

Tisotumab vedotin-tftv, for injection 40 mg, Eye Care Consult Form

This patient has been prescribed tisotumab vedotin-tftv. Tisotumab vedotin-tftv can cause changes in the corneal epithelium and conjunctiva resulting in changes in vision, including severe vision loss, and corneal ulceration. Conduct an ophthalmic exam at baseline, prior to each dose, and as clinically indicated.

The information in this form is important to the prescriber of tisotumab vedotin-tftv to make treatment and dose modification decisions in the event of an ocular adverse reaction.

INSTRUCTIONS:

Please complete this form and promptly provide it to the prescribing physician. The completed form may be carried by the patient, faxed, or included in electronic medical records.

Eye Care Reminders

- Patients should adhere to Premedication and Required Eye Care before, during, and after infusion
- Patients should avoid wearing contact lenses throughout treatment unless otherwise specified

Patient Name: _____ Date of Birth: ____/____/____

Visit: Baseline Follow-up Exam Date of Exam: ____/____/____

Oncologist Contact Information

Name: _____

Fax: _____ Phone: _____

Email: _____

Eye Care Provider Contact Information

Name: _____

Fax: _____ Phone: _____

Email: _____

Baseline Exam Only

Ocular conditions at baseline: _____

Relevant medical history (including, but not limited to: medication-induced ocular disorders, ocular medications, systemic medications, and prior ocular surgeries, such as LASIK, cataract surgery, etc.) _____

Does the patient wear glasses or contact lenses for distance vision correction? Yes No

Is there evidence of corneal and/or conjunctival abnormality at baseline? Yes No

If yes, please detail findings: _____

Has the patient experienced any prior episode of cicatricial conjunctivitis? Yes No

Baseline and Follow-up Exams

Visual Acuity

	Right Eye	Left Eye
Distance Visual Acuity^a <small>^aPatient should wear prescribed corrective lenses at the time of assessment, if applicable.</small>	20/_____	20/_____

Has there been a decrease in visual acuity since treatment initiation? Yes No N/A

Slit Lamp

Has there been a change since last appointment? Yes No N/A

Please detail findings: _____

Follow-Up Exams

Ocular Adverse Reaction Assessment^{a,b}

Please complete this form and promptly provide it to the prescribing physician. The information in this form is important to the prescriber of tisotumab vedotin-tftv to make treatment and dose modification decisions in the event of an ocular adverse reaction.

Patient Name: _____

Date of Birth: ____ / ____ / _____

Date of Exam: ____ / ____ / _____

Keratitis

Superficial punctate keratitis (SPK)/punctate staining (non-confluent) (Any occurrence)

Confluent SPK/punctate staining (First occurrence) Confluent SPK/punctate staining (Second occurrence)

Ulcerative keratitis or perforation (Any occurrence)

Conjunctival ulceration

Any ulceration (First occurrence) Any ulceration (Second occurrence)

Conjunctival scarring/syblepharon or corneal scarring

Any scarring or syblepharon (Any occurrence)

Conjunctivitis and/or other ocular adverse reactions^{b,c} (please specify: _____)

Grade 1/Mild (Any occurrence) Grade 2/Moderate (First occurrence)

Grade 2/Moderate (Second occurrence) Grade 2/Moderate (Third occurrence) Grade 3 or 4/Severe (Any occurrence)

Are there any ocular medications being added and/or modified at this visit? Yes; please specify: _____
 No

Please report any ocular adverse reactions that occur.

^aThese are not all of the ocular adverse reactions that occurred in patients taking tisotumab vedotin-tftv in clinical trials. For a complete list of ocular adverse reactions, please see [full prescribing information](#), including dosage modification table.

^bAdditional details about grading ocular adverse reactions can be found in the Common Terminology Criteria for Adverse Events.

^cPlease use terminology from the Common Terminology Criteria for Adverse Events when describing ocular adverse reactions.

Additional Comments (Please include any additional information that may help the prescribing physician make treatment and dose modification decisions)

 Eye Care Provider signature

 Date

This form is intended to help facilitate communication between the patient's eye care professional and prescribing physician and to help inform the appropriate treatment decision for tisotumab vedotin-tftv. This may include maintaining the current dose, implementing a dose modification, or discontinuing treatment completely. The information collected does not constitute an exhaustive or definitive record of eye care information that may be relevant. The information contained on this form is not intended to be a substitute for professional medical advice, and both the eye care professional and oncologist should exercise their own professional judgment and expertise in making diagnoses, treatment decisions, and determining what information should be collected, shared, or relied upon.