Short Title

ClarVista CVM-00001 / NCT03681886

Long Title

EVALUATION OF VISUAL AND REFRACTIVE OUTCOMES OF THE CLARVISTA HARMONI™ MODULAR INTRAOCULAR LENS SYSTEM

1 TITLE PAGE

Protocol Number:	ClarVista CVM-00001
Medical Specialty:	Surgical
Project Name /Number:	NA
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Test Article(s) / Product(s):	ClarVista HARMONI® Modular Intraocular Lens System

TITLE PAGE

EVALUATION OF VISUAL AND REFRACTIVE OUTCOMES OF

THE CLARVISTA HARMONI™ MODULAR INTRAOCULAR LENS SYSTEM

Protocol Number	**#CVM-00001 REV.03**
Sponsor	**CLARVISTA MEDICAL, INCORPORATED** **26800 ALISO VIEJO PARKWAY, SUITE 120** **ALISO VIEJO, CA 92656** **PHONE +001 949 916-5412** **FAX +001 949 916-5412**
Rev.03	**7 January 2016**

This clinical investigation is being conducted in accordance with 21 CFR Parts 11, 50, 54, 56, and 812, ISO 14155 (2011) Clinical Investigation of Medical Devices for Human Subjects, ISO 11979-7:2014 Ophthalmic implants — Intraocular lenses — Part 7: Clinical investigations, ANSI Z80.7-2013 Ophthalmic Optics – Intraocular Lenses, ICH GCPs, and applicable local regulations.

CONFIDENTIAL

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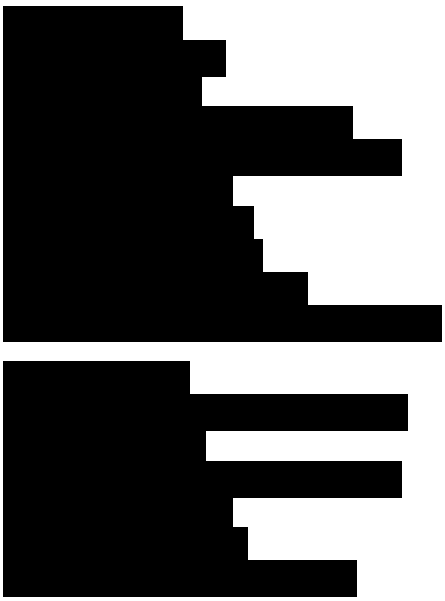

PROTOCOL APPROVAL

Evaluation of Visual and Refractive Outcomes
of The ClarVista HARMONI™ Modular Intraocular Lens

The following individuals approve Protocol #CVM-00001 Rev.03 dated 7 January 2016. Any changes to this version of the protocol must have an amendment or administrative letter.

[redacted]

STUDY ACKNOWLEDGEMENT

I understand this protocol contains information that is confidential and proprietary to ClarVista Medical (ClarVista).

I have read this protocol and agree that it contains all the details necessary to conduct the study as described. I will follow this protocol in the conduct of the study and will make a reasonable effort to complete the study in the time noted.

I will provide the contents of this protocol to study staff under my direct supervision in order to conduct the study. I will discuss this information with the study staff to ensure they are fully informed about the study and the test article. I will provide the contents of the protocol to the responsible Ethics Committee. These disclosures may be made; providing the contents are not used in any other clinical study and they are not disclosed to any other person or entity without prior written consent from ClarVista. This condition does not apply to disclosure required by government regulations or laws; however, I agree to give prompt notice to ClarVista of any such disclosure.

I understand the study may be terminated or enrollment suspended at any time by ClarVista, with or without cause, or by me if it becomes necessary to protect the interests of the study subjects.

Any additional information added to this protocol is also confidential and proprietary to ClarVista and must be treated in the same manner as the contents of this protocol.

_____
Printed Name of Principal Investigator

_____ _____
Investigator Signature Date

Protocol # CVM-00001 Rev.03
Date: 7 January 2016

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LIST OF ABBREVIATIONS

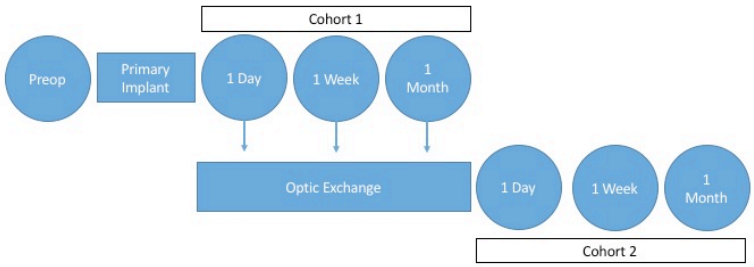
Abbreviation/Acronym	Term
AE	Adverse Event
ACD	Anterior Chamber Depth
ADE	Adverse Device Effect
AL	Axial Length
ANSI	American National Standards Institute
BCDVA	Best-Corrected Distance Visual Acuity
CFR	Code of Federal Regulations
D	Diopter
DD	Device Deficiencies
DFE	Dilated Fundus Examination
EC	Ethics Committee
CRF	Case Report Form
EPR	Error Predicted Refraction
ETDRS	Early Treatment Diabetic Retinopathy Study (Chart)
EtO	Ethylene oxide
FDA	United States Food and Drug Administration
GCPs	Good Clinical Practices
HIPAA	Health Insurance Portability and Accountability Act
HMIOL	HARMONI™ Modular Intraocular Lens System
IB	Investigator Brochure
ICF	Informed Consent Form
ICH	International Conference on Harmonization
ID	Identification
IDE	Investigational Device Exemption
IOL	Intraocular Lens
IOP	Intraocular Pressure
IRB	Institutional Review Board
ISO	International Organization for Standardization
K	Keratometry
LASIK	Laser In-Situ Keratomileusis
MR	Manifest Refraction
MRSE	Manifest Refraction Spherical Equivalent
MST	MicroSurgical Technology
Nd:YAG	Neodymium:Yttrium-aluminum-garnet
ND	Not Done
OD	Right Eye

OS	Left Eye
OVD	Ophthalmic Viscoelastic Device
PCO	Posterior Capsule Opacification
PH	Pinhole
PMA	Premarket Approval
PRK	Photorefractive Keratectomy
RRE	Residual Refractive Error
SAE	Serious Adverse Event
SLE	Slit Lamp Examination
SOC	Standard of Care
SPK	Superficial Punctate Keratitis
SSI	Secondary Surgical Intervention
TRRE	Target Residual Refractive Error
UCDVA	Uncorrected Distance Visual Acuity
US	United States
VA	Visual Acuity

NOTE: The first occurrence of some abbreviations are not spelled out in the document (e.g. units of measure).

PROTOCOL SYNOPSIS

Protocol Number #CVM-00001 Rev.03	
Title	Evaluation of Visual and Refractive Outcomes of The ClarVista HARMONI™ Modular Intraocular Lens System
Regulatory Status	CE marked
Investigational Device	ClarVista HARMONI™ Modular Intraocular Lens System (HMIOL)
Objectives	• To evaluate visual and refractive outcomes of the ClarVista HARMONI™ Modular Intraocular Lens System in primary implantation and optic exchange procedure [redacted] • To evaluate surgeon experience in the use of the ClarVista HARMONI™ Modular Intraocular Lens System in primary implantation and optic exchange procedure
Number of Clinical Sites and Study Subjects	Up to 200 subjects will be treated in this study at up to 5 investigational sites. Enrollment will be monitored as outlined in Sample Size section and adjusted accordingly.
Study Duration	All subjects will be followed for at least 1 month. Total patient participation duration will be approximately 5 months. Total study duration will be approximately 24 months.
Study Design	Prospective, non-randomized, multi-center clinical study. All subjects will be seen for a Preoperative Visit to capture baseline measurements then undergo cataract surgery with the study eye receiving a test lens (HMIOL). The investigator will determine if the test lens is to be implanted in OD, OS, or OU based on target refraction and the best interests of the subject. Subjects will be followed for 1 month after primary implantation. The HMIOL design allows easy optic exchange. The Investigator and Subject will decide if an optic exchange in the study eye is in the best interests of the subject based on refractive outcome and target. Subjects will be followed for 1 month after an optic exchange procedure. Subjects may be followed up beyond 1 month as deemed necessary by the surgeon.

	For purposes of accountability and analysis, there will be the following Cohorts: • HMIOL Cohort 1 (HMIOL eyes without optic exchange) • HMIOL Cohort 2 (HMIOL eyes with optic exchange) **Post-Operative Visits** HMIOL Cohort 1 (HMIOL subjects not undergoing optic exchange) 1 Day, 1 Week, 1 Month visits following primary cataract extraction HMIOL Cohort 2 (HMIOL subjects undergoing optic exchange) • Optic exchange decision and assignment to Cohort 2 as deemed necessary by Investigator and Subject • 1 Day, 1 Week, 1 Month visits following optic exchange  **FIGURE 1 - COHORT SCHEDULE**
Study Endpoints	The surgeon experience with HMIOL for the treatment of aphakia in subjects following cataract extraction will be characterized along with the HMIOL optic exchange procedure in the subgroup of study subjects with optic exchange. **Endpoints:** • Uncorrected Distance Visual Acuity (UCDVA) • Manifest Refraction Spherical Equivalent (MRSE) • Best Corrected Distance Visual Acuity (BCDVA) • Surgeon questionnaire • Secondary Surgical Intervention (SSI) (other than optic exchange) • Adverse Events (AEs) **Planned Analyses:** Postoperative data will be summarized in the following visit windows. Cohort 1 • 1 Day: 1-2 Days • 1 Week: 7 – 14 Days • 1 Month: 30 – 60 Days

	Cohort 2 (Available pre-exchange visits, plus post-exchange visits below) • 1 Day: 1-2 Days • 1 Week: 7 – 14 Days • 1 Month: 30 – 60 Days Descriptive statistics will be used to summarize the data. Continuous variables will be summarized by mean, standard deviation, median, minimum, and maximum. Categorical variables will be summarized by frequency and percentage. Aggregate data will be categorized, explored and analyzed in an ad hoc manner as deemed necessary or desirable by ClarVista. [redacted]
Main Clinical Assessments	1) UCDVA 2) Manifest Refraction (MR) 3) BCDVA 4) Slit Lamp Exam (SLE) 5) Intraocular Pressure (IOP) 6) Dilated fundus exam (DFE) 7) Surgeon Questionnaire
Sample Size	Up to 200 patients eligible for cataract surgery will be enrolled to evaluate the visual and refractive outcomes of patients and surgeon experience in the use of the HMIOL. This study is not designed to test a hypothesis.

1.0 INTRODUCTION

Cataract surgery is a minimally invasive procedure designed to restore vision with short recovery time. Advances in instrumentation and techniques over the past few decades have facilitated the enhancement in safety[1] while allowing for reproducible outcomes. While the serious adverse event rate remains low, selecting the right intraocular lens (IOL) implant for spectacle independence remains an on-going challenge. This is referred to as residual refractive error (RRE) and typically involves ~0.6 diopters (D)[2] of uncorrected focusing power. Furthermore, it is reported that current biometry measurements for selecting the correct IOL and subsequent surgical methods are associated with:

1. Up to 16% of patients undergoing additional surgical correction to achieve 20/20 unassisted vision[2].
2. Up to 55% of patients falling outside of their targeted postoperative refraction by at least 0.5D[3,4,5].
3. Between 14 and 24% of surgeries result in greater than 1 D of residual refractive error, when using manufacturer suggested constants[3].

Patients are frequently satisfied with the results of their cataract surgery and enjoy relatively quick recovery with restoration of vision. However, as expectations have evolved over time, patients are demanding the same degree of spectacle independence that other refractive surgeries such as LASIK provide. Currently available options to help achieve spectacle independence when RRE is present include: contact lenses, corneal modification (surgery or other), IOL exchange/manipulation, or sulcus placement of a "piggyback" IOL. These alternatives have significant limitations and risks.

Complications due to contact lenses are rare; however, contact lens intolerance and contact lens-related infections could be serious and sight threatening. For some patients, contact lens wear is contraindicated and they must resort to the use of spectacles. Elderly patients in particular have difficulty handling contact lenses.

If the patient is willing to accept the additional cost and risks of a secondary procedure, the physician has more options; however, each of them poses a significant risk to the patient as outlined below.

Corneal modifications have been performed on tens of millions of people across the world with some form of refractive surgery (e.g. LASIK). For example, in the U.S. (where the most extensive data exists) 11.5M Americans have had corneal refractive surgery and over the next two decades many will need cataract surgery. LASIK increases the likelihood for residual refractive error post cataract surgery due to inaccurate IOL power calculations with biometry. There is hesitation among many ophthalmologists to repeat LASIK for RRE after cataract surgery because the FDA has not specifically evaluated the safety and effectiveness of repeated LASIK in this setting. All the risks associated with the original LASIK procedure apply to retreatment, along with the increased potential for epithelial ingrowth, corneal ectasia and less robust nomograms for IOL selection for post cataract patients.

Furthermore, even for eyes that have not undergone prior corneal refractive surgery, the FDA has not specifically evaluated the safety and effectiveness of corneal refractive procedures (e.g., astigmatic keratotomy, LASIK, PRK, etc.) to address RRE following lens replacement surgery, so the use of approved lasers for this purpose in the U.S. is considered off-label and the risks are not well characterized. For example, it is unclear how optical aberrations that might be present with an IOL in place are increased by aberrations induced by corneal refractive procedures, how likely corneal refractive procedures are to induce irregular astigmatism and worsen dry eye that is induced by cataract surgery, and whether corneal refractive procedures could create potential complications related to cataract surgery wound healing or IOL stability.

Furthermore, cornea based interventions do not address the root cause of RRE after cataract extraction (imprecise IOL power selection) and expose the patient to a new and independent set of possible adverse events. Thus, it would be desirable to be able to correct or modify the optical result without the need to irreversibly and unpredictably alter corneal tissue following cataract extraction.

Sulcus placement of a "piggyback" IOL is a procedure that has not been evaluated for safety and effectiveness by the FDA so the use of approved IOLs for this purpose in the U.S. is off-label. Among the complications reported with this procedure are secondary pigment dispersion, iris/pupil irregularities, chronic iritis, hyphema, glaucoma, zonular disruption and/or posterior capsular rupture. Thus, it would be desirable to be able to correct or modify the optical result without the need to implant a "piggyback" IOL with its inherent serious risks.

IOL Exchange/Manipulation in general, is technically challenging for the surgeon and poses an iatrogenic risk to intraocular structures including the lens capsule, iris, and endothelium of the cornea. Manipulation of the capsular bag to remove an IOL is the major risk in this setting and can damage the capsular bag including posterior capsular rupture and capsular bag dislocation. The capsular bag cannot be repaired once damaged. This risk increases over time as the capsular bag adheres to the IOL and haptics. Even when IOL exchange is not required, manipulation of traditional IOL's to rotate or center the optic introduces the risk of capsular or zonular damage which can cause further lens instability and lens malposition. Thus, it would be desirable to be able to correct RRE without the need to remove the entire IOL particularly after capsular contraction or fibrosis.

The modular IOL concept will serve as a valuable addition to the armamentarium of cataract surgeons. The goal of this technology is to improve refractive (spherical and toric) outcomes and avoid the significant risks of secondary procedures currently being performed as standard practice to address RRE in an indirect manner. It is anticipated that this modular lens will provide clinical utility in two basic areas, the first being the focus of this study.

1. Post-operative correction of residual spherical refractive error – Based on existing performance of conventional cataract surgery, researchers have concluded that refractive outcomes in normal eyes should be within 0.5D for 45% and within 1D for 85% of cataract cases[5]. This theoretical performance goal still falls substantially short of the real-world outcomes seen with corneal refractive surgery and which cataract patients and surgeons increasingly demand. As a consequence, secondary procedures to optimize visual outcomes following cataract surgery can be as high as 16% in some practices, particularly for premium lens patients[2].

   Another common approach associated with residual spherical refractive error is referred to as monovision (which can be achieved with contact lenses, corneal refractive surgery, or IOL selection), a monofocal IOL which targets distance vision is used in the dominant eye and the opposite, the non-dominate eye is targeted for near vision. This approach allows patients to see at both distance and near and is a popular choice for patients wishing to achieve spectacle independence.

   While it is commonly used for this purpose, not all patients are able to adapt to monovision.[7,8,9,10] They may have difficulty with acuity-based tasks and with tasks demanding depth perception. Monovision patients may also experience problems with headaches and troublesome visual symptoms such as glare and halos around point sources of light, particularly under low-light conditions. Typically, within three months of the surgery a patient's acceptance or lack of acceptance of monovision correction will be known. At that point, dissatisfied patients are offered glasses to overcome the refractive disparity between eyes. Of course, this is contrary to the patient's desire to be independent of glasses. Furthermore, spectacle correction is not ideal due to the significant imbalance between the required lens power for each eye creating visual discomfort and intolerance (i.e. asthenopia). Refractive surgery on the cornea (e.g., LASIK or PRK) to reverse the over correction of the non-dominant eye is also an option, but not all monovision patients have a suitable cornea (e.g., too thin) and such surgery introduces additional risk.

   Modular IOL technology is intended to directly improve refractive outcomes without the inherent risk of a full lens exchange or resorting to the use of a corneal refractive laser. With the HARMONI™ design the spherical optic component is intended to allow exchange for a different power optic or adjusted to align with the visual axis without extensive manipulation of the delicate capsular bag, thereby avoiding the potential for intraocular (e.g., capsular and endothelial) trauma that is seen with traditional IOL exchanges.

2. Post-operative correction of displaced or off-axis toric lens – For every 1 degree a toric IOL axis is off from the true postoperative axis of astigmatism, there will be a 3.3% loss of toric correction. Study data supporting a recent approval of a toric IOL (P930014/S045) showed that 6.7% of eyes underwent a secondary surgical intervention (SSI) in the form of IOL repositioning to resolve RRE. The HARMONI™ modular technology can be used to improve outcomes in patients where the toric lens has been displaced to an unintended position during the post-operative period. The HARMONI™ optic allows for adjustment

to align with the astigmatic meridian or visual axis without manipulation of the base component thereby avoiding the potential for capsular trauma that is seen when approved toric IOLs are manipulated in the post-operative period.

[redacted]

The HARMONI™ IOL is a CE marked medical device and complies with all the Health Essentials and Safety requirements from all directives that apply to this product.

2.0 OBJECTIVE

The primary objective of this study is to evaluate visual and refractive outcomes with the use of the HARMONI™ Modular Intraocular Lens (HMIOL) System implantation, assembly, and optic exchange in subjects undergoing cataract surgery. [redacted]

3.0 STUDY DESIGN

3.1 DESCRIPTION OF THE STUDY

This is a prospective, non-randomized, multi-center study. The site will have Institutional Review Board (IRB) or Ethics Committee (EC) review and approval prior to recruiting potential subjects. Up to 200 eligible subjects with cataracts will undergo cataract extraction in each eye during participation.

Subjects with satisfactory outcomes, or those opting not to pursue an optic exchange, will be entered into Cohort 1.

Subjects who opt for an HMIOL optic exchange in their primary eye will be entered into Cohort 2.

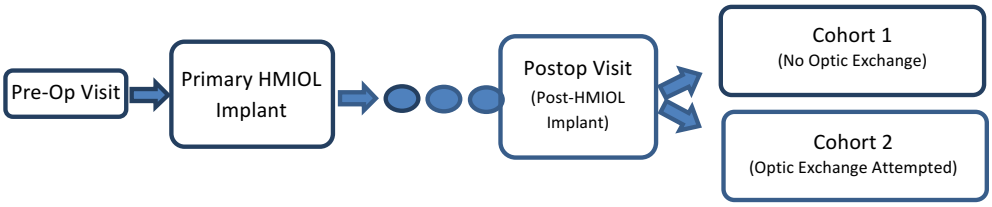


FIGURE 2 - COHORT DESIGNATION

All subjects enrolled in this study will be evaluated for at least 1 month following either primary cataract extraction or optic exchange, whichever is later (see Appendix A – Schedule of Assessments).

3.2 STUDY POPULATION

After completing the informed consent process, subjects will be screened for participation in the study.

3.2.1 INCLUSION CRITERIA

1. Must be able to understand and provide informed consent themselves or through a representative with a witness present on the IRB or EC approved Informed Consent Form (ICF)
2. Must be willing and able to return for scheduled treatment and follow-up examinations for at least month study duration
3. Must be at least 22 years of age or older at the time of consent
4. Planned removal of cataracts (cortical, nuclear, subcapsular, or a combination) by manual phacoemulsification cataract extraction
5. Dilated pupil size ≥ 6 mm in primary study eye

3.2.2 EXCLUSION CRITERIA PRIOR TO SURGERY

1. Participation in any other drug or device clinical trial within 30 days prior to enrolling in this study and/or during study participation
2. History of any ocular conditions which could affect the stability of the IOL (e.g. pseudoexfoliation, zonular dialysis, evident zonular weakness or dehiscence, etc.) in either eye
3. Traumatic or congenital cataract
4. Any anterior segment pathology that may increase the risk of operative complications such as chronic iritis, uveitis, aniridia, corneal opacity, etc
5. Pregnancy or planned pregnancy during the study period.
6. Subject who, in the clinical judgment of the investigator, is not suitable for participation in the study for another clinical reason, as documented by the investigator
7. Taking systemic medications that, in the opinion of the investigator, may confound the outcome or increase the risk to the subject (e.g. Tamsulosin Hydrochloride – Flomax) or other medications including anticholinergics, alpha adrenergic blocking agents with similar side effects (e.g. small pupil/floppy iris syndrome)

3.2.3 EXCLUSION CRITERIA DURING SURGERY

1. Vitreous loss prior to use of the investigational device
2. Positive posterior pressure preventing safe implantation of the lens system
3. Anterior chamber hyphema preventing visualization of implantation
4. Any zonular or capsular rupture or capsular bag instability
5. Intraoperative miosis preventing visualization of fixation features
6. Need for concomitant procedures (e.g. glaucoma surgery, LRI, RK, LASIK, etc.)

7. Subject who, in the clinical judgment of the investigator, is not suitable for participation in the study for another clinical reason, as documented by the investigator

3.2.4 EXCLUSION CRITERIA –POST-PRIMARY CATARACT EXTRACTION (AFFECTING ELIGIBILITY FOR HMIOL OPTIC EXCHANGE)

1. Any clinical finding or intraocular complication during primary cataract extraction that (in the judgment of the Investigator) is likely to increase complications with optic exchange procedure or present undue risk to the subject (e.g. unexplained endothelial cell loss, post-primary cataract extraction macular edema, persistent ocular inflammation, etc.)

2. Presence of YAG Capsulotomy in the primary (HMIOL) eye

3.3 STUDY VISITS

The timing and frequency of each assessment to be performed at each visit, will be carried out according to "Appendix A – Schedule of Assessments."

3.3.1 PRE-OPERATIVE VISIT – SCREENING/BASELINE (DAY -90 TO DAY 0)

After providing informed consent (see Section 4.1), prospective subjects will be screened to determine whether they meet enrollment criteria. Demographic information, relevant ocular history, and current ocular medication use will be collected. If all criteria are met, the subject will be considered enrolled, IOL calculation completed to determine appropriate HMIOL power, and the subject scheduled for surgery.

3.3.2 DAY 0 VISIT (PRIMARY CATARACT EXTRACTION SURGERY)

Prepare the subject for surgery in the study eye and review inclusion/exclusion criteria to ensure subject still qualifies to participate.

The principal investigator will perform the cataract surgery and implant the Harmoni Modular IOL.

Once the subject is confirmed stable post-surgery, provide standard post-operative instructions and discharge.

Record any AEs, adverse device effects (ADEs), unexpected adverse device effects (UADEs), or device deficiencies (DD) (see Sections 6.1.1, 6.1.2, 6.1.3, or 6.1.4 respectively) observed pre-, intra-, or post-operatively.

In the event the subject is not implanted with an HMIOL device due to an intra-operative complication, the subject will be discontinued (see Section 4.5).

3.3.3 POST-OPERATIVE VISITS (DAYS 1 – 60)

All subjects implanted with a study lens will be seen for 1 Day, 1 Week, and 1 Month assessments as outlined in Appendix A.

3.3.4 COHORT 2: OPTIC EXCHANGE VISIT

The Investigator will carry out the optic power determination, surgical procedure, and HMIOL optic exchange.

Once the subject is confirmed stable post-surgery, provide standard post-operative instructions and discharge.

Following successful completion of HMIOL optic exchange, the subject is entered into Cohort 2. Record any AEs, ADEs, UADEs, or DDs (see Sections 6.1.1, 6.1.2, 6.1.3, or 6.1.4 respectively) observed pre-, intra-, or post-operatively.

3.3.5 COHORT 2: POST-OPERATIVE VISITS (DAYS 1 - 30 POST-OPTIC EXCHANGE VISIT)

All subjects in Cohort 2 will be seen for 1 Day, 1 Week, 1 Month (post-optic exchange) assessments. (see Appendix A – Table 3).

NOTE: All concomitant medication, AE, ADE, UADE, DD, and SAE collection must be continued throughout the course of the study.

3.3.6 UNSCHEDULED VISITS

If at any time during the study, outside of the above scheduled visits, the subject requests or the Investigator determines the subject should be assessed, an unscheduled visit may occur. Adverse events and concomitant medications will be recorded and assessments deemed necessary by the Investigator should be performed on either or both eyes. NOTE: Only data relevant to the primary study eye (if applicable) will be captured on the Unscheduled Visit CRFs.

If a subject is seen for multiple visits during a given visit window, the data from a visit that is intended to meet the protocol requirements for the scheduled visit should be captured in the visit CRF. Where such a determination cannot be made, the first visit within the scheduled visit window will be used for completion of the protocol required visit. If assessments are missing from that visit, however captured at subsequent visits within window, those assessments can be collected as part of the protocol visit. In such a circumstance, the visit date will remain consistent with the first visit established within the visit window, per the scenario above. Any additional and applicable data captured and associated with the Study Eye will be captured as an Unscheduled Visit.

3.3.7 MISSED VISITS

If a subject misses any scheduled visit and cannot be seen prior to the start of the next visit window, the visit will be considered “missed.”

4.0 STUDY METHODS

Prior to recruitment of any subjects into the study, review and written approval of the protocol and informed consent must be obtained from the Institutional Review Board (IRB) or Ethics Committee (EC) by each participating clinical site.

4.1 INFORMED CONSENT

Informed consent must be obtained and documented in writing prior to the initiation of any study procedures. The subject (or the subject's legally authorized representative) must be allowed sufficient time to thoroughly read (or have explained), the informed consent form. The Investigator or his/her designee should answer any questions that the subject/representative might have. If the subject agrees to participate in the study, (i.e. provides informed consent)

the subject/representative must sign two copies of the informed consent form. The witness and the Investigator must also sign both copies of the informed consent form. One copy of the informed consent form should be given to the subject/representative. If applicable, it will be provided in a certified translation of the local language. As part of the consenting process, the subjects will be informed of their right to treatment for any injuries related to the study. Any and all such treatment if necessary, will be paid for by the Sponsor to the extent it is not covered by a subject's healthcare coverage (subject to local ethics committee approval). Completion of the consenting process as well as the date of the subject's signature on the informed consent form should be noted in the subject's medical chart.

Subjects who complete the informed consent process will be screened for eligibility. Screened subjects will be recorded on site-specific screening logs and once they are determined as being eligible, they will be enrolled into the study and an HMIOL order placed with the Sponsor if necessary.

Subjects scheduled for an optic exchange will complete an addition IRB / EC approved informed consent process for this procedure.

4.2 ASSIGNMENT OF SUBJECT IDENTIFICATION

A unique and sequential subject identification number (ID) will be assigned at screening and never duplicated for another subject. This ID will be used on all study-related documents. To maintain confidentiality, the subject's name will not be recorded on any study document other than the informed consent form.

4.3 SCREEN FAILURE

A record of screen failures and the reasons for the screen failures will be recorded in the subject source documents and captured in the CRF for summary.

4.4 SUBJECT COMPLETION

The subject has completed the entire study when the HMIOL has been implanted and / or the Optic Exchange completed and the Sponsor receives completed electronic Case Report Form (CRF) documentation for all visits and a Study Exit CRF. Subjects who require further follow-up for an AE will be followed according to Section 6.3.4.

A Study Exit CRF must be completed for all subjects who complete the clinical investigation.

4.5 SUBJECT DISCONTINUATION

A subject MUST be discontinued prior to the final study visit for any of the following reasons:

- Death
- Subject is enrolled and scheduled for surgery but is not implanted with an HMIOL at Day 0 (Operative Visit – Primary Cataract Extraction)
- Surgical complication(s) unrelated to the investigational device preventing the implantation of the HMIOL (i.e. capsulorhexis tear, zonular rupture, evident zonular weakness or dehiscence, posterior capsular rupture, vitreous loss, posterior capsular plaque, significant detached Descemet's membrane, significant anterior chamber bleeding, iris incarceration or damage, corneal endothelial touch, unsuccessful/incomplete phacoemulsification, haptic and/or optic damage/haptic amputation)
- Explantation of the HMIOL System

If the study lens is explanted, one postoperative visit should be completed to record best-corrected distance visual acuity (BCDVA) before the subject is discontinued. The sponsor will provide a commercially available IOL to replace the explanted study lens.

Subjects who withdraw from the study will be asked to complete procedures outlined in the 1 Month Visit (if withdrawn prior to that visit). Subjects who are terminated due to an AE will be followed, if possible, at least until resolution or stabilization of the AE. Subject withdrawals will be documented clearly on the source document and applicable CRF.

Prior to discontinuing a subject, every effort should be made to contact the subject, schedule a final study visit, and obtain as much follow-up data as possible. Adverse events will be followed as described in Section 6.3.4. Discontinued subjects should be followed outside of the study protocol according to the Investigator's normal postoperative standard of care.

A Study Exit CRF must be completed for all subjects who discontinue from the clinical investigation.

4.6 LOST TO FOLLOW-UP

Subjects who miss at least two consecutive visits, as defined by the visit windows and cannot be contacted, may be considered lost to follow-up. All follow-up attempts will be documented and kept with the subject's source documentation, and the applicable CRFs will be completed.

Subjects that voluntarily withdraw consent after implantation with the HMIOL will be considered Lost to Follow-Up.

4.7 STUDY COMPLETION

ClarVista will notify the Investigators when to contact the IRB / EC to announce study completion at the site.

4.7.1 EARLY STUDY TERMINATION

ClarVista has the right to terminate this study at any time. Reasons for terminating the study may include, but are not limited to, the following:

- The incidence or severity of adverse events in this or any ongoing studies involving the same technology (if applicable), indicates a potential health hazard to subjects
- Subject enrollment is unsatisfactory
- Data recording is inaccurate or incomplete.

In the event of premature study termination, appropriate notification will be given to the Investigators, IRB / ECs, and regulatory bodies as applicable. In addition, ClarVista (or designee) will instruct all Investigators to discontinue dispensing study materials or treatments, will ensure all subjects complete appropriate follow-up, and will arrange study closeout visits at each site as appropriate.

4.8 TRANSPORTATION AND MEAL ALLOWANCE

Subjects will receive monetary allowance to cover transportation and meal expenses as specified in the ICF.

4.9 CONCOMITANT THERAPIES

4.9.1 CONCOMITANT MEDICATION

Concomitant medications are any prescription drugs used by a subject until conclusion of study participation. Any medication the Investigator deems in the best interest of the subject, is acceptable to prescribe or administer. However, any and all ophthalmic medications are to be recorded in both the Concomitant Medication source document and CRF as well as the reason for use (indication). An AE is to be reported and/or recorded as appropriate (see Section 6.0).

4.9.2 CONCOMITANT PROCEDURES

A concomitant procedure is any invasive or non-invasive ocular or peri-ocular procedure that takes place during study participation and will be captured in both the Concomitant Procedure Source Document and CRF. The following are examples of two such procedures:

- Fellow Eye cataract extraction and IOL implantation, which will be listed as "Phaco with PCIOL."
- Neodymium: Yttrium-aluminum-garnet (Nd:YAG) procedure to treat Posterior Capsule Opacification (PCO), if necessary. This will be listed as "Nd:YAG Capsulotomy."

Note: *Any Nd:YAG capsulotomy procedures prior to exit will be performed only in response to spontaneous subject complaints (i.e. not solicited by study personnel) of reduced Visual Acuity (VA) or glare that affects functional vision, which is associated with PCO or striae, and captured on the eCRF in SLE findings.*

An AE is to be reported and/or recorded as appropriate (see Section 6.0). Any procedure reported in the Concomitant Procedure eCRF must have a corresponding Indication listed in either the Ocular History or AE CRF *(Only exception: PCO – See Section 6.1 for further details).*

4.10 PROTOCOL DEVIATIONS

All protocol deviations, the date of deviation, and reason will be documented in the Source Document and eCRF. All deviations will be categorized as either major or minor in the following manner:

Major:

- Deviations impacting subject safety
- Deviations impacting subject rights
- Deviations impacting data integrity

Minor:

- All other deviations (e.g. out of window visits, missed data point, etc.)

All major deviations must be reported by the Investigator to the Sponsor and IRB/EC immediately. Subject assessments will continue per protocol for the duration of planned participation unless the deviations put the subject at risk or the subject's condition requires that he/she be discontinued from the study.

5.0 STUDY MATERIALS

5.1 DESCRIPTION OF TEST ARTICLE

The HARMONI™ Modular Intraocular Lens (HMIOL) System is an investigational device designed to allow safe exchange or adjustment of an IOL optic after implantation. [redacted]

FIGURE 3 - THE HARMONI™ MODULAR INTRAOCULAR LENS (HMIOL) SYSTEM
The HMIOL includes a base component (A) and an optic component (B) that are delivered and assembled (C) in the eye.

[redacted] All components are sterilized using ethylene oxide (EtO) and has a shelf life 1 year from the date of sterilization.

Test article:

- HARMONI™ Modular Intraocular Lens System Base Component
- HARMONI™ Modular Intraocular Lens System Optic Component

5.1.1 INSTRUCTIONS FOR USE – STUDY EYE

Refer to the Surgical Guide for all use and administration details.

5.2 PACKAGING AND LABELING

All packaging and labeling will be consistent with the current study design. The labeling will include at a minimum, the following:

- Sponsor name and address
- "For Single Use Only" statement (or equivalent symbol)
- Sterility symbol
- Storage temperature range requirements or equivalent
- Expiration date
- Power designation

- Unique serial number
- Model number

5.3 ACCOUNTABILITY

The Investigator is responsible for keeping accurate accountability records of the number of study lenses received, dispensed, and returned to Sponsor. The study lenses must be stored under the appropriate conditions in a secure area and are to be implanted only in subjects enrolled in the study, in accordance with the conditions specified in this protocol.

All accountability records will include the following:

- Model and serial numbers
- Receipt date
- Quantities received
- Initials (attributability) of site personnel who received, dispensed, or returned study lenses
- Date of use
- Subject treated with the study lens (by Subject ID and Initials only)
- Date returned to Sponsor
- Defective or damaged study devices

Periodically throughout the study and/or upon completion, the Sponsor (or designee) will review and verify the Investigator's accountability records. Following verification, and as directed by the Sponsor, all unused and explanted products must be returned to the Sponsor.

Note: *In addition, any study lenses or components deemed defective, damaged, malfunctioning, or explanted must be retained by the site and returned to the Sponsor for evaluation. Under no circumstances are any components to be discarded or otherwise disposed of. If there is any question as to the applicability of this directive, consult the Protocol Contacts page of this protocol and discuss the situation with a Sponsor representative.*

5.4 OTHER MATERIALS

Additional materials can be provided to sites for the duration of the study on an as-needed basis and may include:

- Medicel injectors
- IOL micro-incision cutter and forceps

6.0 ADVERSE EVENTS

Safety assessments include ocular adverse events, all serious adverse events, and adverse device events. The reporting time period is from the time of consent through the last study visit (1 Month Visit post-primary cataract extraction for Cohort 1 and post-optic exchange for Cohort 2).

6.1 DEFINITIONS

6.1.1 ADVERSE EVENT (AE)

An AE is any untoward ocular event in a subject that does not necessarily have a causal relationship to the study device or protocol. AEs include Adverse Device Effects (ADEs). Conditions or diseases that are chronic but stable should not be recorded on AE pages of the CRF. Similarly, changes in a chronic condition of disease that are consistent with natural disease progression are NOT adverse events and also should not be recorded on the AE pages of the CRF.

Refer to Section 6.3.1 for instructions regarding events that require expedited reporting to the Sponsor and IRB/EC.

Experience with cataract surgery and the implantation of IOLs has shown that some conditions can be considered normal or expected events following these procedures. The following may be considered normal or expected events after cataract surgery and only need to be reported as AEs as specified here:

- Iritis (cell / flare) – if treated
- Persistent Corneal Stroma Edema (if present at 1 Month)
- Increased IOP only if medical/surgical intervention is required (i.e. medication, paracentesis manipulation)
- VA decrease of 10 or more letters (2 lines) from any previous visit not secondary to any underlying condition
- Any expected post-operative ocular event requiring a change in standard postoperative medication regimen

Note: *PCO is not to be reported as an AE, as per ISO 11979-7:2014.*

Particular attention should be paid to ensure timely and accurate reporting of any of the following cataract surgery related events:

- Endophthalmitis
- Capsular injury
- Vitreous loss
- Macular edema
- Retinal detachment
- Lens dislocation
- Moderate to severe corneal edema
- Pupillary block / angle closure
- Hypopyon or hyphema

6.1.2 ADVERSE DEVICE EFFECT (ADE)

An ADE is any untoward or unintended effect, event, or response surrounding and with a causal relationship with the use of a medical device. This definition may include any event resulting from insufficiencies or inadequacies in the instructions for use or the deployment of the device or other device malfunctions. This definition includes any event that is a result of a user error and any event that affects a user of the device (i.e. caregiver, bystander, etc).

6.1.3 UNANTICIPATED ADVERSE DEVICE EFFECT (UADE)

A UADE is any ADE, which is unanticipated and poses a risk to 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 (see Investigator Brochure [IB]). UADEs also include any unanticipated sight-threatening events and any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects.

6.1.4 DEVICE DEFICIENCIES (DD)

A Device Deficiency (DD) is a failure of the device to meet its performance specifications or expectations, or otherwise not perform as intended. This can include either a malfunction or damage to the device or any part thereof, regardless of the source of malfunction or damage, including user error, and regardless of the presence of injury (or lack thereof) to subject, user, or bystander.

6.2 AE EVALUATION

AEs experienced in this study may be associated with the study device (i.e. ADE) or the study protocol as demonstrated in the following non-exhaustive list of examples:

Study Device (ADE)

- IOL dislocation
- Explant due to haptic break/damage
- Explant due to base and/or optic damage

Study Protocol

- Allergic reaction to dilating drops
- Lens remnants following surgery
- Capsular tear during surgery to implant study device

6.2.1 EVALUATION

All AEs will be evaluated for and by the following criteria:

- Classification (SAE, AE, ADE or combination)
- Diagnosis (or description if ADE)
- Severity
- Relationship (Causality) to study protocol or device
- Outcome
- Treatment or action taken

6.2.1.1 CLASSIFICATION

When evaluating AEs, the Investigator must determine if the event is serious using the following guidelines:

A **Serious Adverse Event (SAE)** is any AE (ocular or non-ocular) that:

- results in death

- results in serious injury, defined as:
  - life-threatening
  - permanent impairment of a body function (e.g. blindness) or structure
  - necessitates medical or surgical intervention to prevent permanent impairment of a body function or permanent damage to a body structure, or
  - results in a potentially sight-threatening condition
- is a malfunction that might cause or contribute to a serious injury or death if it were to recur
- requires in-patient hospitalization or prolongation of existing hospitalization*, or
- leads to fetal distress, fetal health, a congenital abnormality, or birth defect

* 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 serious or an AE:

- admission for treatment of a pre-existing condition not associated with the development of a new AE or with worsening of the pre-existing condition (e.g. for work-up of persistent pretreatment lab abnormality)
- social admission (e.g. subject has no place to sleep)
- administrative admission (e.g. for yearly physical exam)
- optional admission not associated with a worsening of a pre-existing condition (e.g. elective cosmetic surgery or elective surgery for pre-existing repair of the Achilles tendon [which had not worsened while on study])
- hospitalization for admission without a medical AE

NOTE: For the purposes of this protocol, any UADE will be considered an SAE.

6.2.1.2 DIAGNOSIS OR DESCRIPTION

In all instances, it is preferable to report all AEs and SAEs by diagnosis rather than a sign or symptom if possible. This may necessitate the revision of a previously reported AE or SAE as more information is obtained.

6.2.1.3 SEVERITY

When evaluating AEs, the Investigator must determine the severity of symptoms using the following guidelines:

- Mild: Subject awareness of a sign or symptom that is easily tolerated, requires no treatment, and does not interfere with the 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

6.2.1.4 RELATIONSHIP (CAUSALITY) TO STUDY DEVICE OR STUDY PROTOCOL

When evaluating AEs, the Investigator must evaluate the relationship of the event to the study device and study protocol, using the following guidelines:

- Not Related: AEs which are clearly and incontrovertibly due to causes other than the study device or study protocol (e.g. concomitant disease, etc)
- Related: AEs which are felt with a reasonable degree of certainty to be related to the study device or study protocol
- Unknown: Adverse events for which a connection with the study device or study protocol cannot be ruled-out with certainty, or not enough information is available to assess the relationship

6.2.1.5 OUTCOME

The clinical outcome of an AE will be categorized as follows:

- Resolved without sequellae
- Resolved with sequellae (specify)
- Ongoing (i.e. continuing at time of study discontinuation)
- Death

6.2.1.6 TREATMENT OR ACTION TAKEN

Treatment or Action Taken will be categorized as follows:

- None
- Medical Intervention (specify on Concomitant Medication Source and CRF)
- Surgical Intervention (specify on Concomitant Procedure Source and CRF)
- Other (specify)

6.3 REPORTING

6.3.1 ON-SITE EXPEDITED REPORTING

The Investigator is obligated to report the following to the Sponsor within 24 hours of becoming aware of the event to ensure the safety of all participants in the study and to meet regulatory reporting requirements:

- All SAEs, regardless of relationship to study device or study protocol
- All AEs determined to be related to the study device (ADEs or UADEs)
- All HMIOL explants (consult Medical Monitor listed on Protocol Contacts page prior to explant, if possible)
- All Device Deficiencies (DD)

Refer to the Protocol Contacts page for appropriate Sponsor contact to report the above events.

NOTE: Any explanted HMIOL devices, exchanged HMIOL optics, or any components of the HMIOL System presenting a deficiency or malfunction are to be retained by the site until collected by the Sponsor. Under no circumstances are they to be destroyed or otherwise discarded.

When reporting these events to the Sponsor, the site should forward any supporting documents along with the appropriate reporting form and complete the corresponding CRF, if applicable. Sites must also report applicable events to the reviewing IRB/EC per its established reporting procedures.

6.3.2 OFF-SITE SAE REPORTING

As a multicenter clinical trial, the Investigators may receive "off-site" reports (e.g. an SAE Report). These are Sponsor reports of SAEs which occurred at other sites for the same trial, or in different trials using the same test article, that met the criteria for reporting. These should be reported to the reviewing IRB per their established reporting procedures.

6.3.3 REPORTING OF COMPLAINTS FOR ANCILLARY MARKETED PRODUCTS

Any complaints, malfunctions or similar events related to ancillary marketed products used in this study should be reported by the Investigators in accordance with the reference information provided on the associated commercial packaging.

6.3.4 ADVERSE EVENTS AND SERIOUS ADVERSE EVENTS AT SUBJECT EXIT

Ongoing SAEs and ADEs will be followed until resolution or no further change in the condition is expected. Non-serious AEs that are ongoing at study exit visit or upon discontinuation from the study will be followed per the Investigator's standard of care. Documentation in the CRF of this follow-up is not required although subject care should continue as appropriate.

6.4 SAFETY MONITORING AND REVIEW

All reported AEs will be reviewed on a weekly basis and assessed for trending and causality to study device or procedure. ADEs, UADEs, DDs, and SAEs will be reviewed upon receipt of expedited reporting (Section 6.3.1). Any unexpected trends or events will necessitate careful review and assessment of any change in the risks associated with participation or study continuation.

If an event occurs affecting a subject's risk of participation, Off-Site Reporting (Section 6.3.2) will be utilized to update sites and the IRB(s) / EC(s). If the safety profile of the event provides for the continuation of the study, Informed Consent Forms will be revised as necessary to ensure subjects' consent to continue participation given the known revised risks.

As outlined in Section 4.7.1, the Sponsor reserves the right to discontinue enrollment at any time.

7.0 CLINICAL ENDPOINTS

7.1 ENDPOINTS

Safety will be evaluated by assessing the following:

HMIOL Cohort 1

- UCDVA by study visit
- MR by study visit

- BCDVA by study visit
- Surgeon questionnaire
- AE incidence rate
- Device deficiencies
- SSI (planned Optic Exchanged procedures excluded)

HMIOL Cohort 2

- UCDVA by study visit
- MR by study visit
- BCDVA by study visit
- Surgeon questionnaire
- AE incidence rate
- Device deficiencies
- SSI (planned Optic Exchanged procedures excluded)

8.0 STATISTICAL METHODS

This is a study to evaluate visual and refractive outcomes of patients with HMIOL during primary cataract surgery and subjects with HMIOL optic exchange. In general, the analyses will be provided based on available data. The mean, standard deviation, minimum, and maximum will be prepared for the continuous clinical parameters, and counts and percentages will be presented for the categorical outcomes.

8.1 SAMPLE SIZE CALCULATION

This study is not designed to power a hypothesis.

8.2 ANALYSES POPULATIONS

Subjects that are screened but disqualified based on the preoperative and intra-operative eligibility criteria will be excluded from the analyses. However, their reasons for the screen failure will be summarized. The analyses populations defined below are defined for the study lens.

8.2.1 IMPLANTED-EYE POPULATION

The **Implanted-Eye** Population consists of eyes with successful HMIOL implantations during surgeries.

8.2.2 PER PROTOCOL POPULATION

The **Per Protocol** (PP) Population contains eyes with successful HMIOL implantations during surgeries and do not have major protocol deviation (such as improperly enrolled in the study or lens power calculation errors) and will be considered the primary population for effectiveness outcomes.

The protocol deviations will be determined reviewed by ClarVista clinical personnel prior to analysis.

8.3 STATISTICAL METHODS

The data analyses will be based on the analysis populations described above. No imputation for missing data will be performed. The statistical summaries will be prepared for HMIOL Cohort 1, HMIOL Cohort 2.

8.3.1 OUTCOMES

Each endpoint will be analyzed based on the Implanted-eye Population and PP Population.

9.0 DATA MANAGEMENT

9.1 DATA QUALITY ASSURANCE

All requested information must be entered on the CRF and confirmable through source documentation. If an item is not available or not applicable, this fact should be clearly indicated.

Data will be entered into a computer database developed specifically for this trial. During the course of the trial, data queries will be generated for data points that are potentially erroneous and require appropriate clarification or correction.

9.1.1 DATA MONITORING

Periodic monitoring (either remote and/or on-site) will take place to ensure data integrity. Study monitoring involves the following elements:

ClarVista personnel, or designee, 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 and support staff with the study protocol.

ClarVista personnel, or designee, may meet with the investigators at the time enrollment is initiated in order to ensure that subjects are being properly selected, that the methods described in the study protocol are thoroughly understood by the investigator, and that study data are being correctly recorded.

ClarVista personnel, or designee, may visit the clinical site at any time during the course of the study to review and/or collect completed case report forms. Additionally, telephone consultation will occur as necessary during the course of the study to ensure the proper progress and documentation of the study findings.

The study data will be carefully protected, and masking utilized to the extent possible, in order to prevent bias.

9.2 RECORD RETENTION

The investigator shall maintain all subject records for whichever of the following periods is shorter:

- A period of two years after the date on which FDA approves the marketing of the device
- A period of five years after the date on which the results of the study are submitted to the FDA in support of the marketing of the device

The Investigator / Site must contact ClarVista as provided in the Protocol Contacts page prior to discarding or disposing of any study related supplies or documents. The Sponsor retains the right to have all study documents shipped (at Sponsor's expense) for archival purposes, as an alternative to disposal.

10.0 REFERENCES

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[redacted]

APPENDIX A – TABLE 1: SCHEDULE OF ASSESSMENTS – HMIOL & COHORT 1

Table 1	**Cohort 1**					
Procedure/Assessments	Pre-Op Visit Day -90 to -0	Op Visit 1 Day 0	Form 1 1 Day Visit (Day 1-2)	Form 2 1 Wk Visit (Day 7-14)	Form 3 1 Mo Visit (Day 30 - 60)	Optic Exchange Window (Day 1 - 30)
Informed Consent	X			X		
Demographics	X					
Med/Ophthalmic History	X	X				
Eligibility	X	X				
UCDVA			X	X	X	
Manifest Refraction	X			X	X	
BCDVA	X			X	X	
Keratometry	X				X	
IOL Power Calculation	X					
Slit Lamp Examination	X		X	X	X	
IOP	X		X	X	X	
Pupil Size	X					
Dilated Fundus Exam	X				X	
Primary Surgery (HMIOL)		X				
Surgeon Questionnaire		X				
Optic Exchange (see Table 2)						

APPENDIX A – TABLE 2: SCHEDULE OF ASSESSMENTS – COHORT 2

Table 2	**Cohort 2 - Optic Exchange Complete**			
Procedure/Assessments	Op-Visit 2 Optic Exchange Visit (+1-301 Days)	Form 1.1 OE 1 Day Visit (Day 1-2)	Form 2.1 OE 1 Wk Visit (Day 7-14)	Form 3.1 OE 1 Mo Visit (Day 30-60)
Eligibility	X			
UCDVA		X	X	X
IOL Power Calculation	X			
Keratometry				X
Manifest Refraction			X	X
BCDVA			X	X
Slit Lamp Examination		X	X	X
IOP		X	X	X
Dilated Fundus Exam				X
Optic Exchange Procedure	X			
Surgeon Questionnaire	X			

APPENDIX B

Surgeon Questionnaire

Primary Implantation

1. How would you rate the surgical difficulty of the base implantation?
    a. Easier than a traditional single piece IOL
    b. Slightly easier than a traditional single piece IOL
    c. The same as a traditional single piece IOL
    d. Slightly more difficult than a traditional single piece IOL
    e. More difficult than a traditional single piece IOL
2. How would you rate the surgical difficulty of the optic implantation and assembly?
    a. Very easy
    b. Easy
    c. Neutral
    d. Difficult
    e. Very difficult

Optic exchange

1. How would you rate the surgical difficulty of the optic disassembly?
    a. Very easy
    b. Easy
    c. Neutral
    d. Difficult
    e. Very difficult
2. How would you rate the surgical difficulty of the optic explantation?
    a. Very easy
    b. Easy
    c. Neutral
    d. Difficult
    e. Very difficult
3. How would you rate the surgical difficulty of the optic implantation and assembly?
    a. Very easy
    b. Easy
    c. Neutral
    d. Difficult
    e. Very difficult