Mesnex (mesna)

Override(s)	Approval Duration
Prior Authorization	1 year

Medications
Mesnex (mesna) tablets
Mesnex (mesna) intravenous solution

APPROVAL CRITERIA

Requests for Mesnex (mesna) may be approved if the following criteria are met:

I. Individual is using as a prophylactic agent in reducing the incidence of ifosfamide-induced hemorrhagic cystitis;

OR

II. Individual is using as a prophylactic agent in reducing incidence of hemorrhagic cystitis in those receiving high-dose cyclophosphamide (NCCN 2A).

Requests for **brand** Mesnex tablets must also meet the following criteria, in addition to the above Prior Authorization criteria:

I. Documentation is provided that individual has failed an adequate trial of one chemically equivalent generic mesna tablet agent. Medication samples/coupons/discount cards are excluded from consideration as a trial.; **AND**
   A. Generic mesna tablet had inadequate response; **OR**
   B. Generic mesna tablet caused adverse outcome; **OR**
   C. The individual has a genuine allergic reaction to an inactive ingredient in generic agent. Allergic reaction(s) must be clearly documented in the individual's medical record.

Key References:

1. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Updated periodically.
2. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
3. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2024; Updated periodically.
4. NCCN Clinical Practice Guidelines in Oncology™. © 2024 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp. Accessed on September 9, 2024
   a. Acute Lymphoblastic Lymphoma. V2.2024. Revised July 19, 2024.
   b. B-Cell Lymphomas. V3.2024. Revised August 26, 2024.
   c. Bladder Cancer. V4.2024. Revised May 9, 2024.
   d. Bone Cancer. V1.2025. Revised August 20, 2024.
   e. Gestational Trophoblastic Neoplasia. V2.2024. Revised August 19, 2024.
   f. Hematopoietic Cell Transplantation. V2.2024. Revised August 30, 2024.
   g. Hodgkin Lymphoma. V3.2024. Revised March 18, 2024.
   h. Neuroblastoma. V2.2024. Revised July 2, 2024.

i. Ovarian Cancer. V3.2024. Revised July 15, 2024.
j. Pediatric Acute Lymphoblastic Leukemia. V1.2025. Revised August 28, 2024.
k. Pediatric Aggressive Mature B-Cell Lymphomas. V2.2024. Revised September 3, 2024.
l. Pediatric Hodgkin Lymphoma. V1.2024. Revised May 14, 2024.
m. Penile Cancer. V1.2024. Revised October 25, 2023.
n. Primary Cutaneous Lymphomas, V3.2024. Revised August 22, 2024.
o. Soft Tissue Sarcoma. V2.2024. Revised July 31, 2024.
p. T-Cell Lymphomas. V4.2024. Revised May 28, 2024.
q. Testicular Cancer. V1.2024. Revised March 15, 2024.
r. Thymomas and Thymic Carcinomas. V1.2024. Revised November 21, 2023.
s. Uterine Neoplasms. V2.2024. Revised March 6, 2024.

Federal and state laws or requirements, contract language, and Plan utilization management programs or polices may take precedence over the application of this clinical criteria.