

enVista Aspire™ Toric

Hydrophobic Acrylic IOL

IO MONOFOCAL TORIC

Elevate the everyday.
Transcend the boundaries
of standard monofocal IOLs.



IO INTERMEDIATE-
OPTIMIZED
OPTIC

BROADER DEPTH OF FOCUS

COMPARED TO THE AO MONOFOCAL OPTIC¹

AVAILABLE TO TREAT
**<1D OF
ASTIGMATISM**
AT THE CORNEAL PLANE²

3C (controlled curvature change) Technology. Uncompromised distance contrast sensitivity compared to the AO monofocal optic.¹

Unique AccuSet™ Haptic Design (110 degrees of capsular bag contact) provides exceptional rotational stability.³

The original glistening-free optic material.⁴

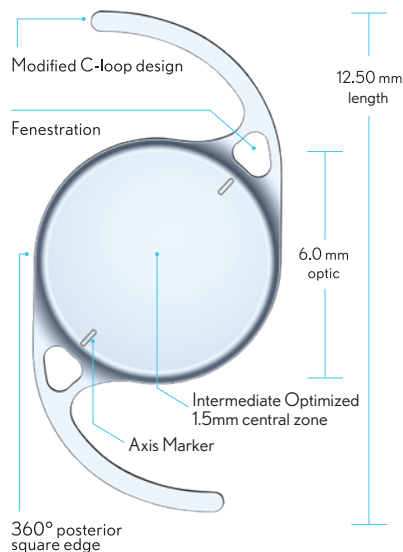
enVista **ASPIRE™** TORIC
HYDROPHOBIC ACRYLIC IOL

BAUSCH + LOMB



HYDROPHOBIC ACRYLIC IOL

ETA order number ETAU CCC+XXX
ETPA order number ETPAU CCC+XXX



MODEL NUMBER	ETA (non-preload)	ETPA (preloaded)
OPTIC DESIGN	One-piece Aspheric, biconvex Posterior high-order aspheric surface Posterior toricity	One-piece Aspheric, biconvex Posterior high-order aspheric surface Posterior toricity
OPTIC SIZE	6mm	6mm
LENGTH	12.5mm	12.5mm
HAPTICS	Modified C, fenestrated	Modified C, fenestrated
OPTICAL BIOMETRY		
Optical A-constant*	119.1	119.1
ACD	5.61mm	5.61mm
Surgeon Factor	1.85mm	1.85mm
APPLANATION BIOMETRY		
Applanation A-constant*	118.7	118.7
ACD	5.37mm	5.37mm
Surgeon Factor	1.62mm	1.62mm
OTHER FEATURES	Glistening free Refractive index: 1.53 UV absorbing Sharp 360° square posterior edge	Glistening free Refractive index: 1.53 UV absorbing Sharp 360° square posterior edge
DIOPTRER RANGE	+6 D to +34 D (0.5 D increments)	+10D to +30D (0.5 D increments)
CYLINDER POWERS IOL PLANE	1.25, 1.50, 2.00, 2.50, 3.00, 3.50, 4.25, 5.00, 5.75	1.25, 1.50, 2.00, 2.50, 3.00, 3.50

* A-constant values are suggested as a guideline. Physicians should calculate lens power based on optimization of their experience and preference with IOL technology.

Storz® BLIS Inserter System



FOR INSERTING LENS MODEL ETA; +6 D to +34 D with X1 cartridge
RECOMMENDED INCISION SIZE 2.2mm–2.4mm
TYPE OF ACTION Screw-type
COMMENTS Controlled delivery. Reusable. Sterilization required.

c represents the cylinder, x represents the diopter

1. enVista Aspire Directions for Use, Bausch & Lomb.
2. enVista Toric Directions for Use, Bausch & Lomb.
3. Data on File, Bausch & Lomb.
4. enVista Directions for Use, Clinical Data [May 2017].

EyeGility™ Inserter



FOR INSERTING LENS MODEL ETPA
RECOMMENDED INCISION SIZE 2.4mm
TYPE OF ACTION Push-type
COMMENTS Semi-preload. Single use. Disposable.



Find B+L IOL surgical equipment online at www.StorzEye.com

Indications and Important Safety Information for enVista Aspire™ Toric IOL

INDICATIONS: The enVista Aspire™ toric hydrophobic acrylic IOL (non-preloaded model ETA) is indicated for primary implantation in the capsular bag of the eye in adult patients for the visual correction of aphakia and corneal astigmatism following the removal of a cataract lens for improved uncorrected distance vision.

DEVICE DESCRIPTION: The Aspire IOL uses an optical modification of the posterior aspheric surface to create a small continuous increase in IOL power within the central 1.5 mm diameter to slightly extend the depth of focus. However, clinically meaningful extension of the depth of focus has not been demonstrated in clinical trials.

WARNINGS: Physicians considering IOL implantation under any of the following circumstances should weigh the potential risk/benefit ratio: (1) Recurrent severe anterior or posterior segment inflammation or uveitis; (2) Patients in whom the IOL may affect the ability to observe, diagnose, or treat posterior segment diseases; (3) Surgical difficulties at the time of cataract extraction, which might increase the potential for complications (e.g., persistent bleeding, significant iris damage, uncontrolled positive pressure, or significant vitreous prolapse or loss); (4) A distorted eye due to previous trauma or developmental defect in which appropriate support of the IOL is not possible; (5) Circumstances that would result in damage to the endothelium during implantation; (6) Suspected microbial infection; (7) Patients in whom neither the posterior capsule nor zonules are intact enough to provide support; (8) Rotation of the IOL away from the intended axis can reduce its astigmatic correction. Misalignment greater than 30° may increase postoperative refractive cylinder. If necessary, IOL positioning should occur prior to capsule fibrosis and IOL encapsulation.

PRECAUTIONS: Neither the safety and effectiveness, nor the effects of the Aspire IOL optical design on depth of focus, contrast sensitivity, and subjective visual disturbances (glare, halo, etc.) have been evaluated clinically. MTF testing of the Aspire IOL optical design (used in model ETA) may aid the surgeon in understanding the theoretical image quality expected with the Aspire IOL compared to the enVista monofocal IOL MX60E. However, these do not fully assess all aspects of clinical difficulties under all conditions. Surgeons must weigh the potential benefits of the modified optical design of the Aspire IOL (model ETA) against the potential for

risks associated with a degradation in vision quality and the lack of clinical data to characterize the impact of the Aspire IOL optical design on contrast sensitivity and subjective visual disturbance. These considerations may be especially relevant to patients with certain pre-existing ocular conditions (prior corneal refractive surgery, irregular corneal astigmatism, severe corneal dystrophy, macular disease, optic nerve atrophy, etc.) or intraoperative conditions (posterior capsular rupture, complications in which the IOL stability could be compromised, inability to place IOL in capsular bag, etc). The safety and effectiveness of the IOL have not been substantiated in patients with pre-existing ocular conditions and intraoperative complications. Careful preoperative evaluation and sound clinical judgment should be used by the surgeon to decide the benefit/risk ratio before implanting an IOL in a patient with one or more of these conditions. Physicians considering IOL implantation in such patients should explore the use of alternative methods of aphakic correction and consider IOL implantation only if alternatives are deemed unsatisfactory in meeting the needs of the patient. Patients with preoperative problems, such as corneal endothelial disease, abnormal cornea, macular degeneration, retinal degeneration, glaucoma, and chronic drug miosis may not achieve the visual acuity of patients without such problems. The physician must determine the benefits to be derived from IOL implantation when such conditions exist.

ADVERSE EVENTS: As with any surgical procedure, there is risk involved. Potential complications accompanying cataract or implant surgery may include, but are not limited to the following: corneal endothelial damage, infection (endophthalmitis), retinal detachment, vitritis, cystoid macular edema, corneal edema, pupillary block, cyclitic membrane, iris prolapse, hypopyon transient or persistent glaucoma, and secondary surgical intervention. Secondary surgical interventions include but are not limited to: lens repositioning, lens replacement, vitreous aspiration or iridectomy for pupillary block, wound leak repair, and retinal detachment repair.

CAUTION: Federal law restricts this device to sale by or on the order of a physician.
ATTENTION: This is not all you need to know. Please refer to the Directions For Use labeling for a complete listing of indications, full risk and safety information, clinical study information, etc