Tzield® (teplizumab-mzwv) Injection | 2 mg/2mL

Tzield® COMPASS

Reimbursement Request Form

TZIELD Copay Program*

To request reimbursement for your copay for TZIELD® (teplizumab-mzwv) Injection 2 mg/2 mL, please complete all fields below.

HCPs/Infusion Sites

Complete this form and attach the following documents: detailed Explanation of Benefits (EOB), Health Insurance Claim Form, and a copy of the patient's copay receipt. Submit all documents by fax (888-230-9325), mail (Paysign, PO Box 530492, Henderson, NV, 89053), or via the **Rapid Claim Portal**.

Copay claims can also be submitted directly via electronic submission with an Availity account. **No Reimbursement Form is needed for this option.**

Patients

If you are seeking reimbursement for yourself, complete this form and attach your or your provider's Explanation of Benefits (EOB) and a copy of your payment receipt. If the EOB does not include billable codes, you **MUST** also submit a Health Insurance Claim Form from your provider or infusion site (CMS-1500 or CMS-1450). If you are submitting for your provider, please attach your provider's EOB and a Health Insurance Claim Form (CMS-1500 or CMS-1450). Submit all required documents by email (mailinrebate@paysign.com) or mail (Paysign, PO Box 530492, Henderson, NV 89053).

Patient Information

Patient Name: _____ Date of Birth (mm/dd/yyyy): _____

Parent/Legal Guardian (if applicable): _____

Phone Number: _____ Email Address: _____

TZIELD Copay Program Member ID: _____

Patient Member ID was provided via email. Call your Paysign Reimbursement Team at 844-320-8860 if you need help accessing it.

Provider Information

Provider Name: _____ Drug Name: TZIELD® (teplizumab-mzwv) Injection 2 mg/2 mL

Provider Phone Number: _____ Provider Email Address: _____

Reimbursement Information

Indicate who will receive reimbursement: ☐ Patient ☐ Legally Authorized Person† ☐ Provider/Infusion Site

Make Check Payable to: _____

Address: _____

City: _____ State: _____ ZIP: _____

Date of Service (mm/dd/yyyy): _____ Out-of-Pocket Cost Requested: _____

*Not valid for prescriptions covered by or submitted for reimbursement under Medicare, Medicaid, VA, DoD, TRICARE, or similar federal or state programs including any state pharmaceutical programs. Not valid where prohibited by law. Sanofi reserves the right to modify or terminate the Copay Program at any time without notice. Any savings provided by the Copay Program may vary depending on patients' out-of-pocket costs. Upon registration, patients receive all program details. †Legally authorized person must be 18 years of age or older and have legal authority to act on the patient's behalf.

Attestation and Signature

I certify that, to the best of my knowledge, the information on this Reimbursement Request Form is true and correct.

_____ _____

Provider, Patient, or Parent/Legal Guardian Signature **Date (mm/dd/yyyy)**

Please see accompanying full Prescribing Information, including Risk of SERIOUS SIDE EFFECTS and Medication Guide.

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