



**PROTOCOL CSP-025-05**

**A PROSPECTIVE MULTI-CENTER CLINICAL STUDY TO  
EVALUATE UNCORRECTED DISTANCE VISION AND QUALITY OF  
VISION AFTER LIGHT TREATMENTS OF AN IMPLANTED  
RXSIGHT LIGHT ADJUSTABLE LENS (RXLAL) WITH THE LIGHT  
DELIVERY DEVICE (LDD) IN SUBJECTS WITH PREOPERATIVE  
CORNEAL ASTIGMATISM**

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

**May 16, 2019**

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

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

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Site Name

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*Principal Investigator's Signature*

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*Date*

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*Sponsor Signature*

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*Date*

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**RXSIGHT, INC.**

**PROTOCOL NO. CSP-025-05**

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UNCORRECTED DISTANCE VISION AND QUALITY OF VISION AFTER LIGHT  
TREATMENTS OF AN IMPLANTED RXSIGHT LIGHT ADJUSTABLE LENS  
(RXLAL) WITH THE LIGHT DELIVERY DEVICE (LDD) IN SUBJECTS WITH  
PREOPERATIVE CORNEAL ASTIGMATISM**

**1 STUDY SYNOPSIS**

**STUDY OBJECTIVE**

The primary objective of this study is to evaluate uncorrected distance vision and quality of vision as measured by the McAlinden QoV questionnaire 3 months following the final lock-in treatment of an implanted RxSight Light Adjustable Lens (RXLAL) with the Light Delivery Device (LDD) in subjects with preoperative keratometric astigmatism.

**STUDY POPULATION**

The study population will consist of at least 100 eyes in 50 subjects (and not more than 200 eyes in 100 subjects) with 0.50 to 4.00 D of pre-operative keratometric astigmatism bilaterally implanted with the RXLAL. Approximately 2/3 of the study population should have  $\geq 0.50$  D and  $\leq 1.5$  D of preoperative keratometric astigmatism and approximately 1/3 of the study population should have  $> 1.5$  D and  $\leq 4.00$  D of preoperative keratometric astigmatism. At least 5 eyes should have  $> 2$  D of preoperative keratometric astigmatism.

**STUDY DESIGN**

A prospective, multi-center, clinical study will be conducted at a minimum of 4 sites. Subjects will be followed for a 6-month period.

Patients who require cataract extraction and binocular intraocular lens implantation will be screened for eligibility. If it is determined that the patient may be eligible to participate, study staff will explain the study purpose, procedures, risks/benefits and subject responsibilities to the potential participant. Written informed consent will be obtained prior to any study specific testing. The patient is enrolled upon signing the informed consent. Ocular dominance will be preoperatively determined based on ocular dominance testing or based on the investigator's clinical judgment, for example, based on history of successful monovision eye assignment. It will be utilized to designate the subject's dominant eye as the primary eye and the subject's non-dominant eye as the fellow eye. The subject's primary eye will be scheduled for surgery prior to the fellow eye. If surgical complications occur with the primary eye and no RXLAL is implanted, the subject is exited from the study.

At 3 weeks post-implantation of the fellow eye, the subject will return for a first adjustment on both eyes.

[REDACTED] Subjects will return 3 to 7 days after the first adjustment and the same measurements performed again. Depending on the adjustment(s) performed, RxLAL eyes will receive one to three adjustments and one or two lock-in treatments. All light treatments are separated by 3 to 7 days. [REDACTED]

Postoperatively, subjects will undergo complete ophthalmic examinations at regular intervals over a 6-month period to evaluate effectiveness and safety parameters.

Uncorrected distance visual acuity (UCDVA) and responses from the Quality of Vision (QoV) questionnaire will be summarized. All ocular adverse events (device related and unrelated) during the conduct of the study will be reported. All Secondary Surgical Interventions (SSIs) in study eyes during the conduct of the study will also be reported.

Both eyes of all subjects should be screened and both eyes must meet the following inclusion criteria for the subject to be study eligible.

#### **INCLUSION CRITERIA**

- Must sign a written Informed Consent form and be willing to undergo cataract surgery for the bilateral implantation of the RxLAL.
- Greater than the age of 40 on the day the cataract surgery is performed.
- Preoperative keratometric cylinder of  $\geq 0.50$  D and  $\leq 4.00$  D in both eyes.
- Cataract causing reduction in best corrected distance visual acuity (BCDVA) to a level of 20/32 or worse with or without a glare source in both eyes.
- Best corrected distance visual acuity projected (by clinical estimate based upon past ocular history or retinal exam) to be 20/20 or better after cataract removal and IOL implantation in both eyes.
- Clear intraocular media other than cataract in both eyes.
- Willing and able to comply with the requirements for study specific procedures and visits.
- Dilated pupil diameter of  $\geq 7.0$  mm in both eyes.
- Requires an IOL power within the range available for the RxLAL for both eyes.

Both eyes of all subjects should be screened and either eye must not have any of the following exclusion criteria present for the subject to be study eligible.

#### **EXCLUSION CRITERIA**

- Zonular laxity or dehiscence.
- Pseudoexfoliation.
- Age-related macular degeneration involving the presence of geographic atrophy or soft drusen.
- Retinal degenerative disorder or macular disorder (other than mild macular degeneration) that is expected to cause future vision loss.
- Diabetes with any evidence of retinopathy.
- Evidence of glaucomatous optic neuropathy.
- History of uveitis.
- Significant anterior segment pathology, such as rubeosis iridis, aniridia, or iris coloboma.
- Corneal pathology that is either progressive or sufficient to reduce BCDVA to worse than 20/20.
- Keratoconus or suspected of having keratoconus.
- Previous corneal or intraocular surgery, except eyes with previous pterygium excision are permitted as long as the pterygium did not extend more than 2mm onto the cornea from the limbus.
- Serious co-morbid conditions that in the judgment of the investigator makes inclusion in the study not in the best interest of the subject.
- Subjects taking systemic medication that may increase sensitivity to UV light such as tetracycline, doxycycline, psoralens, amiodarone, phenothiazines, chloroquine, hydrochlorothiazide, hypericin, ketoprofen, piroxicam, lomefloxacin, and methoxsalen. LDD treatment in patients taking such medications may lead to irreversible phototoxic damage to the eye. This is only a partial list of photosensitizing medications. Please evaluate all medications that the patient is taking for this effect prior to consideration for implantation.
- Subjects taking a systemic medication that is considered toxic to the retina such as tamoxifen.
- Irregular astigmatism.
- History of ocular herpes simplex virus.
- History of a congenital color vision defect.

#### **OUTCOME PARAMETERS**

##### **Effectiveness Parameter:**

- Percent of eyes with monocular UCDVA of 20/20 or better at 6 Months Postop (3 Months Post Lock-In)

The primary effectiveness analyses will be based on the 6-month monocular UCDVA of all study eyes successfully implanted with the RxLAL.



**Safety Parameters:**

The following safety parameters will be evaluated at 6 Months Postop (3 Months Post Lock-In):

- Ocular adverse events (device related and unrelated) of the study eyes that occur during the conduct of the study.
- Secondary Surgical Interventions (SSIs) of the study eyes that occur during the conduct of the study.

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

**Examination Schedule:**

Evaluation	
Preoperative OU	Maximum of 60 days prior to Operative Visit for either Primary eye or Fellow eye
Operative Primary Eye	Day 0, day of surgery for Primary eye
Postop Day 1 Primary Eye	Days 1 to 2 post-Operative Visit Primary Eye
Operative Fellow Eye	Minimum of 2 days post-Operative Visit Primary Eye
Postop Day 1 Fellow Eye	Days 1 to 2 post-Operative Visit Fellow Eye
Postop Week 1 Primary Eye	Days 7 to 14 post-Operative Visit Primary Eye
Postop Week 1 Fellow Eye	Days 7 to 14 post-Operative Visit Fellow Eye
Postop Week 3 (bilateral) <sup>1</sup>	Days 17 to 24 post-Operative Visit Fellow Eye: Adjustment #1
Adjustment #2 (bilateral) <sup>2</sup> , if needed	3 to 7 days post Adjustment #1
Adjustment #3 (bilateral) <sup>2</sup> , if needed	3 to 7 days post Adjustment #2
Lock-in #1 (bilateral) <sup>1</sup>	3 to 7 days post final adjustment visit
Lock-in #2 (bilateral) <sup>2</sup> , if needed	3 to 7 days post lock-in #1
Post Lock-In (bilateral)	3 to 7 days post final lock-in visit
3 Months Post Lock-In/6 Months Postop (bilateral) <sup>3</sup>	Days 120 to 180 postop-Operative Visit Fellow Eye

- 1- Light treatments will be performed bilaterally at the same visit
- 2- Light treatments will be performed bilaterally at the same visit if guided by the Light Delivery Device (Adjustment #2 and Lock-In #2) or if specific clinical criteria are measured as described in section 7.3.2 of the protocol (Adjustment #3)
- 3- If both treated eyes are simultaneously within the 6 Months Postop visit windows, both eyes can be examined at the same visit and the binocular UCDVA and UCIVA will be measured at the corresponding visit. Otherwise, for each study subject, the binocular UCDVA and UCIVA will be measured at the 6 Months Postop Visits of the fellow eye.

**Clinical Parameters:**

Clinical assessments when indicated will be performed in the following order:

1. Quality of Vision (QoV) questionnaire
2. Demographics
3. Ocular history including medications
4. Ocular Biometry: ACD and axial length (Optical biometry only)

5. Autorefraction
6. Corneal Keratometry
7. Subjective symptoms/complaints (subject reported)
8. Uncorrected distance visual acuity (UCDVA) Monocular
9. Binocular UCDVA (only measured at 6 months postop)
10. Manifest Refraction
11. Best corrected distance visual acuity (BCDVA) Monocular
12. Monocular uncorrected intermediate visual acuity
13. Binocular UCIVA (only measured at 6 months postop)
14. Ocular Dominance
15. [REDACTED]
16. [REDACTED]
17. Intraocular pressure
18. Dilated pupil diameter
19. Slit Lamp Examination
20. Fundus Exam
21. Adverse Events

**ABBREVIATIONS AND DEFINITION OF TERMS**

AE	Adverse Event
ANSI	American National Standards Institute
BCDVA	Best Corrected Distance Visual Acuity
CI	Confidence Interval
CRF	Case Report Form
D	Diopter
ETDRS	Early Treatment Diabetic Retinopathy Study
GCP	Good Clinical Practice
ICH	International Conference on Harmonization
IOL	Intraocular Lens
IOP	Intraocular Pressure
LD <sup>D</sup>	Light Delivery Device
MR	Manifest Refraction
MRCYL	Manifest Refraction Cylinder
MRSE	Manifest Refraction Spherical Equivalent
OD	Right eye
OS	Left eye
OUS	Outside United States
PCO	Posterior Capsular Opacity
PI	Principal Investigator
RxLAL	RxSight Light Adjustable Lens
SAE	Serious Adverse Event
SD	Standard Deviation
SE	Spherical Equivalent
UCDVA	Uncorrected Distance Visual Acuity
UCIVA	Uncorrected Intermediate Visual Acuity

## 2 INTRODUCTION AND RATIONALE

In modern cataract surgery, spectacle freedom for the patient, either for distance vision, near vision, or both, is becoming more important. Globally, key cataract technology advancements (e.g.; monofocal, toric, and foldable IOLs; ultrasound, optical and intraoperative biometry; phacoemulsification and femtosecond laser assisted surgery), have resulted in important reductions in residual refractive error and improved uncorrected distance visual acuity (UCDVA), both of which are highly correlated with patient satisfaction following cataract surgery.<sup>1,2</sup>

However, while the potential for significant post-operative residual refractive error has been reduced, it remains the most frequent cataract surgery complication. Approximately 30-60% of patients undergoing monofocal IOL implantation and 15-30% of patients undergoing toric IOL procedures require spectacle correction for distance correction as a result of a non-emmetropic refraction.<sup>3,4,5,6</sup> The large majority of these patients have residual refractive errors that are less than 2 D of magnitude.<sup>4,7,8</sup>

The major causes for residual refractive error following cataract surgery include:

- Estimation errors for postoperative IOL position, preoperative axial length measurement and limitations of IOL calculation formulas that affect both spherical and toric IOLs.<sup>9,10</sup>
- Pre-existing corneal astigmatism (reported to exceed 1.00 D in approximately one-third of cataract patients) and imprecise preoperative measurement of corneal astigmatism.<sup>11,12</sup>

<sup>1</sup> Nordan, LT. *The Surgical Rehabilitation of Vision*. Gower Medical, New York, 1991.

<sup>2</sup> Kirwan C, Nolan JM, Stack J, et al. Determinants of patient satisfaction and function related to vision following cataract surgery in eyes with no visually consequential ocular co-morbidity. *Graefes Arch Clin Exp Ophthalmol* 2015;253:1735-1744.

<sup>3</sup> Agresta B, Knorz MC, Donatti C, Jackson D. Visual acuity improvements after implantation of toric intraocular lenses in cataract patients with astigmatism: a systematic review. *Graefes Arch Clin Exp Ophthalmol* 2012;12:41.

<sup>4</sup> Brandser R, Haaskjold E, Drolsum L. Accuracy of IOL calculation in cataract surgery. *Acta Ophthalmol Scand* 1997;75:162-165.

<sup>5</sup> Steinert RF, Aker BL, Trentacost DJ, Smith PJ, Tarantino N. A prospective comparative study of the AMO ARRAY zonal-progressive multifocal silicone intraocular lens and a monofocal intraocular lens. *Ophthalmology* 1999;106(7):1243-55.

<sup>6</sup> Connors R 3rd, Boseman P 3rd, Olson RJ. Accuracy and reproducibility of biometry using partial coherence interferometry. *J Cataract Refract Surg* 2002;28(2):235-238.

<sup>7</sup> Olsen T, Bargum R. Outcome monitoring in cataract surgery. *Acta Ophthalmol Scand*. 1995;73(5):433-7.

<sup>8</sup> Wegener M, Alsibrik PH, Hojgaard-Olsen K. Outcome of 1000 consecutive clinic- and hospital-based cataract surgeries in a Danish county. *J Cataract Refract Surg* 1998;24(8):1152-60.

<sup>9</sup> Norrby S. Sources of error in intraocular lens power calculation. *J Cataract Refract Surg* 2008;34:368-376.

<sup>10</sup> Hirnschall N, Hoffmann PC, Drasch P, et al. Evaluation of factors influencing the remaining astigmatism after toric intraocular lens implantation. *J Refract Surg* 2014;6:1-7.

<sup>11</sup> Ferrer-Blasco T, Montes-Mico R, Peixoto-de-Matos SC, et al. Prevalence of corneal astigmatism before cataract surgery. *J Cataract Refract Surg* 2009;35:70-75.

<sup>12</sup> Lekhanont K, Wuthisiri W, Chatthaipun P, Vongthongsri A. Prevalence of corneal astigmatism in cataract surgery candidates in Bangkok, Thailand. *J Cataract Refract Surg* 2011;37:613-615.

- Surgical variations in the size and central position of the capsulorhexis which may influence the final position of the IOL inside the bag and are surgeon-dependent, and surgically induced astigmatism (SIA).<sup>13</sup>
- Healing process, such as anterior movement of the IOL resulting from postoperative capsular bag fibrosis and contraction.<sup>13</sup>

When spectacle or contact lens correction is not adequate or desired, secondary surgical procedures currently available to address residual refractive error include excimer laser corneal surgery, astigmatic keratotomy, piggyback (second) IOL placement and IOL exchange. Incorrect lens power remains one of the major causes cited for the removal of intraocular lenses.<sup>5,6,14</sup>

RxSight addresses the problem of residual refractive error with an IOL for which spherical and cylindrical power can be adjusted post-implantation. Following surgical implantation and a period of post-operative stabilization, patients return for examination and refractive adjustment in the office using a profiled beam of light from the Light Delivery Device (LDD). By producing the desired change in lens curvature and spherocylindrical power of the implanted RxSight Light Adjustable Lens (RxLAL), this approach can obviate the need for secondary surgical procedures for the vast majority of patients with residual refractive error.

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

### **U.S. Phase III Study**

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

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

Co-primary effectiveness endpoints included percent reduction in manifest cylinder, percent mean absolute reduction in manifest refraction spherical equivalent (MRSE), and rotation of the LAL. All primary effectiveness endpoints compared pre-adjustment (LAL) or 17-21 days (Control) to 6 months postoperatively and the first two endpoints compared results between

<sup>13</sup> McIntyre JS, Werner L, Fuller SR, et al. Assessment of a single-piece hydrophilic acrylic IOL for piggyback sulcus fixation in pseudophakic cadaver eyes. J Cataract Refract Surg 2012;38:155-162.

<sup>14</sup> Mamalis, N.; Spencer, T. S.; Complications of foldable intraocular lenses requiring explantation or secondary intervention – 2000 survey update. J Cataract Refract Surg 2001;27(8):1310-1317.

the LAL and Control groups. All three co-primary effectiveness endpoints were met with a p-value <0.0001. The difference in means for percent reduction in manifest cylinder was 54.7%, with a p-value <0.0001. The difference in means for percent reduction in absolute MRSE was 41.1% with a p-value <0.0001. Rotation of the LAL of  $\leq 5$  degrees was observed in 96.1% of LAL implanted eyes with both the upper and lower bound of the 95% confidence interval exceeding the requirement of 90%.

100% of eyes in both the LAL and Control groups had BCDVA of 20/40 or better, exceeding the historic grid rate of 92.5% (ISO 11979-7).

#### **Outside the United States Clinical Evaluations**

Other clinical evaluations have been conducted outside the United States (OUS) to study the effectiveness and safety of spherical and spherocylindrical light treatment profiles of the LAL in aphakic patients.



In a post-CE mark study published by Hengerer et al.<sup>15</sup> of 122 LAL eyes with eighteen months follow-up in Bochum, Germany, the authors reported 88% of eyes achieving a UCDVA of 20/20 or better and 98% of eyes within 0.50 diopters of their intended target refraction at 18 months after lock-in treatment. 100% of the eyes met the  $\geq 20/40$  BCDVA safety criteria.

In summary, clinical evaluations have demonstrated that the Light Adjustable Lens and Light Delivery Device provide a predictable, stable, and safe treatment of aphakia in patients in whom the cataractous natural lens has been removed by phacoemulsification and who wish to minimize their postoperative spherical/spherocylindrical refractive error and improve their uncorrected visual acuity.

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<sup>15</sup> Hengerer F, Dick HB, Conrad-Hengerer I. Clinical Evaluation of an Ultra violet Light Adjustable Intraocular Lens Implanted after Cataract Removal: Eighteen Months Follow-up. Ophthalmology 2011; 118:2382-2388.

### **3 STUDY OBJECTIVE**

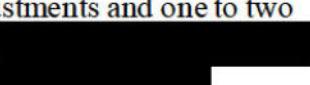
The primary objective of this study is to evaluate uncorrected distance vision and quality of vision as measured by the McAlinden QoV questionnaire 3 months following the final lock-in treatment of the implanted RxSight Light Adjustable Lens (RxLAL) with the Light Delivery Device (LDD) in subjects with preoperative keratometric astigmatism.

### **4 STUDY DESIGN**

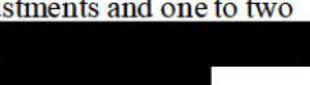
A prospective, multi-center, clinical study will be conducted at a minimum of 4 sites. Subjects will be followed for a 6-month period.

Patients who require cataract extraction and binocular intraocular lens implantation will be screened for eligibility. If it is determined that the patient may be eligible to participate, study staff will explain the study purpose, procedures, risks/benefits and subject responsibilities to the potential participant. Written informed consent will be obtained prior to any study specific testing. The patient is enrolled upon signing the informed consent. Ocular dominance will be preoperatively determined based on ocular dominance testing or based on the investigator's clinical judgment, for example, based on history of successful monovision eye assignment. It will be utilized to designate the subject's dominant eye as the primary eye and the subject's non-dominant eye as the fellow eye. The subject's primary eye will be scheduled for surgery prior to the fellow eye. If surgical complications occur with the primary eye and no RxLAL is implanted, the subject is exited from the study.

At 3 weeks post-implantation of the fellow eye, the subject will return for a first adjustment on both eyes.



Subjects will return 3 to 7 days after the first adjustment and the same measurements performed again. Depending on the adjustment(s) performed, RxLAL eyes will receive one to three adjustments and one to two lock-in treatments. All light treatments are separated by 3 to 7 days.



Postoperatively, subjects will undergo complete ophthalmic examinations at regular intervals over a 6-month period to evaluate effectiveness and safety parameters.

#### **4.1 DURATION OF STUDY**

Each subject will participate in the study for six months. [REDACTED]

#### **4.2 STUDY SITES**

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

## 5 OUTCOME PARAMETERS

### 5.1 EFFECTIVENESS PARAMETER

- Percent of eyes with monocular UCDVA of 20/20 or better at 6 Months Postop (3 Months Post Lock-In)

The primary effectiveness analyses will be based on the 6-month monocular UCDVA of all study eyes successfully implanted with the RxLAL.



### 5.2 SAFETY PARAMETERS

The following safety parameters will be evaluated at 6 Months Postop (3 Months Post Lock-In):

- Ocular adverse events (device related and unrelated) of the study eyes during the conduct of the study.
- Secondary Surgical Interventions (SSIs) of the study eyes during the conduct of the study.

## 6 STUDY POPULATION

The study population will consist of at least 100 eyes in 50 subjects (and not more than 200 eyes in 100 subjects) with 0.50 to 4.00 D of pre-operative keratometric astigmatism bilaterally implanted with the RxLAL. Approximately 2/3 of the study population should have  $\geq 0.50$  D and  $\leq 1.5$  D of preoperative keratometric astigmatism and approximately 1/3 of the study population should have  $> 1.5$  D and  $\leq 4.00$  D of preoperative keratometric astigmatism. At least 5 eyes should have  $> 2$  D of preoperative keratometric astigmatism.

Both eyes of all subjects should be screened and both eyes must meet the following inclusion criteria for the subject to be study eligible.

### 6.1 INCLUSION CRITERIA

- Must sign a written Informed Consent form and be willing to undergo cataract surgery for the bilateral implantation of the RxLAL.
- Greater than the age of 40 on the day the cataract surgery is performed.
- Preoperative keratometric cylinder of  $\geq 0.50$  D and  $\leq 4.00$  D in both eyes.
- Cataract causing reduction in best corrected distance visual acuity (BCDVA) to a level of 20/32 or worse with or without a glare source in both eyes.
- Best corrected distance visual acuity projected (by clinical estimate based upon past ocular history or retinal exam) to be 20/20 or better after cataract removal and IOL implantation in both eyes.
- Clear intraocular media other than cataract in both eyes.

- Willing and able to comply with the requirements for study specific procedures and visits.
- Dilated pupil diameter of  $\geq 7.0$  mm in both eyes.
- Requires an IOL power within the range available for the RxLAL for both eyes.

Both eyes of all subjects should be screened and either eye must not have any of the following exclusion criteria present for the subject to be study eligible.

## 6.2 EXCLUSION CRITERIA

- Zonular laxity or dehiscence.
- Pseudoexfoliation.
- Age-related macular degeneration involving the presence of geographic atrophy or soft drusen.
- Retinal degenerative disorder or macular disorder (other than mild macular degeneration) that is expected to cause future vision loss.
- Diabetes with any evidence of retinopathy.
- Evidence of glaucomatous optic neuropathy.
- History of uveitis.
- Significant anterior segment pathology, such as rubeosis iridis, aniridia, or iris coloboma.
- Corneal pathology that is either progressive or sufficient to reduce BCDVA to worse than 20/20.
- Keratoconus or suspected of having keratoconus.
- Previous corneal or intraocular surgery, except eyes with previous pterygium excision are permitted as long as the pterygium did not extend more than 2mm onto the cornea from the limbus.
- Serious co-morbid conditions that in the judgment of the investigator makes inclusion in the study not in the best interest of the subject.
- Subjects taking systemic medication that may increase sensitivity to UV light such as tetracycline, doxycycline, psoralens, amiodarone, phenothiazines, chloroquine, hydrochlorothiazide, hypericin, ketoprofen, piroxicam, lomefloxacin, and methoxsalen. LDD treatment in patients taking such medications may lead to irreversible phototoxic damage to the eye. This is only a partial list of photosensitizing medications. Please evaluate all medications that the patient is taking for this effect prior to consideration for implantation.
- Subjects taking a systemic medication that is considered toxic to the retina such as tamoxifen.
- Irregular astigmatism.
- History of ocular herpes simplex virus.
- History of a congenital color vision defect.

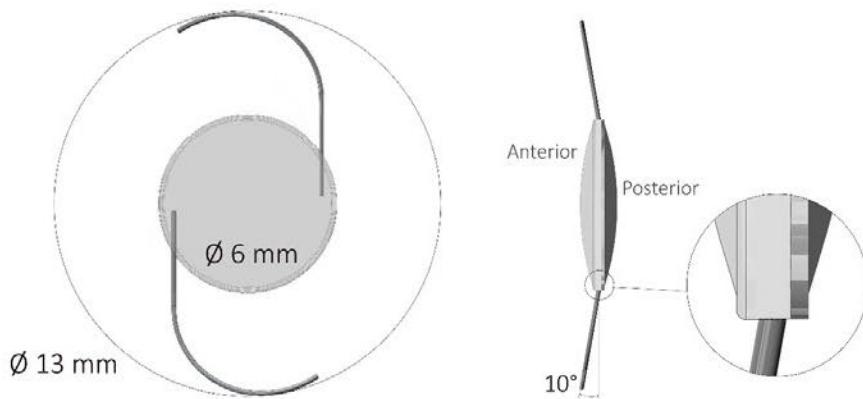
## 7 STUDY MATERIALS AND METHODS

### 7.1 DEVICE DESCRIPTION

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

#### 7.1.1 RXSIGHT LIGHT ADJUSTABLE INTRAOCULAR LENS

The RxSight Light Adjustable Lens (RxLAL) is a foldable posterior chamber, UV filtering, three-piece photoreactive silicone lens with blue PMMA (polymethylmethacrylate) modified-C haptics, a 6.0 mm biconvex optic with squared posterior edge, and an overall diameter of 13.0 mm. The RxLAL optic design (Figure 1) features a posterior surface layer, 0.05 mm thick, to further enhance the UV absorbing properties of the RxLAL lens and limit retinal exposure.



**FIGURE 1: RXSIGHT LIGHT ADJUSTABLE LENS (RxLAL)**  
**(A) TOP VIEW AND (B) CROSS-SECTION VIEW OF THE OPTIC SHOWING**  
**RxLAL WITH A POSTERIOR LAYER**

A summary of the RxLAL design characteristics is presented below:

#### Lens Optic

- Material: Photo-reactive, UV absorbing Silicone
- Light transmission: UV cut-off at 10% T $\geq$ 392 nm for all lens powers
- Index of refraction: 1.43
- Diopter power: +10 to +15.0 diopters and +25.0 to +30.0 D in 1.0 diopter increments; +16.0 to +24.0 diopters in 0.5 diopter increments
- Optic type: Biconvex
- Optic edge: Square on posterior surface and round on anterior surface
- Overall diameter: 13.0 mm
- Optic diameter: 6.0 mm

#### Haptics

- Configuration: Modified C
- Material: Blue polymethylmethacrylate
- Haptic angle: 10°

The RxLAL silicone material is designed to respond to a narrowband UV light of a select spatial intensity profile. The silicone material contains photoreactive additive, which is selectively photo-polymerized in targeted areas upon exposure to the near-UV light to alter the lens shape thus modifying spherical and spherocylindrical power of the RxLAL. The change in the shape becomes permanent when the remaining photoreactive additive is consumed following application of a non-profiled beam of the same ultraviolet light.

### 7.1.2 LIGHT DELIVERY DEVICE (LDD)

RxSight's Light Delivery Device (LDD) is a UV light projection system (Figure 2) used to induce a predictable change in RxLAL power after implantation. RxSight's LDD consists of an anterior segment biomicroscope with the addition of an optical projection system, electronic control circuitry, and a UV source. The LDD delivers spatially light profiles with adequate intensity and duration to induce polymerization of photoreactive additive leading to a refractive power change of the RxLAL. Because this procedure is performed after implantation, residual refractive errors can be corrected, reducing the need for spectacles, corneal refractive procedures, or additional IOL procedures to optimize a patient's vision.



**FIGURE 2: RXSIGHT LIGHT DELIVERY DEVICE (LDD)**

**7.1.3 RXSIGHT INSERTION DEVICE**

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

**7.1.4 INDICATIONS FOR USE**

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

**7.2 SUBJECT ENTRY**

Patients who require cataract extraction and bilateral intraocular lens implantation will be screened for eligibility. If it is determined that the patient may be eligible to participate, study staff will explain the study purpose, procedures, risk/benefits and subject responsibilities to the potential participant. Written informed consent will be obtained prior to any study specific testing. The patient is enrolled upon signing the informed consent. The subject will sign and date the informed consent form in the presence of the person conducting the consent process. The investigator and/or the person conducting the consent process will also sign and date the consent form. The preoperative examination will be performed no more than 60 days prior to surgery for either eye. If the 60-day time period elapses, it is acceptable for patients to be re-screened by undergoing a complete preoperative examination. Ocular dominance will be preoperatively determined based on ocular dominance testing or based on the investigator's clinical judgment, for example, based on history of successful monovision eye assignment. It will be utilized to designate the subject's dominant eye as the primary eye and the subject's non-dominant eye as the fellow eye. The subject's primary eye will be scheduled for surgery prior to the fellow eye. If surgical complications occur with the primary eye and no RxLAL is implanted, the subject is exited from the study.

Only subjects meeting all inclusion/exclusion criteria will be implanted. Those subjects who do not meet the inclusion/exclusion requirements will be considered screen failures. Subjects will continue to be enrolled until at least 100 eyes in 50 subjects (and not more than 200 eyes in 100 subjects) have undergone implantation. Unique identification numbers will be assigned to each subject.

Study enrollment will be tracked to ensure that approximately 2/3 of the study population will have  $\geq 0.50$  D to  $\leq 1.5$  D of preoperative keratometric astigmatism and approximately 1/3 of the study population will have  $> 1.5$  D to  $\leq 4.00$  D of preoperative keratometric astigmatism. At least 5 eyes should have  $> 2$  D of preoperative keratometric astigmatism.

Implantations in one bin may be suspended to ensure enrollment in all bins meets these requirements.

The implant lens power for the RxLAL will be calculated based upon the ocular biometry data and SRK/T lens power formula. For all subjects, a postoperative spherical equivalent (SE) outcome closest to emmetropia will be targeted bilaterally. The primary eye will be scheduled for implantation prior to the fellow eye.

### **7.3 RxLAL IMPLANTATION AND REFRACTIVE ADJUSTMENT**

#### **7.3.1 SURGICAL PROCEDURE**

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

No additional refractive procedures such as limbal relaxing incisions, PRK, or LASIK are allowed until after the 3 Month Post Lock-In/6 months postop visit.

If surgical complications occur with the primary eye and no RxLAL is implanted, the subject should be Exited from the study and no RxLAL should be implanted in the fellow eye.

The surgical procedure will be performed as follows:

1. Prepare and drape the eye for surgery in accordance with standard surgical procedures.
2. A temporal clear corneal incision will be made at a location of the surgeon's discretion using the surgeon's standard instrumentation and techniques.
3. Use viscoelastic to fill the anterior chamber through the incision opening.
4. Perform an anterior circular capsulorhexis of a maximum of 5.2 mm in diameter using standard technique. The capsulorhexis should be well-centered with a 360° overlapping capsular edge to minimize IOL tilt and decentration and longitudinal IOL shift. The capsulorhexis and/or nuclear fragmentation can be performed with a femtosecond laser. Precision pulse capsulotomy (PPC) can also be used to perform the capsulorhexis.
5. The surgeon will extract the cataract by phacoemulsification.
6. In the event of an intraoperative complication prior to implantation of the RxLAL, including posterior capsule rupture, zonular rupture, radial capsulorhexis tear, vitreous loss, iris trauma, corneal complications or any intraoperative abnormality that may affect the postoperative pupillary dilation, or the centration or tilt of the intraocular lens, do not implant the RxLAL.
7. The RxLAL will be introduced into the eye using the RxSight Insertion Device through a clear temporal corneal incision up to 3.2 mm and placed into the capsular bag. If utilizing additional surgical instruments near the incision upon insertion, precaution should be taken not to contact the RxLAL optic with this additional instrument.
8. Verify proper orientation of the RxLAL
9. Aspirate any residual viscoelastic from the eye using a preferred technique.

10. Immediately after completion of the surgery, medications will be used as deemed necessary at the surgeon's discretion.
11. The subject will be provided with UV protective eyewear and written instructions to wear them outdoors during daylight hours and indoors when exposed to daylight or any other UV light sources, until 24 hours after all lock-in treatments are completed. If an optional patch is used post-operatively according to the surgeon's preference, the subject will be instructed not to remove the patch and keep it in place until the surgeon removes it at the Postop Day 1 visit. The UV protective eyewear will be provided once the patch is removed.

### 7.3.2 LIGHT TREATMENT PROCEDURE

Seventeen (17) to 24 days after surgery on the fellow eye, the subject will return for the Postop Week 3 evaluation and a 1<sup>st</sup> adjustment treatment on both implanted RxLALs. Subsequent second and third adjustment treatments, if necessary, will all be separated by 3-7 days. The necessity of the second adjustment treatment is guided by the LDD based on inputted manifest refraction and target values.

Otherwise proceed to lock-in #1 treatment. The subject will receive the 1<sup>st</sup> lock-in treatment 3-7 days after the final adjustment treatment. If necessary, lock-in #2 may be performed 3-7 days after lock-in #1. Depending on the adjustment(s) performed, subjects will receive one to three adjustments and one or two lock-in treatments.

#### 7.3.2.1 Postponement of Light Treatment Procedure(s)

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

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

- If sutures were utilized at the time of surgery to close the incision wound, light treatments should not commence on the study eye until a minimum of 4 weeks after suture removal.<sup>16</sup>
- A study eye with an ocular adverse event that could be negatively impacted by light treatment or negatively impact the effectiveness or safety of a light treatment should have light treatments delayed until after the adverse event has subsided. This includes corneal edema and superficial punctate keratitis (SPK) (Grade 3 (moderate) or more severe), retinal conditions including diabetic retinopathy and cystoid macular edema, epithelial defect, and endophthalmitis.
- If a study eye is discovered with evidence of premature photopolymerization as evidenced as a zone on the lens surface, the investigator should contact the Sponsor for further instructions. (see [REDACTED] for additional details regarding premature photopolymerization).
- Any study eye possessing clinically significant posterior capsular (PC) haze should undergo a YAG capsulotomy procedure prior to the adjustment. A minimum of 48 hours should separate the YAG treatment from the corresponding refraction and LDD adjustment.

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<sup>16</sup> Azar D, Stark W, Dodick J, et al. Prospective, randomized vector analysis of astigmatism after three-, one-, and no-suture phacoemulsification. J Cataract Refract Surg 1997; 23:1164-1173.

### 7.3.2.2 Procedure Preparation

Protocol-required measurements should be completed prior to adjustment or lock-in treatments.

The subject should be prepared for light treatments as follows:

1. The study eye will be dilated using any of the following pupil dilation drops ( [REDACTED] or pupil dilation gel [REDACTED] ). After waiting an appropriate amount of time for dilation to occur, the study eye will be examined to ensure that adequate dilation (enough of the edge of the RxLAL optic can be visualized to allow for centration during LDD light treatment) has been obtained. If adequate dilation has not been obtained, additional dilating drops with manual punctal occlusion or a sponge soaked in mydriatic medication and applied to the ocular surface can be utilized to try and gain further dilation. If adequate pupil dilation is still not achieved with the methods described above, the treatment will be rescheduled and the dilation attempted at another visit.
2. Once adequate pupil dilation is achieved, the subject's fellow eye will be patched and the subject will be comfortably positioned in front of the LDD with chin in the chinrest and forehead against the support bar. The subject is asked to grasp the handles on the LDD for support and is asked to look straight ahead and concentrate on the green fixation light presented in front of them and to try to minimize eye movement.

### 7.3.2.3 Adjustment Procedure(s)

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

1. All adjustment procedure(s) will be recorded.
2. To adjust the lens power, follow the touchscreen prompts within the Patient ID and/or Patient Data screen to enter the subject identification, subject date of birth (if prompted), eye to be treated, i.e. Right Eye or Left Eye, RxLAL serial number, RxLAL lens power, the manifest refraction (sphere, cylinder and axis) as determined from testing at 4 meters, and confirm the refractive target is 0 D sphere and 0 D cylinder [REDACTED]  
[REDACTED] Press the "Proceed" button.
3. Within the Confirmation screen, review all information and press the "Confirm" button.
4. Verify that the LDD ring lights are activated.
5. Apply topical anesthetic.

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

Note: Always maintain the RxLAL in focus by focusing at the haptics. Never focus onto the CCC (capsulotomy) or Purkinje images.
13. If the event of an aborted Adjustment Treatment, do not initiate a new treatment sequence; instead; instruct the subject to return 3-7 days later for refractive evaluation to assess whether an adjustment treatment is required or to proceed directly to a lock-in treatment.
14. Following the light adjustment, the subject will be instructed to continue to wear their UV protective eyewear as instructed, until exactly 24 hours after the final lock-in treatment for both eyes has been completed.
15. The subject will return 3 to 7 days following the power adjustment treatment for another light treatment. Depending on the manifest refraction as determined from testing at 4 meters, the subject may receive up to 3 adjustment treatments before receiving the 1<sup>st</sup> lock-in treatment. The necessity of the second adjustment treatment is guided by the LDD.  
[REDACTED]  
[REDACTED]  
Otherwise proceed to lock-in #1 treatment.

#### **7.3.2.4 Lock-In Procedure(s)**

Refer to the LDD Operator's manual for instructions on LDD start up and instructions for the daily alignment test to be performed prior to the first treatment of the day to ensure the UV beam is aligned to the reticle. If the UV beam is not aligned to the reticle within the

specifications detailed in the LDD Operator's manual, do not perform treatments and call RxSight customer service immediately.

1. All lock-in procedure(s) will be recorded.
2. Within the Patient ID and/or Patient Data screen, utilize the pop-out menu within the Patient ID field to select the appropriate subject identification with eye to be treated. Reconfirm that eye to be treated, i.e. Right Eye or Left Eye, RxLAL serial number, and RxLAL lens power are all correct. If prompted, enter the manifest refraction (sphere, cylinder and axis) as determined from testing at 4 meters. Press the "Proceed" button.
3. Within the Confirmation screen, review all information and press the "Confirm" button.
4. Verify that the LDD ring lights are activated.
5. Apply topical anesthetic.
6. Position the RxSight supplied contact lens [REDACTED] on the cornea using [REDACTED] or [REDACTED] as the coupling medium. The contact lens supplied is similar to those used in other ophthalmic procedures. Only the RxSight designated contact lens shall be used.
7. Instruct the subject to focus straight ahead on the LDD fixation light with the study eye.
8. Using the microscope, focus on the cornea and verify that there are no trapped bubbles present. Confirm alignment of the contact lens by approximately aligning the Purkinje images to the inner circle of the reticle target.
9. Using the microscope, focus on the RxLAL haptics and align the reticle target with the periphery of the RxLAL.
10. Press the "Ready" button
11. Initiate the irradiation delivery as prompted by the LDD display using the joystick or foot pedal to keep the RxLAL centered in the alignment reticle.
12. Perform micro adjustments to keep the reticle target centered to the RxLAL and to keep the RxLAL in focus. In the case of subject movement, loss of alignment, or loss of focus, pause the treatment, quickly refocus, realign the lens with respect to the reticle beam, and immediately resume treatment to limit the duration of any pauses once the light treatment has been initiated.

Note: Always maintain the RxLAL in focus by focusing at the haptics. Never focus onto the CCC (capsulotomy) or Purkinje images.
13. If the lock-in treatment is aborted before completion, contact the Sponsor for technical assistance.
14. Upon completion of the lock-in #1 treatment, a notification may appear that informs the user that a lock-in #2 treatment is not required for the subject. If this notification appears, proceed to step #16. If no notification appears, then the subject will require a lock-in #2 treatment and proceed to step #15.

15. The subject will return for the second lock-in treatment 3 to 7 days after the first lock-in treatment.
16. The subject will be permitted to discontinue wear of the UV protective eyewear exactly 24 hours after the final lock-in treatment for both eyes has been completed.

#### 7.4 EXAMINATION SCHEDULE

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

Evaluation	
Preoperative OU	Maximum of 60 days prior to Operative Visit for either Primary eye or Fellow eye
Operative Primary Eye	Day 0, day of surgery for Primary eye
Postop Day 1 Primary Eye	Days 1 to 2 post-Operative Visit Primary Eye
Operative Fellow Eye	Minimum of 2 days post-Operative Visit Primary Eye
Postop Day 1 Fellow Eye	Days 1 to 2 post-Operative Visit Fellow Eye
Postop Week 1 Primary Eye	Days 7 to 14 post-Operative Visit Primary Eye
Postop Week 1 Fellow Eye	Days 7 to 14 post-Operative Visit Fellow Eye
Postop Week 3 (bilateral) <sup>1</sup>	Days 17 to 24 post-Operative Visit Fellow Eye: Adjustment #1
Adjustment #2 (bilateral) <sup>2</sup> , if needed	3 to 7 days post Adjustment #1
Adjustment #3 (bilateral) <sup>2</sup> , if needed	3 to 7 days post Adjustment #2
Lock-in #1 (bilateral) <sup>1</sup>	3 to 7 days post final adjustment visit
Lock-in #2 (bilateral) <sup>2</sup> , if needed	3 to 7 days post lock-in #1
Post Lock-In (bilateral)	3 to 7 days post final lock-in visit
3 Months Post Lock-In/6 Months Postop (bilateral) <sup>3</sup>	Days 120 to 180 postop-Operative Visit Fellow Eye

- 1- Light treatments will be performed bilaterally at the same visit
- 2- Light treatments will be performed bilaterally at the same visit if guided by the Light Delivery Device (Adjustment #2 and Lock-In #2) or if specific clinical criteria are measured as described in section 7.3.2 of the protocol (Adjustment #3)
- 3- If both treated eyes are simultaneously within the 6 Months Postop visit windows, both eyes can be examined at the same visit and the binocular UCDVA and UCIVA will be measured at the corresponding visit. Otherwise, for each study subject, the binocular UCDVA and UCIVA will be measured at the 6 Months Postop Visits of the fellow eye.

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

## **7.5 CLINICAL PARAMETERS**

The following study parameters will be assessed as specified in Table 2. Assessments will be performed using the techniques described in [REDACTED] and in the order presented here and in Table 2.

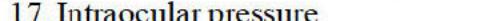
1. Quality of Vision (QoV) questionnaire
2. Demographics
3. Ocular history including medications
4. Ocular Biometry: ACD and axial length (Optical biometry only)
5. Autorefraction
6. Corneal Keratometry
7. Subjective symptoms/complaints (subject reported)
8. Uncorrected distance visual acuity (UCDVA) Monocular
9. Binocular UCDVA (only measured at 6 months postop)
10. Manifest Refraction
11. Best corrected distance visual acuity (BCDVA) Monocular
12. Monocular uncorrected intermediate visual acuity
13. Binocular UCIVA (only measured at 6 months postop)
14. Ocular Dominance
  
  
17. Intraocular pressure
18. Dilated pupil diameter
19. Slit Lamp Examination
20. Fundus Exam
21. Adverse Events

Table 2. Schedule of Visits and Clinical Parameters for Eyes Implanted with the RxLAL

Visits	Preop OU	Operative Primary Eye	Postop Day 1 Primary Eye	Operative Fellow Eye	Postop Day 1 Fellow Eye	Postop Week 1 Primary Eye	Postop Week 1 Fellow Eye	Postop Week 3 (bilateral)	Adjustment #2 (bilateral, if needed)	Adjustment #3 (bilateral, if needed)	Lock-in #1 (bilateral)	Lock-in #2 (bilateral, if needed)	Post Lock-In (bilateral)	6 Months Postop (3 Months Post Lock-In) (bilateral)	Unscheduled Visit
Quality of Vision (QoV) Questionnaire	X							X						X	
Demographics	X														
Ocular History	X														
Medications	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Ocular Biometry	X														
Autorefraction						X	X	X	X	X	X	X	X	X	
Corneal Keratometry	X							X							X
Subjective Symptoms/Complaints (Subject reported)			X		X	X	X	X	X	X	X	X	X	X	X
Monocular uncorrected distance visual acuity (UCDVA)	X		X		X	X	X	X	X <sup>1</sup>	X <sup>1</sup>	X <sup>1</sup>	X <sup>1</sup>	X <sup>1</sup>	X <sup>1</sup>	X
Binocular UCDVA															X
Manifest Refraction	X					X	X	X	X	X	X	X	X	X	X
Monocular Best corrected Visual Acuity Distance (BCDVA)	X					X	X	X	X	X	X	X	X	X	X
Monocular uncorrected intermediate visual acuity (UCIVA)								X							X
Binocular UCIVA															X
Ocular Dominance	X														
Intraocular Pressure	X		X		X	X	X	X	X	X	X	X	X	X	X
Dilated Pupil Diameter	X							X	X	X	X	X			



## 7.6 DATA REPORTING

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

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

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

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

## 7.7 METHODS FOR ANONYMIZING DATA

Only subject numbers will be recorded on the CRF. All data will be anonymized before being published.

## 7.8 STUDY COMPLETION PROCEDURES

Every effort must be made to ensure that subjects complete all visits and all assessments. An End of Study Form must be completed for all subjects enrolled in the study upon subject completion, withdrawal or discontinuation. Subjects will be advised to return to routine ophthalmological care provided by their usual physician once discharged from the study.

### 7.8.1 SUBJECT COMPLETION

Subjects are considered to have completed the study if they have completed the 6 Months Postop (3 Months Post Lock-In) examination. Subjects with ocular serious adverse events or adverse device effects that are unresolved at study exit should continue to be followed until resolution of the event or until they are stable per the investigator's evaluation.

### 7.8.2 SUBJECT DISCONTINUATION OR WITHDRAWAL

A subject may voluntarily discontinue from the study at any time he or she chooses. Additionally, subjects may be discontinued from the study for non-treatment-related reasons only when no other option is possible. The reason for discontinuation will be recorded on the appropriate case report form. Furthermore, the study Sponsor will have the ability to limit or close study/investigational site enrollment based on issues of subject safety and study goals.

### 7.8.3 SUBJECT WITHDRAWAL PRIOR TO IMPLANTATION

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

#### **7.8.4 SUBJECT WITHDRAWAL DUE TO INTRAOPERATIVE COMPLICATIONS PRIOR TO IMPLANTATION**

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

#### **7.8.5 SUBJECT DISCONTINUATION AFTER IMPLANTATION**

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

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

#### **7.8.6 LOST TO FOLLOW-UP**

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

#### **7.8.7 STUDY TERMINATION**

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

- Safety concerns. Clinical data from the study will be monitored in real time to assure the safety of enrolled subjects.
- Failure of the Investigator to follow protocol requirements and GCP guidelines.
- Failure of the Investigator to comply with country specific regulations.
- Inadequate recruitment of subjects by the Investigator.

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

## 8 STATISTICAL METHODS

### 8.1 SAMPLE SIZE CALCULATION

The sample size calculation is based on the effectiveness parameter (Section 5.1) and the analysis described below.

In order to estimate the percent of eyes with 20/20 or better monocular UCDVA [REDACTED]

[REDACTED] at 6 months

postop (3 months post lock-in), the 95% confidence interval of the percent of eyes with 20/20 or better monocular UCDVA at 6 months postop (3 months post lock-in) will be calculated based on the normal distribution approximation.

Let the LAL implanted primary eyes and LAL implanted fellow eyes have the same binomial distribution with a success probability of  $p$ ;  $X$  and  $Y$  be the numbers of primary and fellow eyes of  $N$  subjects achieving 20/20 or better monocular UCDVA at 6 months, respectively; the correlation coefficient of  $X$  and  $Y$  is  $\rho$ . Then, the observed responder rate based on all eyes  $(X+Y)/(2xN)$ , has an approximately normal distribution with a mean of  $p$  and a variance of  $(p \times (1-p)) \times (1+\rho)/(2 \times N)$ . With a sample size of 90 study eyes of 45 subjects and a  $\rho$  of 0.4 between two eyes of the same subject, per the normal distribution approximation, the width of the 95% confidence interval is < 25% with the maximum of 24.5% at an observed success rate of 0.5. According to the pivotal study of RxLAL and LDD under G100240, the observed percent of eyes with 20/20 or better monocular UCDVA at 6 months is 70%. Therefore, for an observed outcome of 70% and a  $\rho$  of 0.4, the 95% confidence interval per normal distribution approximation is (58.8%, 81.2%) with a width of 22.4%. If a drop-out rate of 10% is considered, at least 100 study eyes should be treated. Since the study is intended to treat the bilateral subjects, at least 50 eligible bilateral subjects should be treated.

### 8.2 GENERAL CONSIDERATION

The statistical analysis of the data will be performed using SAS version 9.3 or higher or another industry standard statistical software package.

### 8.3 POPULATIONS FOR ANALYSIS

Effectiveness analyses will be performed on observed data for all study eyes successfully implanted with the RxLAL. Effectiveness analyses will also be presented for all primary and fellow eyes separately.

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

#### 8.3.1 EFFECTIVENESS PARAMETER

##### 8.3.1.1 Primary Analyses

The primary analysis will be based on the observed 6-month monocular UCDVA [REDACTED]

[REDACTED] of all study

eyes successfully implanted with the RxLAL. Number and percent of all study eyes with a monocular UCDVA of 20/20 or better at 6 Months Postop (3 Months Post Lock-In) and the corresponding 95% confidence interval for the percent based on the normal distribution approximation with an observed correlation coefficient will be calculated.

### 8.3.1.2 Secondary Analyses

The percent of eyes with monocular UCDVA of 20/20 or better at 6 Months Postop will be performed on the 6-month monocular UCDVA of primary and fellow eyes successfully implanted with the RxLAL separately. The 95% confidence interval will be calculated based on the binomial distribution.

### 8.3.2 ADDITIONAL EFFECTIVENESS ANALYSES

The following effectiveness outcomes will be summarized descriptively based on the observed data of all study eyes successfully implanted with the RxLAL. Effectiveness outcomes will also be presented for all primary and fellow eyes separately.

#### Monocular Uncorrected Visual Acuity

UCDVA will be presented with the number and percent of eyes that fall into each category of UCDVA (e.g. 20/20 or better, 20/25 or better, 20/32 or better, etc.) at each visit. The mean UCDVA letter score will be calculated for each visit. Change in UCDVA from Postop Week 3 will be presented at each visit as categorical outcomes of “increase in 15 letters or more”, “Increase in 10-14 letters”, “Increase in 5-9 letters”, “No change”, “Decrease in 5-9 letters”, “Decrease in 10-14 letters”, and “Decrease in 15 letters or more”. The mean change from Postop Week 3 will also be presented. The same analyses will be performed for monocular UCIVA on data collected at the Postop Week 3 and 6 months postop visits.

UCDVA will also be presented with the number and percent of eyes that fall into each category of UCDVA (e.g. 20/20 or better, 20/25 or better, 20/32 or better, etc.) stratified into two bins based on preoperative keratometric cylinder ( $\geq 0.50$  D and  $\leq 1.50$  D) and ( $< 1.50$  D and  $\leq 4.00$  D). The mean UCDVA letter score will be calculated for each of the two defined preoperative keratometric cylinder bins. The same analysis will be performed for UCIVA.

#### Binocular Uncorrected Visual Acuity

The 6-month binocular UCDVA and UCIVA will be presented with the number and percent of subjects who fall into each category of visual acuity at each visit (e.g. 20/20 or better, 20/25 or better, 20/32 or better, etc.). The logMAR value will be summarized by descriptive statistics.

#### Quality of Vision<sup>17</sup> Questionnaire

Results of the Quality of Vision Questionnaire will be summarized descriptively for subjects bilaterally implanted with the RxLAL and for subjects with the RxLAL implanted only in the

<sup>17</sup> McAlinden C, Pesudovs K, Moore JE. The Development of an Instrument to Measure Quality of Vision: The Quality of Vision (QoV) Questionnaire. Invest Ophthalmol Vis Sci. 2010;51:5537-5545.

primary eye preoperatively, at Postop Week 3, and at 6 Months Postop (3 Months Post Lock-In).



Manifest Cylinder

Refractive cylinder will be presented beginning at Post lock-in. The number and percent of eyes with a MRCYL of  $\leq 0.25$  D, 0.50 D, 0.75 D, 1.0 D, 1.25 D, 1.5 D, 1.75 D, and  $\geq 2.0$  D will be reported for each visit. In addition, manifest cylinder at 6 Months Postop (3 Months Post Lock-In) will be stratified and summarized descriptively (mean, standard deviation, minimum, maximum, quartiles) by both the Postop Week 3 manifest cylinder and separately by the pre-operative corneal cylinder (using 0.25 D bins). The number in each bin will also be provided.

For eyes with 0.50 D or more of cylinder at Postop Week 3, mean and percent reduction in cylinder compared to Postop Week 3 will be presented beginning at Post Lock-in.

### Cylinder Correction Accuracy

Accuracy of cylinder correction to intended target within 0.50 D and 1.00 D will be reported beginning at Post lock-in.

### MRSE

MRSE will be summarized by the descriptive statistics for continuous outcomes (such as mean and standard deviation) for each visit. The change in MRSE from Postop Week 3 will also be summarized descriptively.

### Accuracy of MRSE

The number and percent of eyes with a MRSE correction compared to the intended target within 0.25 D, 0.50 D, 0.75 D, 1.0 D, 1.25 D, 1.5 D, 1.75 D, and  $\geq 2.0$  D will be reported at each visit beginning at Post Lock-In.

### Defocus Equivalent (DEQ)

DEQ will be summarized descriptively at Postop Week 3 and beginning at Post lock-in. The number and percent of eyes with DEQ  $\leq 0.5$  D and 1.0 D will also be summarized at the corresponding visit.

## **8.4 SAFETY PARAMETERS**

All ocular adverse events (device related and unrelated) and all Secondary Surgical Interventions (SSIs) of the study eyes during the conduct of the study will be presented.

### **8.4.1 ADDITIONAL SAFETY ANALYSES**

Except for the Subjective Symptoms/Complaints (subject reported), the safety outcomes will be summarized descriptively for all eyes that have the procedure attempted. For the Subjective Symptoms/Complaints, the observed data will be summarized based on subjects.

### BCDVA

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

[REDACTED]

### Intraocular Pressure (IOP)

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

### Slit Lamp Examination and Fundus Examination Findings

The outcomes will be summarized descriptively by count and percent of eyes with each possible finding category.

### Subjective Symptoms/Complaints

Results of the Subjective Symptoms/Complaints will be summarized descriptively for subjects bilaterally implanted with the RxLAL and for subjects with the RxLAL implanted only in the primary eye at each required visit.

[REDACTED]

[REDACTED]

## **9 ADVERSE EVENTS**

If an adverse event (AE) occurs, the first concern will be the safety and welfare of the subject; treatment should be provided as appropriate for the event. During the study, the Investigator should appropriately treat and follow each AE until it resolves, stabilizes, or it is determined that further improvement is not expected.

### **9.1 ADVERSE EVENT DEFINITIONS**

An adverse event (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 1 to entry: This definition includes events related to the investigational medical device or the comparator.

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

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

The following may be considered normal events after cataract surgery and only need to be reported as AEs as specified:

- Iritis/cells/flare (if present after Postop Week 1 and greater than grade 1 (trace)) or (any iritis/cells/flare present at 6 Months Postop (3 Months Post Lock-In) of any grade)
- Corneal edema (if present after Postop Week 1 and greater than grade 1 (trace)) or (if present at 6 Months Postop (3 Months Post Lock-In) of any grade)
- Raised intraocular pressure (IOP) >10 mmHg above preoperative and greater than 25 mmHg (if present after Postop Week 1)

In addition, the specific following events should be reported as an AE:

- A [REDACTED] at any time after Postop Week 3.
- An [REDACTED] at any time after Postop Week 3.
- An [REDACTED] at the 6 Months Postop (3 Months Post Lock-In) visit.

### **9.2 SERIOUS ADVERSE EVENT DEFINITION**

A serious adverse event is any untoward occurrence during a clinical trial or performance evaluation requiring authorization, which directly or indirectly caused, may have caused in the past, or may cause in the future, death or a serious aggravation of the state of health of a subject, a user, or another person, irrespective of whether the occurrence was caused by the medical device; this applies mutatis mutandis to serious adverse events that occur during a clinical trial or performance evaluation for which the requirement for authorization in accordance with Section 20, sub-section 1, sentence 2 of the Act on Medical Devices was waived.

### **9.2.1 IDENTIFICATION AND COLLECTION**

Identification and collection of an AE begins after informed consent has been obtained and documented. Standard sources of identifying AEs include:

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

Ocular AEs and SAEs and systemic SAEs observed or elicited by the Investigator, reported by the subject, or resulting from a test result, etc., occurring during the clinical investigation must be documented. During the study, the Investigator should treat the study subject as appropriate to ensure his/her safety and welfare. Refer to Section 7.7.1 for additional information pertaining to ongoing AEs at subject exit.

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

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

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

### **9.2.2 EVALUATIONS**

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

#### **1. Severity**

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

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

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

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

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

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

## 9.3 ADVERSE EVENT REPORTING REQUIREMENTS TO BFARM

The procedures for documentation, evaluation and reporting of serious adverse events will be as follows:

- An Investigator located in the European Union / EFTA reports without delay the occurrence of any SAE to the Sponsor.
- The current version of the “Meldeformular\_Klinische-Pruef\_SAE” downloadable from the website of the BfArM is used to document the initial information through the Sponsor and Investigator.
- The report for those SAEs for which a causal relationship to the study device, study related therapeutic or diagnostic measures or study participation cannot be excluded is delivered without delay to the BfArM (mpsae@bfarm.de) by the Sponsor with a copy to the Director, Clinical Studies of the Sponsor and the Principal Investigator.
- For SAEs for which a causal relationship to the study device, study related therapeutic or diagnostic measures or study participation can be excluded, a report is delivered to the BfArM (mpsae@bfarm.de) in summarized form on a quarterly basis or upon request of the BfArM by the Sponsor with a copy to the Director, Clinical Studies of the Sponsor and the Principal Investigator.
- The Sponsor assesses the root cause and risk analysis review in collaboration with the Principal Investigator with specific assessment of the potential need for corrective measures.
- A final (or interim) report “Meldeformular\_Klinische-Pruef\_SAE” is provided to the BfArM by the Sponsor as assessment proceeds / is finalized.
- SAEs identified outside of the European Union / EFTA shall be reported in analog fashion to the BfArM “Meldeformular\_Klinische-Pruef\_SAE”. The Director, Clinical Studies of the Sponsor shall deliver the salient information to the Sponsor without delay for transmission to the BfArM.
- Reporting of SAEs to the Competent Authorities of countries outside of Germany shall be consistent with the statutory requirements of those countries.

#### **9.4 ORDINANCE ON THE RECORDING, EVALUATION AND DEFENSE OF RISKS IN MEDICAL PRODUCTS (MEDICAL DEVICES SAFETY PLAN - MPSV) § 2 DEFINITIONS**

For the purposes of this ordinance:

- An incident is a malfunction, failure, a modification of the features or performance, or an inaccurate label or instruction manual for a medical device, which directly or indirectly caused, may have caused in the past, or may cause in the future, death or a serious aggravation of the state of health of a patient, a user, or another person; a defect in suitability for use which causes misuse is also considered to be a malfunction,
- A corrective measure is a measure to eliminate, reduce, or prevent the recurrence of a risk linked to a medical device,
- A recall is a corrective measure leading to return, exchange, conversion or improvement, isolation, or destruction of a medical device, or whereby users, operators, or patients are provided with instructions on how to use or operate medical devices safely in the future,
- A recommendation for action is the notification of the person responsible in accordance with Section 5 of the German Act on Medical Devices, leading to a recall

#### **9.5 PREGNANCY**

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

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

## 9.6 POTENTIAL ADVERSE EVENTS

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

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

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

Additional specific risks of the RxLAL include:

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

## 10 STUDY MONITORING

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

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

## **11 ETHICAL AND REGULATORY CONSIDERATIONS**

### **11.1 SUBJECT INFORMATION AND CONSENT**

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

All enrolled subjects will be provided with any new information promptly so that they can assess if they wish to continue participation in the study. Subjects will be informed that their individual data will be summarized along with the data from other subjects and may be used for publications without disclosing any of their personal information.

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

### **11.2 DECLARATION OF HELSINKI**

The study will be performed in accordance with the relevant recommendations guiding physicians in biomedical research involving human subjects adopted by the 18<sup>th</sup> World Medical Assembly, Helsinki, Finland, 1964 and later revisions.

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

### **11.3 ADDITIONAL REGULATORY CONSIDERATIONS**

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

### **11.4 OFFICIAL REGISTRATION OF STUDY**

The study will be registered on EUDAMED: European Database on Medical Devices.

### **11.5 STUDY INITIATION/CONDUCT**

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

## **11.6 COMPLIANCE WITH THE CLINICAL INVESTIGATIONAL PLAN**

The Investigator shall conduct this clinical investigation in accordance with the signed agreement with the Sponsor, the investigational plan, and the applicable regulations. The Investigator shall avoid improper influence on or inducement of the subject, Sponsor, Monitor, other Investigator(s) or other parties participating in or contributing to the clinical investigation. The Investigator should not deviate from the clinical protocol. The date of and reason for deviation(s) will be documented by the Monitor on the monitoring report and further detail may be requested from the Investigator. All protocol deviations will be noted on the protocol deviation tracker following verification of source data information. The protocol deviations will be reviewed and categorized by RxSight's clinical personnel prior to data analysis. Reporting of protocol deviations must adhere to the requirements of the governing Competent Authority. A log of all deviations from the Clinical Investigational Plan (CIP) will be retained,

## **11.7 RECORD RETENTION**

The Investigator shall maintain all subject records for a period of fifteen years after the database lock. The Investigator must contact RxSight prior to discarding or disposing of any study related supplies or documents. The Sponsor retains the right to have all study documents shipped (at Sponsor's expense) for archival purposes, as an alternative to disposal.

## **11.8 PROTOCOL AMENDMENTS**

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

## **11.9 PUBLICATION POLICY**

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

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