Testosterone Therapy in Women

Prescriber Reference · Compounded Options from The Medicine Shoppe

Patient flyer available — ask us for a copy to display in your practice.

Clinical Rationale

Testosterone is the most abundant biologically active steroid in premenopausal women, produced by the ovaries and adrenal glands. Serum levels begin declining in the mid-30s and may fall by **50% or more by menopause.** Surgical menopause (oophorectomy) causes an abrupt deficit. Testosterone supports sexual desire and arousal, lean muscle mass, bone density, mood, motivation, and cognitive sharpness. Standard HRT (estrogen ± progesterone) does not replace testosterone, and a meaningful subset of women on HRT report persistent symptoms attributable to androgen insufficiency.

Clinical Indications / Patient Selection

- Hypoactive sexual desire disorder (HSDD) — strongest evidence base for testosterone in women
- Persistent fatigue, low motivation, or cognitive complaints not resolved by estrogen therapy
- Low total or free testosterone on laboratory evaluation with consistent symptoms
- Post-oophorectomy androgen insufficiency (natural or surgical menopause)
- Women already on estrogen ± progesterone who report incomplete symptom relief

Note: No FDA-approved testosterone product currently exists for women in the United States. Off-label compounded therapy is the standard approach.

Laboratory Evaluation

Test	Timing	Notes
Total testosterone	Baseline; recheck 4–8 weeks after initiation, then q6–12 months	Morning draw preferred; use same lab for consistency
Free testosterone	Baseline; follow if SHBG is elevated	Equilibrium dialysis method preferred over calculated
SHBG	Baseline — especially if on oral estrogen	Oral estrogens raise SHBG and lower free testosterone
Hematocrit / CBC	Baseline; monitor annually	Erythrocytosis rare at female-range doses but worth tracking
LFTs (if oral)	Baseline + 3–6 months on methyltestosterone capsule	Routine LFT monitoring advised for oral route due to first-pass metabolism
Lipid panel	Baseline; annually	Methyltestosterone may lower HDL at higher doses; monitor

Compounded Formulations Available

Feature	Methyltest. Capsule	Methyltest. Topical	Testosterone Topical	Considerations
Route	Oral — once daily	Applied to skin daily	Applied to skin daily	Patient preference drives route selection

Feature	Methyltest. Capsule	Methyltest. Topical	Testosterone Topical	Considerations
Liver first-pass	✗ Subject to hepatic metabolism — routine LFTs advised	✓ Bypasses first-pass via skin	✓ Bypasses first-pass via skin	Topical preferred when hepatic monitoring is a concern
Compound type	Methyltestosterone (synthetic androgen)	Methyltestosterone (synthetic androgen)	**Bioidentical testosterone**	Bioidentical preferred by many patients and prescribers
Typical dose range	0.25 mg · 0.5 mg · 1 mg · 1.25 mg once daily	0.5–2 mg per daily application	0.5–2 mg per daily application	Start low; titrate based on symptoms and labs
Best for	Women preferring a once-daily oral option	Women wanting topical with a familiar synthetic compound	Women wanting bioidentical testosterone topically	Discuss options with patient; shared decision-making

Dosing & Titration Guidance

- Start at the lowest effective dose — 0.25–0.5 mg/day oral or 0.5 mg/day topical
- Reassess symptoms at 4–8 weeks; check testosterone levels before dose adjustment
- Target total testosterone in the mid-to-upper premenopausal normal range (not supraphysiologic)
- Most women respond within 4–12 weeks; full effect on libido may take 3–6 months
- Avoid supratherapeutic dosing — androgenic side effects are dose-dependent

Monitoring for Androgenic Side Effects

At female-range doses, androgenic side effects are uncommon but should be assessed at follow-up:

- Acne or oily skin — usually mild; dose reduction often resolves
- Increased facial or body hair (hirsutism) — rare at physiologic doses
- Clitoral sensitivity or enlargement — monitor; typically reversible with dose reduction
- Voice deepening — rare; permanent if prolonged — discontinue promptly if noted
- Mood changes or increased aggression — uncommon at low doses

If any androgenic effects emerge, reduce dose or switch formulation before discontinuing entirely.

Contraindications & Precautions

- Active or suspected androgen-sensitive malignancy (e.g., certain breast cancers)
- Pregnancy or breastfeeding
- Significant hepatic impairment (particularly for oral methyltestosterone)
- Uncontrolled polycythemia
- **Use with caution:**
- **Use with caution:** Women with a history of hormone-sensitive cancers, cardiovascular disease, or metabolic syndrome — individualize risk-benefit assessment.

How to Prescribe — The Medicine Shoppe

Sample Rx Language

Testosterone 1 mg/mL topical cream — Apply 0.5 mL (0.5 mg) to inner forearm or thigh once daily. #30 mL. Refills 3.

Methyltestosterone 0.5 mg capsule — Take 1 capsule orally once daily. #30 capsules. Refills 3.

Send to us: Phone (717) 846-0500 · Fax (717) 845-8767 · E-prescribe (NCPDP/Surescripts) · 1698 S Queen St, York PA 17403

Please note: Testosterone is a controlled substance. Per DEA regulations, a faxed prescription must contain a 'wet' signature (not computer generated) and a DEA number.

Evidence Summary

Key references supporting testosterone use in women include:

- Davis SR et al. (2019) — Global Consensus Position Statement on testosterone therapy for women (J Clin Endocrinol Metab). Supports use for HSDD with monitoring.
- Islam RM et al. (2019) — Systematic review and meta-analysis: testosterone improves sexual function, wellbeing, and lean body mass in women (Lancet Diabetes Endocrinol).
- Traish AM et al. — Multiple reviews on androgen deficiency in women and the role of compounded low-dose testosterone.
- Endocrine Society Clinical Practice Guideline — Recommends against routine use for conditions other than HSDD pending further evidence; supports use in appropriate candidates with informed consent.

No FDA-approved female testosterone product is currently marketed in the US. Compounded therapy fills a recognized clinical gap.

Questions? Our pharmacists are available to consult on formulation selection, dosing, and monitoring.

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