

# Copay Assistance Guide

## A guide to submitting copay claims for eligible\* patients enrolled in the TZIELD Copay Program

\*The TZIELD Copay Program is not valid for prescriptions paid, in whole or in part, by Medicaid, Medicare, VA, DOD, TRICARE, or other federal or state programs including any state pharmaceutical assistance programs. Not valid where prohibited by law, taxed, or restricted. Sanofi reserves the right to rescind or amend this offer, eligibility, and terms of use at any time without notice. Upon registration, patients receive all Program details.

Eligibility requirements and terms and conditions apply. Click [here](#) for more information. This program is intended to help with the cost of TZIELD and its infusion administration only. It does not help with the cost of other medicines patients take at the same time as TZIELD or with other facility fees.

### TZIELD Copay Program Overview

The TZIELD Copay Program is an offering through TZIELD COMPASS, a support program that will provide:



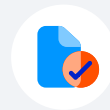
Helpful tools and resources



Information on reimbursement and financial assistance options



Additional support throughout the treatment journey



In order to enroll in the copay program, eligible\* commercially insured patients and their caregivers must have enrolled in TZIELD COMPASS by completing the [Patient START Form](#).

Copay expenses may include TZIELD and the administration of infusion services. If you qualify, a COMPASS Navigator can help enroll you into the copay program so you may be able to lower your out-of-pocket costs.

### HCPs can submit for reimbursement in 1 of 4 ways

**1** Fax

**2** Mail

**3** Upload

**4** Electronic Data Interchange (EDI)

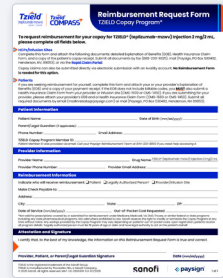
# How to Submit Claims via Fax, Mail, or Upload

Copay claims may be submitted by the healthcare provider/facility/infusion site, specialty pharmacy, or billing entity by completing the following steps:

## Step 1: Fill out the Reimbursement Request Form

- Complete every field on the form. A copy of the form is located on [page 5](#).

You can also download the form at <https://www.tziield.com/assets/pdf/tziield-copay-reimbursement-request-form.pdf>.



## Step 2: Include required documents with the completed form

- Explanation of Benefits (EOB) from the HCP that includes
  - Insurance carrier's name and logo
  - Plan name
  - Patient responsibility
  - Date of service
  - Drug information
    - Name, J-code, and/or National Drug Code
- Health Insurance Claim Form from your provider or infusion site
  - CMS-1500 **OR** CMS-1450
- Copy of patient's payment receipt if the patient paid upfront

## Step 3: Submit the completed form and documentation



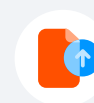
**Fax**  
888-230-9325

OR



**Mail**  
Paysign, PO Box 530492,  
Henderson, NV 89053

OR



**Upload**  
[Rapid Claim Portal](#)

# How to Submit EDI Claims

Copay claims can be submitted directly via electronic submission with an Availity account. **No Reimbursement Form is needed.** If billing entities are interested in setting up EDI, please reach out to TZIELD COMPASS.

## Medical Claims

### In your practice management software, select “PSN22” as a payer

- If PSN22 is not available, contact your software vendor and/or clearinghouse to make PSN22 available in your system\*
- Once PSN22 is available to select as a payer in your system, you are ready to submit electronic claims transactions (EDI 837 files)

\*The process of adding a new payer to practice management software or a clearinghouse varies by vendor. Please work directly with your vendor’s customer support team if you require assistance.

### Add “Tzield Copay Program” to your patient’s insurance profile as a secondary payer

- When inputting Tzield Copay Program to the patient’s profile, make sure to include the following required information:
  - Payer ID: PSN22
  - Program Group Number: 99995296
  - Patient Member ID: Unique patient identifier provided to patient
- Failure to include this information will result in your claim being rejected

### Submit a request to your software vendor and/or clearinghouse to accept electronic remittance advice (ERA) transactions (EDI 835 files) from PSN22

- Once this request is complete, you should begin to receive ERAs for claims submitted via EDI about 5 to 7 business days from the date of claim submission

## Prescription Drug Benefit Claims Run by SP

### SP enters the following:

- Payer ID: PSN22
  - Program Group Number: 99995296
  - Patient Member ID: Unique patient identifier provided to patient

### Coding Considerations for HCP:

**Approvable CPT® Codes<sup>1</sup>:** 36415, 36569, 36573, 36584, 96413, 96365, 99601, 99234, 99235, 99236

**Approvable HCPCS Codes<sup>2</sup>:** A4222, E0780, J9381, S9329, S9379

For more information, please see the **TZIELD Billing and Coding Guide**.

These codes are provided as examples only and are not all-inclusive; appropriate codes can vary by patient, setting of care, and payer. This guide is not meant to provide medical or legal advice or recommendations regarding the use of specific codes for billing purposes. The provider submitting the claim is responsible for determining the medical necessity, appropriate coding, and accuracy of claims.

Current as of July 2025.

For questions on completing the Reimbursement Form or regarding a copay claim, please call Paysign, the Copay Program administrator, at 1-844-320-8860 Monday through Friday, 8 AM-8 PM ET.



If you have questions or would like to learn more about **TZIELD COMPASS**, please call 1-844-778-2246 Monday through Friday, 8 AM-8 PM ET.

## TZIELD COPAY PROGRAM TERMS AND CONDITIONS

- Individuals must have a valid TZIELD® (teplizumab-mzwv) Injection 2 mg/2 mL prescription for a United States Food and Drug Administration (FDA)-approved indication
- Patient must have commercial (private or non-governmental) insurance. This includes plans available through state and federal health insurance marketplaces. Offer is not valid for cash-paying individuals
- Patient, or patient's parent or guardian, must be 18 years or older
- Patient must not be a government beneficiary and/or participant in a federal or state-funded health insurance program (for example, Medicare, Medicare Advantage, Medigap, Medicaid, Civilian Health and Medical Program of the Uniformed Services [CHAMPUS], Veterans Affairs [VA], United States Department of Defense [DoD], TRICARE, Children's Health Insurance Program [CHIP], or the Indian Health Service). No cost of any portion of TZIELD that is dispensed can be submitted to a federal or state healthcare program for purposes of counting it toward out-of-pocket expenses
- Offer is not valid for use with any other program, discount, or offer involving TZIELD or where insurance is paying the entire cost of the prescription. Where third-party reimbursement covers a portion of the prescription, the offer is valid only for the actual out-of-pocket costs
- Patients may have insurance plans that attempt to dilute the impact of the assistance available under the program. In those situations the program may change its terms
- The TZIELD Copay Program is exclusively and entirely for the benefit of the enrolled patient
- Patient, or the patient's parent or guardian, is responsible for complying with any applicable limitations and requirements of their health plan related to the use of the TZIELD Copay Program
- The TZIELD Copay Program is not valid where prohibited by law. Valid only in the United States and US Territories. For administration claims only: the program is not available in Rhode Island; only patients may submit copay program claims in Massachusetts and Minnesota—any copay program claims submitted by healthcare providers will be rejected
- The TZIELD Copay Program is not health insurance and may not be combined with any third-party rebate, coupon or offer
- Sanofi reserves the right to rescind, revoke, or amend program benefits at any time without notice
- Expiration date is 12 months from enrollment. Individuals eligible for pharmacy benefits must have an out-of-pocket cost for TZIELD, and the product must be administered prior to the expiration date of the TZIELD Copay Program
- The available benefit is valid for the out-of-pocket cost for TZIELD and the infusion process only. It is not valid for any other out-of-pocket costs (for example, office visit charges or medication administration charges, evaluations, or diagnostic testing) even if such costs are associated with the administration of TZIELD

**References:** **1.** American Medical Association. CPT® 2025 Professional Edition. American Medical Association; 2024. **2.** CMS. HCPCS Quarterly Update: April 2025. Published February 28, 2025. Accessed May 21, 2025. <https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update>.

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TZIELD is manufactured by Provention Bio, a Sanofi company.  
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# 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)