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

This patient has been prescribed tisotumab vedotin-tftv. Tisotumab vedotin-tftv can cause severe ocular toxicities resulting in changes in vision, including severe vision loss, and corneal ulceration. Conduct an ophthalmic exam, including an assessment of ocular symptoms, visual acuity, and slit lamp exam of the anterior segment of the eye prior to initiation of tisotumab vedotin-tftv, prior to every cycle for the first 9 cycles, 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 Required Premedication and 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] [a]Patient should wear prescribed corrective lenses at the time of assessment, if applicable.	20/_____	20/_____

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

Slit Lamp Exam of the Anterior Segment of the Eye

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

Please detail findings: _____

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Turn form over to complete the remaining fields ▶

Follow-Up Exams

Ocular Adverse Reaction Assessment*

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

- ☐ Nonconfluent superficial keratitis (Any occurrence)
- ☐ Confluent superficial keratitis, a corneal epithelial defect, or a 3 line or more loss in best corrected visual acuity (First occurrence)
- ☐ Confluent superficial keratitis, a corneal epithelial defect, or a 3 line or more loss in best corrected visual acuity (Second occurrence)
- ☐ Ulcerative keratitis or perforation (Any occurrence)

Conjunctival or corneal scarring or symblepharon

- ☐ Any scarring or symblepharon (Any occurrence)

Conjunctivitis and/or other ocular adverse reactions (please specify: _____)

- ☐ Nonconfluent superficial punctate conjunctival defects, mild vasodilation (Any occurrence)
- ☐ Confluent superficial punctate conjunctival defects, moderate to severe vasodilation (First occurrence)
- ☐ Confluent superficial punctate conjunctival defects, moderate to severe vasodilation (Second occurrence)
- ☐ Confluent superficial punctate conjunctival defects, moderate to severe vasodilation (Third occurrence)
- ☐ Conjunctival ulcer, conjunctival neovascularization, or fibrovascular scarring (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.

*These 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 dose modification table.

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 provider 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 provider 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.

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