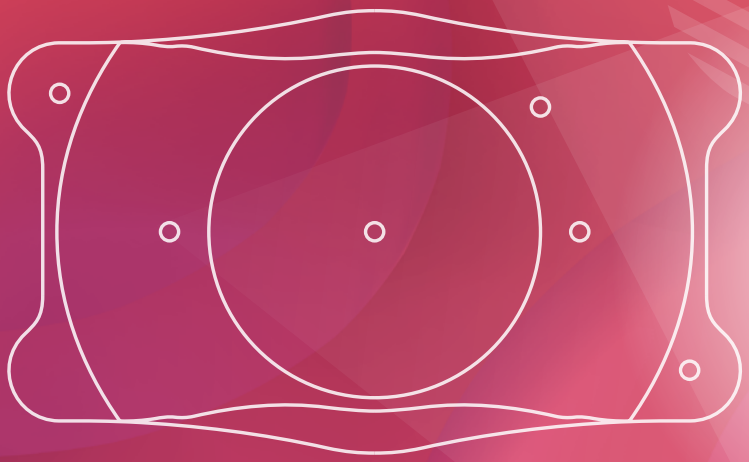
STAARSURGICAL™



eDFU-0036/1

PHAKIC INTRAOCULAR LENS

EVO Viva™

Evolution in Visual Freedom™

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STAAR® SURGICAL

EVO *Viva*™
Implantable Collamer® Lens (ICL) with Aspheric (EDOF) Optic

DIRECTIONS FOR USE

PRODUCT INFORMATION

Please review this product information completely before performing your initial clinical procedure. All physicians must complete the STAAR Surgical EVO ***Viva*** Physician Certification Program; special attention is placed on sizing methodologies for determination of EVO ***Viva*** overall diameter. Improper EVO ***Viva*** size may lead to adverse events ranging from mild to severe.

DEVICE DESCRIPTION

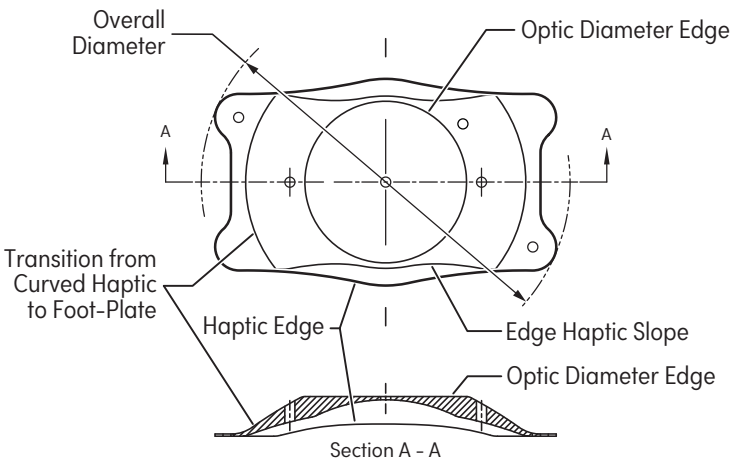
EVO ***Viva*** features a single piece lens design with a concave/convex optic zone of 4.9 to 6.1 mm diameter (according to model and diopter) and a 0.36 mm diameter central hole in the optic known as the KS-AquaPORT®. The lens is manufactured in four overall diameters: 12.1, 12.6, 13.2, 13.7 mm to suit different eye sizes. The lenses are capable of being folded and implanted through an incision of 3.5 mm or less. The lenses are manufactured from a proprietary ultraviolet (UV) radiation absorbing polymer containing hydroxyethylmethacrylate (HEMA) and porcine collagen.

The 10% UV cut-offs for STAAR's phakic IOL lens family are:

- 377 nm for the thinnest central thickness lens, -5.5 D and
- 388 nm for the thickest central thickness lens, +10.0 D.

Table 1 : VICM6 Models

Brand Name	Model Name	Dioptric Power (D)	Overall Diameter (mm)	Optic Diameter (mm)	Haptic Design
EVO ***Viva***	VICM6 12.1	-0.5 to -18.0	12.1	4.9 to 6.1	Flat, plate
EVO ***Viva***	VICM6 12.6	-0.5 to -18.0	12.6	4.9 to 6.1	Flat, plate
EVO ***Viva***	VICM6 13.2	-0.5 to -18.0	13.2	4.9 to 6.1	Flat, plate
EVO ***Viva***	VICM6 13.7	-0.5 to -18.0	13.7	4.9 to 6.1	Flat, plate



VICM6 Diagram

INDICATIONS

- EVO ***Viva*** is indicated for use in phakic eye treatment in patients 21-60 years of age and pseudophakic eye treatment in patients with monofocal IOLs with and without cylinder correction 21 years of age and older for:
- The correction/reduction of myopia in patients ranging from -0.5 D to -20.0 D at the spectacle plane.
- The correction/reduction of myopia with presbyopia in patients ranging from -0.5 D to -20.0 D at the spectacle plane.
  - For extended depth of focus and improved near visual acuity.
- With an anterior chamber depth (ACD) equal to or greater than 2.8 mm as measured from the corneal endothelium to the anterior lens capsule.

MODE OF ACTION

EVO ***Viva*** is intended to be placed entirely within the posterior chamber directly behind the iris and in front of the anterior surface of either the natural lens of a phakic patient or the implanted monofocal intraocular lens with or without cylinder correction of a pseudophakic patient. When correctly positioned, the lens functions as a refractive element to optically correct/reduce myopia with or without presbyopia.

CONTRAINDICATIONS

EVO ***Viva*** is contraindicated in the presence of any of the following circumstances and/or conditions:

1. Patients with low/abnormal corneal endothelial cell density, Fuchs' dystrophy or other corneal pathology.
2. Ocular hypertension in either eye.
3. Any cataract in the operative eye or non-traumatic cataract in the fellow eye.
4. Persons under the age of 21 years.
5. Primary Open Angle or Narrow Angle Glaucoma.
6. Narrow anterior chamber angles (i.e. less than Grade III as determined by gonioscopic exam).
7. Pregnant or nursing.
8. Previous or pre-existing ocular disease that would preclude post-operative visual acuity of 0.477 logMAR (20/60 Snellen) or better.
9. Patients who are amblyopic or blind in the fellow eye.
10. Implantation of a lens in an eye with an anterior chamber depth (ACD), as measured from the corneal endothelium to the anterior lens capsule, less than 2.8 mm.

COMPLICATIONS AND ADVERSE REACTIONS

Adverse reactions and complications due to, or following surgery and implantation of any EVO ***Viva*** may include, but are not limited to: Hyphema, Non-reactive Pupil, Pupillary Block, Additional YAG Iridotomy, Secondary Glaucoma, Cataract, Intraocular Infection, Uveitis/Iritis, Retinal Detachment, Vitritis, Corneal Edema, Macular Edema, Corneal Decompensation, Over/Under Correction, Significant Glare and/or Halos (under night driving conditions), Hypopyon, Increased Astigmatism, Loss of BSCVA, Decentration/Subluxation, IOP Elevation from Baseline, Corneal Endothelial Cell Loss, Iris Pigment Dispersion, Secondary Surgical Intervention to Remove/Replace/Reposition the Lens, Peripheral Anterior Synechia (PAS), Iris Synechia to Implant, Conjunctival Irritation, Vitreous Loss.

PRECAUTIONS

1. Do not attempt to sterilize (see caution).
2. Do not autoclave (see caution).
3. The lens should not be exposed to any solutions other than the normally used intraocular irrigating solutions (e.g. isotonic saline, BSS, viscoelastic, etc.).
4. The lens should be handled carefully. No attempts should be made to reshape or cut any portion of the lens or to apply undue pressure to the lens optical portion with a sharp object.
5. Do not allow the lens to dry in air. The lens should be stored in sterile BSS solution during surgery.
6. The long-term effect of the lens has not been determined. Therefore, physicians should continue to monitor implant patients postoperatively on a regular basis.
7. Safety and effectiveness of the lens has not been established in patients with: unstable refractive error in either eye, keratoconus, history of clinical signs of iritis/uveitis, synechia, pigment dispersion syndrome, pseudo exfoliation, insulin-dependent diabetes or diabetic retinopathy, history of previous ocular surgery including refractive corneal surgery.
8. Implantation of a lens may result in a decrease in corneal endothelial cell density.

MANAGING PRESBYOPIC PATIENT EXPECTATIONS

Proper patient counselling constitutes an important aspect of presbyopia correction because patients must "understand the compromise" required to achieve spectacle independence.[32] For example, a lack of understanding may manifest as dissatisfaction if patients have "unrealistic expectations."

In the clinical study of EVO ***Viva***, a "compromise" was represented by 10 events (14.3%) of transient decrease in CDVA secondary to the slower progress of the neuroadaptation process in some patients. Preoperative counselling represents an opportunity to inform patients of the potential for this type of occurrence, so that it may inform their expectations regarding the postoperative course.

NOTE: As with other ophthalmic surgical procedures, decreased visual acuity in the early postoperative period may be related to a number of potential etiologies. When a significant reduction of two or more lines of best-corrected visual acuity is observed, a comprehensive clinical evaluation should be performed. Delayed neuroadaptation should only be diagnosed if the evaluation does not reveal the pathophysiology of the reduced visual acuity.

CALCULATION OF LENS POWER AND SIZING

The lens power and size calculation should be performed by the surgeon using the OCOS Calculation Software. Using the software potentially prevents calculation errors that may result in secondary surgery due to refractive surprise, excessive vaulting, lens rotation, IOP elevation from baseline, etc. During the U.S. FDA trial for the ICM/TICM, the white to white and ACD (from the corneal endothelium to the anterior lens capsule) were used to determine the ICL overall diameter. There are some reports suggesting that white to white corneal measurements do not correlate with sulcus to sulcus. Recent publications indicate that new imaging technologies may provide optimal visualization and measurement of the intraocular dimensions involved in phakic intraocular lens implantation.

CONSIDERATIONS FOR PSEUDOPHAKIC EYES

The optical power calculation in a pseudophakic eye is the same as the power calculation in a phakic eye; however, the calculation for the size of the ICL differs in that the anterior chamber depth (i.e., "true ACD") that is inputted should either be the phakic anterior chamber depth measured prior to intraocular lens implantation or should be adjusted for the difference between the phakic and pseudophakic eye. For example, to calculate the true ACD in the pseudophakic eye, the following adjustments to the distance from the corneal endothelium to the anterior intraocular lens surface have been recommended:

- Optical coherence tomography measurements: subtract 1.5 mm;
- Optical biometry measurements: subtract 1.2 mm.[33]
- Scheimpflug measurements: use true ACD≅distance between the endothelium and mid-iris plane.[34]

LENS PREPARATION

Verify that the level of the liquid fills at least 2/3 of the vial. The thermoformed tray and vial should be opened in a sterile field. Record control number on operative report to retain traceability. Remove the aluminum cap and stopper. Using the foam tip plunger, remove the lens from the vial. The lens should not be exposed to a dry environment (air) for more than one minute.

CAUTION: Do not use if package has been opened or damaged.

CAUTION: Do not allow the lens to dry after removal from the glass vial.

ADMINISTRATION AND INSTRUCTION FOR USE

Implantation of the EVO ***Viva*** should only be attempted by a surgeon who is highly skilled in the required surgical technique. The following procedure is recommended for implantation of EVO ***Viva***. The patient should be prepared for surgery according to standard operating procedure. A clear scleral or corneal tunnel wound incision of 3.5 mm or less should be used, followed by filling of the anterior and posterior chamber with an appropriate viscoelastic.

The lens is then folded using a MICROSTAAR® injector MSI-PF or MSI-TF with SFC-45 cartridge and injected into the anterior chamber. Please refer to the product insert provided with the injector for instructions regarding proper loading and injection of the lens using the MICROSTAAR injection system. Verify correct orientation of the lens and that the lens is not inverted. If the pupil remains sufficiently dilated, the lens should be well centered and positioned under the iris in front of the natural lens of a phakic patient or the implanted intraocular lens of a pseudophakic patient, so that the footplates are placed in the sulcus. Complete removal of the viscoelastic material must be performed before the eye is closed (without sutures). From this point the operation can proceed according to the surgeon's standard procedure. Postoperative medical care of the patient should also follow the surgeon's standard procedure.

WARNINGS

1. Check the label of the lens package for proper lens model and power.
2. Open the package to verify the dioptric power of the lens.
3. Handle the lens by the haptic portion. Do not grasp the optic with forceps and never touch the center of the optic once the lens is place inside the eye.
4. Complete removal of viscoelastic from the eye after completion of the surgical procedure is essential. STAAR Surgical recommends a low molecular weight 2% hydroxypropyl methylcellulose (HPMC) or dispersive, low viscosity ophthalmic viscosurgical device.
5. STAAR Surgical recommends using the MICROSTAAR® MSI-PF or MSI-TF with SFC-45 cartridge delivery systems to insert the lens in the folded state.

NOTE: The primary viscoelastic used during the US FDA clinical trial was a low molecular weight 2% hydroxypropyl methylcellulose preparation.

CLINICAL TRIAL ICM

Summary Findings of the Clinical Studies:

The Model ICM Implantable Collamer® Lenses were found to be safe and effective as refractive elements to optically reduce moderate to high myopia.

Table 2: Adverse Events

a summary of adverse events reported in the 696 eyes enrolled during the clinical trial (at any postoperative exam) is presented below:

Adverse Event	N	%
ICL Removal Due to Elevated IOP	2	0.3
ICL Replacement (Due to Incorrect Sizing)	6	0.9
ICL Repositioning	4	0.6
ICL Removal Due to Cataract	5	0.7
Other Secondary Surgical Interventions	6	0.8

Table 3: Patient Demographics

696 Eyes Treated of 404 Patients

Sex		
Male	158	(39.1%)
Female	246	(60.9%)
Ethnic Origin		
Caucasian	348	(86.1%)
Black	6	(1.5%)
Hispanic	26	(6.4%)
Other	24	(5.9%)
Mean Age 37.1 years		

Table 4

Best Spectacle Corrected Visual Acuity with Time for Patients with PREOP BSCVA 20/20 or better
The Implantable Collamer® Lens for Myopia

	Preop n%	1 Week n%	1 Month n%	3 Months n%	6 Months n%	12 Months n%	24 Months n%
≤20/20	439/439 (100.0%)	376/417 (90.2%)	403/419 (96.2%)	391/404 (96.8%)	368/386 (95.3%)	270/280 (96.4%)	76/82 (92.7%)
≤20/25	439/439 (100.0%)	408/417 (97.8%)	416/419 (99.3%)	403/404 (99.8%)	384/386 (99.5%)	279/280 (99.6%)	82/82 (100.0%)
≤20/32	439/439 (100.0%)	414/417 (99.3%)	419/419 (100.0%)	404/404 (100.0%)	386/386 (100.0%)	279/280 (99.6%)	82/82 (100.0%)
≤20/40	439/439 (100.0%)	416/417 (99.8%)	419/419 (100.0%)	404/404 (100.0%)	386/386 (100.0%)	279/280 (99.6%)	82/82 (100.0%)
≤20/80	439/439 (100.0%)	417/417 (100.0%)	419/419 (100.0%)	404/404 (100.0%)	386/386 (100.0%)	280/280 (100.0%)	82/82 (100.0%)
≤20/200	439/439 (100.0%)	417/417 (100.0%)	419/419 (100.0%)	404/404 (100.0%)	386/386 (100.0%)	280/280 (100.0%)	82/82 (100.0%)
>20/200	0/439 (0.0%)	0/417 (0.0%)	0/419 (0.0%)	0/404 (0.0%)	0/386 (0.0%)	0/280 (0.0%)	0/82 (0.0%)
Not Reported	0	11	4	3	5	0	1
Total	439	422	421	405	391	280	83

Table 5

Uncorrected Visual Acuity over Time for Patients with PREOP BSCVA 20/20 or better
The Implantable Collamer® Lens for Myopia

	Preop n%	1 Week n%	1 Month n%	3 Months n%	6 Months n%	12 Months n%	24 Months n%
≤20/20	0/439 (0.0%)	162/421 (38.5%)	197/421 (46.8%)	210/404 (52.0%)	200/391 (51.2%)	158/278 (56.8%)	33/83 (39.8%)
≤20/25	0/439 (0.0%)	248/421 (58.9%)	278/421 (66.0%)	281/404 (69.6%)	274/391 (70.1%)	206/278 (74.1%)	44/83 (53.0%)
≤20/32	0/439 (0.0%)	316/421 (75.1%)	351/421 (83.4%)	338/404 (83.7%)	323/391 (82.6%)	235/278 (84.5%)	63/83 (75.9%)
≤20/40	0/439 (0.0%)	364/421 (86.5%)	377/421 (89.5%)	369/404 (91.3%)	346/391 (88.5%)	253/278 (91.0%)	71/83 (85.5%)
≤20/80	0/439 (0.0%)	408/421 (96.9%)	409/421 (97.1%)	397/404 (98.3%)	382/391 (97.7%)	271/278 (97.5%)	80/83 (96.4%)
≤20/200	0/439 (0.0%)	421/421 (100.0%)	421/421 (100.0%)	404/404 (100.0%)	391/391 (100.0%)	278/278 (100.0%)	83/83 (100.0%)
>20/200	439/439 (100.0%)	0/421 (0.0%)	0/421 (0.0%)	0/404 (0.0%)	0/391 (0.0%)	0/278 (0.0%)	0/83 (0.0%)
Not Reported	0	3	1	3	1	3	0
Total	439	422	421	405	391	280	83

Table 6

Manifest Refraction Spherical Equivalent with Time
The Implantable Collamer® Lens for Myopia

Spherical Equivalent (D)	Preop n%	1 Week n%	1 Month n%	3 Months n%	6 Months n%	12 Months n%	24 Months n%
≥1.01	0 (0.0%)	4 (0.6%)	7 (1.1%)	6 (1.0%)	5 (0.8%)	4 (0.9%)	0 (0.0%)
+1.00 to +0.01	0 (0.0%)	97 (15.0%)	119 (18.1%)	121 (19.6%)	104 (17.5%)	68 (15.2%)	14 (10.3%)
0.00 to -1.00	0 (0.0%)	399 (61.8%)	405 (61.7%)	374 (60.6%)	356 (59.8%)	283 (63.3%)	75 (55.1%)
-1.01 to -2.00	0 (0.0%)	103 (15.9%)	81 (12.3%)	81 (13.1%)	91 (15.3%)	58 (13.0%)	36 (26.5%)
-2.01 to -6.00	0 (0.0%)	40 (6.2%)	41 (6.3%)	31 (5.0%)	36 (6.1%)	32 (7.2%)	11 (8.1%)
-6.01 to -10.00	284 (40.8%)	3 (0.5%)	3 (0.5%)	4 (0.6%)	3 (0.5%)	2 (0.4%)	0 (0.0%)
-10.01 to -15.00	318 (45.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
-15.01 to -20.00	88 (12.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
<-20.00	6 (0.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	696 (100.0%)	646 (100.0%)	656 (100.0%)	617 (100.0%)	595 (100.0%)	447 (100.0%)	136 (100.0%)
Mean	-11.408	-0.658	-0.566	-0.526	-0.580	-0.623	-0.857

CLINICAL TRIAL: EVO *VIVA* ICL

A prospective, multicenter, open-label clinical study was conducted to evaluate the performance of the EVO ***Viva*** for the improvement of near vision. The study demonstrated that EVO ***Viva*** provides correction or reduction of myopia and presbyopia in patients who desire vision over a continuous range of vision for improved uncorrected distance, intermediate and near visual acuity with increased spectacle independence.

STUDY POPULATION

A total of 35 subjects (70 eyes) were bilaterally implanted with the study lens. The primary performance endpoint was defined as achievement of monocular UNVA of Snellen equivalent 20/40 or better at 40 cm at Postoperative Visit 5 (6 months after implantation) in equal to or greater than 75% of the first 54 implanted eyes that completed the Visit 5 assessments and were exited from the study. The analysis populations defined for the study were:

1. All Enrolled Set (AES)–includes all subjects/eyes enrolled and implanted in the study. The AES includes 70 eyes/35 subjects.
2. Safety Evaluation Set (SES)–includes all subjects/eyes that were implanted with the study lens in the interim analysis cohort. The SES includes 56 eyes/28 subjects.
3. Full Analysis Set (FAS)–contains the data of each eye in the SES for which data has been collected for the primary performance endpoint. One subject (2 eyes) of the first 56 eyes implanted in the study underwent bilateral explantation prior to the final study visit. The FAS includes 54 eyes/27 subjects.
4. Per Protocol Set (PPS)–contains data of each eye in the FAS without major protocol deviations. No protocol deviations were observed in the interim FAS. The PPS=FAS.

Table 7: Subject Demographics

Total N	SES 56 eyes (28 subjects)	AES 70 eyes (35 subjects)
Age (years)		
Mean (SD)	48.2 (3.5)	48.5 (3.9)
Min, Max	41, 54	41, 59
Gender (n(n/N%))		
Male	10 (35.7)	11 (31.4)
Female	18 (64.3)	24 (68.6)
Race (n(n/N %))		
Caucasian	28 (100)	35 (100)
Other	0 (0)	0 (0)

EFFECTIVENESS

The primary effectiveness endpoint of the study was met; a total of 53 of 54 eyes (98.1%) achieved monocular UNVA of 20/40 or better at Postoperative Visit 5.

Table 8
Monocular UCVA (FAS/PPS, N=54 eyes)

Monocular UCVA (FAS/PPS, N=54 eyes)	Preop Mean ± SD (logMAR)	6 Months Postop Mean ± SD (logMAR)	Change from Baseline Lines of Improvement
Monocular UDVA	1.187 ± 0.258	0.153 ± 0.110	10.35 ± 2.94
Monocular UIVA	0.869 ± 0.302	0.066 ± 0.109	8.03 ± 3.29
Monocular UNVA	0.720 ± 0.362	0.064 ± 0.089	6.56 ± 3.70

Table 9
Binocular UCVA at Postoperative Visit 5 (FAS/PPS, N=27 subjects)

	Distance	Intermediate	Near
Mean ± SD (logMAR) (Snellen)	0.056 ± 0.083 (20/23)	-0.010 ± 0.070 (20/20)	-0.010 ± 0.051 (20/20)

Table 10
Combined Binocular UCVA at Distance, Intermediate and Near (FAS/PPS, N=27 subjects)

	All 20/22 or better	All 20/25 or better	All 20/32 or better
n (n/N%)	12 (44.4%)	17 (63.0%)	26 (96.3%)

Table 11
MRSE (FAS/PPS, N=54 EYES)

MRSE (D)	Preoperative Visit (Day -90 to Day 0) (N=54)	Postoperative Visit 5 (Week 21-26) (N=54)
n (Reported)	54	54
Mean ± SD	-5.578 ± 2.287	-0.658 ± 0.573
95% CI	(-6.203, -4.954)	(-0.814, -0.502)
Median	-5.380	-0.565
Min, Max	-11.25, -1.13	-2.25, 0.75
Mean ± SD change from baseline	NA	4.920 ± 2.487
Not Reported	0	0

SAFETY

The most common device-related AE reported in this study was a transient decrease in CDVA of greater than or equal to 0.2 logMAR; however, no subject who was followed through Postoperative Visit 5 demonstrated decreased CDVA of greater than or equal to 0.2 logMAR at the final visit.

One subject (2 eyes) of the first 56 eyes implanted in the study underwent bilateral explantation prior to the final study visit due to dissatisfaction. This subject experienced transient decrease in CDVA of greater than or equal to 0.2 logMAR and requested explant of study lenses despite ongoing improvement in CDVA. Following explant surgery, the subject experienced complete resolution of CDVA loss.

Mean monocular CDVA was 20/18 at the Preoperative Visit and 20/21 at Postoperative Visit 5, representing a mean decrease of 0.64±0.71 lines of CDVA from the Preoperative Visit at Postoperative Visit 5.

Table 12: Ocular Adverse Events

MedDRA System Organ Class Preferred Term	SES (N=56 eyes) n	%	Number of AEs	AES (N=70 eyes) n	%	Number of AEs
Eyes with at least 1 ocular AE, number of AEs	19	33.9	32	21	30.0	35
Ocular AE rate		0.57			0.50	
Eye disorders	19	33.9	26	20	28.6	27
Visual acuity reduced	10	17.9	11	10	14.3	11
Dry eye	10	17.9	11	10	14.3	10
Corneal edema	1	1.8	1	2*	2.9	2
Eye pruritus	2	3.6	2	2	2.9	2
Eye inflammation	1	1.8	1	1	1.4	1
Lacrimation increased	1	1.8	1	1	1.4	1
Infections and infestations	2	3.6	4	3	4.3	5
Hordeolum	2	3.6	3	3*	4.3	4
Conjunctivitis	1	1.8	1	1	1.4	1
Investigations	1	1.8	1	2	2.9	2
Intraocular pressure increased	1	1.8	1	2*	2.9	2
Injury, poisoning and procedural complications	1	1.8	1	1	1.4	1
Conjunctival laceration	1	1.8	1	1	1.4	1

*Corneal edema, hordeolum and IOP increased were reported for Subject ES03-06. This subject not in the interim analysis SES.
AEs affecting both eyes (OU) were counted twice for the analysis by eye.

SATISFACTION

Table 13
Subject Satisfaction (FAS/PPS, N=27 subjects)

Overall satisfaction: "Over the last month, how satisfied were you with your vision?"	Preoperative Visit (Day -90 to Day 0) (N=27)		Postoperative Visit 5 (Week 21-26) (N=27)	
	n	(n/N %)	n	(n/N%)
Completely satisfied	0	(0.0)	6	(22.2)
Very satisfied	3	(11.1)	18	(66.7)
Somewhat satisfied	4	(14.8)	1	(3.7)
Somewhat dissatisfied	7	(25.9)	1	(3.7)
Very dissatisfied	5	(18.5)	1	(3.7)
Completely dissatisfied	8	(29.6)	0	(0.0)

ADVERSE EVENT REPORTING

Adverse Reactions and/or potentially sight-threatening complications that may reasonably be regarded as lens related must be reported to STAAR Surgical immediately. This information is being requested from surgeons in order to document potential long-term effects of EVO ***Viva*** implantation.

HOW SUPPLIED

EVO ***Viva*** is supplied sterile and non-pyrogenic in a sealed vial containing BSS. The vial is sealed within a sterile thermoformed tray placed in a box with labels and product information. Sterility is assured until the expiration date indicated on package label, if the tray and vial seal are not punctured or damaged. EVO ***Viva*** is steam sterilized.

Patient Card Instructions: A Patient Card is supplied in the unit package.

This card should be given to the patient to keep it as a permanent record of the implant and to show the card to any eye care practitioner seen in the future.

EXPIRATION DATE

The expiration date on the device package is the sterility expiration date. This device must not be used past the indicated sterility expiration date.

RETURN POLICY FOR STAAR EVO *VIVA*

Contact STAAR Surgical. EVO ***Viva*** must be returned dry. Do not attempt to re-hydrate the lens.

WARRANTY AND LIMITATION OF LIABILITY

STAAR Surgical warrants that reasonable care was taken in making this product. STAAR Surgical shall not be responsible for any incidental or consequential loss, damage, or expense which arises directly or indirectly from the use of this product. To the extent permitted by law, STAAR Surgical's sole liability from any and all causes pursuant to EVO ***Viva*** shall be limited to the replacement of the EVO ***Viva*** which is returned to and found to be defective by STAAR Surgical. This warranty is in lieu of and excludes all other warranties not expressly set forth herein, whether expressed or implied by operation of law or otherwise, including but not limited to, or any implied merchantability or fitness for use.

STORAGE

Store the lens at room/ambient temperature.

CAUTION

- Do not autoclave the lens. Do not store at temperatures greater than 40°C. Do not freeze. If temperature requirements are not met, return the lens to STAAR Surgical.
- STAAR Surgical EVO ***Viva*** and disposable accessories are packaged and sterilized for single use only. Cleaning, refurbishing and/or resterilization are not applicable to these devices. If one of these devices were reused after cleaning, refurbishing, it is highly probable that it would be contaminated and the contamination could result in infection and/or inflammation.

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EC REP

STAAR Surgical AG Spain
Avenida Meridiana 216,
Despacho 4
Barcelona 08027
Spain

CE
0344

STAAR Surgical AG
Hauptstrasse 104
CH-2560 Nidau
Switzerland
Tel: +41 32 332 8888

SYMBOL GLOSSARY

MD	**Medical device**
2	**Do not re-use**
2 STERILIZE	**Do not resterilize**
	Do not use if the product sterile barrier system or its packaging is compromised
∅B	**Body diameter (Optic diameter)**
∅	**Overall diameter**
	Single sterile barrier system with protective packaging outside
	Importer into the European Union
	Use-by date
D	**Diopter**
31	**Date**
	Caution
BIO	**Contains biological material of animal origin**
Rx Only	**U.S. (Federal) law restricts this device to sale by or on the order of a physician**
0°C 40°C RT	**Store at room/ambient temperature. Do not freeze. Do not expose to temperature greater than 40°C**
STERILE	**Sterilized using steam**
EC REP	**Authorized representative in the European Community**
CE	**CE conformity marking per European Council Directive 93/42/EEC or European Council Regulation (EU) 2017/745**
	Manufacturer
	Date of manufacture
US	**Country of manufacture–United States**
CH	**Country of manufacture–Switzerland**
UDI	**Unique Device Identifier**
REF	**Catalogue number**
OD	**Right eye**
OS	**Left eye**
SN	**Serial number**
edfu.staar.com +1-800-352-7842 +41 32 332 88 88	**Consult electronic instructions for use**
	Health care center or Doctor