THESIS.HEALTH

# *The Field Guide to Peptides & Hormones*

A plain-language reference to the peptides and hormone support available through physician-supervised care — what they do, who they're considered for, and what they won't do.

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thesis.health · 2026

## THE THESIS

*A thesis is a foundational belief — one grounded in evidence, shaped by experience, and strong enough to stand on its own.*

It is the guiding idea that informs identity, behavior, and expression. Every person has a unique thesis formed by their history, habits, challenges, and circumstances. But it is not fixed. It can be rewritten, elevated, and strengthened through intentional action and the right inputs.

Your identity — the way you show up in the world — is shaped by what you consistently do, how you treat your body, and the principles you live by. With the right structure, tools, support, and personal commitment, your visible thesis becomes one of excellence, discipline, longevity, strength, vitality, and resilience.

This guide is one small part of that. It won't make you healthier on its own. But it will make you harder to sell to, and that's a real thing to be.

SECTION ONE

# *What changed*

For most of the last decade, if you wanted access to the compounds in this guide, you had exactly one path: order research-grade material online and figure out the rest yourself.

Dosing. Reconstitution. Titration. Cycling. Sterility. All of it resting on you, and on whatever the label happened to say. For some people that worked out fine. For others it didn't, and they never knew which they were until something went wrong.

That's not the only path anymore. A meaningful set of these compounds is now available through the clinical side of what we do — a licensed clinician evaluates whether something is appropriate for you, and a licensed pharmacy compounds it against that prescription.

Same molecules, completely different experience around them. You are not doing arithmetic at your kitchen counter with a vial of powder and a syringe. You are not guessing whether what arrived is what the label claimed, at the potency it claimed, free of the things you'd rather not inject. There is a prescriber accountable for the decision and a pharmacy accountable for the product — and there is someone to ask when a question comes up.

## *What happened in July*

On July 23rd and 24th, 2026, an FDA advisory committee met to review seven of the most widely used peptides. It voted to recommend six of them — including several in this guide — for the list of substances compounding pharmacies are permitted to prepare against a prescription. It did so over the objection of the FDA's own scientists, who had recommended against all seven.

That vote is a recommendation, not an approval, and the agency hasn't acted on it. But it's the clearest signal in years that compounds pushed to the margins in 2023 are moving back toward a pharmacy-based pathway rather than away from one.

> WORTH BEING PRECISE ABOUT
>
> Availability through a pharmacy is not the same thing as FDA approval, and this guide won't pretend otherwise. Anyone who blurs that distinction is selling you something.

SECTION TWO

# *How to read this guide*

Before you read a single compound page, I need you to understand the one idea that determines whether any of this works for you. Get it wrong and you will spend a great deal of money on very little.

## *The bucket*

Picture your body as a bucket, and your energy, health, and vitality as the water in it. The problem for most people my age isn't that the bucket is empty. It's that it's full of holes — poor sleep, chronic stress, insulin resistance, lost muscle, broken metabolic signals. Every one of those is a leak.

So what does everybody do? They pour more water in. A hard diet. A new supplement. More cardio. And some people skip straight to the powerful stuff — peptides, hormones — and pour that in too. For a few weeks the level comes up. Then it drains right back out, because nobody plugged the holes.

> *Compounds don't fill a leaking bucket. They multiply what a sealed one is already holding. That's the whole logic of this guide, and the reason the compound pages come after this one.*

This is why I'm careful about the phrase *force multiplier*. Don't hear "multiplier" as "minor" — a multiplier takes what's there and makes it dramatically more. But it also means that if what's there is a mess, you are multiplying a mess. The order is not negotiable. Foundation first, then the tools.

SECTION TWO, CONTINUED

# *What plugging the holes actually looks like*

Sealing a bucket isn't a slogan, it's five specific areas of work. This is the structure I use with the people I coach, and it's the reason the compounds land differently for them.

| | | |
|---|---|---|
| 01 | **Mindset & Identity** | You don't rise to your goals, you fall to your identity. This one gets skipped, and it's the one that holds the rest up. |
| 02 | **Lifestyle & Nutrition** | Food as an insulin event rather than a calorie event. Resistance training as a requirement, not a suggestion. |
| 03 | **The Force Multipliers** | Peptides and hormone support, under real supervision, layered on a foundation that's already holding. |
| 04 | **Data & Biometrics** | Labs, wearables, body composition. Not to drown you in numbers — to stop us both from guessing. |
| 05 | **Accountability** | Somebody paying attention. The thing almost nobody has, and the thing that decides whether any of it happens. |

Most people reading this will use the guide on their own, and that's genuinely fine — it's written to be useful that way.

A smaller number end up working with me directly, inside a private group where all five pillars get built deliberately over six months. That's a different thing, it isn't for everyone, and there's more about it near the back of this guide.

> ONE NOTE
>
> Inside the coaching group, compounds come through at pharmacy cost. No markup. That's not available otherwise, and it's deliberate — I'd rather be paid for your results than for your refills.

SECTION THREE

# *How this actually works*

This is the part most guides leave out, and it's the part I'd want to read first. There's a real process between reading a compound page and having anything arrive at your door — and it can end in no.

1

### *You start with data, not a shopping list*

Bloodwork first. Not because it's a formality, but because a compound page is a general description and you are a specific person. Half of what people think they need turns out to be a ferritin or a vitamin D problem.

2

### *A licensed clinician evaluates you*

They review your history, your labs, your medications, and your goals, and they determine whether anything here is appropriate for you. That decision is theirs. It is not mine, and it is not yours.

3

### *You can be declined*

This happens, and it should. Certain histories rule out certain categories. Some people are told the honest answer is sleep and resistance training. If a service can't say no to you, it isn't a clinical service.

4

### *A licensed pharmacy compounds against that prescription*

It arrives prepared, labeled, and with instructions. You are not reconstituting powder or calculating units.

5

### *Somebody stays reachable*

Questions come up at week three. That's when most protocols quietly fail — not from the compound, from the unanswered question.

## *Where I sit in this*

I want to be exact about my role, because the distinction matters and plenty of people in this space are deliberately vague about it.

**I am not a physician.** I don't diagnose, treat, or prescribe. I'm a coach and an educator. What I do is coordinate the whole picture — the labs, the lifestyle work, the data, the accountability — so that nothing happens in a vacuum, and so that the clinical decisions are made by clinicians with full context instead of in a seven-minute appointment.

My own background is not a medical one. I spent twenty years as a winemaker in Napa Valley, built that with no formal training through obsessive study and good mentors, and then did the same thing to my own health after building a business at the expense of it. That's the qualification I'll claim and the only one.

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## *How to use the pages that follow*

Each compound gets the same four things: what it does in plain language, an analogy to make it stick, who it tends to be considered for, and — the one nobody else prints — what it won't do.

You will not find doses or protocols here. That's deliberate. A dose without your labs and your history in front of it is a guess, and I'd rather give you nothing than give you a number to act on alone.

> READ THIS PART
>
> Everything described here is educational. It reflects what research associates with these compounds and what people commonly report, not a promise of what will happen to you. Individual responses vary enormously, and the honest answer for some readers is that none of this is the right next move.

SECTION FOUR

# *The twelve*

The compounds and combinations most recently added to the clinical side of what we offer — one page each, in plain language.

BODY HEALING
BPC-157

SKIN & TISSUE
GHK-Cu

CELLULAR ENERGY
MOTS-c

CELLULAR ENERGY
SS-31

LONGEVITY
Epithalon

GROWTH HORMONE
Tesamorelin

GROWTH HORMONE
CJC-1295 + Ipamorelin

IMMUNE
Thymosin Alpha-1

COGNITIVE & STRESS
Selank + Semax

STACK
Wolverine

STACK
Glow

STACK
KLOW

SEXUAL HEALTH
PT-141

BODY HEALING

# BPC-157

Body Protection Compound · Injection

> *You have a shoulder, a knee, or a back that has been almost better for two years.*

## WHAT IT DOES

BPC-157 is a short chain of amino acids based on a protective sequence found in your own stomach lining. Its main job is signaling repair — research associates it with new blood vessel formation into damaged tissue, which is how the raw materials for healing actually get delivered to a site that has stopped receiving them.

It has also drawn considerable research interest for the gut lining specifically, which is where the original sequence came from.

*Think of a stubborn injury as a construction site with no supply road. Materials exist, crews exist, but nothing reaches the site — so nothing finishes. BPC-157 builds the road.*

## WHO IT TENDS TO BE CONSIDERED FOR

People with nagging soft-tissue problems that never fully resolve — tendons, ligaments, the old injury you've stopped mentioning because you're tired of hearing yourself bring it up. It's the most requested compound in this entire category, and the reason is that the problem it targets is extremely common past forty.

## WHAT IT WON'T DO

Two things worth knowing. It works poorly alongside regular NSAID use — ibuprofen and naproxen damage tissue while BPC is signaling repair, so a meaningful share of the effect gets spent cleaning up after your Advil. And repair happens overnight. On five hours of sleep you have removed the window it depends on.

If you have a personal or family cancer history, that belongs in the conversation with the prescribing clinician before anything else. Not as a footnote.

Browse peptide therapy in the Thesis catalog ›

SKIN & TISSUE

# *GHK-Cu*

Copper Tripeptide-1 · Injection

> *Fifty years of published research, and most people have never heard of it.*

## WHAT IT DOES

GHK-Cu is a tripeptide — three amino acids — first isolated from human blood in 1973. It binds readily to copper, which your body needs for tissue repair, antioxidant defense, and connective tissue synthesis. Your natural levels of it fall by roughly sixty percent between age twenty and sixty.

What makes it unusual among peptides is breadth. Rather than acting on one narrow pathway, research associates it with modulating expression across thousands of genes involved in collagen and elastin production, tissue repair, and inflammatory signaling.

*Most compounds flip one switch. This one adjusts a whole control panel — which is either the most interesting thing about it or the reason it's hard to describe simply.*

## WHO IT TENDS TO BE CONSIDERED FOR

People whose interest is skin quality, elasticity, and visible tissue aging, and people who want repair support that isn't limited to one injury site. It's also among the more evidence-supported compounds in this guide, which is not something I can say about everything here.

## WHAT IT WON'T DO

Be careful reading GHK-Cu research. Most of the well-known human trial data — the collagen density and wrinkle numbers quoted everywhere — comes from topical creams at specific concentrations, not from injection. Different delivery routes, and the numbers don't transfer.

Injection also comes with things people aren't warned about: a burning sensation at the site lasting fifteen to twenty minutes, a temporary metallic taste, and occasionally a temporary blue or green discoloration of the skin. That last one is alarming if nobody tells you first. And because this delivers copper, more is emphatically not better — excess can accumulate and interfere with iron absorption.

Browse skin & hair health in the Thesis catalog ›

CELLULAR ENERGY

# *MOTS-c*

Mitochondrial Open Reading Frame · Injection

> *Your mitochondria make this themselves. They make roughly a fifth less of it than they used to.*

## WHAT IT DOES

MOTS-c is a signaling peptide your mitochondria produce. It's often described as an exercise mimetic, because research associates it with activating AMPK — the same cellular fuel-sensing pathway that responds to training and fasting — improving glucose utilization and shifting the body toward burning fat for fuel.

Levels decline measurably with age, and tend to run lower in people with metabolic disease. The people who would benefit most are generally walking around with the least of it.

*This isn't a stimulant and it won't make you feel wired. It changes how efficiently your cells use fuel — which people experience later as not crashing, rather than immediately as energy.*

## WHO IT TENDS TO BE CONSIDERED FOR

People whose issue is endurance and metabolic flexibility rather than acute injury — energy that fades under sustained load, crashes during a calorie deficit, recovery that takes longer than it should. It's also mechanistically distinct from GLP-1 medications, which work through appetite; these come at the same problem from opposite ends.

## WHAT IT WON'T DO

This is not a starting point. Clinicians who use it commonly treat it as a later layer, introduced after a foundation is established rather than as the first thing you reach for. There's also a sequencing argument that matters — see SS-31 on the next page, because running these in the wrong order is the most common way people waste both.

Some people report flushing or jitteriness. Human safety data remains limited.

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CELLULAR ENERGY

# SS-31

Elamipretide · Injection

> *It doesn't give you energy. It stops you losing the energy you're already making.*

## WHAT IT DOES

Inside every mitochondrion is an inner membrane lined with a fatty molecule called cardiolipin, and the energy-producing assembly line depends on that membrane holding its structure. Age, stress, and physical demand degrade it. When it degrades, the line leaks — and those leaks produce cellular exhaust that causes further damage.

SS-31 binds to cardiolipin and stabilizes that structure. It isn't adding capacity. It's clearing what was blocking the capacity you have.

*It doesn't pour more water into the bucket. It plugs the holes so you stop losing what you're already producing. Which is, not coincidentally, the same argument this entire guide is built on.*

## WHO IT TENDS TO BE CONSIDERED FOR

People past thirty-five with accumulated wear — persistent fatigue, brain fog, recovery that has quietly gotten worse. The common clinical view is repair before you optimize: stabilize the membrane with SS-31 first, then bring in MOTS-c to ask those mitochondria to work harder. Reverse that order and you're revving a broken engine.

## WHAT IT WON'T DO

There is no direct stimulant effect. Nothing happens twenty minutes after a dose, and people expecting that conclude it isn't working. The benefit is downstream of a structural repair, which takes weeks and shows up as a gradual absence of fatigue rather than a noticeable lift.

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LONGEVITY

# *Epithalon*

Epitalon · Injection

> *Every cell you have carries a countdown. This one is aimed at the countdown itself.*

## WHAT IT DOES

Your chromosomes end in protective caps called telomeres. Each time a cell divides, those caps shorten, and when they get short enough the cell stops dividing. That process is about as close to a molecular definition of aging as we have.

Epithalon is modeled on a substance secreted by the pineal gland. In cellular research it has been associated with upregulating telomerase, the enzyme that rebuilds those caps, and separately with circadian rhythm and melatonin regulation.

*Most of this guide is about how hard the system runs. This one is about how long the blueprint holds up. Different question entirely.*

## WHO IT TENDS TO BE CONSIDERED FOR

People whose priority is longevity rather than performance or an acute problem. It's typically approached as a short cycle run once or twice a year rather than something taken continuously, which makes it unusual among the compounds here. People running it commonly report deeper sleep as the most noticeable near-term effect.

## WHAT IT WON'T DO

Be honest with yourself about this one: you will likely not feel it working, and the outcome it targets is not measurable on any timeline that will satisfy you. Much of the supporting research is older, from a narrower body of work than the compounds earlier in this guide, and a good deal of the enthusiasm around it is anecdotal.

Browse longevity in the Thesis catalog ›

GROWTH HORMONE

# *Tesamorelin*

GHRH Analog · Injection

> *The fat around your organs behaves differently than the fat you can pinch.*

## WHAT IT DOES

Tesamorelin is an analog of growth hormone-releasing hormone. Rather than introducing growth hormone directly, it signals your pituitary to release more of your own — which preserves your natural pulse pattern and feedback loops instead of overriding them.

It's most associated with visceral fat: the deep abdominal fat that surrounds your organs and drives metabolic and cardiovascular risk in a way subcutaneous fat doesn't. There's a reason it targets that fat specifically — visceral fat carries more growth hormone receptors than the rest of your fat, so it's listening for this signal more intently.

Tesamorelin also differs from its neighbors structurally. Sermorelin and CJC-1295 are built from a fragment of the natural hormone; Tesamorelin is a full-length analog of it. That's the practical reason it behaves differently despite sitting in the same family.

*It walks up to the pituitary's front door and asks it to open. It doesn't break in, and it doesn't bypass the building.*

## WHO IT TENDS TO BE CONSIDERED FOR

People whose body composition problem is specifically central — the midsection that hasn't responded to weight loss elsewhere.

## WHAT IT WON'T DO

Growth hormone pathway compounds carry real considerations for anyone with a personal or family cancer history, because growth signaling doesn't distinguish between tissue you want to grow and tissue you don't. This category warrants an explicit conversation with the prescribing clinician and ongoing lab monitoring, and for some people the answer is simply no.

Allergic reactions to GHRH-class compounds are uncommon but documented, and some have been severe.

Browse peptide therapy in the Thesis catalog ›

GROWTH HORMONE

# *CJC-1295 + Ipamorelin*

GHRH Analog + Selective Secretagogue · Injection

> *The most popular stack in this space, and the one most people run wrong.*

## WHAT IT DOES

Your body releases growth hormone in pulses, governed by two opposing signals: GHRH tells the pituitary to release, and somatostatin tells it to stop. These two compounds work opposite ends of that system. CJC-1295 is a GHRH analog that amplifies the release signal. Ipamorelin binds ghrelin receptors and quiets the inhibitory one.

Ipamorelin is described as selective because, unlike older compounds in its class, it does this without meaningfully raising cortisol or prolactin or driving hunger.

*One walks up to the front door and asks the pituitary to open. The other goes around back and disables the alarm.*

## WHO IT TENDS TO BE CONSIDERED FOR

People whose goals are recovery, sleep quality, and body composition together — and who understand that the mechanism is amplifying your own natural pulses rather than forcing output your endocrine system wasn't going to produce.

## WHAT IT WON'T DO

Run carelessly, it stops working. Push it too hard and the body compensates by releasing more of the inhibitory signal, and further doses do progressively less. Timing relative to food and sleep matters more here than with most compounds in this guide — which is exactly the sort of thing you cannot get right by yourself off a forum post.

The same cancer-history considerations described under Tesamorelin apply fully here.

Browse peptide therapy in the Thesis catalog ›

IMMUNE

# *Thymosin Alpha-1*

Tα1 · Injection

> *There's an organ behind your breastbone that has been shrinking since you were a child.*

## WHAT IT DOES

Your thymus trains the immune cells that decide what your body attacks and what it leaves alone. It begins shrinking in childhood and keeps going, which is a large part of why immune function changes with age. Thymosin Alpha-1 is a peptide the thymus produces.

It's best understood as a regulator rather than a booster. Research associates it with restoring immune coordination — helping the response calibrate rather than simply amplifying it.

*Not an accelerator. A thermostat. It's aimed at a system that's badly calibrated, not one that's merely underpowered.*

## WHO IT TENDS TO BE CONSIDERED FOR

People whose immune function is measurably compromised — commonly by age or metabolic dysfunction. It is among the more extensively studied peptides here, with safety data across a very large number of human subjects, and it holds orphan drug designations for several conditions.

## WHAT IT WON'T DO

The largest randomized trial ever run on it missed its primary endpoint outright. The subgroup picture was more interesting — a signal of benefit in older patients and in patients with diabetes, and a signal of harm in patients under sixty — which is consistent with the mechanism but is not the same as proof.

The benefit is also not durable the way tissue repair is. It compensates for an ongoing decline, so when you stop, the support fades.

COGNITIVE & STRESS

# *Selank + Semax*

Nootropic Pair · Injection

> *One is aimed at the noise. The other is aimed at the fog.*

## WHAT IT DOES

These are paired because they address different halves of the same complaint. **Selank** has been studied for anxiety and for modulating an overactive cortisol response, with research comparing its effect to anxiolytic medications but without the sedation or dependence associated with that class.

**Semax** sits on the cognitive side — focus, memory, and mental endurance — and is associated with BDNF signaling, a growth factor involved in maintaining and building neural connections.

*Selank turns down the volume. Semax sharpens the picture. Most people arrive wanting one and discover the other was the actual problem.*

## WHO IT TENDS TO BE CONSIDERED FOR

People carrying a real cognitive load alongside real stress — the overthinking at two in the morning, the mental friction that makes ordinary decisions feel heavy, the fog that has been getting slowly worse and getting blamed on age.

## WHAT IT WON'T DO

Here's the thing almost nobody says about nootropics: the more dialed-in you already are, the less you will feel. These work on a gap. If you sleep well, train, and aren't chronically stressed, you may notice close to nothing — and the version of you that would feel the most is the version that should probably fix sleep first.

STACK

# *Wolverine*

BPC-157 + TB-500 · Injection

BPC-157 TB-500

> *The nickname did more for this combination's popularity than the research ever did.*

## WHAT IT IS

Not a distinct compound — a pairing of two repair peptides that work at different scales. You already met BPC-157: localized repair signaling, building the supply road into a specific damaged site.

**TB-500** works more systemically. It regulates actin, one of the fundamental building proteins of your cells, and acts as a kind of cellular scaffold that directs repair cells to migrate toward injury sites. Where BPC tends to be described as targeted, TB-500 is described as broad.

*BPC-157 is the specialist crew sent to one address. TB-500 is the crew working the entire job site. People pair them because most bodies past forty are not a single address.*

## WHO IT TENDS TO BE CONSIDERED FOR

People with accumulated wear rather than one clean injury — the training history that left four things half-healed, where treating any single one of them never quite resolves how the whole body feels.

One correction, because it's the most repeated myth here: you do not have to inject either compound near the injury. Both act systemically.

## WHAT IT WON'T DO

The NSAID and sleep caveats from the BPC-157 page apply here in full, and matter more — two compounds now depend on the same overnight repair window.

TB-500 also has notably thinner controlled human data than its popularity suggests. And the cancer-history conversation applies here — a nickname is not a safety profile.

Browse peptide therapy in the Thesis catalog ›

STACK

# *Glow*

BPC-157 + TB-500 + GHK-Cu · Injection

BPC-157 | TB-500 | GHK-Cu

> *Wolverine, plus the one that shows up where people can see it.*

## WHAT IT IS

The two repair peptides from Wolverine with GHK-Cu added. The logic is that the first two work on structural tissue — tendon, ligament, gut, muscle — while GHK-Cu extends the same repair theme outward into skin, collagen, and elastin.

The name is not subtle about who it's for. It's the most-searched of the combinations for exactly that reason.

*The first two rebuild the frame of the house. The third one handles the finish work. Same project, different trades.*

## WHO IT TENDS TO BE CONSIDERED FOR

Glow is the routine-recovery option: everyday wear, skin quality, scar and collagen work, and the deflated look that follows significant weight loss. If you're weighing this against KLOW on the next page, the dividing line is inflammation — Glow for ordinary recovery, KLOW when a lot of inflammation is expected.

## WHAT IT WON'T DO

All three components carry their own caveats and they stack rather than cancel: the NSAID interaction, the overnight repair dependency, the topical-versus-injection evidence problem, and copper accumulation if the GHK-Cu is overdone.

There's also a principle worth holding onto — running several compounds at once makes it genuinely impossible to know which one is doing what. Convenient, but it costs you information. And whatever you do, don't combine separate peptides into one syringe yourself.

Browse peptide therapy in the Thesis catalog ›

STACK

# *KLOW*

BPC-157 + TB-500 + GHK-Cu + KPV · Injection

BPC-157 | TB-500 | GHK-Cu | KPV

> *Glow with an anti-inflammatory added. The most comprehensive of the combinations, and the least selective.*

## WHAT IT IS

Everything in Glow, plus **KPV** — a three amino acid fragment of alpha-MSH, a hormone your body already makes. KPV is described as entering the cell nucleus and inhibiting NF-κB, which functions as a master on-switch for inflammation.

Steroids act on that same switch. The distinction people draw is one of scale: steroids suppress the whole immune system broadly, while KPV is characterized as turning down an oven that's running too hot. Much of the supporting work involves gut inflammation specifically, where its transport mechanism is highly active.

*The first three are repair. The fourth lowers the inflammation that was making repair harder in the first place.*

## WHO IT TENDS TO BE CONSIDERED FOR

KLOW is the higher-inflammation option. Where Glow suits routine recovery, this one is generally reserved for situations where a lot of inflammation is expected — significant tissue trauma, orthopedic surgery, major dental work — or for people whose picture involves inflammation alongside tissue damage rather than a mechanical injury on its own.

## WHAT IT WON'T DO

Be clear-eyed here. KPV's human data is genuinely thin — most of what's cited is animal research and anecdote. Everything said about Glow applies and more so: four compounds means four sets of considerations and no ability to attribute any result to any one of them.

This is the combination I'd be slowest to reach for first — not because it's worse, but because starting here tells you nothing about what you actually needed.

Browse peptide therapy in the Thesis catalog ›

SEXUAL HEALTH

# PT-141

Bremelanotide · Injection

> *Viagra works on plumbing. This one works on wanting to.*

## WHAT IT DOES

PT-141 acts on MC4 receptors in the hypothalamus, a region that governs sexual desire and arousal in both men and women. Activating those receptors triggers dopamine release, which amplifies the neural circuits that generate desire in the first place.

That's a genuinely different mechanism from PDE5 inhibitors like Viagra or Cialis, which increase blood flow downstream. This works upstream, on the signal itself.

*One of them opens the road. The other one is why you wanted to drive somewhere. They solve different problems, and people frequently have the second one.*

## WHO IT TENDS TO BE CONSIDERED FOR

People whose difficulty is desire rather than mechanics — including the substantial number who tried a PDE5 inhibitor and found it didn't address what was actually wrong. It has some of the strongest clinical trial data of anything in this guide, having been through phase three randomized controlled trials in both men and women. It's used situationally rather than daily.

## WHAT IT WON'T DO

Nausea is the commonly reported side effect and it isn't rare. And a compound that acts on desire cannot fix a problem whose actual origin is a relationship, chronic stress, sleep debt, or hormone levels that have quietly fallen — all of which are more common causes than anything PT-141 addresses. This is worth being honest with a clinician about, because the useful answer is often somewhere else entirely.

Browse sexual health in the Thesis catalog ›

SECTION FIVE

# *Everything else*

The twelve are the newest additions — not the whole of what a clinician can prescribe through us.

The rest spans metabolic support, hormone optimization, and several categories that matter considerably more to most people than anything in the previous section. Here's how it's organized.

*Peptide Therapy*
The largest category. GLP-1s, growth hormone support, and the compounds covered earlier.

*Body Composition*
Fat loss and lean mass. Overlaps heavily with peptide therapy.

*Performance & Recovery*
Energy, recovery capacity, inflammation balance.

*Longevity*
Cellular energy, oxidative stress, healthy aging.

*Women's Hormonal Health*
Estradiol, progesterone, and low-dose testosterone.

*Men's Hormonal Health*
Testosterone and the supporting compounds that go with it.

*Sexual Health*
Overlaps with both hormonal categories, because that's usually where the answer is.

*Skin & Hair Health*
Topical copper peptide work.

The next four pages cover the areas where the choice is least obvious. Everything else is straightforward enough that a clinician can walk you through it directly.

See the full Thesis catalog ›

BODY COMPOSITION

# *Tirzepatide*

Dual GIP / GLP-1 Agonist · Three Formats

Tirzepatide acts on two metabolic pathways rather than one, which is what separates it from the single-agonist GLP-1s. The decision most people actually face isn't whether to take it — it's which of these three you're taking, and they are not the same product with different numbers on them.

### *Full Dose*

WEEKLY INJECTION

The standard approach. Strongest appetite effect of the three — it reduces hunger, quiets food noise, and supports steady fat loss.

This is what most people mean when they talk about being "on a GLP-1."

*For meaningful weight loss as the primary goal.*

### *Microdose*

WEEKLY INJECTION

A different goal, not a smaller version of the same one. At low dose the target is metabolic — insulin sensitivity, inflammation, glucose control — rather than appetite.

You will not get dramatic appetite suppression here, and that's the design.

*For metabolic health when weight isn't the main problem.*

### *Oral*

DAILY SUBLINGUAL

Dissolves under the tongue. No needles, taken daily instead of weekly, and available at either full or microdose strength.

The trade is consistency — a daily habit is easier to miss than a weekly one.

*For people who won't inject, and know it.*

Injectable formats pair with either B12 or glycine — a formulation detail, not a fourth decision.

**BEFORE YOU START ANY OF THESE**

Weight dropping is not the same as body composition improving. A meaningful share of what people lose on a GLP-1 can be lean mass — muscle and bone — and the scale makes that look like winning. My free eight-part course covers this in Lesson 3.

The GLP-1 education course ›

Browse body composition in the Thesis catalog ›

BODY COMPOSITION

# *Semaglutide*

GLP-1 Agonist · Three Formats

Semaglutide works on the GLP-1 pathway alone. It's the more established of the two — a longer track record and more accumulated clinical experience — and for many people it's the more appropriate starting point. It comes in the same three formats.

### *Full Dose*

WEEKLY INJECTION

The standard weekly injection. Reduces appetite, quiets cravings, and supports steady weight loss.

Generally the first thing a clinician reaches for unless there's a reason to do otherwise.

*For weight loss as the primary goal.*

### *Microdose*

WEEKLY INJECTION

Low dose, aimed at metabolic health rather than appetite — insulin sensitivity, inflammation, and glucose regulation.

Increasingly used by people whose labs are drifting but whose weight is manageable.

*For metabolic support without the full effect.*

### *Oral*

DAILY SUBLINGUAL

Needle-free, dissolves under the tongue, taken daily. Available at full or microdose strength.

Same trade as the tirzepatide version — daily habits are easier to break than weekly ones.

*For people who won't inject.*

**BEFORE YOU START ANY OF THESE**

Weight dropping is not the same as body composition improving. A meaningful share of what people lose on a GLP-1 can be lean mass — muscle and bone — and the scale makes that look like winning. My free eight-part course covers this in Lesson 3.

The GLP-1 education course ›

## CHOOSING BETWEEN THE TWO

Tirzepatide hits two pathways and tends to produce a stronger appetite response. Semaglutide has the longer record. Neither is universally better — that depends on your labs, history, and tolerance.

Browse body composition in the Thesis catalog ›

WOMEN'S HORMONAL HEALTH

# *Hormone support for women*

> *For a lot of women past forty, this is the highest-impact thing in this entire guide. It is not a peptide.*

Perimenopause and menopause change energy, sleep, mood, recovery, libido, and body composition all at once — and because it happens gradually, it usually gets attributed to age, stress, or work. Restoring what's declined, under physician supervision and with real labs behind it, produces the kind of change people describe as getting themselves back.

### *Estradiol*

TOPICAL CREAM, DAILY

The primary estrogen. Associated with relief from hot flashes, night sweats, and the sleep disruption that comes with them.

### *Vaginal Estradiol*

LOW-DOSE TOPICAL CREAM

A localized low-dose form for dryness, discomfort, and urinary symptoms tied to menopause.

### *Progesterone*

ORAL, DAILY

Often taken alongside estrogen. Frequently reported to help with sleep and mood as much as with hormone balance.

### *Testosterone*

TOPICAL GEL OR WEEKLY INJECTION

Low-dose, and routinely overlooked in women. Associated with libido, energy, and overall wellbeing. Requires recent labs.

## WHAT THIS REQUIRES

Current bloodwork, not a symptom checklist. Hormone decisions belong with a physician who can see your numbers and your history — this is the category where guessing does the most damage, and where the internet is least useful.

Browse women's hormonal health in the Thesis catalog ›

MEN'S HORMONAL HEALTH

# *Hormone support for men*

> *The flat, gray, tired feeling that everyone calls getting older. Often it isn't.*

Testosterone declines with age, and the symptoms are easy to write off one at a time — energy that used to be automatic, workouts that stop producing, mood that's slightly off, drive that's faded in every sense. Taken together and confirmed on labs, that's a treatable picture rather than an inevitable one.

### *Testosterone*

WEEKLY INJECTION OR DAILY CREAM

Cypionate by injection, or a topical cream. For men with documented low testosterone. Requires recent labs.

### *Enclomiphene*

ORAL, DAILY

A different approach — rather than supplying testosterone, it supports your own production while preserving fertility.

### *hCG*

WEEKLY INJECTION

Supports natural production and fertility, commonly used alongside testosterone therapy rather than instead of it.

### *Anastrozole*

ORAL, AS DIRECTED

Used with testosterone therapy to manage estrogen levels. Supporting cast, not a starting point.

## WORTH KNOWING BEFORE YOU START

Testosterone therapy is a commitment, not an experiment — starting it affects your own production, and the decision to begin deserves more thought than the decision to try a peptide. If fertility matters to you now or later, say so at the first conversation, because it changes the approach.

Browse men's hormonal health in the Thesis catalog ›

PERFORMANCE, RECOVERY & LONGEVITY

# *The supporting cast*

Less discussed than the compounds earlier in this guide, and for several people more useful. These are single-purpose, well-established, and generally straightforward decisions.

### *NAD+*

WEEKLY INJECTION

A coenzyme central to cellular energy production. Availability declines with age. Associated with mental clarity, focus, and healthy aging.
It's the third piece of the mitochondrial sequence covered earlier: SS-31 repairs the structure, MOTS-c optimizes the output, NAD+ supplies the fuel. Running it alongside either of those is the common approach. It's also typically cycled off after a stretch rather than run continuously, since the body adapts to it.

### *Sermorelin*

NIGHTLY INJECTION

The gentlest of the growth hormone pathway options and the most established. Signals your pituitary rather than overriding it.
Nightly and fasted is the point, not a preference — your largest natural growth hormone pulse happens overnight, and eating close to the injection blunts the thing you just paid for. Most people who report nothing from it were eating into that window.

### *Glutathione*

TWICE-WEEKLY INJECTION

A naturally occurring antioxidant your body already produces, often described as its primary one. Associated with detoxification pathways, immune function, and skin clarity.
This is a quiet one. Nobody reports a dramatic day-one effect, and anyone promising you one is overselling it.

### *Low-Dose Naltrexone*

ORAL, DAILY

The same molecule used at roughly a tenth of its conventional dose, where it behaves in a completely different way. Associated with inflammation balance, pain modulation, and sleep.
Effects tend to build over weeks rather than days, and some people find sleep gets stranger before it gets better. Worth knowing going in.

### *Lipo-Mino*

WEEKLY INJECTION

A blend of lipotropic compounds and B vitamins aimed at energy and metabolic support.
I'll be straight about this one: it's a supportive add-on, not a driver. If it's the only thing on your list, the list is wrong.

### *GHK-Cu Cream*

TOPICAL, 0.5%

The topical form of the copper peptide covered earlier — and notably, the form most of the well-known human skin research was actually done on.
If your interest is skin specifically rather than whole-body repair, this is arguably the better-evidenced choice of the two, and the easier one to live with.

Browse performance & recovery in the Thesis catalog ›

SECTION SIX

# *Working with me directly*

Everything in this guide is available to anyone a clinician clears. That's the point of it, and I'd rather you use it well on your own than not at all.

There's a smaller thing I also do, and I'm deliberately not going to oversell it here.

A limited number of people work with me directly over six months — all five pillars built in order, labs and biometrics reviewed continuously, protocol sequencing designed around their data rather than around a page in a guide, and somebody paying close enough attention to catch a drift before it becomes a plateau. It's white-glove, and it's capped, because doing it properly takes real time from me and my team.

It isn't for everyone, and I turn down more people than I take. The ones who do well are the ones who arrive already decided — not curious, not *after the holidays*, but done. If that isn't where you are yet, the guide stands on its own and this will be here later.

If it is where you are, the video on the next page explains how the whole thing works, and there's a way to reach me at the end of it.

# *Where to go from here*

If you've read this far, you're not browsing. So let me be straight about the next step instead of dressing it up.

Here's what I'd want you to notice: this entire guide covers one pillar. The compounds. That's the third of five, and on its own it's the one that does the least — because a force multiplier applied to a leaking bucket is just an expensive way to lose water faster.

The other four are where the change actually happens, and I can't fit them in a document like this. So I recorded them.

## *Watch the five pillars*

The whole system, start to finish — how the pillars fit together, why the order matters, and why fixing them out of sequence is where most people stall. About thirty minutes, free, and there's a way to reach me at the end of it.

**Tap here to watch ›**

Questions before then? Reply to the email this guide arrived in. It comes to me.

*If you built your business at the expense of your biology — and you know the bill is coming due — it's time to fix your health before it's too late.*

## EDUCATIONAL PURPOSE

This guide is provided for educational and informational purposes only. It does not constitute medical advice, diagnosis, treatment, or therapeutic guidance, and it is not a substitute for consultation with a qualified healthcare provider. Content reflects research contexts and commonly reported subjective experiences. No outcome is promised, implied, or guaranteed, and individual responses vary considerably.

## NOT A PHYSICIAN

Jason Moore is a wellness coach and educator. He is not a licensed medical provider and does not diagnose, treat, prescribe, or provide medical care of any kind. All clinical decisions described in this guide are made by licensed clinicians exercising independent professional judgment.

## PRESCRIPTION AND ELIGIBILITY

Availability of any compound described here is determined solely by a licensed clinician following individual evaluation, and is subject to that clinician's judgment regarding appropriateness. Inclusion in this guide does not indicate that any product is suitable, available, or advisable for any particular reader. Requests may be declined.

## REGULATORY STATUS

Compounded preparations are not FDA-approved products. FDA approval, removal from restricted compounding lists, advisory committee recommendation, and placement on approved compounding lists are legally distinct events and should not be treated as equivalent. Regulatory status in this area is subject to change; nothing in this guide should be read as a representation of the current approval status of any substance.

## CANCER HISTORY AND GROWTH SIGNALING

Compounds affecting growth hormone or growth factor signaling warrant specific discussion with a prescribing clinician for anyone with a personal or family history of cancer. This guide does not evaluate individual suitability and should not be relied upon for that purpose.

## NO DOSING GUIDANCE

This guide intentionally contains no dosing, administration, cycling, or protocol information. Such decisions require individual clinical evaluation and should never be made from general educational material.

## PRICING

No pricing information is contained in this guide. Costs are discussed individually and are subject to change.