AURLUMYN® (iloprost) Injection

Reimbursement and Coding Guide

Product Information and Diagnosis Codes for AURLUMYN

Product information	
NDC to be submitted on the claim[1]	**How supplied**[1]
11-digit Carton and Vial: 50633-0340-01 **10-digit Carton and Vial:** 50633-340-01	Carton containing one clear, colorless sterile solution supplied as 100 mcg per mL in a single-dose glass vial.

Product J-code	
Coding system	**Code and description**
HCPCS[2]	J1749 Injection, iloprost, 0.1 mcg

Possible patient diagnosis codes				
Coding system		**Initial encounter**	**Subsequent encounter**	**Sequela**
ICD-10-CM[3]	**Codes and descriptions for frostbite with tissue necrosis of fingers/toes**			
	Frostbite with tissue necrosis of **right finger(s)**	T34.531A	T34.531D	T34.531S
	Frostbite with tissue necrosis of **left finger(s)**	T34.532A	T34.532D	T34.532S
	Frostbite with tissue necrosis of **unspecified finger(s)**	T34.539A	T34.539D	T34.539S
	Frostbite with tissue necrosis of **right toe(s)**	T34.831A	T34.831D	T34.831S
	Frostbite with tissue necrosis of **left toe(s)**	T34.832A	T34.832D	T34.832S
	Frostbite with tissue necrosis of **unspecified toe(s)**	T34.839A	T34.839D	T34.839S
	Codes and descriptions for superficial frostbite of fingers/toes			
	Superficial frostbite of **right finger(s)**	T33.531A	T33.531D	T33.531S
	Superficial frostbite of **left finger(s)**	T33.532A	T33.532D	T33.532S
	Superficial frostbite of **unspecified finger(s)**	T33.539A	T33.539D	T33.539S
	Superficial frostbite of **right toe(s)**	T33.831A	T33.831D	T33.831S
	Superficial frostbite of **left toe(s)**	T33.832A	T33.832D	T33.832S
	Superficial frostbite of **unspecified toe(s)**	T33.839A	T33.839D	T33.839S

INDICATIONS AND USAGE

AURLUMYN is a prostacyclin mimetic indicated for the treatment of severe frostbite in adults to reduce the risk of digit amputations. Effectiveness was established in young, healthy adults who suffered frostbite at high altitudes.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions

- AURLUMYN may cause symptomatic hypotension. Correct hypotension prior to administration of AURLUMYN. Monitor vital signs while administering AURLUMYN.

HCPCS, Healthcare Common Procedure Coding System; ICD-10-CM, International Classification of Diseases, 10th Revision, Clinical Modification; NDC, National Drug Code.

Please see Indications and Important Safety Information on pages 1 and 2 and full Prescribing Information for AURLUMYN.

SERB Pharmaceuticals

Possible patient diagnosis codes (continued)	
Coding system	**Codes and descriptions**
MS-DRG[3]	**901** Wound debridements for injuries with MCC
	902 Wound debridements for injuries with CC
	904 Skin grafts for injuries with CC/MCC
	906 Hand procedures for injuries
	907 Other OR procedures for injuries with MCC
	908 Other OR procedures for injuries with CC
	909 Other OR procedures for injuries without CC/MCC
	922 Other injury, poisoning and toxic effect diagnoses with MCC
	923 Other injury, poisoning and toxic effect diagnoses without MCC

AURLUMYN Granted New Technology Add-On Payment (NTAP) Status by CMS

SERB Pharmaceuticals has secured NTAP approval from CMS for AURLUMYN. NTAP designation for AURLUMYN became effective October 1, 2025. CMS will provide add-on payments through FY 2028. NTAP is available for qualifying cases involving AURLUMYN.[4,5]

- The NTAP is offered by CMS to provide extra reimbursement to hospitals for using qualifying new medical technologies, drugs, or devices[6]

IMPORTANT SAFETY INFORMATION (continued)

Adverse Reactions

- Adverse events reported with the use of intravenous (IV) iloprost in patients with frostbite include headache, flushing, palpitations/tachycardia, nausea, vomiting, dizziness, and hypotension.

Use in Specific Populations

- Advise women not to breastfeed during treatment with AURLUMYN.
- The safety and efficacy of AURLUMYN in pediatric patients have not been established.
- Dosage adjustment is recommended in patients with moderate or severe hepatic impairment.
- In patients with eGFR <30 mL/min, dosage adjustment can be considered based on tolerability. The effect of dialysis on the clearance of AURLUMYN has not been evaluated.

To report suspected adverse reactions, contact BTG at 1-877-377-3784 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

CC, complication or comorbidity; CMS, Centers for Medicare and Medicaid Services; MCC, major complication or comorbidity; MS-DRG, Medicare severity diagnosis-related group; OR, operating room.

NTAP ICD-10-PCS codes	
Codes	**Descriptions**
XW033QB[4]	Introduction of Iloprost into Peripheral Vein, Percutaneous Approach, New Technology Group 11
XW043QB[4]	Introduction of Iloprost into Central Vein, Percutaneous Approach, New Technology Group 11

NTAP details for AURLUMYN	
Eligible facilities[6-10]	Acute care hospitals that are reimbursed under the IPPS. Hospitals not reimbursed under the IPPS, including but not limited to, inpatient rehabilitation facility hospitals, long-term care hospitals, and cancer hospitals, are not eligible to receive the add-on payment.
Setting of care[6,7]	Acute care hospital inpatient setting
Qualified patients[4]	Traditional (fee-for-service) Medicare beneficiaries where the cost of the case exceeds the MS-DRG payment for the case
NTAP payment amount[4]	The lesser of: 1. 65% of the cost of AURLUMYN, or 2. 65% of the amount by which the total covered costs of the case exceed the MS-DRG payment The maximum payment is $28,600* per admission. *The current NTAP estimated maximum payment of $28,600 was based on an estimated cost of $44,000 per patient, assuming the use of 8, single-use 100 mcg per mL vials (1 per day over 8 days) at a cost of $5,500 per vial. If the total covered costs of the case do not exceed the MS-DRG payment, then no additional payment is made for the admission.[3]
Effective date[4,5]	October 1, 2025

DISCLAIMER:

The publicly available information provided in this Reimbursement and Coding Guide is intended for informational purposes only and does not constitute legal, medical, or professional advice. It is designed to assist healthcare providers in understanding reimbursement policies, coding guidelines, and billing procedures. However, it is not exhaustive, and healthcare providers are advised to consult the most current official sources, including but not limited to payer policies, government regulations, and relevant professional organizations, for the most up-to-date and accurate information. It is not intended to guarantee, increase, or maximize reimbursement by any payer.

Healthcare providers are responsible for ensuring compliance with all applicable federal, state, and local laws, regulations, and payer-specific policies when submitting claims for reimbursement. Individual coding decisions should be based upon diagnosis and treatment of individual patients. SERB does not warrant, promise, guarantee, or make any statement that the codes supplied in this guide are appropriate or that the use of this information will result in coverage or payment for treatment using AURLUMYN or that any payment received will cover providers' costs.

This guide does not guarantee reimbursement or the success of any claim submission. Reimbursement decisions are made solely by the payer, and healthcare providers are advised to seek guidance from the payer directly to confirm coverage and payment policies. Before any claims or appeals are submitted, hospitals and physicians should review official payer instructions and requirements, should confirm the accuracy of their coding or billing practices with these payers, and should use independent judgment when selecting codes that most appropriately describe the services or supplies furnished to a patient. It is the provider's responsibility to determine and document that the services provided are medically necessary and that the site of service is appropriate.

ICD-10-PCS, International Classification of Diseases, 10th Revision, Procedure Coding System; IPPS, inpatient prospective payment system; MS-DRG, Medicare severity diagnosis-related group; NTAP, new technology add-on payment.

Outlier payments for AURLUMYN

Hospitals may qualify for outlier payments for AURLUMYN claims from Medicare.[11]

Outlier payments are payments for which a hospital is eligible after incurring extraordinarily high costs.[11]

- A case must have costs **above a fixed-loss cost threshold amount**[11]
  - Thresholds are dollar amounts by which the costs of a case must exceed payments in order to qualify. The threshold for the 2026 fiscal year—from October 1, 2025 through September 30, 2026—is $40,397[11,12]
- Relevant costs, treatment factors, and calculations are typically submitted to CMS in spreadsheet format[11,13]

Outlier payments may help with AURLUMYN-associated costs throughout the NTAP eligibility period and after that period expires.[11]

Hospital Outlier Payment Backgrounder

Section 1886(d)(5)(A) of the Social Security Act provides for Medicare payments to participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs.[11]

To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers).[11]

Cost outliers apply to all inpatient facilities, including but not limited to[14-18]:

- Acute care facilities
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities
- Long-term care facilities
- Veterans Affairs-related claims

Billing

To bill an outlier, there must be days of utilization (Medicare benefit days) available to the beneficiary.[19,20]

Coding

To properly code an outlier claim, the provider must know the Covered, Non-covered, Co-insurance, and Lifetime Reserve (LTR) days available. It is only after all days have been used that benefits are exhausted.[19,20]

Two pieces of information are needed to determine if an outlier should be coded[11]:

1. Total covered charges
2. Inpatient Prospective Payment System (IPPS) threshold amount

CMS, Centers for Medicare and Medicaid Services; NTAP, new technology add-on payment.

Hospital Outlier Payment Backgrounder *(continued)*

Payment[5,11-13]

For a case to qualify for outlier payment, it must have ***total*** costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers). The outlier fixed-loss threshold for FY 2026, which runs from October 1, 2025, through September 30, 2026, is $40,397. CMS pays 80% of costs exceeding DRG payment.

Key factors that will impact qualification for outlier payment are:

- DRG assignment
- Charges reported on the claim
- Your hospital's cost-to-charge ratio

Geography, indirect medical education (IME) factors, and disproportionate share hospital (DSH) factors also impact calculation. Hospitals should determine if a claim should be submitted as an outlier. The Inpatient PPS Web Pricer is available to help estimate payment.

Click or scan to access the Inpatient PPS Web Pricer

Medicare Administrative Contractors (MACs)

Some of the MACs may also provide guidance regarding outlier claim information and submission instructions on their websites:

- First Coast Service Options (FL, Puerto Rico, US Virgin Islands)
- Novitas Outlier Claim Information and Submission Instructions (AR, CO, DC, DE, LA, MD, MS, NJ, NM, PA, OK, TX)
- Noridian Inpatient PPS Billing for Cost Outlier (AK, AZ, CA, HI, ID, MT, ND, NV, OR, SD, UT, WA, WY, American Samoa, Guam, Northern Mariana Islands)
- Palmetto Inpatient PPS Outlier Billing (AL, GA, NC, SC, TN, VA, WV)
- NGS does not provide specific information on their website but provides the link to the Inpatient PPS Web Pricer on the CMS website (CT, IL, MA, ME, MN, NH, NY, RI, VT, WI)
- WPS provides no supplemental information (IA, IN, KS, MI, MO, NE)
- CGS provides no supplemental information (KY, OH)

Click or scan to learn more about MACs

Outlier payment calculation example[13]

The following example simulates the outlier payment for a case at a hospital in the San Francisco, California CBSA, which is a large urban area. The patient was discharged on/after October 1, 2006, and the hospital incurred Medicare-approved charges of $150,000. The DRG assigned to the case was 498. The hospital is 100% Federal for capital payment purposes.

Note: This spreadsheet represents a hypothetical example of an outlier payment calculation. Do not rely on this information for any individual case.

Table of operating values used in calculation	
DRG 498 Relative Weight	2.9896
Labor-related	$3,397.52
Nonlabor-related	$1,476.97
San Francisco CBSA Wage Index	1.5419
Cost of Living Adjustment (COLA)	1
IME Operating Adjustment Factor	0.0744
DSH Operating Adjustment Factor	0.1413
Labor-related portion	0.697
Nonlabor-related portion	0.303
Operating Cost-to-Charge Ratio	0.38

Table of capital values used in calculation	
DRG 498 Relative Weight	2.9896
Federal Capital Rate	$427.03
Large Urban Add-on	1.03
San Francisco CBSA GAF	1.3452
Cost of Living Adjustment	1
IME Operating Adjustment Factor	0.0243
DSH Operating Adjustment Factor	0.0631
Capital Cost-to-Charge Ratio	0.04

Other factors	
Billed Covered Charges	$150,000
Fixed Loss Outlier Threshold	$24,485
Marginal Cost Factor	0.8

CGS, CGS Administrators, LLC; DRG, diagnosis-related group; NGS, National Government Services, Inc; WPS, Wisconsin Physicians Service Government Health Administrators.

Hospital Outlier Payment Backgrounder *(continued)*

Outlier payment calculation example[13] *(continued)*

Step 1: Determine federal operating payment with IME and DSH

Federal Rate for Operating Costs =
(DRG Relative Weight x ((Labor-Related Large Urban Standardized Amount x San Francisco CBSA Wage Index) + (Nonlabor-Related National Large Urban Standardized Amount x Cost of Living Adjustment)) x (1 + IME + DSH))

Federal Operating Payment With IME and DSH = $24,407.58

Step 2: Determine federal capital payment with IME and DSH

Federal Rate for Capital Costs =
((DRG Relative Weight x Federal Capital Rate x Large Urban Add-on x Geographic Cost Adjustment Factor x COLA) x (1 + IME + DSH))

Federal Capital Payment With IME and DSH = $1,923.47

Step 3: Determine operating and capital costs

Operating Costs =
Billed Charges x Operating Cost-to-Charge Ratio

Operating Costs = $57,000

Capital Costs =
Billed Charges x Capital Cost-to-Charge Ratio

Capital Costs = $6,000

Step 4: Determine operating and capital outlier threshold

A. Operating CCR to Total CCR =
Operating CCR / (Operating CCR + Capital CCR)

Operating CCR to Total CCR = 0.9048

B. Capital CCR to Total CCR =
Capital CCR / (Operating CCR + Capital CCR)

Capital CCR to Total CCR = 0.0952

C. Operating Outlier Threshold =
((Fixed Loss Threshold x (Labor-related portion x San Francisco CBSA Wage Index) + Nonlabor-related portion)) x Operating CCR to Total) + Federal Payment With IME and DSH

Operating Outlier Threshold = $54,929.28

D. Capital Outlier Threshold =
(Fixed Loss Threshold x Geographic Adjustment Factor x Large Urban Add-on x Capital CCR to Total CCR) + Federal Payment With IME and DSH

Capital Outlier Threshold = $5,153.16

CBSA, core basic statistical area; DRG, diagnosis-related group; DSH, disproportionate share hospital; GAF, geographic adjustment factor; IME, indirect medical education.

Hospital Outlier Payment Backgrounder *(continued)*

Outlier payment calculation example[13] *(continued)*

Step 5: Determine operating and capital outlier payment amount

A. Determine if Total Costs are greater than Combined Threshold =
(if (Operating Costs + Capital Costs) > (Operating Threshold + Capital Threshold))

Determine if Total Costs are greater than Combined Threshold = TRUE, Continue With Next Step

B. Operating Outlier Payment =
(Operating Costs - Operating Outlier Threshold - NTAP payment) x Marginal Cost Factor

Operating Outlier Payment = $1,656.58

C. Capital Outlier Payment =
(Capital Costs - Capital Outlier Threshold) x Marginal Cost Factor
Note: If Capital Outlier Payment Amount is Negative, we default this amount to 0.

Capital Outlier Payment = $677.47

Special NTAP Considerations[4]

Determining NTAP payment amount

For discharges on or after October 1, 2019, if the costs of a discharge involving a new technology exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of:

- 65% of the costs of the new medical service or technology:
  0.65 x average treatment cost of $44,000* (as determined by CMS based on WAC) = **$28,600**

or

- 65% of the amount by which the Operating Costs of the case exceed the standard DRG payment:
- Operating Costs ($57,000) - Standard DRG Payment ($26,331.05†) x 0.65 = **$19,934.81**

In this example, the lesser and correct NTAP payment amount is $19,934.81.

*For this example, a hypothetical average treatment cost of $44,000 is being used.
†As several factors influence the standard DRG payment, a hypothetical amount of $26,331.05 is being used for this example.

Guidelines for factoring the NTAP into outlier and total payments[11]

Determining maximum outlier payment based on NTAP amount

Outlier payments are limited to 80% of the result of the following Adjustment Calculation, which accounts for NTAP payments:

- Total Costs - Standard DRG Payment - NTAP Amount - Outlier Fixed Loss Threshold =
  Adjustment Calculation Result
- Maximum outlier payment, now accounting for NTAP amount:
  0.80 x **Adjustment Calculation Result**

Determining total payment amount when NTAP applies

Total Payment amount to the customer is calculated as:

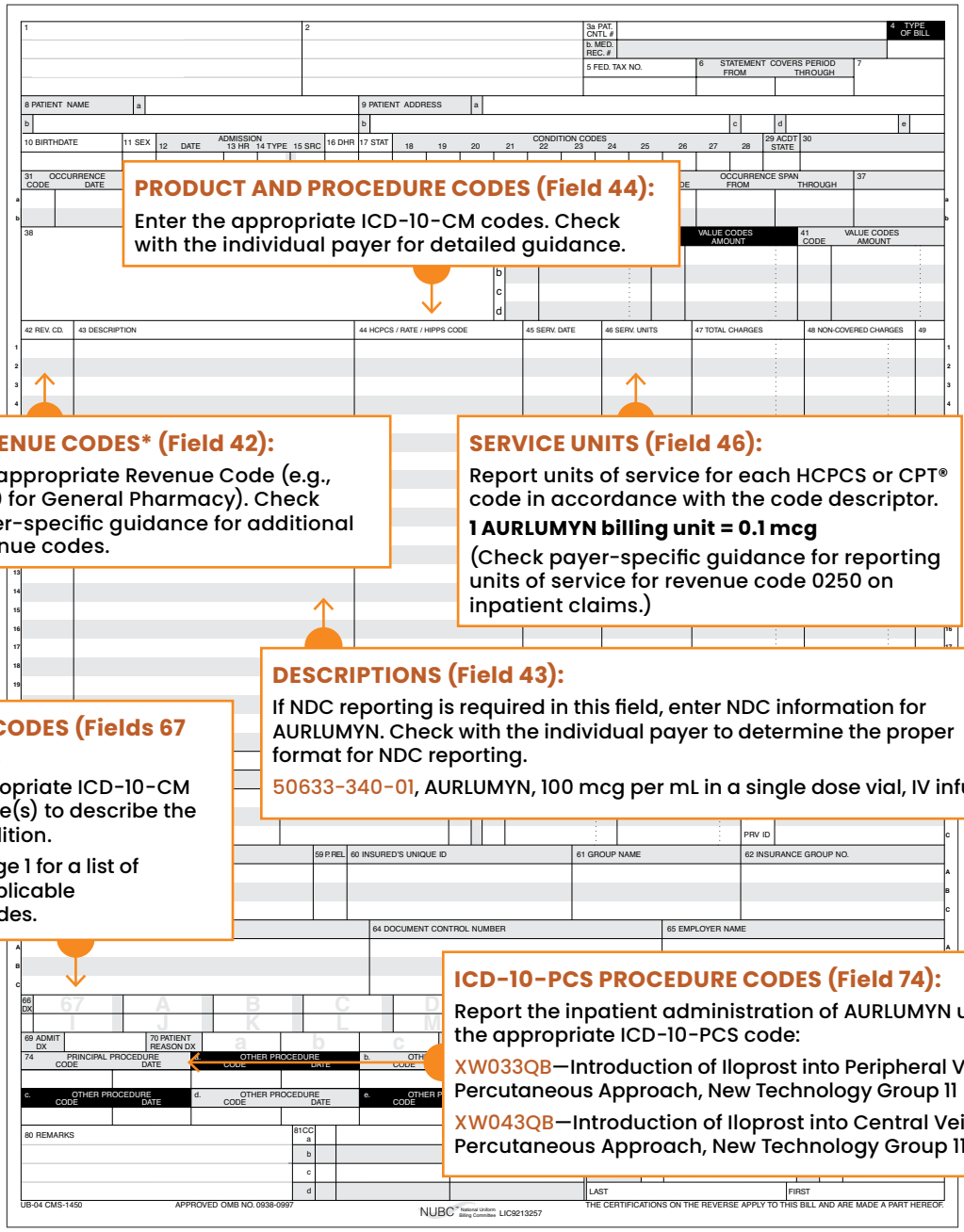
- Standard DRG Payment + NTAP Amount + Outlier Payment Amount that accounts for NTAP

Click or scan to access the spreadsheet in the downloads section
Spreadsheet can be located in the downloads section at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier

CBSA, core basic statistical area; CCR, cost-to-charge ratio; DSH, disproportionate share hospital; IME, indirect medical education.

Sample UB-04 (CMS 1450) form: Hospital — inpatient status site of service

Use the guidance on the form below when submitting AURLUMYN claims for the inpatient setting.

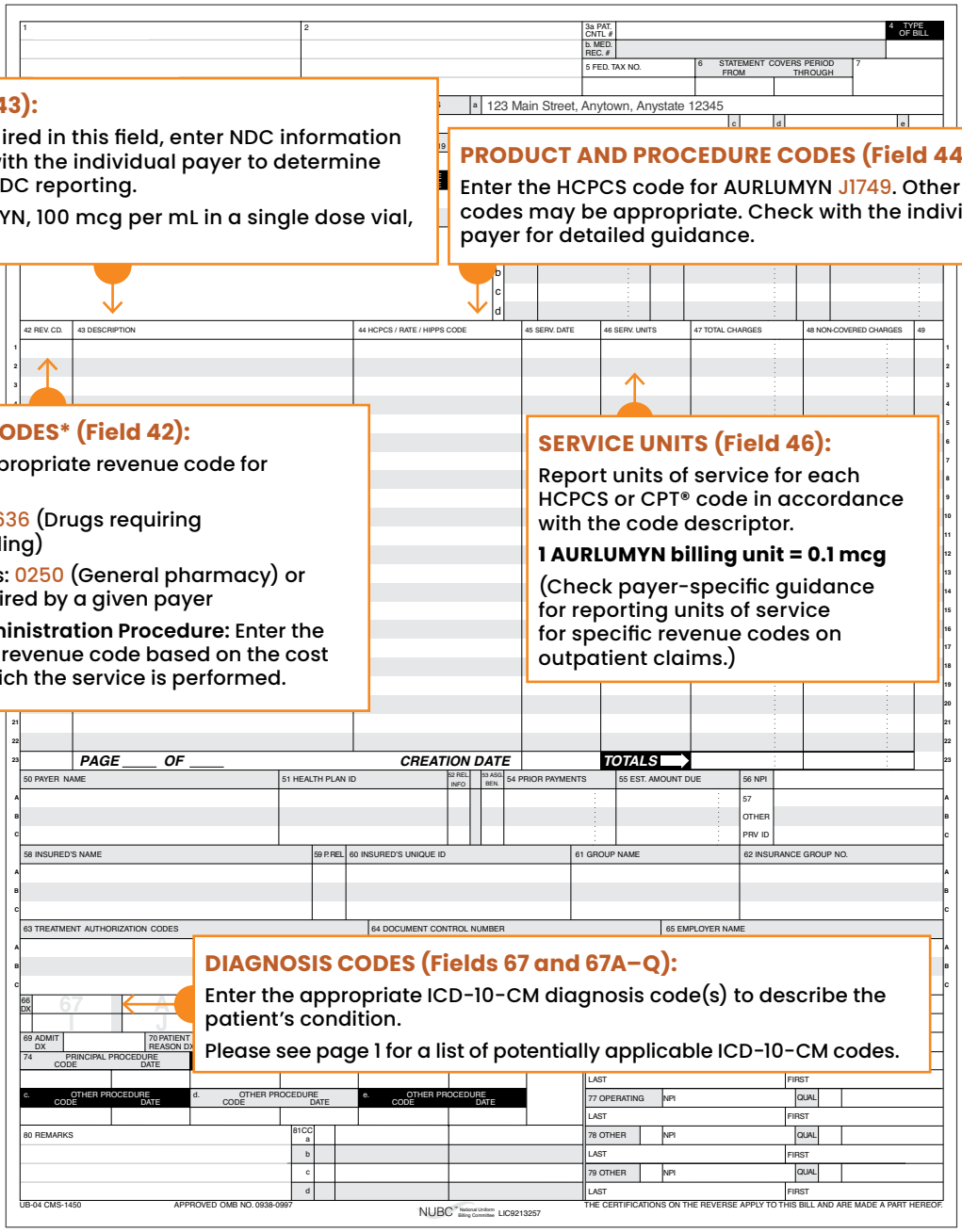


*Revenue codes will vary by institution. Revenue codes are only required on the CMS-1450. This sample form is intended as a reference for coding and billing for products and associated services. It is not intended to be directive; the use of any information in this guide does not guarantee reimbursement. Healthcare providers may deem other codes or policies more appropriate and should select the coding options that most accurately reflect their internal system guidelines, payer requirements, practice patterns, and the services rendered. Healthcare providers are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.

CMS, Centers for Medicare & Medicaid Services; CPT®, Current Procedural Terminology; HCPCS, Healthcare Common Procedure Coding System; ICD-10-CM, International Classification of Diseases, 10th Revision, Clinical Modification; IV, intravenous; NDC, National Drug Code; UB, uniform billing.

Sample UB-04 (CMS 1450) form: Hospital — outpatient status

Use the guidance on the form below when submitting AURLUMYN claims for the outpatient setting.

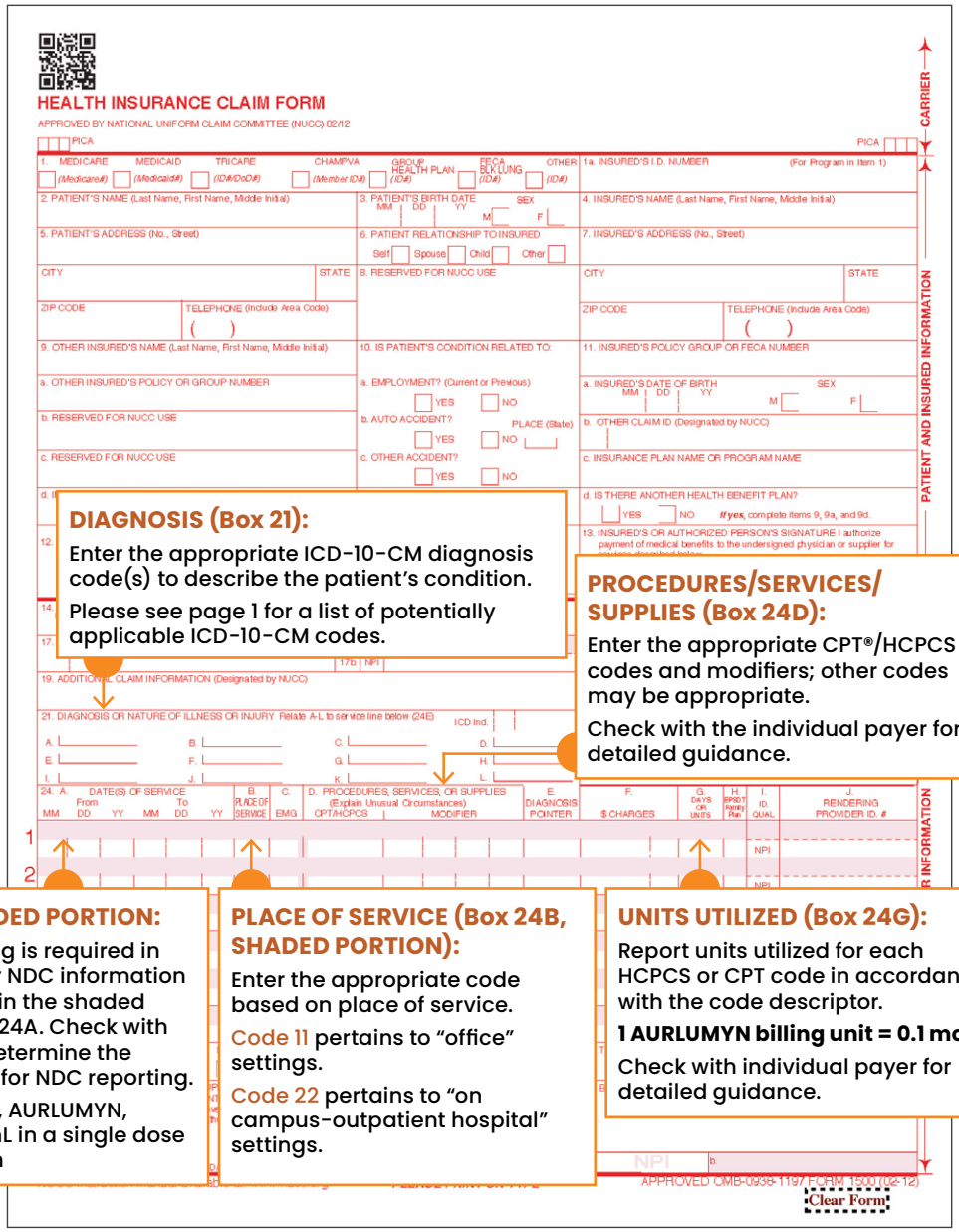


*Revenue codes will vary by institution. Revenue codes are only required on the CMS-1450. This sample form is intended as a reference for coding and billing for products and associated services. It is not intended to be directive; the use of any information in this guide does not guarantee reimbursement. Healthcare providers may deem other codes or policies more appropriate and should select the coding options that most accurately reflect their internal system guidelines, payer requirements, practice patterns, and the services rendered. Healthcare providers are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.

CMS, Centers for Medicare & Medicaid Services; CPT®, Current Procedural Terminology; HCPCS, Healthcare Common Procedure Coding System; ICD-10-CM, International Classification of Diseases, 10th Revision, Clinical Modification; IV, intravenous; NDC, National Drug Code; UB, uniform billing.

Sample CMS-1500 form: Physician office — multiple payers (Medicare and non-Medicare)

Use the guidance on the form below when submitting AURLUMYN claims for cases involving Medicare AND non-Medicare payers.



This sample form is intended as a reference for coding and billing for products and associated services. It is not intended to be directive; the use of the recommended codes does not guarantee reimbursement. Healthcare providers may deem other codes or policies more appropriate and should select the coding options that most accurately reflect their internal system guidelines, payer requirements, practice patterns, and the services rendered. Healthcare providers are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.

CMS, Centers for Medicare & Medicaid Services; CPT®, Current Procedural Terminology; HCPCS, Healthcare Common Procedure Coding System; ICD-10-CM, International Classification of Diseases, 10th Revision, Clinical Modification; NDC, National Drug Code; IV, intravenous.

References

1. AURLUMYN® [package insert]. West Conshohocken, PA: BTG International, Inc. **2.** HCPCS code for injection, iloprost, 0.1 mcg J1749. The American Academy of Professional Coders. Accessed September 24, 2025. https://www.aapc.com/codes/hcpcs-codes/J1749?srsltid=AfmBOoqoBqizGqXTRNLjbRUn4Ae2LdLIjDjPplryJhLTeo6lhH0GNPb1 **3.** Data on file. FY 2026 NTAP AURLUMYN Cost Criterion Codes and MS-DRG. BTG International, Inc.; 2024. **4.** Federal Register Volume 90 No. 147: rules and regulations. Centers for Medicare and Medicaid Services. August 4, 2025. Accessed September 23, 2025. https://www.govinfo.gov/content/pkg/FR-2025-08-04/pdf/2025-14681.pdf **5.** General schedule of rulemaking for Medicare payment systems. Centers for Medicare and Medicaid Services. September 10, 2024. Accessed September 23, 2025. https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/payment/rulemaking-schedule **6.** New medical services and new technologies. Centers for Medicare and Medicaid Services. September 10, 2025. Accessed September 24, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/new-medical-services-and-new-technologies **7.** Inpatient prospective payment system (IPPS). Centers for Medicare and Medicaid Services. September 10, 2024. Accessed September 24, 2025. https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/payment/ipps **8.** Long-term care hospital PPS. Centers for Medicare and Medicaid Services. August 1, 2025. Accessed September 24, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/long-term-care-hospital **9.** Inpatient rehabilitation facility PPS. Centers for Medicare and Medicaid Services. August 4, 2025. Accessed September 24, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation **10.** PPS-exempt cancer hospitals (PCH). Centers for Medicare and Medicaid Services. Accessed September 24, 2025. https://data.cms.gov/provider-data/topics/hospitals/pps-exempt-cancer-hospitals **11.** Outlier payments. Centers for Medicare & Medicaid Services. September 10, 2024. Accessed September 24, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/outlier-payments **12.** CMS releases FY 2026 hospital inpatient prospective payment system final rule. Michigan Health and Hospital Association. August 8, 2025. Accessed August 28, 2025. https://www.mha.org/newsroom/cms-releases-fy-2026-hospital-inpatient-prospective-payment-system-final-rule/ **13.** Outlier example FY2007. Centers for Medicare and Medicaid Services. Accessed October 18, 2024. https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/downloads/outlier_example_fy07.zip **14.** Acute inpatient PPS. Centers for Medicare and Medicaid Services. August 1, 2025. Accessed September 24, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps **15.** Outlier reconciliation. Centers for Medicare and Medicaid Services. September 10, 2024. Accessed September 24, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/outlier-reconciliation **16.** Inpatient psychiatric facility PPS. Centers for Medicare and Medicaid Services. August 4, 2025. Accessed September 25, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility **17.** CMS releases FY 2026 final rule for long-term care hospitals. American Hospital Association. July 31, 2025. Accessed September 25, 2025. https://www.aha.org/news/headline/2025-07-31-cms-releases-fy-2026-final-rule-long-term-care-hospitals **18.** Estimating Medicare payments. US Department of Veterans Affairs. April 22, 2025. Accessed September 25, 2025. https://www.herc.research.va.gov/include/page.asp?id=estimate-medicare-payments **19.** Medicare benefit policy manual: chapter 3—duration of covered inpatient services. Centers for Medicare and Medicaid Services. Accessed September 25, 2025. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c03pdf.pdf **20.** Medicare benefit policy manual: chapter 5—lifetime reserve days. Centers for Medicare and Medicaid Services. Accessed September 25, 2025. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c05.pdf

AURLUMYN®
(iloprost) Injection

Please see Indications and Important Safety Information on pages 1 and 2 and full Prescribing Information for AURLUMYN.

SERB Pharmaceuticals

US-AUR-2500074 12/25