PROTOCOL CSP-027

A PROSPECTIVE RANDOMIZED CONTROLLED MULTI-CENTER CLINICAL STUDY TO EVALUATE THE SAFETY AND EFFECTIVENESS OF THE RXSIGHT LIGHT ADJUSTABLE LENS (LAL) IN SUBJECTS WITH PRIOR CORNEAL REFRACTIVE SURGERY

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

Version 06
July 03, 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.

_____
Site Name

_____ _____
Principal Investigator's Signature *Date*

TABLE OF CONTENTS

RXSIGHT, INC.

PROTOCOL NO. CSP-027

A PROSPECTIVE RANDOMIZED CONTROLLED MULTI-CENTER CLINICAL STUDY TO EVALUATE THE SAFETY AND EFFECTIVENESS OF THE RXSIGHT LIGHT ADJUSTABLE LENS (LAL) IN SUBJECTS WITH PRIOR CORNEAL REFRACTIVE SURGERY

1 STUDY SYNOPSIS

STUDY OBJECTIVE

The primary objective of this study is to evaluate, for the visual correction of aphakia, the safety and effectiveness of the RxSight Light Adjustable Lens (LAL) and Light Delivery Device (LDD) to reduce postoperative refractive error and improve uncorrected distance visual acuity in eyes with prior corneal refractive surgery. A control group consisting of fellow eyes implanted with a commercially available monofocal IOL will be used to compare the safety and effectiveness of the LAL.

STUDY POPULATION

The study population will consist of up to 120 subjects with implantation of the LAL attempted in the primary eye. Eyes successfully implanted with the LAL will have a commercially available monofocal control, the Sensar AR40e (Abbott Medical Optics), implanted in the fellow eye following cataract removal. All study eyes must have undergone prior corneal refractive surgery, have preoperative keratometric astigmatism of ≤ 2.00 D, and meet all the applicable inclusion criteria and none of the exclusion criteria.

STUDY DESIGN

A prospective, randomized, controlled, multi-center, clinical study will be conducted at a maximum of 8 sites located in the United States. Subjects will be followed for a 6-month period. A minimum of 12 bilateral subjects will undergo study implantation at each participating site, with less than 25% of the total study population implanted at one clinical site.

Patients who require bilateral cataract extraction and 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. Both eyes of all subjects will be screened for eligibility at the same preoperative visit. A pre-determined randomization scheme will be utilized to designate each of the patient's eyes as the primary eye (LAL) or the fellow eye (Control). The subject's fellow eye will be scheduled for surgery a minimum of 7 days after the primary eye. If surgical complications occur with the primary eye and no LAL is implanted, the subject is exited from the study.

Commencing at the Postop Week 3 visit, all primary eyes will be refracted, undergo visual testing, and receive a power adjustment based on the manifest refraction as determined from testing at 4 meters. [redacted] Subjects will return 3 to 7 days after their adjustment and the same measurements performed again. Depending on the adjustment(s) performed, primary 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, all subjects will undergo complete ophthalmic examinations starting with the Postop Week 1 visit. Bilateral ophthalmic examinations can occur if the postoperative visit windows allow. Examinations will occur at regular intervals over a 6-month period to evaluate the safety and effectiveness of the LAL compared to the control. [redacted] Masked examiners will be utilized at Postop Week 3, Postop Month 3, and Postop Month 6.

Effectiveness data will be compared between the LAL and Control groups. Safety for all study eyes will be evaluated per ISO 11979-7.

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

INCLUSION CRITERIA

- Must sign a written Informed Consent form and be willing to undergo cataract surgery for the bilateral implantation of an intraocular lens (IOL).
- Between the ages of 40 and 80 inclusive on the day the cataract surgery is performed.
- Preoperative keratometric cylinder ≤ 2.00 in both eyes.
- History of Laser-Assisted *In Situ* Keratomileusis (LASIK), Photorefractive Keratectomy (PRK), Laser-Assisted Subepithelial Keratomileusis (LASEK), Epi-LASIK, or Epi-LASEK more than 1 year prior in both eyes.
- Cataract causing reduction in best corrected distance visual acuity (BCDVA) to a level of 20/40 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 and retinal exam) to be 20/20 or better after cataract removal and intraocular lens (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.
- Average dilated pupil diameter of ≥7.0 mm in both eyes.
- Able to complete a written questionnaire in English.

- Requires an IOL power within the range available for both the LAL and the Sensar AR40e.

EXCLUSION CRITERIA

- Prior history of Intacs, Radial keratotomy (RK), Conductive keratoplasty (CK), Astigmatic keratotomy (AK), Phakic IOL (ICL), Refractive Lens Exchange (RLE), or Corneal Inlay in either eye.
- Clinically significant dry eye syndrome (DES) in either eye.
- Clinically significant corneal haze in either eye.
- Pseudoexfoliation in either eye.
- Pre-existing macular disease in either eye.
- Patients with sufficiently dense cataracts that preclude examination of the macula in either eye.
- Diabetes with any evidence of retinopathy in either eye.
- Evidence of glaucomatous optic neuropathy in either eye.
- History of uveitis in either eye.
- Significant anterior segment pathology, such as rubeosis iridis, aniridia, or iris coloboma in either eye.
- Corneal pathology or corneal dystrophy that is either progressive or sufficient to reduce BCDVA to worse than 20/20 in either eye.
- Evidence of ectasia in either eye.
- Previous intraocular surgery in either eye. Eyes with previous pterygium excision are permitted as long as the pterygium did not extend more than 2mm onto the cornea from the limbus.
- Subjects with 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.
- Subjects who the doctor believes will be unable to maintain steady fixation that is necessary for centration of the LDD light treatment in either eye.
- Irregular astigmatism in either eye.
- History of ocular herpes simplex virus in either eye.
- Eye that has been compromised due to previous trauma or developmental defects in which appropriate support of the intraocular lens (IOL) is not possible.

- Current vitreoretinal disease or a high risk for future vitreoretinal disease that may require silicone oil as part of therapy in either eye.

OUTCOME PARAMETERS

Effectiveness Parameters:

Primary Endpoints

- Magnitude of manifest cylinder (MRCYL) at Postop Month 6
- Absolute Manifest Refraction Spherical Equivalent (MRSE) at Postop Month 6
- Best corrected distance visual acuity (BCDVA) of 20/40 or better at Postop Month 6

The MRCYL and MRSE outcomes will be compared between the two study groups, LAL and Control.

Per ISO 11979-7:2014 (E), one-sided upper 95% confidence limit of the percentage of LAL-implanted eyes with BCDVA of 20/40 or better at Postop Month 6 is higher than the performance rate of 92.5%. It should be noted that all three effectiveness endpoints must be statistically significant in order to conclude the effectiveness of the LAL. Therefore, no additional significance level adjustment will be performed for these three primary endpoints.

Secondary Endpoints

- Uncorrected distance visual acuity (UCDVA) at Postop Month 6
- UCDVA at Postop Month 6 for subjects measured with keratometric cylinder (Kcyl) <0.75 D in both eyes at the preoperative examination.

The UCDVA outcomes will be compared between the two study groups, LAL and Control.

The secondary effectiveness endpoints will not be tested unless all three primary effectiveness endpoints are statistically significant. Due to this step-down approach, no additional adjustment will be made for the significance levels.

Safety Parameters:

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

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

Examination Schedule:

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

Primary Study Eye (LAL)

Evaluation	
Preoperative OU	Maximum of 60 days prior to Operative LAL Visit
Operative LAL	Day 0, day of LAL surgery
Postop Day 1 LAL	Days 1 to 2 post-Operative LAL Visit
Postop Week 1 LAL	Days 7 to 14 post-Operative LAL Visit
Postop Week 3 LAL (Adjustment #1)	Days 17 to 24 post-Operative LAL Visit
Adjustment #2, if needed	3 to 7 days post Adjustment #1
Adjustment #3, if needed	3 to 7 days post Adjustment #2
Lock-in #1	3 to 7 days post final adjustment
Lock-in #2, if needed	3 to 7 days post lock-in #1
Postop Months 1-2	7 to 14 days post final lock-In
Postop Month 3 LAL	Days 60 to 90 post-Operative LAL Visit
Postop Month 6 LAL	Days 120 to 180 post-Operative LAL Visit
Postop Month 12, if needed	Days 330 to 420 post-Operative LAL Visit

[redacted]

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.

Fellow Study Eye (Control)

Evaluation	
Operative Control	Minimum of 7 days post-Operative LAL Visit
Postop Day 1 Control	Days 1 to 2 post-Operative Control Visit
Postop Week 1 Control	Days 7 to 14 post-Operative Control Visit
Postop Week 3 Control	Days 17 to 24 post-Operative Control Visit
Postop Month 3 Control	Days 60 to 90 post-Operative Control Visit
Postop Month 6 Control	Days 120 to 180 post-Operative Control Visit

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

Clinical Parameters:

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

1. Demographics
2. [redacted]
3. [redacted]
4. Ocular history including medications
5. Ocular Biometry: Anterior chamber depth (ACD) and axial length (Optical or immersion A-scan biometry)
6. Subjective symptoms/complaints (subject reported)
7. [redacted]
8. Corneal Topography
9. Autorefraction
10. Corneal Keratometry
11. Specular Microscopy
12. Uncorrected distance visual acuity (UCDVA)
13. Manifest Refraction
14. Best corrected distance visual acuity (BCDVA)
15. [redacted]
16. [redacted]
17. Distance corrected contrast sensitivity: Mesopic/Photopic with and w/o glare
18. [redacted]

19. Intraocular pressure
20. Slit Lamp Examination
21. Dilated pupil diameter
22. Fundus Exam
23. Fundus Photos
24. [redacted]
25. Adverse Events

ABBREVIATIONS AND DEFINITION OF TERMS

ACD	Anterior Chamber Depth
AE	Adverse Event
AK	Astigmatic Keratotomy
ANSI	American National Standards Institute
BCDVA	Best Corrected Distance Visual Acuity
CCC	Continuous Circular Capsulorhexis
CDRH	Center for Devices and Radiological Health
CFR	Code of Federal Regulations
CI	Confidence Interval
CK	Conductive Keratoplasty
CRF	Case Report Form
CRO	Contract Research Organization
D	Diopter
DES	Dry Eye Syndrome
DEQ	Defocus Equivalent
[redacted]	[redacted]
ECC	Endothelial Cell Count
ECD	Endothelial Cell Density
EDC	Electronic Data Capture
ETDRS	Early Treatment Diabetic Retinopathy Study
FDA	Food and Drug Administration
GCP	Good Clinical Practice
IDE	Investigational Device Exemption
IOL	Intraocular Lens
IOP	Intraocular Pressure
IRB	Institutional Review Board
ISO	International Organization for Standardization
ITT	Intent To Treat
LASEK	Laser Assisted Subepithelial Keratomileusis
LASIK	Laser Assisted In Situ Keratomileusis
LDD	Light Delivery Device
MR	Manifest Refraction
MRCYL	Manifest Refraction Cylinder
MRSE	Manifest Refraction Spherical Equivalent
OCT	Optical Coherence Tomography
PCO	Posterior Capsular Opacity

PMA	Premarket Application
PPC	Precision Pulse Capsulotomy
PRK	Photorefractive Keratectomy
[redacted]	[redacted]
RK	Radial Keratotomy
RLE	Refractive Lens Exchange
LAL	RxSight Light Adjustable Lens
SAE	Serious Adverse Event
SE	Spherical Equivalent
SPK	Superficial Punctate Keratitis
SSI	Secondary Surgical Intervention
[redacted]	[redacted]
UADE	Unanticipated Adverse Device Effect
UCDVA	Uncorrected Distance Visual Acuity
UV	Ultraviolet

2 INTRODUCTION AND RATIONALE

Since 1996, approximately 18 million Americans have undergone LASIK (see Figure 1).[1] With the average age of LASIK patients having remained stable at between 35 and 40 years of age, this means that the post-LASIK population is increasingly entering the age range for cataract surgery.[2,3,4,5,6]

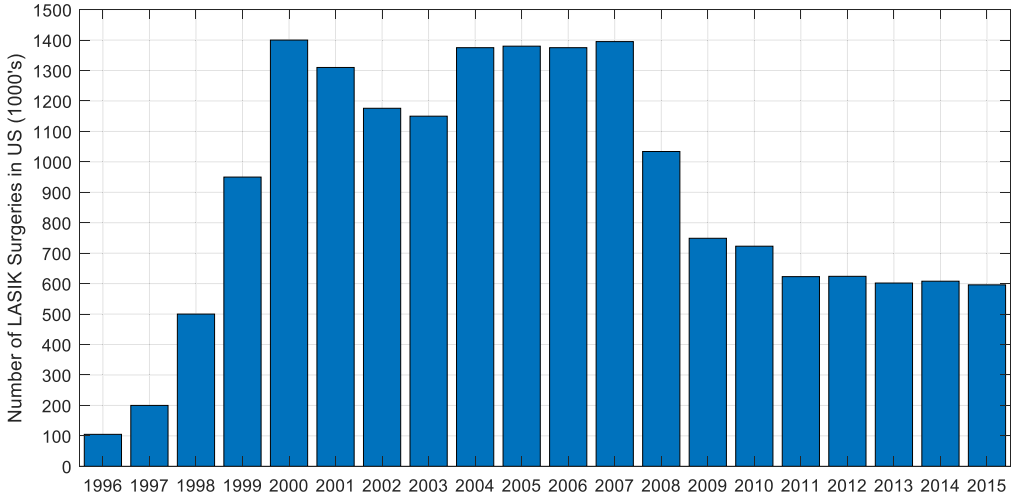

Figure 1: Number of LASIK Surgeries per year in the United States

The rising number of such post-LASIK cataract surgery patients has highlighted the limitations of current cataract surgery planning techniques for accurately predicting IOL power in this group. Specifically, refractive results in this group are inferior to those in non-LASIK eyes because of (1) inaccuracy in determining the total corneal refractive power (due to assumptions embedded in diagnostic devices for the anterior-posterior corneal power ratio and corneal refractive index) and (2) incorrect estimation of the effective lens position by many IOL calculation formulas that rely on keratometry readings that are inaccurate for the post-laser cornea.[7] As a result of these limitations, numerous diagnostic and planning methodologies have been proposed and tested to try to improve refractive accuracy in post-LASIK patients. However, despite these efforts, the percentage of post-LASIK cataract surgery patients who are within ± 0.5 D of the predicted MRSE is generally below 50%, with

1 https://www.statista.com/statistics/271478/number-of-lasik-surgeries-in-the-us/
2 https://www.lasik.com/articles/lasik-increasing-among-younger-adults/
3 https://www.reviewofoptometry.com/article/when-cataract-develops-long-after-lasik
4 https://crstoday.com/articles/2014-jul/choosing-an-iol-after-lasik/
5 https://www.reviewofophthalmology.com/article/cataract-patients-younger-every-year
6 http://www.nj.com/healthfit/index.ssf/2014/09/advances in cataract surgery allow patients to see their way to a clearer future.html
7 Vrijman V, Willem van der Linden J, et al. Multifocal intraocular lens implantation after previous corneal refractive laser surgery for myopia. J Cataract Refract Surg Volume 43, Issue 7, July 2017, 909-914.

approximately 80% of these patients within ± 1.0 D.[8] In addition, these patients can also have unanticipated post-operative astigmatism, since the original LASIK may have included lenticular astigmatism correction, with removal of the lens unmasking laser-induced corneal astigmatism.[9]

These more variable results contrast with non-LASIK patients undergoing cataract surgery with traditional monofocal IOLs, where the percentage within ± 0.5 D of the predicted refraction can reach 80% or more depending on surgeon techniques and the patient population. In the Phase III study conducted under IDE G100240 in patients with low pre-operative keratometric cylinder, 84% of control eyes implanted with a monofocal IOL were within ± 0.5 D of the predicted MRSE. While the LAL group performed even better, with 91% within ± 0.5 D, the main clinical benefit of this improvement in MRSE was a reduction in the number of outliers with significantly higher residual refractive errors. Because the number of such outliers is potentially much higher in post-LASIK eyes undergoing cataract surgery, these patients would likely see a larger clinical benefit by reducing the range of residual MRSE errors due to the inherent difficulties in predicting IOL power in this group. In addition, by producing the desired change in spherocylindrical power of the implanted Light Adjustable Lens (LAL), unanticipated post-operative astigmatism can also be addressed, potentially reducing the need for secondary surgical procedures for the vast majority of post-LASIK patients with residual refractive error.

To evaluate this potential, we propose to compare 6 months postoperative refractive and visual acuity data for LAL eyes compared to a control group of fellow eyes implanted with a commercially available monofocal IOL. Based on the anticipated range of post-operative residual MRSE being within the LAL adjustment range, similar final outcomes are anticipated when compared with the LAL group studied under IDE G100240.

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

Phase III Study Conducted Under IDE G100240

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

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

[8] Hamill E, Wang L, Chopra H, Hill W, Koch D. Intraocular lens power calculations in eyes with previous hyperopic laser in situ keratomileusis or photorefractive keratectomy. J Cataract Refract Surg 2017; 43:189-194.

[9] https://www.reviewofophthalmology.com/article/post-refractive-cataract-choosing-lens-and-target

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

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

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

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

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

[redacted]

[redacted]

[redacted]

[redacted]

3 STUDY OBJECTIVE

The primary objective of this study is to evaluate, for the visual correction of aphakia, the safety and effectiveness of the RxSight Light Adjustable Lens (LAL) and Light Delivery Device (LDD) to reduce postoperative refractive error and improve uncorrected distance visual acuity in eyes with prior corneal refractive surgery. A control group consisting of fellow eyes implanted with a commercially available monofocal IOL will be used to compare the safety and effectiveness of the LAL.

4 STUDY DESIGN

A prospective, randomized, controlled, multi-center, clinical study will be conducted at a maximum of 8 sites located in the United States. Subjects will be followed for a 6-month period. A minimum of 12 subjects will undergo study implantation at each participating site, with less than 25% of the total study population implanted at one clinical site.

Patients who require bilateral cataract extraction and 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. Both eyes of all subjects will be screened for eligibility at the same preoperative visit. A pre-determined randomization scheme will be utilized to designate each of the patient's eyes as the primary eye (LAL) or the fellow eye (Control). The subject's fellow eye will be scheduled for surgery a minimum of 7 days after the primary eye. If surgical complications occur with the primary eye and no LAL is implanted, the subject is exited from the study.

Commencing at the Postop Week 3 visit, all primary eyes will be refracted, undergo visual testing, and receive a power adjustment based on the manifest refraction as determined from testing at 4 meters. [redacted] Subjects will return 3 to 7 days after their adjustment and the same measurements performed again. Depending on the adjustment(s) performed, primary 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, all subjects will undergo complete ophthalmic examinations starting with the Postop Week 1 visit. Bilateral ophthalmic examinations can occur if the postoperative visit windows allow. Examinations will occur at regular intervals over a 6-month period to evaluate the safety and effectiveness of the LAL compared to the control. Masked examiners will be utilized at Postop Week 3, Postop Month 3, and Postop Month 6.

For subject complaints related to refractive anisometropia of greater than 1.5 diopters secondary to a refractive surprise with the fellow eye (Control), a secondary surgical intervention (SSI) may be performed on the fellow eye if both the investigator and subject agree it is in the best interest of the subject. [redacted]

[redacted]

Effectiveness data will be compared between the LAL and Control groups. Safety for all study eyes will be evaluated per ISO 11979-7.

5 OUTCOME PARAMETERS

5.1 EFFECTIVENESS PARAMETER

Primary Endpoints

- Magnitude of manifest cylinder (MRCYL) at Postop Month 6
- Absolute Manifest Refraction Spherical Equivalent (MRSE) at Postop Month 6
- Outcome of best corrected distance visual acuity (BCDVA) of 20/40 or better at Postop Month 6

The MRCYL and MRSE outcomes will be compared between the two study groups, LAL and Control.

Per ISO 11979-7:2014 (E), one-sided upper 95% confidence limit of the percentage of LAL implanted eyes with BCDVA of 20/40 or better at Postop Month 6 is higher than the performance rate of 92.5%. It should be noted that all three effectiveness endpoints must be statistically significant in order to conclude the effectiveness of the LAL. Therefore, no additional significance level adjustment will be performed for these three primary endpoints.

Secondary Endpoints

- Uncorrected distance visual acuity (UCDVA) at Postop Month 6
- UCDVA at Postop Month 6 for subjects measured with keratometric cylinder (Kcyl) <0.75 D in both eyes at the preoperative examination.

The UCDVA outcomes will be compared between the two study groups, LAL and Control.

The secondary effectiveness endpoints will not be tested unless all three primary effectiveness endpoints are statistically significant. Due to this step-down approach, no additional adjustment will be made for the significance levels.

5.2 SAFETY PARAMETERS

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

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

6 STUDY POPULATION

The study population will consist of up to 120 subjects with implantation of the LAL attempted in the primary eye. Eyes successfully implanted with the LAL will have a commercially available monofocal control IOL, the Sensar AR40e (Abbott Medical Optics), implanted in the fellow eye following cataract removal. All study eyes must have undergone prior corneal refractive surgery, have preoperative keratometric astigmatism of ≤2.00 D, and meet all the applicable inclusion criteria and none of the exclusion criteria.

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

6.1 INCLUSION CRITERIA

- Must sign a written Informed Consent form and be willing to undergo cataract surgery for the bilateral implantation of an intraocular lens (IOL).
- Between the ages of 40 and 80 inclusive on the day the cataract surgery is performed.
- Preoperative keratometric cylinder ≤ 2.00 in both eyes.
- History of Laser-Assisted *In Situ* Keratomileusis (LASIK), Photorefractive Keratectomy (PRK), Laser-Assisted Subepithelial Keratomileusis (LASEK), Epi-LASIK, or Epi-LASEK more than 1 year prior in both eyes.
- Cataract causing reduction in best corrected distance visual acuity (BCDVA) to a level of 20/40 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 and 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.
- Average dilated pupil diameter of ≥7.0 mm in both eyes.
- Able to complete a written questionnaire in English.
- Requires an IOL power within the range available for both the LAL and the Sensar AR40e.

6.2 EXCLUSION CRITERIA

- Prior history of Intacs, RK, CK, AK, Phakic IOL (ICL), Refractive Lens Exchange (RLE), or Corneal Inlay in either eye.
- Clinically significant dry eye syndrome (DES) in either eye.
- Clinically significant corneal haze in either eye.
- Pseudoexfoliation in either eye.
- Pre-existing macular disease in either eye.

- Patients with sufficiently dense cataracts that preclude examination of the macula in either eye.
- Diabetes with any evidence of retinopathy in either eye.
- Evidence of glaucomatous optic neuropathy in either eye.
- History of uveitis in either eye.
- Significant anterior segment pathology, such as rubeosis iridis, aniridia, or iris coloboma in either eye.
- Corneal pathology or corneal dystrophy that is either progressive or sufficient to reduce BCDVA to worse than 20/20 in either eye.
- Evidence of ectasia in either eye.
- Previous intraocular surgery in either eye. Eyes with previous pterygium excision are permitted as long as the pterygium did not extend more than 2mm onto the cornea from the limbus.
- Subjects with 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.
- Subjects who the doctor believes will be unable to maintain steady fixation that is necessary for centration of the LDD light treatment in either eye.
- Irregular astigmatism in either eye.
- History of ocular herpes simplex virus in either eye.
- Eye that has been compromised due to previous trauma or developmental defects in which appropriate support of the intraocular lens (IOL) is not possible.
- Current vitreoretinal disease or a high risk for future vitreoretinal disease that may require silicone oil as part of therapy in either eye.

7 STUDY MATERIALS AND METHODS

7.1 DEVICE DESCRIPTION

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

7.1.1 RXSIGHT LIGHT ADJUSTABLE INTRAOCULAR LENS

The RxSight Light Adjustable Lens (LAL) is a foldable posterior chamber, UV filtering, three-piece photoreactive silicone lens with blue PMMA (polymethylmethacrylate) modified-C haptics, a 6.0 mm biconvex optic with squared posterior edge, and an overall diameter of 13.0 mm. The LAL optic design (Figure 2) also features a UV filtering posterior surface layer, to further enhance the UV absorbing properties of the LAL lens and limit retinal exposure.

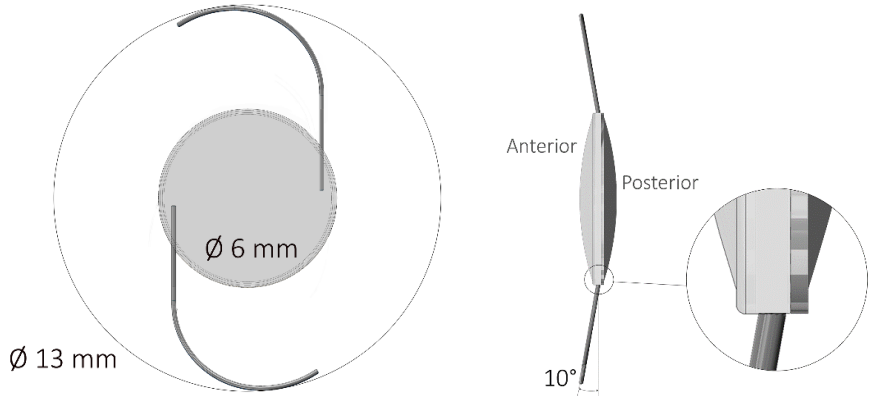

FIGURE 2: RXSIGHT LIGHT ADJUSTABLE LENS (LAL)
(A) TOP VIEW AND (B) CROSS-SECTION VIEW OF THE OPTIC SHOWING LAL WITH A POSTERIOR LAYER

A summary of the LAL design characteristics is presented below:

Lens Optic

- Material: Photo-reactive, UV absorbing Silicone
- Light transmission: UV cut-off at 10% T ≥ 392 nm for all lens power
- 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 LAL silicone material is designed to respond to a narrowband UV light by incorporating photoreactive components in the cross-linked silicone lens matrix. Post implantation, the LAL shape may be altered non-invasively (refractive power may be increased or decreased) by photoinitiation 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 LAL. 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 3) used to induce a predictable change in LAL 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 light profiles with adequate intensity and duration to induce polymerization of photoreactive additive leading to a refractive power change of the LAL. Because this procedure is performed after implantation, residual refractive errors can be minimized, reducing the need for spectacles, corneal refractive procedures, or additional IOL procedures to optimize a patient's vision.

FIGURE 3: RXSIGHT LIGHT DELIVERY DEVICE (LDD)

7.1.3 INSERTION DEVICES

- The RxSight Insertion Device, which is comprised of a re-usable titanium injector and a single-use, non-preloaded polypropylene cartridge with lubricating coating, will be used as the primary device to insert the LAL into the eye.
- The Nichamin III Foldable Lens Inserter (Rhein Medical 05-2349) with the Nichamin II Foldable Lens Insertion Forceps (Rhein Medical 05-2348) can be used as back-up if needed.

7.1.4 INDICATIONS FOR USE [redacted]

The Light Adjustable Lens and Light Delivery Device system is indicated for the reduction of residual astigmatism to improve uncorrected visual acuity after removal of the cataractous natural lens by phacoemulsification and implantation of the intraocular lens in the capsular bag, in adult patients:

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

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

7.2 SUBJECT ENTRY

Patients who require bilateral cataract extraction and 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. Both eyes of all subjects will be screened for eligibility at the same preoperative visit. A pre-determined randomization scheme will be utilized to designate each of the patient's eyes as the primary eye (LAL) or the fellow eye (Control). The preoperative examination will be performed no more than 60 days prior to surgery for either the primary eye (LAL) or the fellow eye (Control). If the 60-day time period elapses for either eye, it is acceptable for patients to be re-screened by undergoing a complete preoperative examination. The subject's fellow eye will be scheduled for surgery a minimum of 7 days after the primary eye. If surgical complications occur with the primary eye and no LAL 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 up to 120 subjects have had LAL implantation attempted in the primary eye. Unique identification numbers will be assigned to each subject.

The implant lens power for the LAL and the Control IOL will be calculated based upon the ocular biometry data and the ASCRS calculator (http://iolcalc.ascrs.org). The investigator should select the IOL formula to be used in a particular subject. The same formula must be used on both eyes of a subject and must be determined prior to randomization. A postoperative spherical equivalent (SE) outcome closest to emmetropia will be targeted in both eyes. The lens power in either eye will not be altered based on intraoperative diagnostics.

7.3 LAL IMPLANTATION AND REFRACTIVE ADJUSTMENT

Each investigative site will follow a standard regimen of pre-, intra-, and postoperative medications to be used in the study that has been reviewed and approved by the study medical monitor. This standard regimen will also specify the ophthalmic viscoelastic device to be used during surgery.

7.3.1 SURGICAL PROCEDURE

The LAL will be implanted using standard microsurgical techniques.

No additional refractive procedures such as limbal relaxing incisions or PRK are allowed on the primary eye (LAL) until after the Postop Month 6 visit.

The surgical procedure will be performed as follows:

1. Prepare and drape the eye for surgery in accordance with standard surgical procedures.
2. A temporal clear corneal incision will be made using the surgeon's standard instrumentation and techniques.
3. Use viscoelastic as agreed upon within the standard regimen to fill the anterior chamber through the incision opening.
4. Perform an anterior circular capsulorhexis [redacted] using standard technique. The capsulorhexis should be well-centered with a 360° overlapping capsular edge to minimize IOL tilt and decentration and longitudinal IOL shift. The capsulorhexis and/or nuclear fragmentation can be performed with a femtosecond laser. Precision pulse capsulotomy (PPC) can also be used to perform the capsulorhexis.
5. The surgeon will extract the cataract by phacoemulsification.
6. In the event of an intraoperative complication prior to implantation of the LAL, including posterior capsule rupture, zonular rupture, radial capsulorhexis tear, vitreous loss, iris trauma, corneal complications or any intraoperative abnormality that may affect the postoperative pupillary dilation, or the centration or tilt of the intraocular lens, do not implant the LAL.
7. [redacted]
8. Verify proper orientation of the LAL
9. Aspirate any residual viscoelastic from the eye using a preferred technique.
10. The wound may close without suturing. If the unsutured wound is not watertight, close it with a either a suture using standard technique or an ocular sealant (ReSure Sealant).
11. After completion of the surgery, postoperative medications should be administered per the agreed upon investigative site standard regimen.

12. The subject will be provided with two pairs of RxSight approved UV protective spectacles (one clear and one tinted) to protect the implanted LAL from extraneous sources of UV light. It is important to direct the subject to follow all instructions that are provided with the UV protective spectacles.

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

7.3.2 LIGHT TREATMENT PROCEDURE

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

7.3.2.1 Postponement of Light Treatment Procedure(s)

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

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

[redacted]

- [redacted]

[redacted]

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

[redacted]

OR

- [redacted]

OR

- [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

7.3.2.3 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 [redacted] has been obtained. If adequate dilation has not been obtained, additional dilating drops with manual punctal

[redacted]

occlusion or a sponge soaked in mydriatic medication and applied to the ocular surface can be utilized to try and gain further dilation. If adequate pupil dilation is still not achieved with the methods described above, the treatment will be rescheduled and the dilation attempted at another visit or another dilation method is used.

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

7.3.2.4 Adjustment Procedure(s)

Refer to the LDD Operator's manual for instructions on LDD start up [redacted]

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

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

the treatment, quickly refocus, realign the lens with respect to the reticle beam, and immediately resume treatment to limit the duration of any pauses once the light treatment has been initiated.

Note: Always maintain the LAL in focus by focusing at the haptics. Never focus onto the CCC (capsulotomy) or Purkinje images.

13. If the 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 continue to wear their UV protective eyewear as instructed until exactly 24 hours after the final lock-in treatment has been completed.
15. The subject will return 3 to 7 days following the power adjustment treatment for another light treatment. The subject may receive up to 3 adjustment treatments before receiving the 1st lock-in treatment. A second adjustment treatment will be performed if guided by the LDD. [redacted]

7.3.2.5 Lock-In Procedure(s)

Refer to the LDD Operator's manual for instructions on LDD start up [redacted]

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

Note: The RxSight contact lens is similar to those used in other ophthalmic procedures in which customized magnification is required. To ensure correct magnification for treatment, use only the RxSight designated contact lens.

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

    Note: Always maintain the LAL in focus by focusing at the haptics. Never focus onto the CCC (capsulotomy) or Purkinje images.
13. If the lock-in treatment is aborted before completion, contact the Sponsor for technical assistance.
14. Upon completion of the lock-in #1 treatment, a notification may appear that informs the user that a lock-in #2 treatment is not required for the subject. If this notification appears, proceed to step #16. If no notification appears, then the subject will require a lock-in #2 treatment and proceed to step #15.
15. The subject will return for the second lock-in treatment 3 to 7 days after the first lock-in treatment.
16. The subject will be permitted to discontinue wear of the UV protective eyewear exactly 24 hours after the final lock-in treatment has been completed.

7.4 CONTROL LENS IMPLANTATION

[redacted] will be implanted in the subject's fellow eye a minimum of 7 days after the LAL has been successfully implanted in the primary eye. Standard microsurgical techniques will be employed. A clear corneal incision of temporal orientation will be made. Limbal relaxing incisions (LRI) are not to be used during surgery to implant the Control lens.

For subject complaints related to refractive anisometropia of greater than 1.5 diopters secondary to a refractive surprise with the fellow eye (Control), a secondary surgical intervention (SSI) may be performed on the fellow eye if both the investigator and subject agree it is in the best interest of the subject.

7.5 EXAMINATION SCHEDULE

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

Primary Study Eye (LAL)

Evaluation	
Preoperative OU	Maximum of 60 days prior to Operative LAL Visit
Operative LAL	Day 0, day of LAL surgery
Postop Day 1 LAL	Days 1 to 2 post-Operative LAL Visit
Postop Week 1 LAL	Days 7 to 14 post-Operative LAL Visit
Postop Week 3 LAL (Adjustment #1)	Days 17 to 24 post-Operative LAL Visit
Adjustment #2, if needed	3 to 7 days post Adjustment #1
Adjustment #3, if needed	3 to 7 days post Adjustment #2
Lock-in #1	3 to 7 days post final adjustment
Lock-in #2, if needed	3 to 7 days post lock-in #1
Postop Months 1-2	7 to 14 days post final lock-In
Postop Month 3 LAL	Days 60 to 90 post-Operative LAL Visit
Postop Month 6 LAL	Days 120 to 180 post-Operative LAL Visit
Postop Month 12, if needed	Days 330 to 420 post-Operative LAL Visit

[redacted]

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.

Fellow Study Eye (Control)

Evaluation	
Operative Control	Minimum of 7 days post-Operative LAL Visit
Postop Day 1 Control	Days 1 to 2 post-Operative Control Visit
Postop Week 1 Control	Days 7 to 14 post-Operative Control Visit
Postop Week 3 Control	Days 17 to 24 post-Operative Control Visit
Postop Month 3 Control	Days 60 to 90 post-Operative Control Visit
Postop Month 6 Control	Days 120 to 180 post-Operative Control Visit

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.

7.6 CLINICAL PARAMETERS

The following study parameters will be assessed as specified here and in Table 2 and 3. Assessments will be performed using the techniques described in [redacted]

1. Demographics
2. [redacted]
3. [redacted]
4. Ocular history including medications
5. Ocular Biometry: ACD and axial length (Optical or immersion A-scan biometry)
6. Subjective symptoms/complaints (subject reported)
7. [redacted]
8. Corneal Topography
9. Autorefraction
10. Corneal Keratometry
11. Specular Microscopy
12. Uncorrected distance visual acuity (UCDVA)
13. Manifest Refraction
14. Best corrected distance visual acuity (BCDVA)
15. [redacted]
16. [redacted]
17. Distance corrected contrast sensitivity: Mesopic/Photopic with and w/o glare
18. [redacted]
19. Intraocular pressure
20. Slit Lamp Examination
21. Dilated pupil diameter
22. Fundus Exam
23. Fundus Photos
24. [redacted]
25. Adverse Events

Table 2. Schedule of Visits and Clinical Parameters for Primary Study Eyes (LAL)

Visits	Preop OU	Operative LAL	Postop Day 1 LAL	Postop Week 1 LAL	Postop Week 3 LAL	Adjustment #2 (if needed)	Adjustment #3 (if needed)	Lock-in #1	Lock-in #2 (if needed)	Post Months 1-2	Postop Month 3 LAL	Postop Month 6 LAL	Postop Month 12 (if needed)	Unscheduled Visit[3]
Demographics	X													
[redacted]	X				X					X	X	X		
[redacted]					X	X	X	X	X	X	X	X	X	
Ocular History Including Medications	X	X	X	X	X	X	X	X	X	X	X	X	X	
Ocular Biometry (ACD + Axial length)	X													
Subjective Symptoms/Complaints (Subject reported)			X	X	X	X	X	X	X	X	X	X	X	X
[redacted]			X	X	X	X	X	X	X					
Corneal Topography	X				M									
Autorefraction				X	M	X	X	X	X	X	M	M	X	
Corneal Keratometry	X				M							M		
Specular Microscopy	X				M							M		
Uncorrected distance visual acuity (UCDVA)	X		X	X	M	X	X	X	X	X	M	M	X	X
Manifest Refraction	X			X	M	X	X	X	X	X	M	M	X	X
Best corrected Visual Acuity Distance (BCDVA)	X			X	M	X	X	X	X	X	M	M	X	X
[redacted]					M	X	X	X	X	X	M	M	X	
[redacted]					M	X	X	X	X	X	M	M	X	
Distance Corrected Contrast Sensitivity (Mesopic/Photopic w and w/o glare)					M							M		
[redacted]					X					X[2]	X[2]	X[2]	X[2]	

Visits	Preop OU	Operative LAL	Postop Day 1 LAL	Postop Week 1 LAL	Postop Week 3 LAL	Adjustment #2 (if needed)	Adjustment #3 (if needed)	Lock-in #1	Lock-in #2 (if needed)	Post Months 1-2	Postop Month 3 LAL	Postop Month 6 LAL	Postop Month 12 (if needed)	Unscheduled Visit[3]
Intraocular Pressure	X		X	X	X	X	X	X	X	X	X	X	X	
Slit Lamp Exam	X		X	X	X	X	X	X	X	X	X	X	X	X
Dilated Pupil Diameter	X				X	X	X	X	X					
Fundus Exam	X				X							X	X	
Fundus Photos	X				X							X	X	
[redacted]					X	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]	
Adverse Events		X	X	X	X	X	X	X	X	X	X	X	X	X

[redacted]

[redacted]

Table 3. Schedule of Visits and Clinical Parameters for Fellow Study Eyes (Control)

Visits	Preop OU	Operative Control	Postop Day 1 Control	Postop Week 1 Control	Postop Week 3 Control	Postop Month 3 Control	Postop Month 6 Control	Unscheduled Visit[1]
Demographics	X							
[redacted]	X				X	X	X	
[redacted]					X	X	X	
Ocular History Including Medications	X	X	X	X	X	X	X	
Ocular Biometry (ACD + Axial length)	X							
Subjective Symptoms/Complaints (Subject reported)			X	X	X	X	X	X
Corneal Topography	X				M			
Autorefraction				X	M	M	M	
Corneal Keratometry	X				M		M	
Specular Microscopy	X				M		M	
Uncorrected distance visual acuity (UCDVA)	X		X	X	M	M	M	X
Manifest Refraction	X			X	M	M	M	X
Best corrected Visual Acuity Distance (BCDVA)	X			X	M	M	M	X
[redacted]					M	M	M	
[redacted]					M	M	M	
Distance Corrected Contrast Sensitivity (Mesopic/Photopic w and w/o glare)					M		M	
Intraocular Pressure	X		X	X	X	X	X	
Slit Lamp Exam	X		X	X	X	X	X	X

Visits	Preop OU	Operative Control	Postop Day 1 Control	Postop Week 1 Control	Postop Week 3 Control	Postop Month 3 Control	Postop Month 6 Control	Unscheduled Visit[1]
Dilated Pupil Diameter	X				X			
Fundus Exam	X				X		X	
Fundus Photos	X				X		X	
Spectral Domain Optical Coherence Tomography (SD-OCT)					X			
Adverse Events		X	X	X	X	X	X	X

[1]Tests indicated with an "X" must be performed at each unscheduled visit. Other tests may be conducted based on the investigator's assessment of the subject.

[redacted]

7.7 DATA REPORTING

Electronic data capture (EDC) will be utilized for this study. Case report forms (CRFs) will be provided by the sponsor for each subject enrolled in the study. In order to facilitate data entry, the CRFs coincide with the data entry pages in the EDC system. The appropriate CRFs will be completed and initialed or signed where indicated at each examination. 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 study CRFs and data entered in the EDC system will be reviewed by the Study Monitor.

All clinical data generated in the study will be submitted to the RxSight Clinical Affairs Department 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.

7.8 STUDY COMPLETION PROCEDURES

An End of Study Form must be completed for all subjects enrolled in the study upon subject completion, withdrawal or discontinuation.

7.8.1 SUBJECT COMPLETION

Subjects are considered to have completed the study if both eyes have completed the Postop Month 6 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 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.

7.8.3 SUBJECT WITHDRAWAL DUE TO INTRAOPERATIVE COMPLICATIONS PRIOR TO IMPLANTATION

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

7.8.4 SUBJECT DISCONTINUATION AFTER IMPLANTATION

After bilateral implantation, subjects may not be withdrawn from the study unless both study lenses have 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 both study lenses have 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.

7.8.5 LOST TO FOLLOW-UP

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

8 STATISTICAL METHODS

8.1 SAMPLE SIZE CALCULATION

The sample size of up to 120 subjects with implantation of the LAL attempted in the primary eye for this study is based on the statistical tests on effectiveness endpoints described below. Safety of the LAL was studied under RxSight's premarket approval application (PMA) P160055 which was approved by the Center for Devices and Radiological Health (CDRH) of the Food and Drug Administration (FDA) on November 22, 2017.

Primary Effectiveness Endpoints

1. Magnitude of Manifest Cylinder (MRCYL) at Postop Month 6

H0: $\mu_{\Delta MRCYL} = 0$ versus Ha: $\mu_{\Delta MRCYL} < 0$ with a one-side significance level of 0.025, where $\mu_{\Delta MRCYL}$ is the mean of difference in MRCYL (ΔMRCYL) at Postop Month 6 between the LAL eye and Control eye of bilateral subjects. The ΔMRCYL for each subject equals MRCYL of the LAL eye minus MRCYL of the Control eye. Since the magnitude of MRCYL will be used in the calculation, a negative ΔMRCYL represents a better outcome in the LAL eye than that in the Control eye.

Per the previous PMA clinical study, the standard deviation of the MRCYL at Postop Month 6 is 0.37 D for the LAL group and 0.62D for the Control group. Assuming that the MRCYL measurement of the two eyes of a subject are independent, the estimated standard deviation of ΔMRCYL is 0.73 (= square-root of the sum of 0.37^2 and 0.62^2). It is expected that the postoperative MRCYL of the post-LASIK or other corneal refractive surgery eyes may have more variation, the standard deviation of ΔMRCYL is estimated as 1.00 D (about 1.5 times of the estimation based on the PMA observations) for sample size calculation. Based on the one-sided one-sample t-test (i.e. paired t-test) with a significance level of 0.025, a sample size of 77 subjects can provide a statistical power of 90% if the true $\mu_{\Delta MRCYL}$ at Postop Month 6 is -0.375 D.

2. Absolute Manifest Refraction Spherical Equivalent (MRSE) at Postop Month 6

H0: $\mu_{\Delta|MRSE|} = 0$ versus Ha: $\mu_{\Delta|MRSE|} < 0$ with a one-side significance level of 0.025, where $\mu_{\Delta|MRSE|}$ is the mean difference in absolute MRSE (Δ|MRSE|) at Postop Month 6 between two eyes of bilateral subjects. The Δ|MRSE| equals |MRSE| of LAL eye minuses |MRSE| of Control eye. A negative Δ|MRSE| represents a better outcome in the LAL eye than that in the Control eye.

Per the previous PMA clinical study, the standard deviation of |MRSE| at Postop Month 6 is 0.23 D for the LAL group and 0.33 for the control group. Assuming that the MRSE measurement at Postop Month 6 of the two eyes of the same subject are independent, the estimated standard deviation of Δ|MRSE| is 0.41 (= square-root of the sum of 0.23^2 and 0.33^2). As mentioned in the section above, a larger standard deviation, 0.62 (~ 1.5 × 0.41), is used for the sample size calculation. Based on the one-sided one-sample t-test (i.e. paired t-test) with a significance level of 0.025, a sample size of 67 subjects can provide a statistical power of 90% if the true $\mu_{\Delta|MRSE|}$ is -0.25 D.

3. Outcome of BCDVA of 20/40 or better at Postop Month 6.

The statistical hypotheses for this endpoint are based on ISO 11979-7: 2014 (E)

H0: $p \geq 0.925$ versus Ha: $p < 0.925$ with a one-side significance level of 0.05, where p is the proportion of LAL eyes with BCDVA of 20/40 or better at Postop Month 6. If the Ha is rejected, then the BCDVA outcome supports the LAL effect on improving BCDVA from pre-operative.

Based on a one-sided Binomial distribution with a significance level of 0.025, a sample size of 99 subjects is needed for a statistical power of 90% at a true rate of 0.825 (i.e. 0.1 lower than the ISO grid of 0.925).

Secondary Effectiveness Endpoints

It should be noted that the LAL effect on the two secondary effectiveness endpoints will not be considered unless all of the three primary effectiveness endpoints demonstrate the LAL effect. Additionally, the statistical objectives here are to demonstrate effectiveness of the LAL on either of these two secondary effectiveness endpoints, so the significance level for each of these two effectiveness endpoints is one-sided 0.0125 (= 0.025 ÷ 2).

1. UCDVA at Postop Month 6.

H0: $\mu_{\Delta UCDVA} = 0$ versus Ha: $\mu_{\Delta UCDVA} < 0$ with a one-side significance level of 0.0125, where $\mu_{\Delta UCDVA}$ is the mean difference in logMAR UCDVA (ΔUCDVA) at Postop Month 6 between two eyes of bilateral subjects. The ΔUCDVA equals logMAR UCDVA of LAL eye minus logMAR UCDVA of Control eye. The lower the logMAR value is, the better the UCDVA is. A negative ΔUCDVA represents a better outcome in the LAL eye than that in the Control eye.

Per the previous PMA clinical study, the standard deviation of logMAR UCDVA at Postop Month 6 is 0.11 D for the LAL group and 0.17 for the control group. Assuming the UCDVA at Postop Month 6 of the two eyes of the same subject are independent, the estimated standard deviation of ΔUCDVA is 0.21 (= square-root of the sum of 0.11^2 and 0.17^2). Again, a larger standard deviation, 0.32 (~ 1.5 × 0.21) is used for the sample size calculation. Based on the one-sided one-sample t-test (i.e. paired t-test) with a significance level of 0.0125, a sample size of 60 subjects can provide a statistical power of 90% if the true $\mu_{\Delta UCDVA}$ is -0.15 (i.e. 1.5 lines).

2. UCDVA at Postop Month 6 for subjects with keratometric cylinder (Kcyl) < 0.75 D at the preoperative examination in both eyes

H0: $\mu_{\Delta UCDVA\_L} = 0$ versus Ha: $\mu_{\Delta UCDVA\_L} < 0$ with a one-side significance level of 0.0125, where $\mu_{\Delta UCDVA\_L}$ is the mean ΔUCDVA at Postop Month 6 for subjects with Kcyl < 0.75 D (low cylinder) at the preoperative examination in both eyes.

Based on the same assumptions discussed in the Section above, the required sample size for the analysis is 60 subjects. It is estimated that about 60% of the subjects at Postop

Month 6 will have a preoperative KCyl of < 0.75 D. Therefore, 100 (= 60 ÷ 60%) bilateral subjects at Postop Month 6 are needed for this endpoint

Study Sample Size

Based on the sample size calculation for the primary and secondary primary effectiveness endpoints above, a sample size of 100 bilateral subjects at Postop Month 6 will be sufficient for the study. With a drop-out rate of at most 10% within the 6-month follow-up period and possible postponed LDD treatment after postoperative 6 months, up to 110 bilateral subjects should be implanted with LAL in one eye and Control lens in the other eye. Considering possible intraoperative complications that prevent the LAL implantation, it is determined that the study should attempt implantation in up to 120 eligible bilateral subjects in order to have at least 100 bilateral subjects at Postop Month 6.

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. Continuous variables will be summarized using descriptive statistics, specifically the mean, median, standard deviation, minimum and maximum. Categorical variables will be summarized by frequencies and percentages. The summaries will be provided for the LAL eyes and Control eyes separately. For continuous outcomes, the difference between the two eyes of the same subject will be calculated and summarized by using descriptive statistics for continuous outcomes.

Unless otherwise specified, all p-values will be two-sided for a two-sided significance level of 0.05 (or one-sided for a one-sided significance level of 0.025) and all confidence intervals will be two-sided at 95% confidence level. Safety analyses will be performed on eyes in which IOL implants are attempted.

A detailed statistical analysis plan (SAP) will be developed and finalized prior to the locking of the database for this study.

8.3 BASELINE CHARACTERISTICS

Baseline characteristics (such as age, gender, race, and pre-operative pathology) will be summarized descriptively for subjects with the LAL implantation attempted and for subjects implanted with LAL in one eye and Control lens in the other eye by means and standard deviations or by counts and percentages, as appropriate. They will also be stratified by the study site in order to assess the similarity of these baseline characteristics among the study sites.

Baseline characteristics will be listed for subjects with a successful LAL implantation but a failed Control lens implantation, if they exist.

8.4 POPULATIONS FOR ANALYSIS

8.4.1 SAFETY POPULATION

The safety population consists of any subject who has signed the informed consent and has the LAL procedure attempted which is defined as the point at which the lens makes contact with the eye. This population will be used for the safety. No imputation will be performed.

8.4.2 INTENT TO TREAT (ITT) POPULATION

The intent to treat (ITT) population contains all enrolled subjects who have been randomized and are intent to have the LAL and Control lens procedures. However, since the ITT subjects that exit from the study before the LAL procedure will not have clinical data regarding either safety or effectiveness for both LAL and control lenses, these subjects will be excluded from the statistical analyses. These subjects include those reported with surgical complications before implantation of LAL is attempted and exited from the study.

8.4.3 FULL ANALYSIS SET (FAS)

The Full Analysis Set (FAS) is a subset of the ITT which consists of the ITT subjects that have the LAL implanted in one eye and the Control lens in the other eye. The primary analyses for the primary and secondary effectiveness endpoints will be based on the FAS. For the FAS subjects that do not have the Postop Month 6 data, the missing MRCYL, MRSE, and UCDVA will be assumed to the same for their two eyes in the primary analyses. Different imputations will be included in the sensitivity analyses described in Section 8.5.2 below and in the SAP of this study protocol.

8.4.4 PER-PROTOCOL (PP) POPULATION

The per-protocol population is a subset of the FAS and is comprised of the FAS subjects who have complete LDD treatment in the LAL eyes, have Postop Month 6 data, and do not have any major protocol deviations. The PP population will be used for supportive effectiveness analyses. Major protocol deviations will include those deviations that may impact subject safety, affect the integrity of study data and/or affect subject willingness to participate in the study, such as implantation, adjustment and lock-in procedures that are not performed as specified in the protocol and/or Operator's manual.

8.4.5 BEST CASE COHORT

The best case cohort is defined as the LAL implanted eyes with no preoperative pathology (pseudoexfoliation, glaucoma, previous glaucoma filtering surgery, poor pupil dilation, previous uveitis, previous retinal detachment, diabetic retinopathy, macular degeneration, and amblyopia). Per ISO 11979-7:2014 (E), the BCDVA outcomes will be summarized for this cohort as well.

8.5 EFFECTIVENESS ANALYSES

8.5.1 PRIMARY ANALYSES FOR THE PRIMARY AND SECONDARY EFFECTIVENESS ENDPOINTS

The primary analyses for the primary and secondary effectiveness endpoints will be based on the FAS described in Section 8.4.2. For each subject, the ΔMRCYL, Δ|MRSE|, and ΔUCDVA at Postop Month 6 will be calculated. For control eyes undergoing a secondary surgical intervention (SSI) prior to the 6-month visit due to refractive anisometropia of > 1.50 D, the outcomes prior to the SSI for the corresponding eyes will be used for the primary analyses of the primary and secondary effectiveness endpoints. This approach is clinically reasonable since the outcomes prior to the SSI represent the unfavorable outcomes that lead to the secondary surgical intervention. For subjects missing the Postop Month 6 data, the difference between the two eyes will be assumed to be 0. The missing Postop Month 6 BCDVA will be assumed to be worse than 20/40.

The histograms of the ΔMRCYL, Δ|MRSE|, and ΔUCDVA at Postop Month 6 will be prepared in order to assess the distribution of these differences. Additionally, the histogram of the ΔUCDVA at Postop Month 6 will be prepared for FAS subjects with a preoperative Kcyl < 0.75 D in both eyes. Means, standard deviations, medium, quartiles, minimum, and maximum will be used to summarize these differences. The 95% confidence intervals for mean ΔMRCYL and mean ΔMRSE based on the t-distribution will be calculated. The 97.5% confidence intervals for mean ΔUCDVA based on the t-distribution will be calculated for all FAS subjects and the FAS subjects with a preoperative Kcyl < 0.75 D in both eyes. The number and percent of LAL eyes with a Postop Month-6 BCDVA of 20/40 or better and the one-sided 95% upper confidence limit of the percentage per binomial distribution will be presented.

The one-sided one-sample t-test (i.e. paired t-test) will be used for the following statistical hypotheses as described in Section 8.1:

H0: $\mu_{\Delta MRCYL} = 0$ versus Ha: $\mu_{\Delta MRCYL} < 0$ with a one-side significance level of 0.025.

H0: $\mu_{\Delta|MRSE|} = 0$ versus Ha: $\mu_{\Delta|MRSE|} > 0$ with a one-side significance level of 0.025.

H0: $\mu_{\Delta UCDVA} = 0$ versus Ha: $\mu_{\Delta UCDVA} < 0$ with a one-side significance level of 0.0125.

H0: $\mu_{\Delta UCDVA\_L} = 0$ versus Ha: $\mu_{\Delta UCDVA\_L} < 0$ with a one-side significance level of 0.0125.

The binomial distribution will be used for the following statistical hypotheses as described in Section 8.1 for the LAL-eye in FAS:

H0: $p \geq 0.925$ versus Ha: $p < 0.925$ with a one-side significance level of 0.05.

8.5.2 SECONDARY/SENSITIVITY ANALYSES FOR THE PRIMARY AND SECONDARY EFFECTIVENESS ENDPOINTS

If there are FAS subjects with missing Postop Month 6 data, the analyses described in Section 8.5.1 will be performed for the FAS using the following imputations for missing MRCYL, MRSE, logMAR UCDVA, and logMAR BCDVA data:

- Baseline value (i.e., a non-responder approach) for continuous parameters and non-responder assumption (BCDVA worse than 20/40) for binary outcome
- Best cases: The best outcome of all eyes for the LAL eyes with missing data and the worst outcome of all eyes for the control eyes with missing data.
- Worst cases: The best outcome of all eyes for the control eyes with missing data and the worst outcome of all eyes for the LAL eyes with missing data
- Mean of observed value at Postop Month 6 of the same eye group in the FAS.
- Mean of observed value at Postop Month 6 of the different eye group in the FAS (i.e. using mean of the LAL group to impute the missing value in the Control group and using mean of the Control group to impute the missing value in the LAL group)
- Last observed carry forward

For the mean logMAR BCDVA, a value of ≤ 0.3 is equivalent to a Snellen value of 20/40. The same analyses will also be performed based on the PP population defined in Section 7.4.3.

Per ISO 11979-7: 2014 (E), the analysis for the outcome of BCDVA of 20/40 or better at Postop Month 6 will also be performed on the observed data of the Best-Case cohort. It should be noted that the performance goal of the percent of Best-Case cohort with BCDVA of 20/40 or better is 96.7%, instead of 92.5%.

8.5.3 COVARIATES AND SUBGROUP ANALYSES

The following covariates will be evaluated for their effect on the primary effectiveness endpoints based on the FAS population with the imputation for the missing data used for the primary analyses:

- Age group (based on observed quartiles)
- Gender (male and female)
- Race (White and non-White)
- Ethnicity (Hispanic-Latino and not Hispanic-Latino)
- Study site

For ΔMRCYL, Δ|MRSE|, and ΔUCDVA at Postop Month 6, two-sample t-test or one-way ANOVA (for covariates with more than two sub-categories) will be used to evaluate the effect of the covariate. For the percentage of LAL-eyes with BCDVA of 20/40 or better at Month 6, Fisher's exact test will be performed to evaluate the covariate effect on the outcome.

A p-value of 0.15 will be used for evaluating the possible covariate effects. It should be noted that the subgroups of these covariates will be re-examined and may be re-categorized or eliminated due to small sample size (if there are < 10 subjects within each subgroup).

8.5.4 ADDITIONAL EFFECTIVENESS ANALYSES

The following effectiveness outcomes will be summarized descriptively based on the observed data for the LAL and Control eyes separately. The analyses on the difference between the LAL-eye and Control eye will only include the subjects implanted with LAL in one eye and control lens in the other eye.

Manifest Cylinder (MRCYL)
The MRCYL and MRCYL change from Postop Week 3 will be presented beginning at Postop Week 3 using descriptive statistics for continuous outcomes. The number and percent of eyes with a MRCYL of ≤0.25 D, 0.50, 0.75 D, 1.0 D, 1.25 D, 1.5 D, 1.75, and ≥2.0 D will be reported for each visit. The ΔMRCYL will also be summarized at each visit by using the descriptive statistics for continuous outcomes.

In addition, for the LAL eyes, MRCYL at Postop Month 6 will be summarized descriptively (mean, standard deviation, minimum/maximum, quartiles) by the Postop Week 3 MRCYL (using 1.00 D bins), by the Postop Week 3 MRSE (using 1.00 D bins) and by the pre-operative Kcyl (using 0.25 D bins). The same analyses will be performed for the control eyes. The observed outcomes will be clinically compared. It should be noted that two eyes of the same subjects can be in different Postop Week-3 MRCYL groups, different Postop Week-3 MRSE groups, or different preoperative Kcyl groups.

Cylinder Correction Accuracy
For eyes without cylindrical treatment, the intended cylinder correct will be assumed to be 0. The accuracy of cylinder correction to intended target within 0.50 D and 1.00 D will be reported beginning at Postop Months 1-2 for the LAL eyes and for the Control eyes. Additionally, the deviation of the achieved adjustment from the attempted adjustment will be summarized by the descriptive statistics for continuous outcomes.

The analyses for the LAL eyes described above will also be stratified by the Postop Week 3 MRCYL (using 1.00 D bins) and the Postop Week 3 MRSE (using 1.00 D bins).

Vector Difference
Vector differences between the intended cylinder change and the achieved cylinder change will be calculated and summarized descriptively. In eyes for which no cylinder adjustment was attempted, the intended change will be considered zero and the entire change from Week 3 will be treated as an error. The summary will be provided for the LAL-eye and control eye separately. The difference in the vector length between the two eyes (= LAL-eye minus Control-eye) will be calculated for each subject and summarized descriptively at each visit.

Additionally, for the LAL eyes, a scatter plot will be presented showing the vector length of the change between the vector cylinder at the Postop Week 3 and Postop Month 6 visit as a

function of intended cylinder change and as a function of intended MRSE change. In order to evaluate the MRSE treatment effect on the cylindrical outcome, a regression analysis on the vector length with the intended cylinder correction and intended MRSE correction as independent factors will be performed. The regression residual will be checked for the model fitting**.**

Refractive Cylinder Stability

Refractive cylinder stability will be presented for consistent cohort and eyes with two consecutive visits. The following statistics will be calculated.

- Percentage of eyes that achieve change of ≤1.00 D of refractive cylinder;
- Percentage of eyes that achieve change of ≤0.50 D of refractive cylinder;
- Mean MRCYL change between two visits and the corresponding 95% confidence interval, mean change per month, and mean change per year

MRSE

MRSE and change in MRSE from Postop Week 3 will be summarized by the descriptive statistics for continuous outcomes (such as mean and standard deviation) for each visit. The number and percent of eyes with an MRSE of ≤ ±0.25 D, ±0.50, ±0.75 D, ±1.0 D, and ±2.0 D will be reported for each visit. For each subject, the difference in the MRSE between two eyes (= LAL-eye – Control-eye) at Postop Week 3 and beyond will be calculated and the difference will be summarized by using descriptive statistics for continuous variables.

In addition, for the LAL eyes, the MRSE at Postop Month 6 will be summarized descriptively (mean, standard deviation, minimum/maximum, quartiles, number and percent of eyes in the outcome categories described above) by the Postop Week 3 MRSE (using 1.00 D bins), by the Postop Week 3 MRSE (using 1.00 D bins), and by the pre-operative Kcyl (using 0.25 D bins). The same analyses will be performed for the control eyes. The observed outcomes will be clinically compared. It should be noted that two eyes of the same subjects can be in different Postop Week-3 MRCYL groups, different Postop Week-3 MRSE groups, or different preoperative Kcyl groups.

Additionally, for the LAL eyes, a scatter plot will be presented showing the change in MRSE between the Postop Week 3 and 6 month visit as a function of intended MRSE change and intended cylinder change. For evaluating the cylindrical treatment effect on the MRSE outcome, a regression analysis on MRSE change with the intended MRSE change and intended cylinder change as independent factors will be performed. The regression residuals will be used to validate the fitted model.

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 ≥2.0 D will be reported at each visit beginning at Postop Months 1-2. For eyes without MRSE correction, 0.00 D will be used for the intended target. Additionally, the deviation of the achieved adjustment from the attempted adjustment will be summarized by the descriptive statistics for continuous outcomes.

The analyses for the LAL eyes described above will also be stratified by the Postop Week 3 MRCYL (using 1.00 D bins) and the Postop Week 3 MRSE (using 1.00 D bins).

Absolute MRSE

Absolute MRSE and change in absolute MRSE from Postop Week 3 will be summarized by the descriptive statistics for continuous outcomes (such as mean and standard deviation) for each visit. The Δ|MRSE| at Postop Week 3 and beyond will also be summarized by using descriptive statistics for continuous variables.

Additionally, for the LAL eyes, the absolute MRSE outcomes at Postop Month 6 will be stratified by signed MRSE at Postop Week 3 (using 0.25 D bins) and summarized descriptively (mean, standard deviation, minimum/maximum, quartiles). The mean percent reduction and the number in each bin will also be provided.

Refractive MRSE stability

The refractive stable point will be determined based on the five criteria described in Section F.3 of ANSI Z80.11-2012 document as follows:

- At least 95% of the treated eyes have a change ≤1.00 D of MRSE between the two refractions;
- The mean rate of change in MRSE, as determined by a paired analysis, is ≤0.5 D per year (0.04 D/month) over the same time period;
- The mean rate of change of MRSE decreases monotonically over time, with a projected asymptote of zero or a rate of change attributable to normal aging;
- The 95% confidence interval for mean rate of change includes zero or a rate of change attributable to normal aging.

The MRSE change between the following post-adjustment visit intervals will be presented.

- From Postop Months 1-2 to Postop Month 3
- From Postop Month 3 to Postop Month 6

Defocus Equivalent (DEQ)

The DEQ will be summarized descriptively at Postop Week 3 and beginning at Postop Months 1-2. The number and percent of eyes with DEQ ≤0.5 D and 1.0 D will also be summarized at the corresponding visit.

Autorefraction

Autorefraction sphere, cylinder, and spherical equivalent will be summarized descriptively at each visit.

Since, for the LAL eyes, the light adjustment will be based on the manifest refraction, the following change in auto-refraction cylinder (Cyl) and reduction in auto-refraction spherical equivalent (SE) will be calculated for each LAL eye:

Change in Cyl = (Postop Month 6 autorefraction Cyl – Postop Week 3 MRCYL),

Change in SE = (Postop Month 6 autorefraction SE – Postop Week 3 MRSE)

The change in cylinder and the change in the spherical equivalent will be summarized descriptively by mean, standard deviation, median, minimum, and maximum.

UCDVA

UCDVA will be presented with the number and percent of eyes who fall into each category of UCDVA at each visit (e.g. 20/20 or better, 20/25 or better, 20/32 or better, etc.). The logMAR UCDVA will be summarized by descriptive statistics for continuous outcomes 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 change in logMAR UCDVA from Postop Week 3 will also be presented.

The outcome of within-subject ΔUCDVA will be presented at each visit as categorical outcomes of "LAL 15 letters or more better", "LAL 10-14 letters better", "LAL 5-9 letters better", "LAL 1-4 letters better", "LAL = Control", "Control 1-4 letters better", "Control 5-9 letters better", "Control 10-14 letters better", and "Control 15 letters or more better". The descriptive statistics for continuous outcomes will also be calculated for the within-subject ΔUCDVA.

BCDVA

BCDVA will be presented with the number and percent of eyes that 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 logMAR BCDVA at each visit will also be presented by using descriptive statistics for continuous variables. The analyses will be repeated for the Best Case Cohort.

Per ISO 11979-7 2014 (E), the BCDVA categorical summaries described above will also be stratified by the following covariates and clinical outcomes for the LAL eyes.

- Age group (based on observed quartiles)
- With versus without ISO cumulative AEs
- With versus without ISO persistent AEs
- With versus without preoperative ocular pathology
- Study site

The analyses above may be reconsidered due to the observed stratification. For example, if no subjects are reported with any ISO persistent AEs, then the BCDVA by ISO persistent AEs will not be performed.

For the LAL and Control eyes that cannot achieve BCDVA of 20/40 or better at the last available visit, the BCDVA data listing along with the reported possible reasons of failing to achieve 20/40 or better will be provided.

8.6 SAFETY PARAMETERS

The following safety outcomes will be summarized descriptively based on the observed data of the Safety population for the LAL eyes and Control eyes separately, except for [redacted], [redacted], and [redacted] which will be summarized based on the observed data of the Safety population subjects. The 95% confidence intervals for means or percentage may be presented, as appropriate.

Adverse Events

Number and percent of eyes will be summarized for each reported ocular AE at the operative visit and each postoperative visit. Serious ocular AEs and the non-ocular serious AEs will be summarized in the same manner. Additionally, for each of the device related AE reported during the study, the number and percent of study eyes reported with the event will be presented. For each reported AE, a two-sided 95% confidence interval will be provided for the percent of eyes reported with the AE during the study (i.e. at ≤ 6 months.)

Each ISO defined cumulative and persistent adverse events at Postop Month 6 will be summarized per ISO 11979-7:2014 (E) using count and percent of subjects reported with such event. The maximum number of cases allowed before the ISO-defined SPE rate of each adverse event will be calculated. For each ISO adverse event, if the observed incidence for the LAL eye group is at most the maximum number of cases, it can be concluded that the LAL does not have a rate higher than the corresponding ISO-defined SPE rate.

The cumulative and persistent adverse events during the 6-month follow-up period will also be stratified by age (per quartiles) and study sites.

Change in BCDVA

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". The 90% confidence interval (corresponding to the one-sided test recommended by the ISO 11979-7 for cumulative and persistent adverse events) for the percent of eyes with a BSCVA loss of ≥ 10 letters will be calculated per binomial distribution. The mean change in logMAR BCDVA from Postop Week 3 or Preoperative with the 95% confidence interval for the mean will also be presented. Similarly, the mean change from the prior visit to the next visit will also be summarized in the same manner.

The listing of BCDVA and the possible reason for BCDVA loss of 10 letters or more will be provided for the eyes reported with a 10-letter or more loss in BCDVA during the study (i.e. from preoperative visit or previous visit).

[redacted]

[redacted]

[redacted]

Distance Corrected Contrast Sensitivity

For the contrast sensitivity (in log units) at each spatial frequency level under each of the four test conditions (photopic with and without glare and mesopic with and without glare) at Postop Week 3 and Postop Month 6 will be summarized by mean, standard deviation, median, minimum and maximum for the eyes participated in the contrast sensitivity sub-study. The number and percent of eyes that cannot see any plate will be presented.

The mean of "within-eye" loss of contrast sensitivity from Postop Week 3 to Postop Month 6 will be provided with the 1-sided 95% confidence interval for each spatial frequency. The percentage of eyes showing > 0.3 log unit loss at two or more spatial frequencies will be calculated.

[redacted]

Increased Astigmatism

Number and percent of eyes with increased astigmatism from Postop Week 3 will be reported at each postoperative visit

Subjective Symptoms and Complaints

Number and percent of eyes will be summarized for each reported subjective symptom.

Other Ocular Examinations

Slit lamp and fundus exam findings and IOP including changes will be summarized descriptively. Number of subjects with fundus exam changes from the pre-op and Postop Week 3 evaluation will be summarized.

Endothelial Cell Density (ECD) and Morphology Data

Specular Microscopy data includes endothelial cell density, hexagonality and coefficient of variation. These endpoints will be summarized by mean, standard deviation, 95% CI of the mean, minimum and maximum. The change in ECD and percent change in ECD from preoperative will be summarized in the same manner. Additionally, ECD change and ECD percent change for each eye will be calculated between Preoperative and Postop Week 3 and between Postop Week 3 and Postop Month 6. These changes will be summarized by mean, standard deviation, 95% CI for mean, minimum, and maximum. Additionally, at Postop Week 3 and Postop Month 6, the number and percent of eyes with an ECD of < 1500 cells/mm^2 and number and percent of eyes with an ECD change from baseline ≤ -25% (i.e. and an ECD loss of ≥ 25%) along with the 95% confidence interval of the percentage derived per binomial distribution will be calculated for the LAL eyes and Control eyes separately.

The percent ECD loss (%ECL) at Postop Month 6 for each eye and the difference between %ECL (Δ%ECL) at Postop Month 6 for each subject are derived as follows:

$$\%ECL = (ECD \text{ at Preop} - ECD \text{ at Postop Month 6}) \div ECD \text{ at Preop} \times 100\%$$
$$\Delta\%ECL = \%ECL \text{ of LAL eye} - \%ECL \text{ for Control eye}$$

The descriptive statistics for continuous variables will be used to summarize Δ%ECL. A one-sided 95% upper confidence limit for mean Δ%ECL will be derived based on t-distribution. If the Nichamin III foldable lens inserter is used during the study, the analyses may be stratified by the subjects with versus without the use of Nichamin III foldable lens inserter.

It should be noted that, per the previous PMA clinical study, the standard deviation of Δ%ECL is estimated as 4%. For a statistical hypotheses test of H0: Mean of Δ%ECL ≥ 5% versus Ha: Mean of Δ%ECL < 5% (i.e. the mean of %ECL in the LAL eyes is at most 5% higher than that in the control eyes) with a one-sided significance level of 0.05, a sample size of 100 bilateral subjects at 6 months can provide the following statistical power at different true values of Mean of Δ%ECL. The derived one-sided 95% upper confidence limit of mean Δ%ECL described above can be used to compare against the 5% used in the statistical hypotheses described above.

True $\mu_{\Delta\%ECL}$	Statistical Power
0.0%	>0.99
0.5%	>0.99
1.0%	>0.99
1.5%	>0.99
2.0%	>0.99

2.5%	>0.99
3.0%	>0.99
3.5%	0.98
4.0%	0.80

[redacted]

8.7 SEQUENCE OF PLANNED ANALYSES

8.7.1 INTERIM ANALYSIS OF ECD

Based on RxSight's previous PMA, no significant ECD loss due to LAL light treatments was demonstrated. Therefore, the ECD loss is primarily due to the corneal trauma during cataract surgery. In order to evaluate the effect of LAL with the RxSight Insertion Device, an interim analysis on the ECD will be performed when all eyes have a chance to complete the Postop Week 3 examination.

All the analyses described in Section 8.6 will be performed based on the preoperative and Postop Week 3 ECD data. The interim analysis will also include the summaries of baseline characteristics and adverse events. No other study parameters will be summarized. No masking of the visual acuity will be broken and study will not be stopped due to the finding of the ECD outcomes. The purpose of this interim analysis is strictly administrative. Therefore, no p-value adjustment for the interim analysis will be performed.

8.7.2 FINAL ANALYSES

When all enrolled subjects have completed or exited the study, the final statistical analyses based on the SAP will be performed.

[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.

Unanticipated Adverse Device Effects (UADE) are any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with a device, if that effect, problem, or death was not previously identified in nature, severity or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects.

An investigator will submit to the Sponsor and to the reviewing IRB a report of any UADE occurring during an investigation as soon as possible, but in no event later than 10 working days after the investigator first learns of the effect. The Sponsor will immediately conduct an evaluation of any unanticipated adverse device effect. The results of the evaluation will be reported to FDA and to all reviewing IRB's and participating investigators within 10 working days of the Sponsor becoming aware of the event. Thereafter the Sponsor shall submit additional reports concerning the effect as FDA requests. If a UADE is determined by the Sponsor to present an unreasonable risk to study subjects, all investigations or parts of the investigation presenting that risk will be terminated as soon as possible. Termination will occur not later than 5 working days after this determination is made, and not later than 15 working days after first receiving notice of the event. The investigation will not be resumed without IRB and FDA approval.

The following need to be reported as AEs as specified:

1. Anterior Chamber Inflammation
    - Iritis/cells/flare (if present after Postop Week 1 and greater than grade 1 (trace)) or (any iritis/cells/flare present at Postop Month 6 of any grade) OR

- Chronic anterior uveitis (Persistent anterior segment inflammation characterized by grade 1+ cell or greater using Standardization of Uveitis Nomenclature criteria; persistent for greater than 3 months after surgery, or relapses in less than 3 months after discontinuation of therapy, or the subject is maintained on therapy for more than 3 months to control inflammation).

2. Corneal edema:
   - If present after Postop Week 1 and greater than grade 1 (trace)) or (if present at Postop Month 6 of any grade) OR
   - Corneal swelling (stromal or epithelial) resulting in BCDVA ≤20/40 after Postop Week 3)
3. Raised intraocular pressure (IOP) >10 mmHg above preoperative and greater than 25 mmHg (if present after Postop Week 1) AND unrelated to mechanical pupillary block

[redacted]

Per the Special Report: The American Academy of Ophthalmology Task Force Consensus Statement on Adverse Events with Intraocular Lenses, the following types of adverse events will be reviewed by the Sponsor to determine if they meet the following definitions for reporting purposes:

Adverse Event	**Definition**
Clinically significant cystoid macular edema	Macular edema diagnosed by clinical examination and adjunct testing (e.g., OCT, FA, or other method) resulting in reduced BCDVA to20/40 or worse after Postop Week 3
Endophthalmitis	Postoperative intraocular inflammation requiring vitreous tap and use of intraocular antibiotics
Mechanical pupillary block	A shallowing of the peripheral and/or central anterior chamber with or without elevation of IOP by obstruction of the flow of aqueous humor from the posterior chamber through the pupil to the anterior chamber. This may be induced by the crystalline lens, vitreous face, or implanted devices
Rhegmatogenous Retinal Detachment	Partial or complete retinal detachment associated with retinal tear
Toxic anterior segment syndrome	An acute, noninfectious inflammation of the anterior segment of the eye that develops within 24 to 48 hours after surgery and is characterized by corneal edema and accumulation of white cells in the anterior chamber of the eye
Secondary IOL intervention	Exchange: The investigational device is replaced with the same lens model. Removal: The investigational device is removed and replaced with a noninvestigational lens or no lens is implanted. Reposition: The existing IOL is surgically moved to another location or rotated.

In addition, the following definition should be used when considering retinal toxicity as an adverse event:

Adverse Event	Definition
[redacted]	[redacted]

All adverse events should be reported and information provided regarding whether the adverse event meets the above definitions.

9.2 SERIOUS ADVERSE EVENT DEFINITION

Serious Adverse Events (SAEs) are AEs that lead to:

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

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.

9.2.3 SAE REPORTING

The site should report any event to the Sponsor and its representative in an expedited manner if it meets the criteria for an SAE and/or is an IOL explant from a study eye. Expedited reporting is calling or e-mailing the Sponsor and its representative within 48 hours of becoming aware of the event. When reporting an SAE to the Sponsor and/or its representative, the site should forward any supporting documents along with the SAE Report Form to the Sponsor and its designee within 5 days of the initial communication. Sites must also report these events to the reviewing IRB/IEC per its established reporting procedures.

9.2.4 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.

9.2.5 POTENTIAL ADVERSE EVENTS

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

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

images, and/or double vision. These and other complications may result in permanent poor vision.

[redacted]

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's Clinical Affairs Department. 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 worksheets and data entered in the EDC system.
- Interim monitoring visits and telephone consultations will occur as necessary during the course of the study to ensure the proper progress and documentation of the study findings.
- RxSight clinical personnel may visit the site at any time during the course of the study to observe implantation of the LAL and the adjustment and lock-in treatments to ensure that the procedures described in the protocol are being followed.
- RxSight clinical personnel may also observe examination techniques used by study personnel to ensure that the procedures being utilized are the procedures described in [redacted] of the protocol.

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 a HIPAA consent form and to ensure the subject is given a copy of each.

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 18th World Medical Assembly, Helsinki, Finland, 1964 and later revisions, as well as applicable U.S. Food and Drug Administration regulations (21 CFR Parts 50, 56, and 812).

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

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 Institutional Review Board (where applicable); obtaining prospective informed consent; monitoring of the conduct of the study, the completeness of the study worksheets, and 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 21 CFR Subpart G-Records and Reports.

12 REFERENCES

1. https://www.statista.com/statistics/271478/number-of-lasik-surgeries-in-the-us/
2. https://www.lasik.com/articles/lasik-increasing-among-younger-adults/
3. https://www.reviewofoptometry.com/article/when-cataract-develops-long-after-lasik
4. https://crstoday.com/articles/2014-jul/choosing-an-iol-after-lasik/
5. https://www.reviewofophthalmology.com/article/cataract-patients-younger-every-year
6. http://www.nj.com/healthfit/index.ssf/2014/09/advances in cataract surgery allow patients to see their way to a clearer future.html
7. Vrijman V. Willem van der Linden J et al. Multifocal intraocular lens implantation after previous corneal refractive laser surgery for myopia. J Cataract Refract Surg Volume 43, Issue 7, July 2017, 909-914.
8. Hamill E, Wang L, Chopra H, Hill W, Koch D. Intraocular lens power calculations in eyes with previous hyperopic laser in situ keratomileusis or photorefractive keratectomy. J Cataract Refract Surg 2017; 43:189-194.
9. https://www.reviewofophthalmology.com/article/post-refractive-cataract-choosing-lens-and-target
10. Brierley L. Refractive Results after Implantation of a Light-Adjustable Intraocular Lens in Postrefractive Surgery Cataract Patients. Ophthalmology 2013 Oct; 120(10):1968-72.
11. Rocha G. Mednick Z. Light Adjustable Intraocular Lens in post-LASIK and post-traumatic cataract patient. J Cataract Refract Surg 2012; 38:1101-1104.
12. 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.
13. [redacted]
14. [redacted]