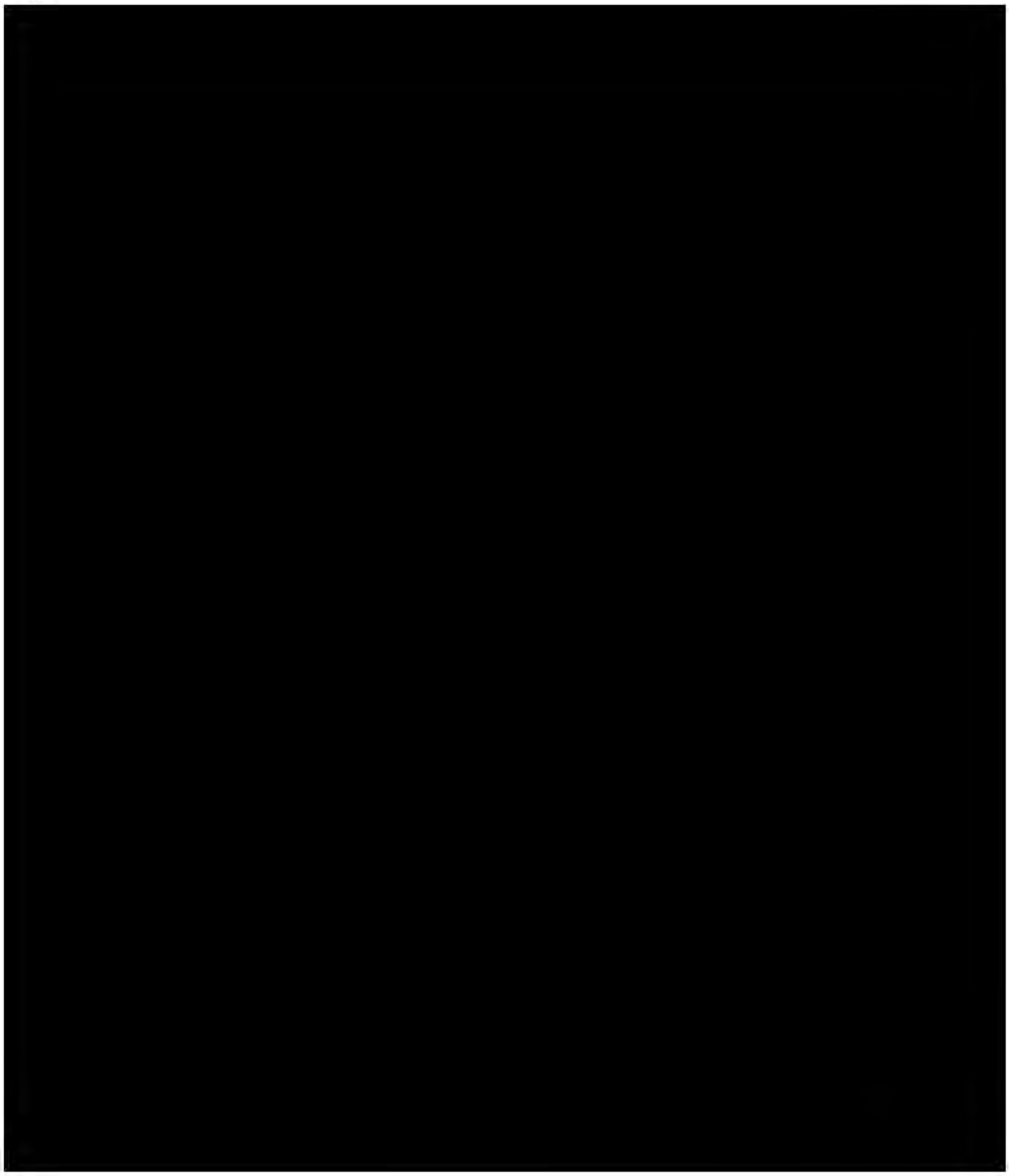
[redacted] **COVER-UNCOVER TEST**

Title: Cover-Uncover Test

Document Type: [redacted]

Document Number: [redacted] **Revision Number: 3**

[redacted]



[redacted]

[redacted] **ISO BIOMICROSCOPY SCALE**

Title: ISO Biomicroscopy Scale

Document Type: [redacted]

Document Number: [redacted] **Revision Number:** 4

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[redacted] VISUAL ACUITY CHART LUMINANCE AND ROOM ILLUMINATION TESTING

Title: Visual Acuity Chart Luminance and Room Illumination Testing

Document Type: [redacted]

Document Number: [redacted] **Revision Number: 4**

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APPENDIX E: FITTING GUIDE 1-DAY ACUVUE® MOIST BRAND CONTACT LENSES

IMPORTANT: Please read carefully and keep this information for future use.

This Package Insert and Fitting Instruction Guide is intended for the Eye Care Professional, but should be made available to patients upon request.

The Eye Care Professional should provide the patient with the appropriate instructions that pertain to the patient's prescribed lenses. Copies are available for download at www.acuvue.com.

1-DAY ACUVUE® MOIST BRAND CONTACT LENSES

1-DAY ACUVUE® MOIST Brand Contact Lenses

1-DAY ACUVUE® MOIST Brand Contact Lenses for ASTIGMATISM

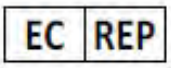
1-DAY ACUVUE® MOIST Brand MULTIFOCAL Contact Lenses

etafilcon A Soft (hydrophilic) Contact Lenses
Visibility Tinted with UV Blocker
for Daily Disposable Wear

℞ Only CAUTION: U.S. Federal law restricts this device to sale by or on the order of a licensed practitioner.

SYMBOLS KEY

The following symbols may appear on the label or packaging:

SYMBOL	DEFINITION
	Consult Instructions for Use
	Manufacturer
	Date of Manufacture
	Use By Date (expiration date)
	Batch Code
	Sterilized Using Steam Heat
	Do Not Re-Use (Single Use)
	Lens Orientation Correct
	Lens Orientation Incorrect (Lens Inside Out)
	Quality System Certification Symbol
	Fee Paid for Waste Management
	Authorized Representative in the European Community

Visit www.acuvue.com/guides for additional information about symbols.

DESCRIPTION

1-DAY ACUVUE® MOIST Brand Contact Lenses, 1-DAY ACUVUE® MOIST Brand Contact Lenses for ASTIGMATISM, and 1-DAY ACUVUE® MOIST Brand MULTIFOCAL Contact Lenses are soft (hydrophilic) contact lenses available as spherical, toric, or multifocal lenses, and include LACREON® Technology.

The lens material (etafilcon A) is a copolymer of 2-hydroxyethyl methacrylate and methacrylic acid cross-linked with 1, 1, 1-trimethylol propane trimethacrylate and ethylene glycol dimethacrylate.

The lenses are tinted blue using Reactive Blue Dye #4 to make the lenses more visible for handling. A benzotriazole UV absorbing monomer is used to block UV radiation.

Lens Properties:

The physical/optical properties of the lens are:

- Specific Gravity (calculated): 0.98 – 1.12
- Refractive Index: 1.40
- Light Transmittance: 85% minimum
- Surface Character: Hydrophilic
- Water Content: 58%
- Oxygen Permeability (D/k):

VALUE	METHOD
21.4 x 10^{-11} (cm^2/sec) (ml O_2/ml x mm Hg) @ 35°C	Fatt (boundary corrected, edge corrected)
28.0 x 10^{-11} (cm^2/sec) (ml O_2/ml x mm Hg) @ 35°C	Fatt (boundary corrected, non-edge corrected)

Lens Parameters Ranges:

- Diameter (DIA): 12.0 mm to 15.0 mm
- Center Thickness: Varies with power
- Base Curve (BC): 7.85 mm to 10.00 mm
- Spherical Power (D): -20.00D to +20.00D
- Cylinder Power (CYL): -0.25D to -10.00D
- Axis (AXIS): 2.5° to 180°
- ADD Powers: +0.25D to +4.00D

AVAILABLE LENS PARAMETERS

1-DAY ACUVUE® MOIST Brand Contact Lenses are hemispherical shells of the following dimensions:

Diameter (DIA): 14.2 mm

Center Thickness: 0.084 mm to 0.230 mm (varies with power)

Base Curve (BC):	8.5 mm, 9.0 mm
Powers (D):	-0.50D to -6.00D (in 0.25D increments) -6.50D to -12.00D (in 0.50D increments) +0.50D to +6.00D (in 0.25D increments)

1-DAY ACUVUE® MOIST Brand Contact Lenses for ASTIGMATISM are hemitoric shells of the following dimensions:

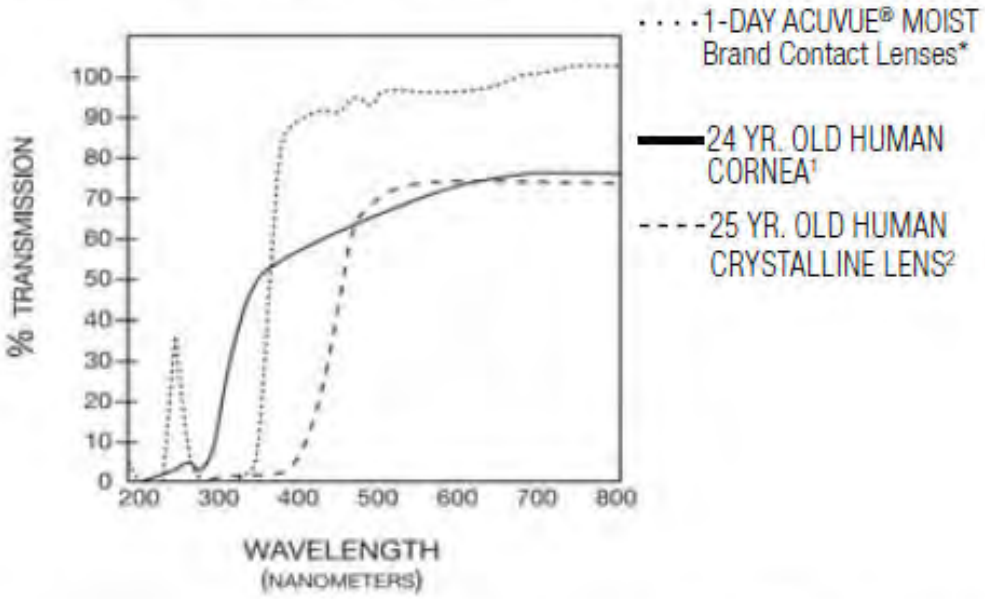
Diameter (DIA):	14.5 mm
Center Thickness:	0.090 mm to 0.189 mm (varies with power)
Base Curve (BC):	8.5 mm
Powers (D):	+0.00 to -6.00D (in 0.25D increments) Cylinders (CYL): -0.75D, -1.25D, -1.75D, -2.25D* Axis (AXIS): 10° to 180° in 10° increments *-2.25D cylinder is available in 10°, 20°, 70°, 80°, 90°, 100°, 110°, 160°, 170°, 180° axes only -6.50D to -9.00D (in 0.50D increments) Cylinders (CYL): -0.75D, -1.25D, -1.75D, -2.25D* Axis (AXIS): 10°, 20°, 60°, 70°, 80°, 90°, 100°, 110°, 120°, 160°, 170°, 180° *-2.25D cylinder is available in 20°, 90°, 160°, 180° axes only +0.25D to +4.00D (in 0.25D increments) Cylinders (CYL): -0.75D, -1.25D, -1.75D Axis (AXIS): 10°, 20°, 70°, 80°, 90°, 100°, 110°, 160°, 170°, 180°

1-DAY ACUVUE® MOIST Brand MULTIFOCAL Contact Lenses are hemispherical shells of the following dimensions:

Diameter (DIA):	14.3 mm
Center Thickness:	0.084 mm to 0.207 mm (varies with power)
Base Curve (BC):	8.4 mm
Powers (D):	+6.00D to -9.00D (in 0.25D increments)
Near ADD Powers (MAX ADD):	Low Near ADD (LOW): +1.25D Medium Near ADD (MID): +1.75D High Near ADD (HGH): +2.50D

TRANSMITTANCE CURVES

1-DAY ACUVUE® MOIST Brand Contact Lenses (etafilcon A) Visibility Tinted with UV Blocker vs. 24 yr. old human cornea and 25 yr. old human crystalline lens.



*The data are representative measurements taken through the central 3-5 mm portion for the thinnest marketed lens (-3.00D lens, 0.084 mm center thickness).

[1] Lerman, S., Radiant Energy and the Eye, MacMillan, New York, 1980, p. 58, figure 2-21

[2] Waxler, M., Hitchins, V.M., Optical Radiation and Visual Health, CRC Press, Boca Raton, Florida, 1986, p. 19, figure 5

WARNING: UV absorbing contact lenses are NOT substitutes for protective UV absorbing eyewear, such as UV absorbing goggles or sunglasses because they do not completely cover the eye and surrounding area. The patient should continue to use UV absorbing eyewear as directed.

ACTIONS

In its hydrated state, the contact lens, when placed on the cornea, acts as a refracting medium to focus light rays on the retina.

The UV Blocking for these lenses averages 97% in the UVB range of 280 nm to 315 nm and 82% in the UVA range of 316 nm to 380 nm for the entire power range.

NOTE: Long-term exposure to UV radiation is one of the risk factors associated with cataracts. Exposure is based on a number of factors such as environmental conditions (altitude, geography, cloud cover) and personal factors (extent and nature of outdoor activities). UV-Blocking contact lenses help provide protection against harmful UV radiation. However, clinical studies have not been done to demonstrate that wearing UV-Blocking contact lenses reduces the risk of developing cataracts or other eye disorders. The Eye Care Professional should be consulted for more information.

INDICATIONS (USES)

1-DAY ACUVUE® MOIST Brand Contact Lenses are indicated for daily disposable wear for the optical correction of refractive ametropia (myopia and hyperopia) in phakic or aphakic persons with non-diseased eyes who may have 1.00D or less of astigmatism.

1-DAY ACUVUE® MOIST Brand Contact Lenses for ASTIGMATISM are indicated for daily disposable wear for the optical correction of refractive ametropia (myopia and hyperopia) in phakic or aphakic persons with non-diseased eyes who may have 0.50D to 3.00D of astigmatism.

1-DAY ACUVUE® MOIST Brand MULTIFOCAL Contact Lenses are indicated for daily disposable wear for the optical correction of distance and near vision in presbyopic phakic or aphakic persons with non-diseased eyes who may have 4.00D of ADD power or less and 0.75D or less of astigmatism.

The lenses contain a UV Blocker to help protect against transmission of harmful UV radiation to the cornea and into the eye.

When prescribed for daily disposable use, no cleaning or disinfection is required. Lenses should be discarded upon removal.

CONTRAINDICATIONS (REASONS NOT TO USE)

DO NOT USE these lenses when any of the following conditions exist:

- Acute or subacute inflammation or infection of the anterior chamber of the eye.
- Any eye disease, injury, or abnormality that affects the cornea, conjunctiva, or eyelids.
- Severe insufficiency of lacrimal secretion (dry eye).
- Corneal hypoesthesia (reduced corneal sensitivity).

- Any systemic disease that may affect the eye or be exaggerated by wearing contact lenses.
- Allergic reactions of ocular surfaces or adnexa that may be induced or exaggerated by wearing contact lenses or use of contact lens solutions.
- Ocular irritation due to allergic reactions which may be caused by use of contact lens solutions (i.e., rewetting drops) that contain chemicals or preservatives (such as mercury, Thimerosal, etc.) to which some people may develop an allergic response.
- Any active corneal infection (bacterial, fungal, protozoal, or viral).
- If eyes become red or irritated.

WARNINGS

Patients should be advised of the following warnings pertaining to contact lens wear:

EYE PROBLEMS, INCLUDING CORNEAL ULCERS, CAN DEVELOP RAPIDLY AND LEAD TO LOSS OF VISION. IF THE PATIENT EXPERIENCES:

- **Eye Discomfort,**
- **Excessive Tearing,**
- **Vision Changes,**
- **Loss of Vision,**
- **Eye Redness, or**
- **Other Eye Problems,**

THE PATIENT SHOULD BE INSTRUCTED TO IMMEDIATELY REMOVE THE LENSES AND PROMPTLY CONTACT THE EYE CARE PROFESSIONAL.

- When prescribed for daily wear, patients should be instructed not to wear their lenses while sleeping. Clinical studies have shown that when lenses are worn overnight, the risk of ulcerative keratitis is greater than among those who do not wear them overnight.[3]
- Studies have shown that contact lens wearers who are smokers have a higher incidence of adverse reactions than nonsmokers.
- Problems with contact lenses or lens care products could result in serious injury to the eye. Patients should be cautioned that proper use and care of contact lenses and lens care products are essential for the safe use of these products.

- The overall risk of ulcerative keratitis may be reduced by carefully following directions for lens care.

[3] New England Journal of Medicine, September 21, 1989; 321 (12), pp. 773-783

Specific Instructions for Use and Warnings:

- **Water Activity**
  Instruction for Use
  Do not expose contact lenses to water while wearing them.

  WARNING:
  Water can harbor microorganisms that can lead to severe infection, vision loss, or blindness. If lenses have been submersed in water when participating in water sports or swimming in pools, hot tubs, lakes, or oceans, the patient should be instructed to discard them and replace them with a new pair. The Eye Care Professional should be consulted for recommendations regarding wearing lenses during any activity involving water.

PRECAUTIONS

Special Precautions for Eye Care Professionals:

- Due to the small number of patients enrolled in clinical investigation of lenses, all refractive powers, design configurations, or lens parameters available in the lens material are not evaluated in significant numbers. Consequently, when selecting an appropriate lens design and parameters, the Eye Care Professional should consider all characteristics of the lens that can affect lens performance and ocular health, including oxygen permeability, wettability, central and peripheral thickness, and optic zone diameter.

  The potential impact of these factors on the patient's ocular health should be carefully weighed against the patient's need for refractive correction; therefore, the continuing ocular health of the patient and lens performance on the eye should be carefully monitored by the prescribing Eye Care Professional.

- Patients who wear these lenses to correct presbyopia using monovision (or modified monovision using 1-DAY ACUVUE® MOIST Brand MULTIFOCAL) may not achieve the best corrected visual acuity for either far or near vision. Visual requirements vary with the individual and should be considered when selecting the most appropriate type of lens for each patient.

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- Fluorescein, a yellow dye, should not be used while the lenses are on the eyes. The lenses absorb this dye and become discolored. Whenever fluorescein is used in eyes, the eyes should be flushed with a sterile saline solution that is recommended for in-eye use.
- Eye Care Professionals should instruct the patient to remove lenses immediately if the eyes become red or irritated.

Eye Care Professionals should carefully instruct patients about the following care regimen and safety precautions.

Handling Precautions:

- Before leaving the Eye Care Professional's office, the patient should be able to promptly remove the lenses or should have someone else available who can remove the lenses for him or her.
- DO NOT use if the sterile blister package is opened or damaged.
- Always wash and rinse hands before handling lenses. Do not get cosmetics, lotions, soaps, creams, deodorants, or sprays in the eyes or on the lenses. It is best to put on lenses before putting on makeup.
- DO NOT touch contact lenses with the fingers or hands if the hands are not free of foreign materials, as microscopic scratches of the lenses may occur, causing distorted vision and/or injury to the eye.
- Carefully follow the handling, insertion, removal, and wearing instructions in the Patient Instruction Guide for these lenses and those prescribed by the Eye Care Professional.
- Always handle lenses carefully and avoid dropping them.
- Never use tweezers or other tools to remove lenses from the lens container. Slide the lens up the side of the bowl until it is free of the container.
- Do not touch the lens with fingernails.

Lens Wearing Precautions:

- If the lens sticks (stops moving) on the eye, follow the recommended directions in "Care for Sticking (Non-Moving) Lenses." The lens should move freely on the eye for the continued health of the eye. If non-movement of the lens continues, the patient should be instructed to immediately consult his or her Eye Care Professional.
- Never wear lenses beyond the period recommended by the Eye Care Professional.

- The patient should be advised to never allow anyone else to wear their lenses. They have been prescribed to fit their eyes and to correct their vision to the degree necessary. Sharing lenses greatly increases the chance of eye infections.
- If aerosol products, such as hairspray, are used while wearing lenses, exercise caution and keep eyes closed until the spray has settled.
- Avoid all harmful or irritating vapors and fumes while wearing lenses.

Lens Care Precautions:

- The patient should be informed that no cleaning or disinfection is needed when lenses are worn for daily disposable wear. Patients should always dispose of lenses when removed and have spare lenses or spectacles available.

Other Topics to Discuss with Patients:

- Always contact the Eye Care Professional before using any medicine in the eyes.
- Certain medications, such as antihistamines, decongestants, diuretics, muscle relaxants, tranquilizers, and those for motion sickness may cause dryness of the eye, increased lens awareness, or blurred vision. Should such conditions exist, proper remedial measures should be prescribed.
- Oral contraceptive users could develop visual changes or changes in lens tolerance when using contact lenses. Patients should be cautioned accordingly.
- As with any contact lens, follow-up visits are necessary to assure the continuing health of the patient's eyes. The patient should be instructed as to a recommended follow-up schedule.

Who Should Know That the Patient is Wearing Contact Lenses?

- Patients should inform all doctors (Health Care Professionals) about being a contact lens wearer.
- Patients should always inform their employer of being a contact lens wearer. Some jobs may require use of eye protection equipment or may require that the patient not wear contact lenses.

ADVERSE REACTIONS

The patient should be informed that the following problems may occur when wearing contact lenses:

- The eye may burn, sting, and/or itch.
- There may be less comfort than when the lens was first placed on the eye.
- There may be a feeling of something in the eye (foreign body, scratched area).
- There may be the potential for some temporary impairment due to peripheral infiltrates, peripheral corneal ulcers, or corneal erosion. There may be the potential for other physiological observations, such as local or generalized edema, corneal neovascularization, corneal staining, injection, tarsal abnormalities, iritis, and conjunctivitis, some of which are clinically acceptable in low amounts.
- There may be excessive watering, unusual eye secretions, or redness of the eye.
- Poor visual acuity, blurred vision, rainbows or halos around objects, photophobia, or dry eyes may also occur if the lenses are worn continuously or for too long a time.

The patient should be instructed to conduct a simple 3-part self-examination at least once a day. They should ask themselves:

- How do the lenses feel on my eyes?
- How do my eyes look?
- Have I noticed a change in my vision?

If the patient reports any problems, he or she should be instructed to IMMEDIATELY REMOVE THE LENS. If the problem or discomfort stops, the patient should discard the lens and place a new fresh lens on the eye.

If after inserting the new lens, the problem continues, the patient should be directed to IMMEDIATELY REMOVE THE LENS AND CONTACT HIS OR HER EYE CARE PROFESSIONAL.

The patient should be advised that when any of the above symptoms occur, a serious condition such as infection, corneal ulcer, neovascularization, or iritis may be present. He or she should be instructed to seek immediate professional identification of the problem and prompt treatment to avoid serious eye damage.

GENERAL FITTING GUIDELINES

A. Patient Selection

Patients selected to wear these lenses should be chosen based on:

- Motivation to wear lenses
- Ability to follow instructions regarding lens wear
- General health
- Ability to adequately handle and care for the lenses
- Ability to understand the risks and benefits of lens wear

Patients who do not meet the above criteria should not be provided with contact lenses.

B. Pre-fitting Examination

Initial evaluation of the patient should begin with a thorough case history to determine if there are any contraindications to contact lens wear. During the case history, the patient's visual needs and expectations should be determined as well as an assessment of their overall ocular, physical, and mental health.

Preceding the initial selection of trial contact lenses, a comprehensive ocular evaluation should be performed that includes, but is not limited to, the measurement of distance and near visual acuity, distance and near refractive prescription (including determining the preferred reading distance for presbyopes), keratometry, and biomicroscopic evaluation.

Based on this evaluation, if it is determined that the patient is eligible to wear these lenses, the Eye Care Professional should proceed to the lens fitting instructions as outlined below.

C. Initial Power Determination

A spectacle refraction should be performed to establish the patient's baseline refractive status and to guide in the selection of the appropriate lens power. Remember to compensate for vertex distance if the refraction is greater than ±4.00D.

D. Base Curve Selection (Trial Lens Fitting)

The following trial lenses should be selected for patients regardless of keratometry readings. However, corneal curvature measurements should be performed to establish the patient's baseline ocular status.

- 1-DAY ACUVUE® MOIST: 8.5 mm/14.2 mm
- 1-DAY ACUVUE® MOIST for ASTIGMATISM: 8.5 mm/14.5 mm
- 1-DAY ACUVUE® MOIST MULTIFOCAL: 8.4 mm/14.3 mm

The trial lens should be placed on each of the patient's eyes and evaluated after the patient has adjusted to the lenses.

1. Criteria of a Properly Fit Lens

   A properly fit lens will center and completely cover the cornea (i.e., no limbal exposure), have sufficient movement to provide tear exchange under the contact lens with the blink, and be comfortable. The lens should move freely when manipulated digitally with the lower lid, and then return to its properly centered position when released.

2. Criteria of a Flat Fitting Lens

   A flat fitting lens may exhibit one or more of the following characteristics: decentration, incomplete corneal coverage (i.e., limbal exposure), excessive movement with the blink and/or edge standoff. If the lens is judged to be flat fitting, it should not be dispensed to the patient.

3. Criteria of a Steep Fitting Lens

   A steep fitting lens may exhibit one or more of the following characteristics: insufficient movement with the blink, conjunctival indentation, and resistance when pushing the lens up digitally with the lower lid. If the lens is judged to be steep fitting, it should not be dispensed to the patient.

If the initial trial base curve is judged to be flat or steep fitting, the alternate base curve, if available, should be trial fit and evaluated after the patient has adjusted to the lens. The lens should move freely when manipulated digitally with the lower lid, and then return to a properly centered position when released. If resistance is encountered when pushing the lens up, the lens is fitting tightly and should not be dispensed to the patient.

E. Final Lens Power (Spherical)

A spherical over-refraction should be performed to determine the final lens power after the lens fit is judged acceptable. The spherical over-refraction should be combined with the trial lens power to determine the final lens prescription. The patient should experience good visual acuity with the correct lens power unless there is excessive residual astigmatism.

Example 1	
Diagnostic lens:	-2.00D
Spherical over-refraction:	-0.25D
Final lens power:	-2.25D

Example 2	
Diagnostic lens:	-2.00D
Spherical over-refraction:	+0.25D
Final lens power:	-1.75D

If vision is acceptable, perform a slit lamp examination to assess adequate fit (centration and movement). If the fit is acceptable, dispense the lenses and instruct the patient to return in one week for reassessment (see **PATIENT MANAGEMENT** section).

All patients should be supplied with a copy of the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

TORIC FITTING GUIDELINES

Although most aspects of the fitting procedure are identical for all types of soft contact lenses, including toric lenses, there are some additional steps and/or rules to follow to assure the proper fit of toric lenses.

The only new steps you must follow in prescribing 1-DAY ACUVUE® MOIST for ASTIGMATISM are that you must determine the stability, repeatability, and drift angle of the lens axis so that you can prescribe the correct lens axis for the patient.

A. How to Determine Lens Cylinder and Axis Orientation

1. Locate the Orientation Marks

To help determine the proper orientation of the toric lens, you'll find two primary marks approximately 1 mm from the lens edge representing the vertical position on opposite ends of the lens at 6 and 12 o'clock (Fig. 1). Because of the lens' ballasting system, either mark can represent the vertical position – there is no "top" and "bottom" as in a prism-ballasted lens. You don't need to view both marks to assess orientation; simply look for the 6 o'clock mark as you would with a prism-ballasted lens.

Figure 1

You'll need a slit lamp biomicroscope with a 1 to 2 mm parallelepiped beam to highlight the marks when the lens is fitted to the eye. There are a number of techniques you can use to improve the visibility of the 6 o'clock mark. Using a parallelepiped beam and medium magnification (10x or 15x), slowly pan down the lens, looking just below the direct illumination at the retroilluminated area. Backlighting the mark this way should make it more visible. Sometimes manipulating the lower lid may be necessary to uncover the mark.

2. Observe Lens Rotation and Stability

Observe the position and stability of the "bottom" mark. It usually stabilizes at the 6 o'clock position. If it does, calculation of the lens power will be straightforward. The 6 o'clock position is not a "must"; however, the absolute requirement is that the axis position be stable and repeatable.

The mark may stabilize somewhat left or right (drift) of the vertical meridian and still enable you to fit a toric lens for that eye, as long as the lens always returns to the same "drift axis" position after settling. The deviation can be compensated for in the final prescription. Your objective is to ensure that whatever position the initial lens assumes near 6 o'clock, this position must be stable and repeatable. With full eye movement or heavy blink, you may see the marks swing away, but they must return quickly to the original stable position. If the lens does not return quickly, you may need to select a different lens.

3. Assessing Rotation

Imagine the eye as a clock dial and every hour represents a 30° interval. If the orientation mark of the initial lens stabilizes somewhat left or right of the vertical position, the final lens will orient on the eye with the same deviation. You can use an axis reticule in the slit lamp or use a line-scribed lens in a spectacle trial frame to measure or estimate the "drift angle" of the cylinder axis.

To compensate for this "drift," measure or estimate the "drift," then add or subtract it from the refractive axis to determine the correct cylinder axis. Use the LARS (Left Add, Right Subtract) method to determine which direction to compensate.

B. Final Lens Power

When the diagnostic lens has its axis aligned in the same meridian as the patient's refractive axis, a spherocylindrical over-refraction may be performed and visual acuity determined. However, in the case of crossed axes, such as when the diagnostic lens axis is different from the spectacle cylinder axis, it is not advisable to perform a full spherocylindrical over-refraction because of the difficulty in computing the resultant power. A spherical over-refraction without cylinder refraction may be performed.

If the required cylinder correction falls between two available cylinder powers, it is recommended to prescribe the lower cylinder power lens. See below for instructions on how to determine the final lens power.

1. For the Sphere

If sphere alone or combined sphere and cylinder Rx > 4.00D, compensate for vertex distance. If sphere alone or combined sphere and cylinder Rx $\leq$ ±4.00D, vertex compensation is not necessary.

2. For the Cylinder

Adjust the axis by the drift angle using the LARS method. Choose a cylinder that is ≤ 0.50D from the refractive cylinder.

3. Case Examples

Example 1

Manifest (spectacle) refraction:

O.D. -2.50D / -1.25D x 180° 20/20
O.S. -2.00D / -1.00D x 180° 20/20

Choose a diagnostic lens for each eye with axis 180°. Place the lens on each eye and allow a minimum of 3 minutes for it to equilibrate, based on the patient's initial response to the lens. If the lens has not yet stabilized, recheck until stable.

Check the orientation of the axis mark. If the bottom axis mark is in the 6 o'clock position on both eyes, choose the appropriate cylinder as listed previously. If the lens has not yet stabilized, recheck until stable.

Here is the Rx prescribed:

O.D. -2.50D / -1.25D x 180°
O.S. -2.00D / -0.75D x 180°

Example 2

Manifest (spectacle) refraction:

O.D. -3.00D / -1.00D x 90° 20/20
O.S. -4.75D / -2.00D x 90° 20/20

Choose diagnostic lenses of -3.00D / -0.75D x 90° for the right eye and -4.50D / -1.75D x 90° for the left eye, the nearest lenses available to the spherical power and axis needed. For the left eye, since the manifest refraction called for -4.75D, compensating for vertex distance the sphere is reduced by 0.25D to -4.50D. The cylinder power will be -1.75D. Place the lens on each eye and allow a minimum of 3 minutes for it to equilibrate, based on the patient's initial response to the lens. If the lens has not yet stabilized, recheck until stable.

Right Eye

The orientation mark on the right lens rotates left from the 6 o'clock position by 10° and remains stable in this position. Compensation for this rotation should be done as follows:

Compensate the 10° axis drift by adding it to the manifest refraction axis.

Here is the Rx prescribed:
O.D. -3.00D / -0.75D x 100°

Left Eye

The orientation mark on the left lens rotates right from the 6 o'clock position by 10° and remains stable in this position. Compensation for this rotation should be done as follows:

Compensate for the 10° axis drift by subtracting it from the manifest refraction axis.

Here is the Rx prescribed:
O.S. -4.50D / -1.75D x 80°

If vision is acceptable, perform a slit lamp examination to assess adequate fit (centration and movement). If fit is acceptable, dispense the lenses instructing the patient to return in one week for reassessment (see **PATIENT MANAGEMENT** section).

All patients should be supplied with a copy of the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

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MULTIFOCAL FITTING GUIDELINES

A. Presbyopic Needs Assessment & Patient Education

Multifocal contact lenses may produce compromise to vision under certain circumstances and the patient should understand that they might not find their vision acceptable in specific situations (i.e., reading a menu in a dim restaurant, driving at night in rainy/foggy conditions, etc.). Therefore, caution should be exercised when the patient is wearing the correction for the first time until they are familiar with the vision provided in visually challenging environments. Occupational and environmental visual demands should be considered. If the patient requires critical visual acuity and stereopsis, it should be determined by trial whether this patient can function adequately with 1-DAY ACUVUE® MOIST MULTIFOCAL. Wearing these lenses may not be optimal for activities such as:

- Visually demanding situations such as operating potentially dangerous machinery or performing other potentially hazardous activities; and
- Driving automobiles (e.g., driving at night). Patients who cannot meet their state driver's license requirements with the 1-DAY ACUVUE® MOIST MULTIFOCAL should be advised to not drive with this correction, OR may require that additional over-correction be prescribed.

1-DAY ACUVUE® MOIST MULTIFOCAL is not recommended for patients who have -1.00D or greater of refractive cylinder as this level of uncorrected cylinder may lead to additional visual compromise. These lenses are available in the following ADD powers:

- Lens "LOW" = low near ADD lens (Max ADD +1.25)
- Lens "MID" = medium near ADD lens (Max ADD +1.75)
- Lens "HGH" = high near ADD lens (Max ADD +2.50)

B. Initial Power Determination

A spectacle refraction should be performed to establish the patient's baseline refractive status and to guide in the selection of the appropriate lens power. Remember to compensate for vertex distance if the refraction is greater than ±4.00D. Determine the spherical equivalent distance prescription for a multifocal patient. Determine the eye dominance using one of the methods below:

Method 1 Determine which eye is the "sighting eye." Have the patient point to an object at the far end of the room. Cover one eye. If the patient is still pointing directly at the object, the eye being used is the dominant (sighting) eye.

Method 2 Determine which eye does not accept added plus power. Place a +1.00D hand-held trial lens in front of one eye and then the other while the distance refractive error correction is in place for both eyes while the patient is viewing the distance visual acuity chart. The eye with the plus over it that the patient notices the greatest reduction in vision is determined to be the dominant eye.

C. Select the Initial Trial Lens

1. For each eye, select the trial lens distance power that is closest to the patient's distance spherical equivalent. Remember to compensate for vertex distance if the refraction is greater than ±4.00D.
2. Select the near power of the lens based on the patients ADD range as follows:
   - ADD: +0.75D to +1.25D use a low near ADD (LOW) lens on each eye
   - ADD: +1.50D to +1.75D use a medium near ADD (MID) lens on each eye
   - ADD: +2.00D to +2.50D use a medium near ADD (MID) on the dominant eye and a high near ADD (HGH) lens on the non-dominant eye
3. Allow the lenses to settle for a minimum of 10 minutes.
4. Assess distance and near vision binocularly and monocularly.
5. Demonstrate the vision under various lighting conditions (normal and decreased illumination) and at distance, intermediate, and near.
6. Make adjustments in power as necessary based on the distance over-refraction. The use of hand-held trial lenses is recommended. Check the impact on distance and near vision.
7. If vision is still unacceptable, make adjustments in power as necessary (see "Multifocal Troubleshooting" below). If distance and near vision are acceptable, perform a slit lamp examination to assess adequate fit (centration and movement). If fit is acceptable, dispense the lenses instructing the patient to return in one week for reassessment (see **PATIENT MANAGEMENT** section).

D. Multifocal Troubleshooting

Unacceptable Near Vision

If it has been determined that no change is required based on the over-refraction, then add +0.25D to the spherical power of the non-dominant eye.

Unacceptable Distance Vision

If it has been determined that no change is required based on the over-refraction, then make the changes as listed below:

- If the patient is wearing two "LOW" ADD lenses, change the dominant eye to a 1-DAY ACUVUE® MOIST sphere lens with a power equal to the spherical equivalent distance prescription.
- If the patient is wearing two "MID" ADD lenses, change the ADD power in the dominant eye to the "LOW" ADD power.
- If the patient is wearing a "MID" ADD lens in the dominant eye and a "HGH" ADD lens in the non-dominant eye, change the non-dominant eye to a "MID" ADD lens and add +0.25D to the distance power.

E. Adaptation

Visually demanding situations should be avoided during the initial wearing period. A patient may at first experience some mild blurred vision, dizziness, headaches and a feeling of slight imbalance. You should explain the adaptational symptoms to the patient. These symptoms may last for a brief minute or for several weeks. The longer these symptoms persist, the poorer the prognosis for successful adaptation.

To help in the adaptation process, the patient can be advised to first use the lenses in a comfortable, familiar environment such as in the home.

Some patients feel that automobile driving performance may not be optimal during the adaptation process. This is particularly true when driving at night. Before driving a motor vehicle, it may be recommended that the patient be a passenger first to make sure that their vision is satisfactory for operating an automobile. During the first several weeks of wear (when adaptation is occurring), it may be advisable for the patient to only drive during optimal driving conditions. After adaptation and success with these activities, the patient should be able to drive under other conditions with caution.

All patients should be supplied with a copy of the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

MONOVISION FITTING GUIDELINES

A. Patient Selection

1. Monovision Needs Assessment

For a good prognosis, the patient should have adequately corrected distance and near visual acuity in each eye. The amblyopic patient or the patient with significant astigmatism (greater than 1.00D) in one eye may not be a good candidate for monovision correction with these lenses.

Occupational and environmental visual demands should be considered. If the patient requires critical vision (visual acuity and stereopsis), it should be determined by trial whether this patient can function adequately with monovision correction. Monovision contact lens wear may not be optimal for activities such as:

- Visually demanding situations such as operating potentially dangerous machinery or performing other potentially hazardous activities; and
- Driving automobiles (e.g., driving at night). Patients who cannot meet their state driver's license requirements with monovision correction should be advised to not drive with this correction, OR may require that additional over-correction be prescribed.

2. Patient Education

All patients do not function equally well with monovision correction. Patients may not perform as well for certain tasks with this correction as they have with spectacles (multifocal, bifocal, trifocal, readers, progressives). Each patient should understand that monovision, as well as other presbyopic alternatives, can create a vision compromise that may reduce visual acuity and depth perception for distance and near tasks. Therefore, caution should be exercised when the patient is wearing the correction for the first time until they are familiar with the vision provided in visually challenging environments (e.g., reading a menu in a dimly lit restaurant, driving at night in rainy/foggy conditions, etc.). During the fitting process, it is necessary for the patient to realize the disadvantages as well as the advantages of clear near vision, and straight ahead and upward gaze that monovision contact lenses provide.

B. Eye Selection

1. Ocular Preference Determination Methods

Generally, the non-dominant eye is corrected for near vision. The following two methods for eye dominance can be used.

Method 1 Determine which eye is the "sighting eye." Have the patient point to an object at the far end of the room. Cover one eye. If the patient is still pointing directly at the object, the eye being used is the dominant (sighting) eye.

Method 2 Determine which eye will accept the added power with the least reduction in vision. Place a hand-held trial lens equal to the spectacle near ADD in front of one eye and then the other while the distance refractive error correction is in place for both eyes. Determine whether the patient functions best with the near ADD lens over the right or left eye.

2. Other Eye Selection Methods

Other methods include the "Refractive Error Method" and the "Visual Demands Method."

Refractive Error Method

For anisometropic correction, it is generally best to fit the more hyperopic (less myopic) eye for distance and the more myopic (less hyperopic) eye for near.

Visual Demands Method

Consider the patient's occupation during the eye selection process to determine the critical vision requirements. If a patient's gaze for near tasks is usually in one direction, correct the eye on that side for near.

Example: A secretary who places copy to the left side of the desk will function best with the near lens on the left eye.

C. Special Fitting Characteristics

1. Unilateral Vision Correction

There are circumstances where only one contact lens is required. As an example, an emmetropic patient would only require a near lens, whereas a bilateral myope would require corrective lenses on both eyes.

Examples:

A presbyopic emmetropic patient who requires a +1.75D ADD would have a +1.75D lens on the near eye and the other eye left without correction.

A presbyopic patient requiring a +1.50D ADD who is -2.50D myopic in the right eye and -1.50D myopic in the left eye may have the right eye corrected for distance and the left eye uncorrected for near.

2. **Near ADD Determination**

Always prescribe the lens power for the near eye that provides optimal near acuity at the midpoint of the patient's habitual reading distance. However, when more than one power provides optimal reading performance, prescribe the least plus (most minus) of the powers.

3. **Trial Lens Fitting**

A trial fitting is performed in the office to allow the patient to experience monovision correction. Lenses are fit according to the **GENERAL FITTING GUIDELINES** for base curve selection described in this Package Insert.

Case history and a standard clinical evaluation procedure should be used to determine the prognosis. Determine the distance correction and the near correction. Next, determine the near ADD. With trial lenses of the proper power in place, observe the reaction to this mode of correction.

Allow the lenses to settle for about 20 minutes with the correct power lenses in place. Walk across the room and have the patient look at you. Assess the patient's reaction to distance vision under these circumstances. Then have the patient look at familiar near objects such as a watch face or fingernails. Again assess the reaction. As the patient continues to look around the room at both near and distance objects, observe the reactions. Only after these vision tests are completed, should the patient be asked to read print. Evaluate the patient's reaction to large print (e.g., typewritten copy) at first and then graduate to newsprint and finally smaller type sizes.

After the patient's performance under the above conditions is completed, tests of visual acuity and reading ability under conditions of moderately dim illumination should be attempted.

An initial unfavorable response in the office, while indicative of a guarded prognosis, should not immediately rule out a more extensive trial under the usual conditions in which a patient functions.

4. Adaptation

Visually demanding situations should be avoided during the initial wearing period. A patient may at first experience some mild blurred vision, dizziness, headaches, and a feeling of slight imbalance. You should explain the adaptational symptoms to the patient. These symptoms may last for a brief minute or for several weeks. The longer these symptoms persist, the poorer the prognosis for successful adaptation.

To help in the adaptation process, the patient can be advised to first use the lenses in a comfortable, familiar environment such as in the home.

Some patients feel that automobile driving performance may not be optimal during the adaptation process. This is particularly true when driving at night. Before driving a motor vehicle, it may be recommended that the patient be a passenger first to make sure that their vision is satisfactory for operating an automobile. During the first several weeks of wear (when adaptation is occurring), it may be advisable for the patient to only drive during optimal driving conditions. After adaptation and success with these activities, the patient should be able to drive under other conditions with caution.

D. Other Suggestions

The success of the monovision technique may be further improved by having your patient follow the suggestions below:

- Have a third contact lens (distance power) to use when critical distance viewing is needed.
- Have a third contact lens (near power) to use when critical near viewing is needed.
- Have supplemental spectacles to wear over the monovision contact lenses for specific visual tasks may improve the success of monovision correction. This is particularly applicable for those patients who cannot meet state driver's licensing requirements with monovision correction.
- Make use of proper illumination when carrying out visual tasks.

Monovision fitting success can be improved by the following suggestions:

- Reverse the distance and near eyes if a patient is having trouble adapting.
- Refine the lens powers if there is trouble with adaptation. Accurate lens power is critical for presbyopic patients.
- Emphasize the benefits of clear near vision, and straight ahead and upward gaze with monovision.

The decision to fit a patient with monovision correction is most appropriately left to the Eye Care Professional in conjunction with the patient after carefully considering the patient's needs.

All patients should be supplied with a copy of the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

PATIENT MANAGEMENT

- Follow the accepted standard of care in fitting and following up with your patient, e.g., American Optometric Association standard of care.
- Schedule the appropriate follow-up examination.
- Preferably, at the follow-up visits, lenses should have been worn for at least six hours.
- Provide the patient with a copy of the PATIENT INSTRUCTION GUIDE for these lenses, which can be found at www.acuvue.com. REVIEW THESE INSTRUCTIONS WITH THE PATIENT SO THAT HE OR SHE CLEARLY UNDERSTANDS THE PRESCRIBED WEARING AND REPLACEMENT SCHEDULES.

WEARING SCHEDULE

The wearing schedule should be determined by the Eye Care Professional. Regular checkups, as determined by the Eye Care Professional, are also extremely important.

Patients tend to over wear the lenses initially. The Eye Care Professional should emphasize the importance of adhering to the initial maximum wearing schedule. Maximum wearing time should be determined by the Eye Care Professional based upon the patient's physiological eye condition, because individual response to contact lenses varies.

The maximum suggested wearing time for these lenses is:

DAY	HOURS
1	6-8
2	8-10
3	10-12
4	12-14
5 and after	all waking hours

REPLACEMENT SCHEDULE

These lenses are indicated for daily disposable wear and should be discarded upon removal.

When disposed of after a single daily use, these lenses may reduce the risk of developing giant papillary conjunctivitis.[4]

When worn as a daily disposable lens, these lenses may provide improved comfort for many patients who experience mild discomfort and itching associated with allergies during contact lens wear, compared to lenses replaced at intervals of greater than 2 weeks.

Clinical research has shown that when worn on a daily disposable basis, these lenses may provide improved comfort for 2 out of 3 patients who reported suffering from discomfort associated with allergies during contact lens wear.

[4]The CLAO Journal, July 1999, Volume 25, Number 3

LENS CARE DIRECTIONS

The Eye Care Professional should review with patients that no cleaning or disinfection is needed with daily disposable lenses. Patients should always dispose of lenses when they are removed and have replacement lenses or spectacles available.

For complete information concerning contact lens handling and care, refer to the PATIENT INSTRUCTION GUIDE for these lenses. Copies are available for download at www.acuvue.com.

Care for Sticking (Non-Moving) Lenses

During removal, if the lens sticks to the eye, the patient should be instructed to apply a few drops of the recommended lubricating or rewetting solution

directly to the eye and wait until the lens begins to move freely on the eye before removing it. If non-movement of the lens continues after a few minutes, the patient should **immediately** consult the Eye Care Professional.

EMERGENCIES

The patient should be informed that if chemicals of any kind (household products, gardening solutions, laboratory chemicals, etc.) are splashed into the eyes, the patient should: FLUSH EYES IMMEDIATELY WITH TAP WATER AND IMMEDIATELY CONTACT THE EYE CARE PROFESSIONAL OR VISIT A HOSPITAL EMERGENCY ROOM WITHOUT DELAY.

HOW SUPPLIED

Each UV-absorbing sterile lens is supplied in a foil-sealed plastic package containing buffered saline solution with povidone. The plastic package is marked with the following:

- **1-DAY ACUVUE® MOIST**: base curve, power, diameter, lot number, and expiration date
- **1-DAY ACUVUE® MOIST for ASTIGMATISM:** base curve, power, diameter, cylinder, axis, lot number, and expiration date
- **1-DAY ACUVUE® MOIST MULTIFOCAL**: base curve, power, diameter, ADD power, lot number, and expiration date

REPORTING OF ADVERSE REACTIONS

All serious adverse experiences and adverse reactions observed in patients wearing these lenses or experienced with these lenses should be reported to:

Johnson & Johnson Vision Care, Inc.
7500 Centurion Parkway
Jacksonville, FL 32256
USA
Tel: 1-800-843-2020
www.acuvue.com

Johnson & Johnson Vision Care, Inc.
7500 Centurion Parkway
Jacksonville, FL 32256
USA
Tel: 1-800-843-2020
www.acuvue.com

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APPENDIX F: FITTING GUIDE MISIGHT® 1 DAY

MiSight 1 Day
(omafilcon A)

SOFT (HYDROPHILIC) CONTACT LENSES FOR DAILY WEAR

PROFESSIONAL FITTING AND INFORMATION GUIDE

NOVEMBER 2019

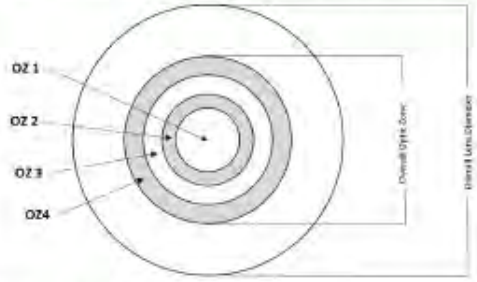
Part Number: PFG01040
Revision: A

TABLE OF CONTENTS

PRODUCT DESCRIPTION

MiSight 1 Day (omafilcon A) Soft (Hyrophilic) Contact Lenses for Daily Wear are made from a material containing 60% water and 40% omafilcon A, consisting of 2-hydroxy-ethylmethacrylate and 2-methacryloyloxyethyl phos-phorycholine polymers cross-linked with ethyleneglycol dimethacrylate. The lens material has a permanently fixed tint using Vat Blue 6, which is added to make the lens more visible for handling.

The optic zone design is a concentric ring design with alternating vision correction zones and treatment zones (shaded in diagram). Zones 1 and 3 are vision correction zones and the label power of the contact lens. Zones 2 and 4 are treatment zones with 2 diopters of defocus to slow the progression of myopia.



The physical/optical properties of the lens are:

- Refractive Index: 1.40 at 25°C
- Light Transmittance: > 90%
- Water Content 60% ± 2%
- OxygenPermeability: 25 $x10^{-11}$ (cm^2/sec)(ml 02/ml x mmHg) (Polarographic FATT Method)
-

LENS PARAMETERS AVAILABLE

Diameter	14.2 mm
Base Curve	8.7 mm
Center Thickness	0.08 mm to 0.14 mm (varies with power)
Sphere Power	-0.50 D to -7.00 D; 0.25D steps

See Price List for Detailed Availability

ACTIONS

When placed on the cornea in its hydrated state, the MiSight daily wear single use (omafilcon A) Soft (Hydrophilic) Contact Lens acts as a refracting medium to focus light rays on the retina and to simultaneously provide an optical stimulus to slow the progression of myopia.

INDICATIONS FOR USE

MiSight 1 Day (omafilcon A) Soft (Hydrophilic) Contact Lenses for Daily Wear are indicated for the correction of myopic ametropia and for slowing the progression of myopia in children with non-diseased eyes, who at the initiation of treatment are 8-12 years of age and have a refraction of -0.75 to -4.00

diopters (spherical equivalent) with ≤ 0.75 diopters of astigmatism. The lens is to be discarded after each removal.

CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, AND ADVERSE REACTIONS

Please refer to the Package Insert (PI01082).

SELECTION OF PATIENTS

- The MiSight Soft Contact Lenses can be prescribed to patients who require vision correction and desire to slow the progression of myopia.
- Parental consent and cooperation when fitting young children is important. Patients selected to wear MiSight Soft Contact Lenses should be chosen for their motivation to wear contact lenses, general health and cooperation. Patient hygiene and ability to follow practitioner instructions are essential to success.

FITTING PROCEDURE

PRE-FITTING EXAMINATION

- An examination, including personal and family history, refraction, keratometry, biomicroscopy, and other pertinent tests and measurements should be performed to rule out contraindications to contact lens wear as described in the Package Insert. If the patient has the necessary qualifications and no contraindications exist, the patient may be considered for fitting.

INITIAL LENS SELECTION

- MiSight (omafilcon A) contact lenses are available in a single base curve and diameter. The soft lens polymer and thin lens design allow for draping across a broad range of corneal curvatures.
- Initial lens power is determined from the patient's spherical equivalent prescription corrected to the corneal plane. A cycloplegic refraction can be a helpful baseline reference before an initial fitting of MiSight lenses. Because of the dual focus optical design of MiSight lenses, it is best to start with maximum plus/least minus lens power that prides good visual acuity.
- Place the lens on the eye. Allow the lens to remain on the eye long enough to achieve a state of equilibrium. Small variation in the tonicity, pH of the lens solutions and individual tear composition may cause slight changes in fitting characteristics.
- The lens should cover the patient's cornea fully, provide discernible movement (0.2 mm to 0.5 mm is ideal) after blink, be comfortable for the patient and provide satisfactory visual performance.
- Full coverage of the cornea is defined as the lens edge extending beyond the limbus area in all directions. Initial lens evaluation must be done after at least 10 minutes of lens wear to allow the lens to stabilize and any tearing to subside.

INITIAL LENS EVALUATION

- Comfort - If the patient experiences lens awareness or discomfort, check to make sure there is no foreign matter under the lens, or the lens is not inside-out or damaged.

- Lens Centration and Movement - Excessive decentration or lens movement may result in unstable vision and is often a sign that the lens is loose. A 0.2mm to 0.5mm range of movement is ideal. See LENS FIT GUIDELINES below.
- Visual Acuity and Power Adjustment - Visual acuity of 20/20 should be achievable for spherical corrections or with low amounts of astigmatism. To avoid over-minusing, reduce minus in 0.25D steps provided there is no decrease in acuity and no subjective visual impact. Increase minus in 0.25D steps only if it significantly improves distance vision.
- Vision Quality - MiSight lenses provide an optical correction that simultaneously presents one image "in-focus" and a second image "out-of-focus." Under certain circumstances (such as low light levels), this optical design can cause reduced image contrast, symptoms of ghost images, and/or glare or halos around bright lights. See the related Warning concerning these problems in the Package Insert. Final Lens Selection - Fitting performance and visual response should be confirmed with the prescription lenses prior to dispensing and the management of certain adaptive symptoms should be discussed with the patient prior to dispensing.

LENS FIT GUIDELINES

Characteristics of a Well-fitted Lens

A well-fit MiSight Contact Lens best satisfies the following criteria:

- Full corneal coverage in all directions of gaze.
- Good centration (concentric about the visible iris).
- Satisfactory lens movement (0.20 to 0.50 mm with blink is ideal)
- The lens moves freely when manipulated with digital pressure against the lower lid.
- Satisfactory comfort response by the patient.
- Satisfactory vision response by the patient.

CHARACTERISTICS OF A TIGHT-FITTING LENS

A tight-fitting MiSight Contact Lens would display some or all of the following characteristics:

- Good centration.
- Little or no movement with blink or up gaze lag.
- The lens resists movement when manipulated with digital pressure against the lower lid.
- Good comfort
- Vision may be blurred and clear immediately following blink.
- Bubble(s) under the lens.
- Conjunctival indentation and/or blanching of limbal vessels at the lens edge.
- Limbal-conjunctival hyperemia.

CHARACTERISTICS OF A LOOSE-FITTING LENS

A loose-fitting MiSight Contact Lens would display some or all of the following characteristics:

- Decentration (usually temporally and/or superiorly).
- Excessive up gaze lag (>1.0mm).

- Reduced comfort response-usually lower lid sensation.
- Unstable vision.

PATIENT INSTRUCTION

- When fitting contact lenses to children, it is important that the child is able to insert and remove lenses by themselves but that the parents are aware and knowledgeable as well. Discuss with the parents the best approach for their child.
- Instruct the patient on the technique for soft lens insertion and removal. Insertion and removal is done in the conventional manner used for soft hydrophilic contact lenses. Provide written instructions and a copy of the MiSight (omafilcon A) Contact Lens Patient Instruction Booklet. It is advisable to review these instructions carefully with your patient but also with their parent(s) .
- It is normal for the new wearers to experience mild symptoms such as lens awareness, variable vision, occasional tearing (watery eyes) and slight eye redness during the adaptation period. Although the adaptation period varies for each individual, generally within a few days these mild symptoms will disappear. If these symptoms persist, the patient should be instructed to contact their eye care practitioner.

RECOMMENDED WEARING SCHEDULE

- New contact lens wearers may wish to increase their wearing time slowly over the first week as they adapt to handling and wearing lenses. A suggested maximum wearing time for the first week may be as follows:

DAY	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
HOURS	6	8	10	12	14	All waking hours

- Based on the clinical study, it is recommended that the patient wear the lens for a minimum of 10 hours per day for at least 6 days per week. Daily wear lenses are not indicated for overnight wear, and patients should be instructed not to wear lenses while sleeping.
- The MiSight lenses are indicated for daily disposable replacement. The lenses should be thrown out at the end of each day.

FOLLOW-UP CARE

- It is recommended during the first several months of wear, that children wearing contact lenses see their eye-care practitioner more often to assure good contact lens hygiene practices are developed.
- Thereafter, it is recommended that a contact lens-wearing patient see his or her eye-care practitioner at least twice each year.
- Follow-up Care for contact lens wear should include at least the following:
  - Case history/ symptoms
  - Visual acuity and over-refraction. Avoid over-minusing as described above.
  - Check lens fit (see LENS FIT GUIDELINES)

- Biomicroscopic examination (with and without the use of fluorescein) of the cornea, conjunctiva and lids.

If any of the above observations are judged to be abnormal, professional judgment is to be used in alleviating the problem and restoring the eye to optimal conditions.

- Prescribe new lens power if necessary.

CARE OF LENSES

MiSight (omafilcon A) Soft (Hydrophilic) Contact Lenses are indicated for daily wear single use only. The lenses are to be discarded upon removal. Therefore, no cleaning or disinfection is required.

Please refer to the Package Insert and the Patient Information Booklet for more information.

HOW SUPPLIED

Each lens is supplied sterile in a blister containing sterile isotonic buffered saline solution. The blisters are packed in boxes. The following information is provided: the base curve, diameter, dioptric power, manufacturing lot number of the lens and the expiration date of the product.

REPORTING ADVERSE ACTIONS

All serious adverse experiences and adverse reactions in patients wearing the MiSight 1 DAY (*omafilcon A*) Soft (Hydrophilic) Contact Lens or experienced with the lenses should be reported to:

CooperVision, Inc.

Attn: Product Services

711 North Road

Scottsville, New York 14546

(800) 341-2020

www.coopervision.com

APPENDIX G: CR-6457 LENS POWER MODIFICATION GUIDE

[redacted]

Clinical Study Protocol
Johnson & Johnson Vision Care, Inc.

[redacted]

[redacted]

APPENDIX H: COVID-19 RISK MITIGATION GUIDELINES

Title:	**Guidelines for COVID-19 Risk Mitigation**
Document Type:	[redacted]
Document Number:	[redacted] **Revision Number: 5**

1.0 PURPOSE

The purpose of this document is to provide guidelines for the re-opening or initiation of clinical study sites participating in Johnson & Johnson Vision Care, Inc. (JJVCI) clinical studies during the COVID-19 pandemic.

2.0 SCOPE

This document provides guidelines for Johnson & Johnson Vision Care (JJVCI) to address the potential risks from COVID-19 to study subjects, investigators, study site staff, and monitors at study sites. The guidance provided in this document is in effect from the date of approval through the date of retirement of this Work Instruction. At a minimum, this Work Instruction will be reviewed and updated on a quarterly basis, as appropriate.

NOTE: Re-opening of sites outside of the US will be evaluated on a country by country basis subject to local health authority guidance.

3.0 DEFINITIONS

American Academy of Optometry (AAO): The American Academy of Optometry is an organization of optometrists based in Orlando, Florida. Its goal is to maintain and enhance excellence in optometric practice, by both promoting research and the dissemination of knowledge. The AAO holds an annual meeting, publishes a monthly scientific journal, gives credentials to optometrists through the fellowship process and publishes position statements.

American Optometric Association (AOA): The American Optometric Association, founded in 1898, is the leading authority on quality care and an advocate for our nation's health, representing more than 44,000 Doctors of Optometry (O.D.), optometric professionals, and optometry students. Doctor of Optometry take a leading role in patient care with respect to eye and vision care, as well as general health and well-being. As primary health care providers, Doctor of Optometry have extensive, ongoing training to examine, diagnose, treat and manage ocular disorders, diseases and injuries and systemic diseases that manifest in the eye. The American Optometric Association is a federation of state, student, and armed forces optometric associations. Through these affiliations, the AOA serves members consisting of optometrists, students of optometry, paraoptometric assistants and technicians. The AOA and its affiliates work to provide the public with quality vision and eye care.

Centers for Disease Control and Prevention (CDC): The Centers for Disease Control and Prevention is a national public health institute in the United States. It is a United States federal agency, under the Department of Health and Human Services, and is headquartered in Atlanta, Georgia.

COVID-19: Current outbreak of respiratory disease caused by a novel coronavirus. The virus has been named "SARS-CoV-2" and the disease it causes has been named "Coronavirus Disease 2019" (COVID-19).

Clinical Study: Voluntary research studies conducted in people and designed to answer specific questions about the safety or effectiveness of drugs, vaccines, other therapies, or new ways of using existing treatments. May also be called clinical trials, studies, research, trials, or protocols.

Clinical Study Site: Location where a clinical study is conducted, such as a doctor's office, university, or laboratory. Clinical studies are conducted by Investigators who are individual(s) responsible for the conduct of the clinical study at a study site. If a study is conducted by a team of individuals, the Investigator is the responsible leader of the team and may be called the Principal Investigator.

Clinical Operations Manager (COM): The Johnson & Johnson Vision Care (JJVCI) individual responsible for the overall management of a clinical trial.

Monitor: An individual designated to oversee the progress of a clinical study and ensure that it is conducted, recorded, and reported in accordance with the protocol, Standard Operating Procedures (SOPs), Good Clinical Practice (GCP), and applicable regulatory requirements.

Medical Safety Officer (MSO): Physician who has primary accountability in their product portfolio for product health and safety, and who serves as an independent medical voice for patient safety.

Safety Management Team (SMT): A cross-functional, collaborative team responsible for review, assessment and evaluation of medical safety data arising from any source throughout the product life cycle.

4.0 GUIDANCE FOR STUDY DOCUMENTS

In alignment with recent health authority guidance, JJVCI is providing recommendations for study-related management in the event of disruption to the conduct of the clinical study. This guidance does not supersede any local or government requirements or the clinical judgement of the investigator to protect the health, safety and well-being of participants and site staff. If, at any time, a participant's safety is considered to be at risk, study intervention will be discontinued, and study follow-up will be conducted as outlined in the protocol.

During the COVID-19 pandemic, the additional risks listed below need to be considered for study participants and study personnel:

4.1 Additional Risks Related to the COVID-19 Pandemic:

- The possible transmission of the Coronavirus infection and consequent complications, beyond the risk of adverse events due to the investigational device and/or procedures.
- The risk may be higher in an optometric clinical study because of the close contact the subject will have with health care professionals during the procedures and assessments (since the investigator must make the measurements close to the subject's face) and, in addition the need for multiple follow-up visits/exams which may expose the subject to other patients and/or healthcare professionals who might be transmitting the virus, even if they do not have symptoms.
- Potential disruptions to the study may be necessary due to current or future pandemic-related emergency restrictions, which may lead to delays in scheduled follow-up visits.
- Subjects experiencing an adverse event related to contact lens wear may receive delayed treatment due to COVID-19 restrictions. In this event, all assessments that can be conducted virtually will be completed by the investigator to determine the best course of treatment for the subject, including an unscheduled visit, up to discontinuation from the study, as appropriate.

If a study subject is found to have contracted COVID-19 during participation in a study, he/she will be discontinued from the study and followed until COVID-19 Adverse Event (AE) resolution.

To help minimize the above potential risks, JJVCI recommend reviewing/complying with local, state, and governmental guidance for COVID-19 risks.

JJVCI will provide the following study specific documents with language pertaining to COVID-19 risks:

4.1.1 Informed Consent:

Will include information concerning the study-associated risks related to the COVID-19 pandemic in bold font and/or boxed on the first page of the Informed Consent document:

STUDY ASSOCIATED RISKS RELATED TO COVID-19 (CORONAVIRUS) PANDEMIC

It is important to note that this study will be conducted, at least in part, during the COVID-19 pandemic. As such, additional risks associated with the infection with COVID-19 exist for you. This is particularly important for this study due, in part, to the closeness of the doctor during the study examinations.

The potential effects of the disease are not fully known, at this time, and may include long-term serious health consequences. In severe cases, this may result in hospitalization and/or death. Based on current knowledge from the Centers for Disease Control and Prevention (CDC), those at high-risk for severe illness from COVID-19 include older adults and people with underlying medical conditions.

During this study, all appropriate measures will be taken to minimize risks including the use of personal protective equipment such as masks and gloves, as well as proper sanitization. This is in conformance to guidance from the CDC, local health departments, and the state and county in which the study doctor's office is located. However, these measures may not completely eliminate the risks associated with contracting COVID-19.

If you are found to have contracted COVID-19 or feel ill with flu-like symptoms during participation in the study, you will not be permitted to continue in-office study follow-up visits, but you will receive instructions and your condition will be monitored by the doctor and/or study staff.

4.1.2 COVID-19 Risk Control Checklist (Attachment-B):

Will include COVID-19 risk control methods that are required by a site to conduct JJVCI clinical studies. The risk controls are consistent with CDC, AOA, AAO Guidance. The Principal Investigator will review/sign the study specific checklist prior to the Site Initiation Meeting.

4.1.3 Protocol Compliance Investigator(s) Signature Page:

Will include a statement indicating that the Principal Investigator (PI) agrees to conduct the study in compliance with all local, state, and governmental guidance's for COVID-19 risk mitigation.

I have read the suggested guidance provided by JJVCI pertaining to the COVID-19 risk mitigation, (COVID-19 Work Instruction in the Appendix of this protocol). I agree to conduct this study in compliance with local, state, governmental guidance for COVID-19 risks.

4.1.4 Study Site Initiation Training Slides:

Will include suggestions to help mitigate potential transmission of COVID-19. Suggestions may include maintaining social distancing in the clinical site by staggered scheduling of study patients, wearing proper PPEs, frequent disinfection, and installing shields on the slit lamp and other applicable equipment.

5.0 GUIDANCE FOR REMOTE SUBJECT VISITS

Potential disruptions to the study may be necessary due to current or future pandemic-related emergency restrictions. Possible disruption of the study as a result of COVID-19 control measures may lead to delays in scheduled follow-up visits.

Subjects may be delayed in being seen for study follow up visit(s), for example due to COVID-19 control measures or due to the subject's concerns or fears about COVID-19 risk. When appropriate, the remote assessment will be conducted to the extent possible. Discussions with the subject during remote assessments may include:

Procedure	Details
Subject Reported Ocular Symptoms	Subjects will respond to a verbal open-ended symptoms questionnaire regarding the test article when applicable and feasible.
Change of Medical History (Adverse Events) and Concomitant Medications / Therapies Review	Record any adverse events or medical history changes from the previous study visit with the subject/parents. Review the subject's concomitant medications/therapies and record any changes from the previous study visit.
Wearing Time and Compliance	Record the average wearing time (including number of hours per day during weekdays and weekends, and number of days per week). Confirm compliance with the prescribed wear schedule. • Record and discuss the lens wear compliance based on the subject's self-report. For example, the subjects will be asked the time of the day the subject typically puts on the study lenses in the morning and takes off in the evening, the number of days per week lenses were worn, and the number of consecutive days the subject didn't wear the study lenses, etc.

The discussion with the subject will be documented in EDC under Tele-Visit and a minor protocol deviation will be noted. If during the telephone consultation, a subject states he/she wishes to discontinue participating in the study, instruct the subject to stop wearing the study lenses and schedule the subject to return to the clinic for a Final Evaluation at the at earliest possible time. Subjects should return all unused lenses to the clinic at the last visit.

Changes in study visit schedules, missed visits, or participant discontinuations may lead to missing data, including data related to protocol-specified procedures. Case report forms should capture specific information regarding the basis of missing data, including the relationship to the COVID-19 pandemic.

6.0 STUDY CONDUCT DURING PANDEMIC

It is recognized that the Coronavirus Disease 2019 (COVID-19) pandemic may have an impact on the conduct of this clinical study due to, for example, self-isolation/quarantine by participants and study-site personnel; travel restrictions/limited access to public places, including Optometry Clinics; and changes in clinic procedures required to address the COVID-19 challenge.

Every effort should be made to adhere to protocol-specified assessments for study participants, including follow-up. However, if scheduled visits cannot be conducted in person at the study site it is suggested that assessments be performed to the extent possible remotely/virtually or delayed until such time that on-site visits can be resumed in order to continue participant monitoring in accordance with the protocol where possible. At each contact, participants will be interviewed to collect safety data. Key efficacy endpoint assessments should be performed if required and as feasible.

Modifications to protocol-required assessments may be permitted via COVID-19 Appendix after consultation with the participant, investigator, and the sponsor. Missed assessments/visits will be captured in the clinical trial management system for protocol deviations. Interruptions of test article wear or discontinuations of study interventions and withdrawal from the study should be documented with the prefix "COVID-19-related" in the case report form (CRF).

The sponsor will continue to monitor the conduct and progress of the clinical study, and any changes will be communicated to the sites and to the health authorities according to local guidance.

If a participant has tested positive for COVID-19, the investigator should contact the sponsor's responsible medical monitor to discuss initial plans for study intervention and follow-up. The medical monitor will notify the Safety Management Team of any subject(s) that have reported "COVID-19", "Asymptomatic COVID-19", or "Suspected COVID-19" adverse events within 24 hours of the notification.

Modifications made to the study conduct as a result of the COVID-19 pandemic will be summarized in the clinical study report.

COVID-19 screening procedures that may be mandated by local healthcare systems do not need to be reported as an amendment to the protocol even if done during clinical study visits.

6.1 Monitoring Visits

When on-site monitoring by the sponsor is not feasible, the sponsor's site monitor will contact the study site to schedule remote visits. In such cases, on-site monitoring visits will resume when feasible, with increased frequency to address the source data verification backlog.

Even with staffing limitations during this COVID-19 pandemic, all routine operations related to clinical trials should be well-documented and archived as part of standard process. When conditions permit, all parties involved in this clinical trial should communicate relevant information in a timely manner so that all relevant parties remain sufficiently informed.

6.1.1 Study Site Initiation:

During the period that this Work Instruction is in effect, Site Initiation Meetings and training of study site staff will be conducted remotely. The JJVCI study team will conduct training via Skype, Zoom, Microsoft Teams or similar software as well as utilize online training materials, as applicable. Study site training will be documented utilizing Site Initiation Report [redacted] per Study Site Initiation [redacted]

On-site visits may be considered when, for example, hands-on training or evaluation of site facilities is required. While on site, the Clinical Research Associate (CRA) will follow all local, state, and governmental policies for COVID-19 Risk Mitigation, including social distancing, wearing of PPE, etc. as applicable for the location of the study site.

6.1.2 Interim Monitoring Visits (if applicable):

During the period that this Work Instruction is in effect, Interim Monitoring On-site visits will be kept to a minimum and include only those tasks that the CRA cannot perform remotely (e.g., source document verification, test article reconciliation, etc.).

To ensure data integrity during the conduct of all JJVC studies, clinical study teams will follow the study specific Clinical Monitoring Plan [redacted]

While on site, the CRA will follow all local, state, and governmental policies for COVID-19 Risk Mitigation, including social distancing, wearing of PPE, etc. as applicable for the location of the study site.

6.1.3 Study Site Closure:

During the period that this Work Instruction is in effect, the duration of the Study Site Closure Visit will be limited to tasks that the CRA cannot perform remotely (e.g., source document verification, test article final reconciliation and return, etc.).

Attachment A: Study Site Correspondence

XXXX XX, 2020

Re: COVID-19 Mitigation Plan, <<CR-xxxx/protocol title>>

Dear <<Principal Investigator>> and Study Team,

Coronavirus (COVID-19) has impacted several communities and business activities over the past several months. While we work toward the successful conduct of clinical studies, our commitment continues to be the safety of patients, healthcare professionals, and to our communities.

Therefore, we would like to share the following revisions/additions related to the above referenced Johnson & Johnson Vision Care company sponsored clinical trial(s) you are currently working on or considering participation within.

Protocol:

- Guidelines for COVID-19 Risk Mitigation provided in the Appendix section.

Protocol Signature Page:

- Will include a statement indicating the Principal Investigator agrees to conduct the study in compliance with all local, state, and governmental guidelines for COVID-19 risk mitigation.

Informed Consent:

- Will include information concerning the study-associated risks related to the COVID-19 pandemic in bold font and/or boxed on the first page of the Informed consent document.

COVID-19 Risk Control Checklist for Clinical Studies:

- Will include COVID-19 risk control measures that are required to ensure the safety and health of subjects, site staff and monitors during the pandemic.

We want to encourage the need for open lines of communication about potential challenges you may foresee as the result of the current COVID-19 situation. Therefore, we encourage you to regularly connect with your respective Johnson & Johnson clinical study team (Clinical Research Associate (CRA), Lead CRA or Study Managers).

Thank you for your continued engagement, collaboration, and dedication to your study subjects during this challenging time.

Please file this letter in your site file study correspondence.

Attachment B: COVID-19 Risk Control Checklist

Study Number
Site Number
Principal Investigator (PI) Name

The following COVID-19 risk control methods are required to conduct Johnson & Johnson Vison Care clinical studies. Please review the following requirements and Initial each requirement.

PI Initials	General Site Safety Planning Measures
	Signage within site describing Risk Control methods
	Social Distancing practices throughout site (waiting rooms, lobby, exam rooms, etc.)
	Non-contact thermometer available to assess temperatures of staff and patients
	Training on patient flow and physical distancing in waiting room
	Establish longer time frame between patient appointments to reduce persons in the site
	Staff should receive job-specific training on PPE and demonstrate competency with selection and proper use of PPE and wear at all times during interactions with subjects (e.g., putting on and removing without self-contamination)

PI Initials	Site Staff Daily Safety Measures
	As part of routine practice, site staff should regularly monitor themselves for fever and symptoms of COVID-19, including temperature checks
	Any staff member (including non-study clinic staff and Investigators) showing signs of being sick or testing positive for COVID-19 must not be permitted to work on activity that may expose study related staff and subject and the Sponsor shall be informed **NOTE: Inform JJVC in 24 hours of any COVID-19 cases and all potential exposure during the clinical study.**
	Ensure that all staff wear a mask Gloves should be required when working directly with patients and changed between each patient
	Have staff thoroughly wash hands for at least 20 seconds or use an alcohol-based hand sanitizer when they arrive, before and after each patient, before eating and after using the bathroom.
	Cleaning and disinfection procedures for exam rooms and instruments or equipment between patients with gloves.
	Cleaning and disinfection procedures for commonly touched surfaces (doors, chairs, computers, phones, etc.) with gloves.

PI Initials	Before a Patient or Study Visit:
	Patients should be asked prior to entering the site about fever and respiratory illness and whether they or a family member have had contact with another person with confirmed COVID-19 in the past 14 days. Patients exhibiting signs of being sick should be rescheduled when their symptoms resolve.
	Instruct patients that companions should remain outside of the facility and not accompany the patient into the facility unless they are a parent/guardian of the patient or if they are a true caregiver and need to assist the patient
	Request the patient to call or text the office upon arrival so entrance to and movement through facility can be coordinated by site staff

Title:	**Guidelines for COVID-19 Risk Mitigation**
Document Type:	[redacted]
Document Number:	[redacted] **Revision Number: 5**

PI Initials	Patients Entering the site:
	Temperature checks utilizing a non-contact thermometer for all patients and companions entering the site.
	All patients and companions must wear cloth or disposable mask at all times in the site
	Maintain social distancing. Waiting rooms or lobbies should be as empty as possible. Advise seated patients to remain at least 6 feet from one another.
	Communal objects in (e.g. toys, reading materials, etc.) should be removed or cleaned regularly.

I certify that I have read and agree to implement all the listed COVID-19 Risk Control Measures required for the conduct of Johnson & Johnson Vision Care studies.

Principal Investigator Signature and Date

RESOURCE LINKS

US Resource Links

- OSHA Training
  https://www.osha.gov/SLTC/covid-19/controlprevention.html

  Personal Protective Equipment (PPE) Training
  CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

- I&R Training
  ACUVUE® LensAssist: https://www.acuvue.com/lensassist

- Clinic Preparedness Guides
  CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinic-preparedness html
  AOA: https://aoa.uberflip.com/i/1240437-aoa-guidance-for-re-opening-practices-covid·19/1?m4=
  American Optometric Association: https://www.aoa.org/optometry-practice-reactivation-preparedness-guide

- In-Office Disinfection of Multi-Patient Use Diagnostic Contact Lenses
  https://www.gpli.info/wp-content/uploads/2020/03/2020-01-15-in-office-disinfecting-of-diagnostic-lenses.pdf

OUS Resource Links

- Updates on local regulations in Hong Kong
  https://www.coronavirus.gov.hk/eng/index.html

- Resumption of optical services in England: Letter from Matt Neligan and Poonam Sharma
  https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0601-reopening-of-optical-services-letter-17-june-2020.pdf

- NHS Optical Letter
  https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0127-optical-letter-1-april-2020.pdf

- The College of Optometrists primary eye care COVID-19 guidance: Red phase
  https://www.college-optometrists.org/the-college/media-hub/news-listing/coronavirus-covid-19-guidance-for-optometrists.html

- The College of Optometrists COVID-19: College updates
  https://www.college-optometrists.org/the-college/media-hub/news-listing/coronavirus-2019-advice-for-optometrists.html#CollegeGuidelines

- Infection Control Guidelines. (n.d.). Retrieved from Canadian Association Of Optometrists: https://opto.ca/sites/default/files/resources/documents/infection_control_guidelines_2016.pdf

- Infection prevention and control for COVID-19: Interim guidance for outpatient and ambulatory care settings. (2020, May 23 May). Retrieved from Government of Canada: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/guidance-documents/interim-guidance-outpatient-ambulatory-care-settings html

- Information for Members On Coronavirus (COVID-19). (n.d.). Retrieved from Canadian Association Of Optometrists: https://opto.ca/sites/default/files/resources/documents/information_for_members_on_coronavirus.pdf

- Coronavirus (COVID-19) resources for health professionals, including aged care providers, pathology providers and health care managers. (2020, September 24). Retrieved from Australian Government Department of Health: https://www health.gov.au/resources/collections/coronavirus-covid-19-resources-for-health-professionals-including-aged-care-providers-pathology-providers-and-health-care-managers

- Environmental Cleaning and Disinfection Principles for COVID-19. (n.d.). Retrieved from Australian Government Department of Health: https://www.health.gov.au/sites/default/files/documents/2020/03/environmental-cleaning-and-disinfection-principles-for-covid-19.pdf

- Infection control guidelines and advice. (n.d.). Retrieved from Optometry Australia : https://www.optometry.org.au/practice-professional-support/coronavirus-covid-19-what-optometrists-need-to-know/covid-19-clinical-advice/infection-control-guidelines-and-advice/

PROTOCOL COMPLIANCE INVESTIGATOR(S) SIGNATURE PAGE

Protocol Number and Title: CR-6457 Visual Performance of Soft Contact Lenses with Myopia Control Optics

Version and Date: 4.0 29 March 2022

I have read and understand the protocol specified above and agree on its content.

I agree to conduct this study according to ISO 14155:2020,[1] GCP and ICH guidelines,[2] the Declaration of Helsinki,[3] United States (US) Code of Federal Regulations (CFR),[4] and the pertinent individual country laws/regulations and to comply with its obligations, subject to ethical and safety considerations. The Principal Investigator is responsible for ensuring that all clinical site personnel, including Sub-Investigators adhere to all ICH[2] regulations and GCP guidelines regarding clinical trials during and after study completion.

I will assure that no deviation from or changes to the protocol will take place without prior agreement from the Sponsor and documented approval from the Institutional Review Board (IRB), except where necessary to eliminate an immediate hazard(s) to the trial participants.

I am responsible for ensuring that all clinical site personnel including Sub-Investigators adhere to all ICH[2] regulations and GCP guidelines regarding clinical trials during and after study completion.

All clinical site personnel involved in the conduct of this study have completed Human Subjects Protection Training.

I agree to ensure that all clinical site personnel involved in the conduct of this study are informed about their obligations in meeting the above commitments.

I shall not disclose the information contained in this protocol or any results obtained from this study without written authorization.

I have read the suggested guidance provided by JJVCI pertaining to the COVID-19 risk mitigation, (COVID-19 Work Instruction in the Appendix H of this protocol). I agree to conduct this study in compliance with local, state, governmental guidance for COVID-19 risks.

Principal Investigator:

_____ _____
Signature Date

_____
Name and Professional Position (Printed)

Institution/Site:

_____
Institution/Site Name

_____
Institution/Site Address