IOL POWER CALCULATION REQUEST FORM

Standard Calculation

This form is provided in response to your request for IOL power calculation assistance. Should you have any questions or need assistance in completing this form, please contact Alcon Medical Information Services at 800.757.9785 or Alcon.MedInfo@alcon.com.

Fax both pages of the completed form to us at 800.757.9786 or email to Alcon.MedInfo@alcon.com.

Alcon provides intraocular lens (IOL) power calculation assistance in response to unsolicited requests from a surgeon for product support to assist a surgeon new to an Alcon IOL product, and for assistance with unusually complex cases. To help determine an accurate calculation, it may be necessary for Alcon to contact the requesting surgeon for confirmation of submitted information and/or additional data to support the request. Alcon may decline requests for lack of sufficient reliable data or for misuse of these services.

Calculation services require a minimum of two business days after all required data have been received; “rush” or immediate services are not available.

<table>
<thead>
<tr>
<th>PLEASE CIRCLE ONE:</th>
<th>Accept Terms</th>
<th>Decline Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Today’s Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Account #</td>
<td></td>
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</tr>
</tbody>
</table>

Surgeon Attestation:

I, as the operating surgeon, attest that the data and information provided herein are true and accurate. I request that Alcon provide me with IOL power calculation assistance to assist me in making a decision regarding intraocular lens power selection. I acknowledge that the Alcon service is dependent on the accuracy of my data. I understand that Alcon does not intend to provide medical or surgical advice, does not warrant or guarantee the accuracy or completeness of this information and disclaims any liability for unanticipated refractive or surgical outcomes. I release Alcon from any liability for this service. I further acknowledge that the selection of the specific intraocular lens model, A-constant, and power used for this patient is solely my responsibility as the operating surgeon. I agree that I will not provide any patient identifiable information on the form.

Surgeon Initials: ____________________

Patient Details

Patient Age: ____________________  Patient ID: ____________________  Gender: □ M □ F

(Do not include DOB)  (Do not include patient identifiable information such as initials or name)

Calculation Assistance Requested for: □ OD  □ OS  □ OU

Date of Surgery: OD _______/_______/_________  OS _______/_______/_________

FOR VALIDATION PURPOSES, PLEASE PROVIDE RELEVANT DATA FOR BOTH EYES EVEN IF REQUEST IS ONLY FOR ONE EYE

FAX COMPLETED FORM TO ALCON AT 800.757.9786 OR EMAIL TO Alcon.MedInfo@alcon.com
**ALCON IOL POWER CALCULATION CONSULT FORM**

**Surgeon Name** ___________________________  **Fax#** ___________________________  **Patient ID** ___________________________  

**FOR VALIDATION PURPOSES, PLEASE PROVIDE DATA FOR BOTH EYES, EVEN IF REQUEST IS FOR ONE EYE.** Should you have any questions or need assistance in completing this form, please contact Alcon Medical Information Services at 800.757.9785.

### OD

**Preoperative Data**

<table>
<thead>
<tr>
<th>Pre-Operative Refraction: ____________ ___________ x ____________</th>
<th>□ Pre-Cataract &quot;Most Plus&quot; (Preferred)  □ Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horiz White to White ____ mm</td>
<td>Phakic Lens Thickness (rec. for AL &lt; 22.0mm) ____ mm</td>
</tr>
<tr>
<td>K1 ______ D @ _______</td>
<td>K2 ______ D @ _______</td>
</tr>
<tr>
<td>Axial Length _____ mm</td>
<td>Phakic ACD _______ mm</td>
</tr>
<tr>
<td>Method used for Axial Length: □ Contact  □ Immersion  □ IOLMaster / LENSTAR</td>
<td></td>
</tr>
</tbody>
</table>

Does the patient have a history of any of the following:

- Keratoconus: □ Yes  □ No
- Scleral Buckle: □ Yes  □ No
- Silicone Oil: □ Yes  □ No
- Other Ocular Pathology: □ Yes  □ No If yes, please explain: _____________________________
- Keratorefractive Surgery: □ Yes  □ No If yes, please explain: _____________________________

**Surgical Plan**

- Alcon Lens Model ___________________________  Lens Constant ___________________________  Optimized ? □ Yes  □ No
- Target Ref _______ D  IOL Power _______ D  Formula Used ___________________________

**TORIC IOL ONLY: SIA Magnitude (D) (Alcon default = 0.5D) _____ Incision Location (e.g. 180 OD, 0 OS) ___________________________**

### OS

**Preoperative Data**

<table>
<thead>
<tr>
<th>Pre-Operative Refraction: ____________ ___________ x ____________</th>
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- Keratorefractive Surgery: □ Yes  □ No If yes, please explain: _____________________________

**Surgical Plan**

- Alcon Lens Model ___________________________  Lens Constant ___________________________  Optimized ? □ Yes  □ No
- Target Ref _______ D  IOL Power _______ D  Formula Used ___________________________

**TORIC IOL ONLY: SIA Magnitude (D) (Alcon default = 0.5D) _____ Incision Location (e.g. 180 OD, 0 OS) ___________________________**

**CALCULATION WILL INCLUDE HOLLADAY 2 FORMULA ONLY** - All data points may be required to process calculation

Comments: _____________________________

**REQUICKED**

**SURGEON SIGNATURE:** ___________________________

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