EXHIBIT A

Print Date: 01/11/2017

Exam Date: 12/07/2016
Expiration Date: 12/07/2017

Final Contact Rx

Patient: [redacted]

RT: **Qty:** 0

Product:	BC	Dia	Sphere	Cylinder	Axis	Add	Tint:
B & L BIO TRUE 90 PACK	8.50	14.10	-7.50	SPH.			Handling Tint

LT: **Qty:** 0

Product:	BC	Dia	Sphere	Cylinder	Axis	Add	Tint:
B & L BIO TRUE 90 PACK	8.50	14.10	-7.50	SPH.			Handling Tint

Wear Schedule: Daily

Replenishment: Daily

DOT: NONE

Care Regimen

Notes

Provider:

License #:

Exam Date : 12/07/2016 Exp Date: 12/07/2017

Rx for:

Provider:

License#:

RT :

BC	Dia.	Sph.	Cyl.	Axis	Add	Prism
8.50	14.10	-7.50	SPH.			

LT :

BC	Dia.	Sph.	Cyl.	Axis	Add	Prism
8.50	14.10	-7.50	SPH.			

Print Date: 08/01/2016

Exam Date: 04/15/2016

Expiration Date: 04/15/2017

Final Contact Lens Rx

Patient: [redacted]

OD: **Qty:** 1

Product:	BC	Dia	Sphere	Cylinder	Axis	Add	Tint:
Air Optix Colors (6Pk)	8.70	14.50	-4.75	SPH.			Handling Tint

OS: **Qty:** 1

Product:	BC	Dia	Sphere	Cylinder	Axis	Add	Tint:
Air Optix Colors (6Pk)	8.70	14.50	-4.75	SPH.			Handling Tint

Wear Schedule

Replenishment

DOT

Care Regimen

Notes

Provider:

License #:

Contact Lens Rx

Patient: [redacted]

Rx Date: 19-Dec-2016
Expiration: 19-Dec-2017
Refills Per Eye:0

	Sphere	Cylinder	Axis	Add	Base Curve
OD:	-6.50	-1.75	170		8.70
OS:	-6.50	-2.25	010		8.70

Diameter	Multifocal
14.5	
14.5	

	Manufacturer	Lens
OD:	CooperVision - Private Label	Aqua Clear Toric 6 Pack
OS:	CooperVision - Private Label	Aqua Clear Toric 6 Pack

Material

NPI#:

Printed: Jan-19-2017 5:30 PM

Lic# _____ NPI# _____

I

Patient Name [redacted] Date 1-22-16

Address _____ DOB [redacted]

R Spectacle Rx

SRX	SPH	CYL	AXIS	ADD	PRISM/BASE
OD	-3.25	-1.25	5	+	
OS	-3.25	-1.00	165	+	

PD: Distance _____ Near _____

- ☐ VeriLite Lenses
- ☐ Progressive Lenses
- ☐ Standard Bifocal
- ☐ VeriClear
- ☐ UV Filter
- ☐ Scratch Resistant Coating
- ☐ Tint
- ☐ Sunsensors
- ☐ Other _____

Ultraviolet light may cause cataracts and retinal degeneration. We recommend that your lenses have ultraviolet protection.

Expires (1) 2 year(s) from Rx date.

Contact Lens Rx

CLRS	SPH	CYL	AXIS	BC	DIA	LENS NAME
OD	-3.50	-0.75	180	8.5	14.5	Soflmed Breathable
OS	-3.50	-0.75	160			Tor C

NOTE TO DISPENSING OPTICIAN: Please direct patient to the prescribed doctor for fitting evaluation and follow-up visits. Dispensing optician will provide removal training and care instructions.

- ☐ Solution _____
- ☐ Disposable
- ☐ Daily Wear
- ☐ Toric
- ☐ Cosmetic Lenses
- ☐ Dailies
- ☐ RGP
- ☐ Backup Eyeglasses Recommended
- ☐ Solution _____

Expires (1) 2 year(s) from Rx date.

[redacted] _____

☐ Dispense as Written

☐ Substitution Permissible

[redacted]

Lic# [redacted] NPI# [redacted]

[redacted]

Patient Name [redacted] Date 5/20/2016

Address _____ DOB _____

Rx Spectacle Rx

SRX	SPH	CYL	AXIS	ADD	PRISM/BASE
OD	-3.50	-0.50	~~[illegible]~~ 165	+2.00	
OS	-3.00	-1.75	170		

PD: Distance _____ Near _____

- ☐ VeriLite Lenses
- ☐ Progressive Lenses
- ☐ Standard Bifocal
- ☐ VeriClear
- ☐ UV Filter
- ☐ Scratch Resistant Coating
- ☐ Tint
- ☐ Sunsensors
- ☐ Other _____

[illegible]

Expires (1) 2 year(s) from Rx date

Contact Lens Rx

CLRS	SPH	CYL	AXIS	BC	DIA	LENS NAME
OD	-3.75			8.5	14.2	[illegible]
OS	-3.00	-1.25	170	8.5	14.5	

NOTE TO DISPENSING OPTICIAN: [illegible]

[illegible]

- ☐ Solution
- ☐ Disposable
- ☐ Daily Wear
- ☐ Toric
- ☐ Cosmetic Lenses
- ☐ Dailies
- ☐ RGP
- ☐ Backup Eyeglasses Recommended
- ☐ Solution

Expires (1) 2 year(s) from Rx date

[redacted]

- ☐ Dispense as Written
- ☑ Substitution Permissible

Name: [redacted] Issue Date: 01/16/17

DOB: [redacted]

	B.C.	Diam.	Sphere	Cyl.	Axis	Add
OD	840	14.0	-3.50			
OS	840	14.0	-3.75			

Brand Name: oasys presbyopic

Manufacturer: visyecon

Quantity: Replacement Schedule:

Remarks:

Doctor:

[redacted]

☑001

PRESCRIPTION COVER SHEET

TO:
FAX#:
FROM
RE:

[redacted]	OD Acuvue Oasys for Astigmatism	BC: 8.6 DIA: 14.5 SPH: -3.25 CYL: -0.75 AX: 20
	OS Acuvue Oasys for Astigmatism	BC: 8.6 DIA: 14.5 SPH: -3.50 CYL: -0.75 AX: 130
	Glasses Rx	**OD:** -3.00+0.75x110 PD:65.0 **OS:** -4.00 +0.50x45

Attach prescription(s) here or on separate page if necessary

(Please make sure you fax us a contact lens prescription and not an eyeglass prescription -- Thank you.)

PATIENT NAME: [redacted] **DOB:** 4/14/1981
Address: [redacted] AL 35014
Exam Date: 1/13/2017
Print Date: 1/13/2017 **Expires:** 1/13/2018

	Sph	Cyl	Axis	Prism			PD	
OD	-2.25	-0.75	20					
OS	-3.50	-0.50	135					
OD	ADD							
OS								

Type: Final Rx **Use:**
Recommendations:
Accuvue Oasis CL
OD: 44.00/44.75
OS: 43.75/45.00
BC: 8.8
Diameter: 14.0
Or Accuvue Toric CL

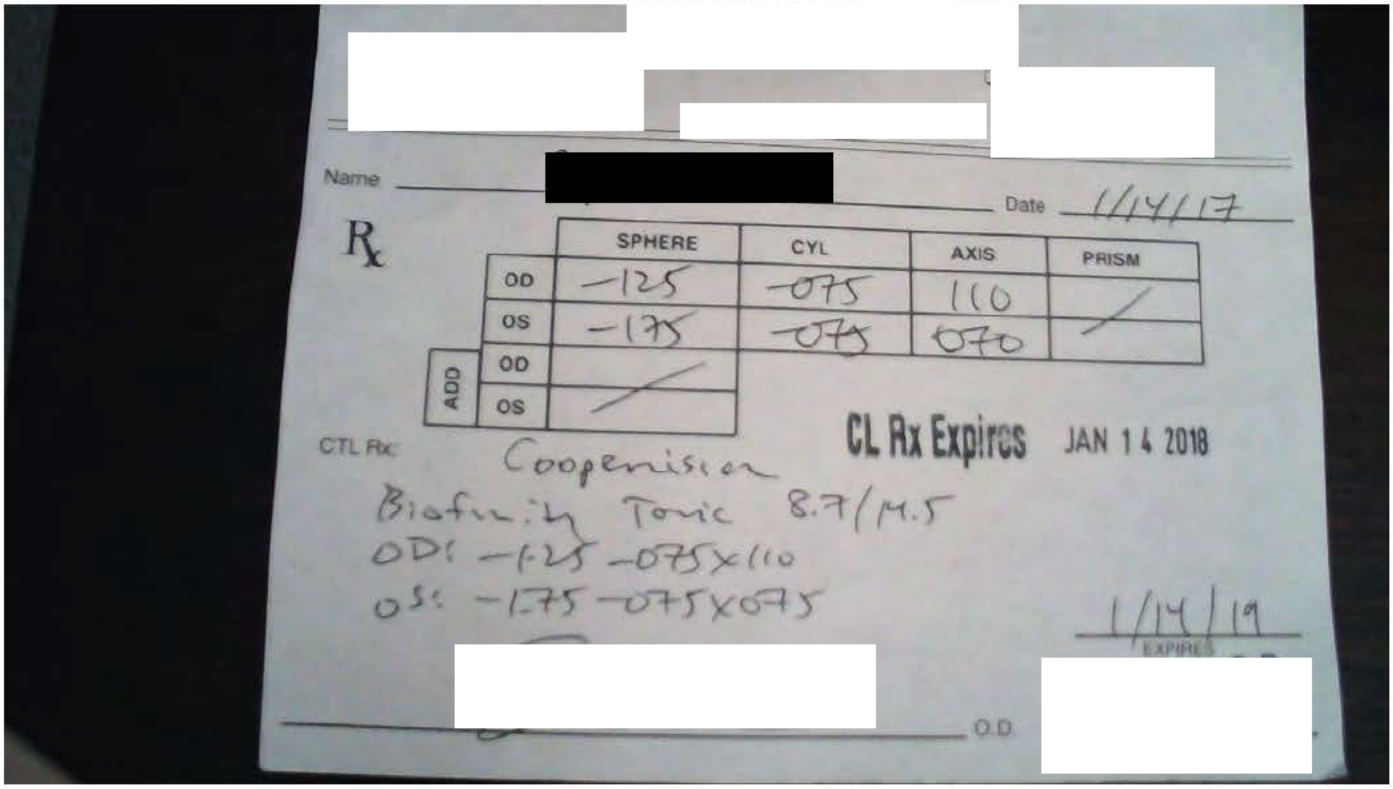
[redacted]

003

PATIENT NAME: [redacted] **DOB:** 4/14/1981
Address: [redacted] AL 35014
Exam Date: 1/13/2017
Print Date: 1/13/2017 **Expires:** 1/13/2018

	Sph	Cyl	Axis	Prism			PD	
OD	-3.00	+0.75	110					
OS	-4.00	+0.50	15					
OD	ADD							
OS								

Type: Final Rx **Use:**
Recommendations:
Disp lenses @ BG as present lenses.



Name [redacted] Date 1/14/17

Rx

		SPHERE	CYL	AXIS	PRISM
	OD	-1.25	-.075	110	/
	OS	-1.75	-.075	070	
ADD	OD	/			
	OS				

CTL Rx: Coopervision

Biofinity Toric 8.7/14.5

OD: -1.25 -.075x110

OS: -1.75 -.075x075

CL Rx Expires JAN 14 2018

1/14/19
EXPIRES

O.D.

Print Date: 05/24/2016

Exam Date: 05/24/2016
Expiration Date: 05/24/2017

Final Contact Rx

Patient: [redacted]

RT: **Qty:** 0

Product:	BC	Dia	Sphere	Cylinder	Axis	Add	Tint:
Acuvue Oasys 24pk			-5.50	SPH.			Handling Tint

LT: **Qty:** 0

Product:	BC	Dia	Sphere	Cylinder	Axis	Add	Tint:
Acuvue Oasys 24pk			-5.50	SPH.			Handling Tint

Wear Schedule

Replenishment

DOT
NONE

Care Regimen

Notes

Provider:

Exam Date : 05/24/2016 Exp Date : 05/24/2017
Rx for: [redacted]
Provider:

RT :

BC	Dia.	Sph.	Cyl.	Axis	Add	Prism
		-5.50	SPH.			

LT :

BC	Dia.	Sph.	Cyl.	Axis	Add	Prism
		-5.50	SPH.			

PATIENT

DOB:

Phone:

Address:

PROVIDER

NPI:

State licensing #:

DEA:

Rx

Prescription Date: 04/28/2015

srx and final cl rx

SIG: OD -2.00-0.25x010 OS plano Acuvue Oasys 8.4 OD only -2.00

Quantity:

Refills: 0

Substitution permitted

Dispense as written

from your account

[redacted]

Lic# [redacted] NPI# [redacted]

✓ [redacted]

Patient Name [redacted] Date 9-21-15

Address [redacted]

℞ Spectacle Rx

SRX	SPH	CYL	AXIS	ADD	PRISM/BASE
OD	-2.50	sph		+	
OS	-2.50			+	

PD: Distance _____ Near _____

- ☐ VeriLite Lenses
- ☐ Progressive Lenses
- ☐ Standard Bifocal
- ☐ VeriClear
- ☐ UV Filter
- ☐ Scratch Resistant Coating
- ☐ Tint
- ☐ Sunsensors
- ☐ Other _____

Ultraviolet light may cause cataracts and retinal degeneration. We recommend that your lenses have ultraviolet protection.

Expires 1 (2) year(s) from Rx date. 9-21-17

Contact Lens Rx

CLRS	SPH	CYL	AXIS	BC	DIA	LENS NAME
OD	-2.50	sph.		8.6	14.0	SWXW
OS	-2.50					

NOTE TO DISPENSING OPTICIAN: Please direct patient to the prescribed doctor for fitting evaluation and follow-up visits. Dispensing optician will provide removal training and care instructions.

- ☐ *Solution* _____
- ☐ *Disposable*
- ☐ *Daily Wear*
- ☐ *Toric*
- ☐ Cosmetic Lenses
- ☐ Dailies
- ☐ RGP
- ☐ Backup Eyeglasses Recommended
- ☐ Solution _____

Expires (1) 2 year(s) from Rx date. 9-21-16

[redacted]

☐ Dispense as Written

☐ Substitution Permissible

EXHIBIT B

Name [redacted] Date 11/14/16

SRX	SPH	CYL	AXIS	ADD	PRISM/BASE	DIST. P.D.
O.D.	-6.00	-0.25	035			
O.S.	-6.25	-0.50	169			

DOCTOR RECOMMENDS:

- ○ POLYCARBONATE
- ○ HIGH-INDEX PLASTIC
- ○ SINGLE VISION
- ○ PROGRESSIVE LENSES
- ○ STANDARD BIFOCAL
- ○ RESISTANT COATING
- ○ UV COATING
- ○ TINT
- ○ ANTI-REFLECTIVE COATING
- ○ LIGHT ADAPTIVE
- ○ OTHER _____

Ultraviolet light may cause cataracts and retinal degeneration. We recommend your lenses have ultraviolet protection.

X APPROVED FOR CONTACT LENSES ○ NOT APPROVED FOR CONTACT LENSES

CLRX	SPH	CYL	AXIS	ADD	BC	DIA
O.D.	-5.75	DS			8.6	14.0
O.S.	-5.75					
LENS NAME						
O.D.	Biofinity					
O.S.						

NOTE TO DISPENSING OPTICIAN: Please direct patient to return to the prescribing doctor for fitting evaluation and follow-up visits. Dispensing optician will provide insertion, removal training and care instructions.

- ○ DISPOSABLE
- ✓ DAILY WEARER
- ○ EXT. WEAR
- ○ TORIC
- ○ DAILIES
- ○ COSMETIC LENSES
- ○ GLASSES RECOMMENDED
- ○ APPROVED FOR ANNUAL SUPPLY

OF REFILLS Monthly Replacement

EXP. DATE: 11/14/17

○ SUBSTITUTION PERMISSIBLE ○ DISPENSE AS WRITTEN

RECEIVED 08/18/2015 01:42AM

REQ DATE/TIME: 11-Jan-2017 12:22PM EST

REF#: **13407657** PX REQUEST DATE:20170111

RE: RX VERIFICATION REQUEST ON BEHALF OF:

[redacted]

Rx info: (PLEASE NOTE PATIENT NAMES)

Biofinity (QT#000001OD)
Patient: [redacted] Eye: OD
BC: 8.6 DIA: 14.0 SPH: -5.75

Biofinity (QT#000001OS)
Patient: [redacted] Eye: OS
BC: 8.6 DIA: 14.0 SPH: -5.75

Patient NO I Found

PLEASE FAX BACK TO

1) ___ Prescription is correct. Expiry date: _____

2) ___ Prescription is incorrect.

Correct OD: _____

Correct OS: _____

3) ___ Prescription expired on _____
Please fill one-time order but notify my patient that they are due for an eye exam.

4) ___ Rx expired. Exam date: _____ Expiry date: _____

If faxing back, please use this form only and fax 1-888-413-5153 or call 1-888-678-4201

OptiContacts.com is requesting verification of the above prescription(s) under the Fairness to Contact Lens Consumers Act. I represent and warrant that the information provided to OptiContacts.com is accurate. If this form is faxed back, a copy will be made available to the patient. For any questions regarding this prescription verification request, please contact T. Hampton at number above.

Doctor Name	Doctor Signature	License#