USER GUIDE · VERSION 1.0

The Peptide User Guide

Dosing, reconstitution and safe handling for every product we stock. Written so a first vial is not frightening, and so the numbers are still there when you already know what you are doing.

PRODUCTS COVERED
16

UPDATED
August 2026

SUPPLIED FOR
Laboratory & research use

Read this before you use anything in this guide

This guide exists because customers kept asking the same questions and deserved a straight answer instead of a shrug. It sets out, in plain terms, the doses and protocols that appear in published clinical trials and in established clinical practice for each product we stock.

It is not medical advice and it is not a substitute for a doctor. We have never met you. We do not know your medical history, your bloodwork, your medications or your goals. A guide cannot do what a consultation does.

Most of the compounds listed here are Schedule 4 (prescription-only) substances in Australia. Two of them, retatrutide and SLU-PP-332, are not approved for human use anywhere in the world. Everything we sell is supplied for laboratory and research use.

What you do with it is your decision and your responsibility, and the sensible version of that decision involves a clinician who can order bloods and follow you over time.

IF YOU TAKE ONE THING FROM THIS PAGE

Start at the lowest dose listed, not the highest.

Almost every bad experience people report with peptides comes from starting too high, escalating too fast, or stacking several compounds at once before knowing how any single one affects them.

STOP AND SEEK MEDICAL ATTENTION IF

- Severe abdominal pain that persists or radiates through to your back — this can indicate pancreatitis and is the most serious risk associated with the GLP-1 class.
- An injection site that becomes hot, hard, spreading-red or produces discharge — that is an infection, not a normal reaction.
- Chest pain, or a racing heart rate that does not settle at rest.
- New lumps, or existing lumps that change rapidly — particularly in the neck.
- Any sign of an allergic reaction: rash, hives, swelling of the face, lips or tongue, wheezing or difficulty breathing. Treat this as an emergency.
- Persistent vomiting, or an inability to keep fluids down for more than 24 hours.
- Sudden changes to your vision.

Contents

PART ONE — GETTING STARTED

PART TWO — THE PRODUCTS

PART THREE — REFERENCE

NEW TO THIS?

Read part one straight through once. It takes about ten minutes and covers everything that applies to every product: mixing a vial, working out a dose, injecting it and storing it.

BEEN HERE BEFORE?

Every product opens with a dose strip across the top, and the quick reference on page 47 puts all sixteen on a single page.

Getting started

Everything that applies to every product: what to buy, how to mix a vial, how to work out a dose, how to inject it and how to store it.

What you need

Six things. None of them expensive, and most pharmacies stock the lot.

Bacteriostatic water, 10 mL	The 0.9% benzyl alcohol is the preservative that makes repeat needle entry safe. Not interchangeable with sterile water.
U-100 insulin syringes 29–31 G, 8 mm	The 100-unit scale is what every dose in this guide is calculated against. An 8 mm needle is right for subcutaneous injection.
A 3 mL syringe 21–23 G needle	Optional, but drawing several millilitres of water through an insulin needle is slow. A larger needle makes reconstitution quicker.
Alcohol swabs	Two per injection: one for each vial stopper, one for the skin.
A sharps container	A rigid, puncture-proof container. Australian pharmacies and councils accept full ones. Never put needles in household rubbish.
Fridge space at 2–8°C	On a shelf, not in the door. The door swings several degrees every time it opens.

THE ONE RULE PEOPLE BREAK

Never shake a reconstituted vial.

Rolling it gently between your palms achieves the same thing without shearing the peptide or foaming the solution.

BACTERIOSTATIC WATER · 10 ML

Reconstituting a vial

Adding liquid to freeze-dried powder so it can be measured and injected. It takes about two minutes, and there are only two ways to get it badly wrong: shaking the vial, and losing track of how much water you added.

1

Bring the vial to room temperature

Take it out of the fridge about 20 minutes beforehand. Cold powder dissolves slowly and unevenly.

2

Tap the powder down

Flick the vial gently so the powder settles at the bottom rather than clinging to the stopper. Lyophilised peptide is light and often sits high after shipping.

3

Swab both stoppers

Wipe the rubber top of the peptide vial and the bacteriostatic water vial with alcohol. Let them air dry — injecting through wet alcohol stings.

4

Equalise the pressure

Pull the plunger back to your target volume with air, inject that air into the water vial, then invert and draw your water. This stops the vacuum that otherwise fights you.

5

Run the water down the wall

Insert the needle into the peptide vial at an angle so the stream hits the glass, not the powder. Firing water directly into the powder shears the peptide.

6

Swirl, never shake

Let it sit for 30–60 seconds, then roll the vial gently between your palms. Shaking breaks peptide bonds and whips the solution into foam.

7

Check it is clear

Wait until the solution is completely clear. Some peptides take several minutes. If it is still cloudy, or has visible particles after 10 minutes, do not use it.

8

Label the vial

Write the contents, how much water you added, the resulting concentration and the date. In four weeks you will not remember, and guessing a concentration is how people take ten times the dose they intended.

9

Refrigerate

Straight into the fridge at 2–8°C once mixed.

STEP 6 MATTERS MOST Shaking is the single most common mistake, and it is invisible: the solution looks fine and simply does less than it should. Roll, do not shake.

The dosing maths

You will not actually need this — every product page gives you the answer — but it is worth understanding once.

THE ONE FORMULA

mcg per unit = (mg ÷ mL) × 10

A U-100 insulin syringe holds 1 mL, marked as 100 units. One unit is 0.01 mL.

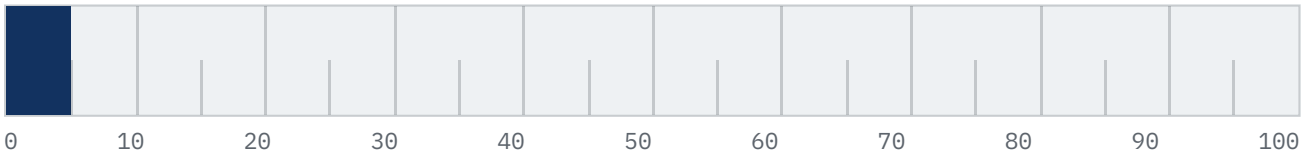
Less water gives a stronger solution, so each dose is fewer units — but small doses become harder to measure accurately. More water is easier to measure precisely, at the cost of a larger injection volume.

Anything above about 50 units (0.5 mL) is an uncomfortably large subcutaneous injection. Split it across two sites, or inject intramuscularly.

WORKED EXAMPLE

You have	a 10 mg vial
You add	2 mL of bacteriostatic water
So	10 mg ÷ 2 sc-camel-m-l = 5 mg/mL
And	5 × 10 = 50 mcg per unit
A 250 mcg dose is	250 ÷ 50 = 5 units

WHERE 5 UNITS SITS ON THE SYRINGE



Every product entry in part two gives you a recommended water volume and the resulting micrograms per unit, so in practice you read the dose straight off the dose card without doing any arithmetic yourself.

Video walkthroughs

Reading about this is less useful than watching it once. These are independent tutorials — we have no affiliation with any of them.

RECONSTITUTION

Reconstituting Your Peptides — Self Administration

Travis Thurston, ND

The clearest end-to-end walkthrough. Start here if you have never done this before.

youtube.com/watch?v=KQJxfVAsXfA

Doctor Explains How To CORRECTLY Prepare And Inject Your Peptides

Dr. Jones, DC

Good coverage of the mistakes people make — particularly shaking and pressure equalisation.

youtube.com/watch?v=L65S1xmKY44

Step-by-Step Guide: How to Reconstitute Peptides

Dr. Rimka

Worked through with a 5 mg vial, the most common size you will handle.

youtube.com/watch?v=2jvkuL0fpzs

Peptide Reconstitution Instructions

Movement Clinic

Short and practical. Useful as a refresher rather than a first watch.

youtube.com/watch?v=b08QwxZW0Ig

How to Reconstitute Peptides

AJAC

An alternative take on the same process, if the others do not click.

youtube.com/watch?v=efPtqH_NZVU

SUBCUTANEOUS INJECTION TECHNIQUE

How To Give Injections: Insulin (Subcutaneous)

Weber State University

Teaching-grade demonstration with an insulin syringe.

youtube.com/watch?v=e7EyFmY7B7A

Subcutaneous Injections

Roswell Park Cancer Center

Patient-education video from a hospital. Calm and thorough on site selection.

youtube.com/watch?v=LNXOFKjTPJc

Subcutaneous Injection (Insulin)

Open RN / WisTech

From an open-access nursing skills textbook. Precise on angle and pinch technique.

youtube.com/watch?v=H0EtSorwGnU

How to Give a Subq Subcutaneous Injection Shot

RegisteredNurseRN

Focused on the abdomen, which is the site most people will use.

youtube.com/watch?v=8MPdw-0HbTg

Injection technique

1. Wash your hands.
2. Choose a site and swab it. Let the alcohol dry completely.
3. Draw your dose. Tap out any large air bubbles — tiny ones are harmless in subcutaneous tissue and are not worth chasing.
4. Pinch up a fold of skin between thumb and finger.
5. Insert the needle at 90° if you have a reasonable layer of subcutaneous fat, or 45° if you are lean.
6. Depress the plunger slowly and steadily. Fast injection is what makes a site sting.
7. Withdraw the needle, release the pinch, and press lightly with a clean swab. Do not rub.
8. Put the needle straight into the sharps container. Never recap it.

Sites and rotation

Divide each zone into a grid and work through it systematically. Do not return to the same spot within two to three days.

Lower abdomen BEST

At least two finger-widths (about 5 cm) from the navel. The most reliable site for most people.

Upper outer buttock

Easy to reach with a hand behind you.

Outer thigh

The fleshy area on the front and outside.

Back of the upper arm

Awkward to reach on yourself.

A ROTATION GRID

Work left to right, top to bottom. Sixteen spots in one zone is more than two weeks before you repeat one.

WHY IT MATTERS Injecting repeatedly into one place causes lipodystrophy: permanent dents in the fat layer that also stop the compound absorbing properly.

Storage and shelf life

Two temperatures and one date on a label. That is the whole discipline.

Unopened powder

Refrigerate at 2–8°C, away from light. Most lyophilised peptides survive shipping at ambient temperature perfectly well, but they belong in the fridge as soon as they arrive. For storage beyond six months, use the freezer.

After reconstitution

Fridge at 2–8°C, always. Twenty-eight days is the working limit. That number comes from USP guidance on how long a preservative can be relied on in a repeatedly punctured multi-dose vial, not from the peptide degrading on day twenty-nine — but it is the right rule to follow.

Never freeze a reconstituted vial

Ice crystals destroy peptide structure. Freezing applies to dry powder only.

Travel

An insulated pouch with a cold pack is enough. A few hours at room temperature will not ruin a reconstituted vial, but do not leave one in a hot car.

When to throw it out

Cloudiness, discolouration, floating particles, or any uncertainty about how long it has been open. A discarded vial costs less than an infection.

2–8°C
Fridge, on a shelf — not in the door

28 days
Working life of a reconstituted vial

Never
Freeze anything already mixed

LABEL EVERY VIAL THE MOMENT YOU MIX IT

01 What is in it

02 How much water you added

03 The resulting mcg per unit

04 The date you mixed it

The products

One entry for each of the sixteen products we stock. Doses are given both as an amount and as units on a standard U-100 insulin syringe, calculated against the water volume recommended in the same entry.

BPC-157 + TB-500

One peptide builds the blood supply, the other moves the repair cells in.

• WADA PROHIBITED

20 MG BLEND

WATER TO ADD	PER UNIT	STANDARD DAILY	ACUTE, 2 WEEKS	VIAL LASTS
4 mL	50 mcg	10 units	20 units	40 days

U-100 SYRINGE — 10 units

WHAT IT IS

BPC-157 is a fifteen-amino-acid peptide derived from a protective protein found in gastric juice. TB-500 is a synthetic fragment of thymosin beta-4. They are paired because they attack the repair problem from two different directions: BPC-157 drives angiogenesis and upregulates growth factor receptors, while TB-500 acts on actin to promote cell migration into the damaged area.

WHAT THE EVIDENCE ACTUALLY SHOWS

Extensive animal data, essentially no controlled human trials. BPC-157 has been studied in rodents for tendon-to-bone healing, ligament repair, gastrointestinal lesions and nerve regeneration with consistently positive results. The absence of human trials is the honest limitation here — the safety record in people is anecdotal rather than measured.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Inject 10 units once daily. For an acute injury, run 20 units daily for the first two weeks and then drop back to 10. Where the injury is localised and reachable, inject as close to the site as is practical — the compound distributes systemically regardless, but proximity appears to help.

REPORTED BENEFITS

- Accelerated healing of tendon, ligament and muscle injuries in animal models
- Gut protection and repair — BPC-157 was originally characterised for gastric ulcer healing
- Reduced inflammation around an injury site
- Improved recovery between training sessions

TIMING

Any time of day. Consistency matters more than timing.

CYCLE

4–6 weeks acute. 8–12 weeks chronic, then four weeks off.

SIDE EFFECTS

- Mild redness or itching at the injection site
- Occasional light-headedness in the first few minutes
- Mild nausea, uncommon

DO NOT USE IF

- Active or suspected cancer — both peptides promote angiogenesis, and anything that builds blood supply is a theoretical risk where a tumour is present
- Pregnancy or breastfeeding

KLOW Blend

A four-peptide cosmetic and repair blend in the GLOW family, built around GHK-Cu.

• WADA PROHIBITED

80 MG BLEND

WATER TO ADD	PER UNIT	STARTING DOSE	STANDARD DOSE	UPPER END	VIAL LASTS
5 mL	160 mcg	15 units	20 units	25 units	~25 days

U-100 SYRINGE — 20 units

WHAT IT IS

KLOW combines a copper peptide with repair and anti-inflammatory peptides in a single vial: GHK-Cu for collagen and matrix remodelling, BPC-157 and TB-500 for angiogenesis and cell migration, and KPV — a tripeptide fragment of alpha-MSH — for its anti-inflammatory action. The intent is layered: rebuild the matrix, supply it with blood, move cells in, and keep inflammation down while it happens.

WHAT THE EVIDENCE ACTUALLY SHOWS

Each component has its own literature — GHK-Cu is well studied in dermatology, BPC-157 and TB-500 in animal repair models, KPV in inflammatory bowel research. The blend itself has not been trialled as a combination. You are relying on the parts, not the whole.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Start at 15 units daily for the first week to check tolerance, then move to 20 units daily. Inject subcutaneously. For cosmetic and skin goals, some people inject into the subcutaneous layer of the target area rather than a general site.

REPORTED BENEFITS

- Skin quality: firmness, texture and hydration, driven mainly by the GHK-Cu component
- Faster wound and soft-tissue healing
- Reduced local inflammation, which is the KPV contribution
- Hair follicle stimulation, reported with copper peptides generally

TIMING

Evening is conventional — the copper peptide can sting and you will not care about that in bed.

CYCLE

4–8 weeks, then four weeks off. The copper component is the reason for the break.

SIDE EFFECTS

- Stinging on injection — the copper peptide is responsible and it is normal
- A blue-green tint to the reconstituted solution, which is the copper and is expected
- Temporary redness at the site

DO NOT USE IF

- Wilson disease or any disorder of copper metabolism
- Active cancer
- Pregnancy or breastfeeding

WORTH KNOWING Check your vial label or certificate of analysis for the exact split between components. Blend ratios vary between suppliers, and the per-component dose you are taking depends entirely on that ratio.

GHK-Cu

A copper-binding tripeptide found naturally in plasma, and one of the best-studied compounds in this guide.

100 MG

WATER TO ADD	PER UNIT	WEEKS 1–2	WEEK 3 ONWARD	WOUND OR HAIR
5 mL	200 mcg	5 units	10 units	15 units

U-100 SYRINGE — 10 units

WHAT IT IS

GHK-Cu is a complex of the tripeptide glycyl-L-histidyl-L-lysine with a copper ion. It occurs naturally in human plasma and its concentration falls sharply with age — roughly a two-thirds decline between twenty and sixty. It works partly by delivering copper to cells and partly as a signalling molecule in its own right, influencing the expression of a very large number of genes involved in tissue remodelling and antioxidant defence.

WHAT THE EVIDENCE ACTUALLY SHOWS

Strong dermatological literature going back decades, including human topical studies showing measurable improvements in skin density and wrinkle depth. Injectable use is far less well studied than topical use — most of the good human evidence is for creams and serums.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Inject 5 units daily for the first two weeks, then increase to 10 units daily. Run five days on and two days off. For skin goals, 1–2 mg daily is sufficient; wound healing and hair protocols run at the higher end.

REPORTED BENEFITS

- Increased collagen and glycosaminoglycan synthesis
- Improved skin texture, elasticity and hydration
- Wound healing and scar remodelling
- Hair follicle stimulation and increased follicle size
- Antioxidant and anti-inflammatory activity

TIMING

Before bed. It stings, and sleeping through the tail end of that is pleasant.

CYCLE

4–12 weeks on, then a full four weeks off. The break is not optional — it prevents copper accumulation.

SIDE EFFECTS

- Stinging or burning on injection, which is characteristic
- Temporary redness at the site
- Occasional metallic taste
- Very rarely, a temporary blue-grey tint to the skin at the site

DO NOT USE IF

- Wilson disease or any copper metabolism disorder
- Active cancer
- Pregnancy or breastfeeding

WORTH KNOWING GHK-Cu is also effective topically, and topical use has considerably better human evidence behind it than injection. If your goal is purely cosmetic skin improvement, a topical preparation is a legitimate and lower-risk route.

CJC-1295 + Ipamorelin

The standard growth hormone secretagogue pairing — one raises the pulse, the other triggers it.

• WADA PROHIBITED

10 MG BLEND

WATER TO ADD	PER UNIT	STARTING DOSE	STANDARD DOSE	UPPER END	VIAL LASTS
2 mL	50 mcg	4 units	8 units	12 units	5 weeks

U-100 SYRINGE — 8 units

WHAT IT IS

These two work on separate receptors, which is the entire reason they are combined. CJC-1295 is a GHRH analogue: it binds the growth hormone-releasing hormone receptor on the pituitary and increases how much GH is available to release. Ipamorelin is a ghrelin mimetic acting at GHS-R1a, which triggers the release itself. Used together the pulse is substantially larger than either produces alone. Ipamorelin is favoured over older secretagogues because it is selective — it does not meaningfully raise cortisol or prolactin.

WHAT THE EVIDENCE ACTUALLY SHOWS

GHRH analogues have solid pharmacological data showing sustained elevation of GH and IGF-1. Ipamorelin is well characterised for selectivity. What is thin is long-term outcome data in healthy adults — the pharmacology is established, the years-long consequences are not.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Inject 8 units once nightly. Start at 4 units for the first week if you are new to secretagogues. Run five nights on, two nights off — the off nights exist to stop the pituitary desensitising.

REPORTED BENEFITS

- Increased natural GH pulses and a raised IGF-1 baseline, without introducing exogenous GH
- Improved sleep quality — usually the first thing people notice, often within the first week
- Better recovery between training sessions
- Gradual improvement in body composition — modest, and slower than exogenous GH
- Skin and connective tissue quality over longer cycles

TIMING

At bedtime, at least two hours after your last meal. Circulating insulin and fatty acids blunt the GH pulse, so eating close to your injection wastes the dose.

CYCLE

8–12 weeks, then four weeks off.

SIDE EFFECTS

- Water retention, particularly in the first fortnight
- Tingling or numbness in the hands
- A brief head rush or facial flushing after injecting
- Vivid dreams
- Increased appetite, though less than with older secretagogues
- Itching at the injection site

DO NOT USE IF

- Active cancer — raising IGF-1 where a tumour is present is a genuine concern, not a theoretical one
- Pregnancy or breastfeeding
- Uncontrolled diabetes
- Known pituitary tumour

Tesamorelin

A stabilised GHRH analogue, and the only compound here with a specific approved indication for fat reduction.

• WADA PROHIBITED

5 MG

WATER TO ADD	PER UNIT	REDUCED-COST	LABEL DOSE	VIAL LASTS
1 mL	50 mcg	20 units	40 units	2.5 days

U-100 SYRINGE — 40 units

WHAT IT IS

Tesamorelin is a synthetic GHRH analogue stabilised against enzymatic breakdown. It is approved in the United States, under the brand name Egrifta, for reducing excess abdominal fat in HIV patients with lipodystrophy. It is the only GH-axis compound in this guide with a regulator-approved fat-reduction indication, which makes its clinical evidence considerably better than its peers.

WHAT THE EVIDENCE ACTUALLY SHOWS

The best-evidenced compound in this section. Multiple Phase III trials, an FDA approval, and published liver-fat outcomes. The caveat is that all of it was generated in HIV-associated lipodystrophy, and extrapolating to a healthy population is an assumption rather than a finding.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Inject 40 units once daily into the abdomen — that is the 2 mg dose used in the approved protocol and in every trial. Many people run 1 mg (20 units) daily instead, purely on cost grounds, accepting a slower and smaller result.

REPORTED BENEFITS

- Reduction in visceral adipose tissue — Phase III trials showed a 15–18% reduction over 26 weeks
- Reduced liver fat: a median 5.3% reduction at twelve months against a 3.6% increase on placebo
- Raised IGF-1 and the general benefits of an elevated GH axis
- Weight-neutral. It redistributes fat rather than reducing scale weight

TIMING

Once daily. Consistency of timing matters less than not missing days. Most people inject before bed.

CYCLE

Trials ran 26 to 52 weeks. Visceral fat returns once you stop, so this is a long commitment rather than a short cycle.

SIDE EFFECTS

- Joint pain and muscle aches
- Swelling and fluid retention, particularly hands and feet
- Tingling or numbness in the extremities
- Injection site redness — more common than with other peptides here
- Raised blood glucose and reduced insulin sensitivity

DO NOT USE IF

- Active cancer
- Pregnancy or breastfeeding
- Any history of pituitary tumour or pituitary surgery
- Uncontrolled diabetes

WORTH KNOWING Be aware before you buy: at the 2 mg label dose a 5 mg vial lasts two and a half days. At 1 mg daily it lasts five. Tesamorelin is by some distance the most expensive compound per week in our range, and running it properly means budgeting for continuous supply rather than a single vial.

HGH (Somatropin)

Recombinant human growth hormone. The direct approach, with the largest effect and the largest downside.

• WADA PROHIBITED • HIGHER RISK

15 IU · ~5 MG

WATER TO ADD	PER UNIT	STARTING DOSE	MAINTENANCE	UPPER END	VIAL LASTS
1.5 mL	0.1 iu	10 units	20 units	30 units	7.5 days

U-100 SYRINGE — **20 units = 2 iu**

WHAT IT IS

Somatropin is a recombinant version of the 191-amino-acid protein your pituitary produces. Unlike the secretagogues, it does not ask your body to make more GH — it introduces GH directly, which means it works regardless of pituitary function and produces effects the secretagogues cannot match. It also means it bypasses every feedback mechanism your body uses to keep GH in a sane range, which is where the risks come from.

WHAT THE EVIDENCE ACTUALLY SHOWS

GH is one of the most thoroughly characterised hormones in medicine, with decades of clinical use in genuine deficiency. What is far less established is the benefit-to-harm ratio in people with normal GH production. In that group, the expected benefits are uncertain and the side effect risk is real.

DOSING, STEPPING UP AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Start at 10 units (1 iu) nightly for two to four weeks. Increase by 5 units (0.5 iu) per month if tolerated. Most people settle between 1 and 3 iu daily. Do not start at 4 iu because a forum said so — side effects are strongly dose-dependent, and starting high is how people end up with carpal tunnel and swollen ankles in week two.

STEPPING UP

Weeks 1–4	1 iu	10 units
Month 2	1.5 iu	15 units
Month 3	2 iu	20 units
Settled range	1–3 iu	10–30 units

Increase by 5 units (0.5 iu) per month only if the previous step was comfortable. Side effects are strongly dose-dependent, and starting high is how people end up with carpal tunnel and swollen ankles in week two.

TIMING

Before bed, away from carbohydrate. Above 2 iu, splitting into a morning and evening injection is better tolerated.

CYCLE

Three to six months minimum for meaningful body composition change. GH is slow. Anyone promising results in four weeks is selling something.

REPORTED BENEFITS

- Increased lean mass and reduced fat mass, the most reliably documented effect
- Improved recovery and connective tissue repair
- Better skin quality and thickness
- Improved sleep and subjective energy in deficient individuals
- Raised IGF-1, substantially and predictably

SIDE EFFECTS

- Fluid retention and puffiness, especially hands, feet and face
- Carpal tunnel symptoms — tingling, numbness or pain in the hands
- Joint and muscle aches
- Insulin resistance and raised fasting glucose — dose-dependent, and the most important long-term concern
- Headaches
- Worsening of existing sleep apnoea
- At sustained high doses over years, coarsening of facial features and enlargement of hands, feet and internal organs

DO NOT USE IF

- Active cancer — this is an absolute contraindication, not a caution
- Proliferative diabetic retinopathy
- Uncontrolled diabetes
- Pregnancy or breastfeeding
- Acute critical illness

WORTH KNOWING Genuine growth hormone deficiency is a diagnosable condition with a proper workup involving stimulation testing. If you suspect you have it, that pathway exists and leads to a prescription, monitoring and follow-up bloods. It is a better route than this one.

Retatrutide

A triple GLP-1, GIP and glucagon receptor agonist, and the most effective weight-loss compound yet published.

- WADA PROHIBITED
- HIGHER RISK
- NOT APPROVED FOR HUMAN USE

10 MG

WATER TO ADD	PER UNIT	STARTING DOSE	TOP OF LADDER	FREQUENCY
1 mL	100 mcg	10 units	120 units	once weekly

U-100 SYRINGE — **10 units to start**

WHAT IT IS

Retatrutide activates three receptors at once. GLP-1 slows gastric emptying and suppresses appetite. GIP adds a complementary effect on insulin and appetite signalling. The glucagon component is what makes it distinct from tirzepatide and semaglutide — glucagon receptor activation raises energy expenditure rather than only reducing intake. It is an Eli Lilly molecule currently in Phase 3, approved nowhere in the world.

WHAT THE EVIDENCE ACTUALLY SHOWS

Published Phase 2 results in the New England Journal of Medicine (Jastreboff et al., 2023) and an ongoing Phase 3 programme. The efficacy data is genuinely strong. What does not yet exist is long-term safety data — no compound with this mechanism has been followed in humans for years, and the glucagon component in particular is novel.

THE PROTOCOL, THE LADDER AND THE CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Once weekly, subcutaneously, on the same day each week. Follow the ladder, which mirrors the Phase 3 TRIUMPH escalation. Do not skip steps and do not compress the timeline — the Phase 2 trial deliberately compared faster and slower escalation and found the slower ramp markedly better tolerated. If side effects are significant at any step, hold at that dose for another four weeks before moving up. Many people find their effective dose well below 12 mg and never need the top of the ladder.

THE ESCALATION LADDER

Weeks 1–4	1 mg	10 units
Weeks 5–8	2 mg	20 units
Weeks 9–12	4 mg	40 units
Weeks 13–16	6 mg	60 units
Weeks 17–20	9 mg	90 units
Week 21+	12 mg	120 units — split into two injections

MAKING IT GO WELL

- Eat protein deliberately. Rapid weight loss on this class costs lean mass, and resistance training plus adequate protein is the only thing that meaningfully protects it.
- Hydrate. Reduced appetite reduces fluid intake too, and dehydration is behind a good share of the fatigue and headaches people report.
- Eat smaller meals and stop earlier than feels natural. Gastric emptying is slowed, and overeating on this compound is genuinely unpleasant.
- Severe abdominal pain radiating to the back means stop and get medical attention the same day.

REPORTED BENEFITS

- The largest weight reduction reported for any pharmacological agent to date: 24.2% mean body weight loss at 48 weeks on 12 mg, against 2.1% on placebo
- At 48 weeks on 12 mg, every participant lost at least 5% of body weight; 93% lost at least 10%, and 83% at least 15%
- Improvements across blood pressure, triglycerides, LDL and total cholesterol, HbA1c, fasting glucose and insulin
- Substantial reductions in liver fat in a separate Phase 2a trial

SIDE EFFECTS

- Nausea — reported by 47% of participants at 12 mg
- Vomiting — 21% at 12 mg
- Diarrhoea and constipation
- Markedly reduced appetite
- Fatigue
- Increased heart rate, peaking around week 24 and declining thereafter
- Injection site reactions
- Gastrointestinal effects are dose-related, mostly mild to moderate, worst during escalation, and tend to settle at a stable dose

DO NOT USE IF

- Personal or family history of medullary thyroid carcinoma — absolute
- Multiple Endocrine Neoplasia type 2 — absolute
- Pregnancy, breastfeeding, or actively trying to conceive — absolute
- History of pancreatitis — seek medical advice first
- Gastroparesis or severe gastrointestinal disease
- Type 1 diabetes
- Diabetic retinopathy
- Advanced kidney disease
- History of an eating disorder

MOTS-c

A mitochondrial-derived peptide that behaves like a metabolic stress signal.

10 MG

WATER TO ADD	PER UNIT	STARTING DOSE	STANDARD DOSE	VIAL LASTS
1 mL	100 mcg	25 units	50 units	1–2 weeks

U-100 SYRINGE — 50 units

WHAT IT IS

MOTS-c is encoded in mitochondrial DNA rather than nuclear DNA, which is unusual and part of why it attracted attention. It appears to act as a signal from the mitochondria to the rest of the cell, activating AMPK and shifting metabolism toward glucose utilisation and fatty acid oxidation. In effect it mimics some of the cellular signalling of exercise and caloric restriction.

WHAT THE EVIDENCE ACTUALLY SHOWS

Genuinely interesting mechanism, mostly animal data. Human dose-finding trials are sparse to non-existent, which means the doses here are inferred rather than established.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Start at 25 units three times per week. Build toward 5–10 mg total per week split across two or three injections. The weekly total is what matters here — protocols circulating that suggest 5–10 mg per injection five times weekly would consume five vials a week and are almost certainly a misreading.

REPORTED BENEFITS

- Improved insulin sensitivity and glucose handling in animal models
- Increased fatty acid oxidation
- Improved exercise capacity and endurance in rodent studies
- Reduced age-related metabolic decline in animal work — endogenous MOTS-c falls with age

TIMING

Morning. Some people inject before training on the endurance rationale.

CYCLE

4–8 weeks, then four weeks off.

SIDE EFFECTS

- Mild injection site reaction
- Occasional fatigue or flushing during the first week

DO NOT USE IF

- Pregnancy or breastfeeding
- Anyone wanting a compound with established human safety data — this is not it

SLU-PP-332

A pan-ERR agonist described as an exercise mimetic. The least-evidenced compound we stock.

• HIGHER RISK • NOT APPROVED FOR HUMAN USE

10 MG

WATER TO ADD	PER UNIT	WEEKS 1–2, 2× DAILY	WEEK 3+, 2× DAILY	VIAL LASTS
2 mL	50 mcg	12 units	25 units	4–8 days

U-100 SYRINGE — **25 units, twice daily**

WHAT IT IS

SLU-PP-332 is a small synthetic molecule rather than a peptide. It activates the estrogen-related receptors ERR-alpha, beta and gamma, with greatest potency at ERR-alpha. In mice it increases mitochondrial density, shifts muscle toward fatigue-resistant fibre types, improves endurance and reduces fat mass without the animal doing any additional exercise — hence the exercise mimetic label.

WHAT THE EVIDENCE ACTUALLY SHOWS

Read this part carefully. SLU-PP-332 has never been tested in a human being. There is no Phase 1 trial, no registered clinical study, no human safety data of any kind. Every human dosing protocol in circulation, including the one here, is extrapolated from mouse studies using body-surface-area conversions. Of everything in this guide, this is the compound where the gap between enthusiasm and evidence is widest.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Twice daily, subcutaneously. Start at 12 units twice daily for two weeks, then 25 units twice daily. The short half-life is why it is split rather than given once.

REPORTED BENEFITS

- Increased mitochondrial biogenesis in mouse muscle
- Improved endurance capacity in rodents — substantially so
- Fat mass reduction without changes in activity or food intake in animal studies
- Increased energy expenditure

TIMING

Morning and early afternoon. Avoid dosing late — increased energy expenditure and a raised heart rate do not help sleep.

CYCLE

4–8 weeks in the extrapolated protocols. There is no evidence base for the right cycle length because there is no evidence base at all.

SIDE EFFECTS

- Unknown in humans
- In animal studies, increased heart rate and raised energy expenditure are consistent findings
- Anything else is unmeasured

DO NOT USE IF

- Any cardiovascular disease or arrhythmia
- Pregnancy or breastfeeding
- Anyone unwilling to accept genuinely unknown risk — which is the honest framing for this compound

NAD+

A coenzyme central to energy metabolism and DNA repair, and one that declines steeply with age.

500 MG

WATER TO ADD	PER UNIT	STARTING DOSE	STANDARD DOSE	UPPER END	VIAL LASTS
5 mL	1 mg	25 units	50 units	100 units	3–4 weeks

U-100 SYRINGE — 50 units

WHAT IT IS

Nicotinamide adenine dinucleotide is a coenzyme present in every cell, required for the reactions that convert food into cellular energy and for the activity of the sirtuins and PARP enzymes involved in DNA repair. Tissue NAD+ falls substantially with age. Injecting it directly bypasses the conversion steps that oral precursors like NMN and NR depend on, which is the argument for the injectable route.

WHAT THE EVIDENCE ACTUALLY SHOWS

The biology of NAD+ decline is well established. What is less established is that raising it by injection produces durable clinical benefit in healthy people — most human data concerns oral precursors, and effects on subjective wellbeing are difficult to separate from expectation.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Start at 25 units and build to 50–100 units over several weeks. Inject two to three times per week rather than daily. Anything at the top of that range should be split across two sites.

REPORTED BENEFITS

- Improved energy and reduced fatigue — the most commonly reported subjective effect
- Mental clarity and focus
- Support for DNA repair pathways and sirtuin activity
- Improved recovery, and reduced perceived effects of jet lag and shift work

TIMING

Morning. It is stimulating for most people and will interfere with sleep if taken late.

CYCLE

Three to four weeks of loading, then once or twice weekly maintenance.

SIDE EFFECTS

- Significant stinging or burning at the injection site — normal for NAD+ and not a sign anything is wrong
- Flushing
- Nausea, chest tightness or light-headedness if injected too quickly

DO NOT USE IF

- Pregnancy or breastfeeding
- Low blood pressure — build up slowly

WORTH KNOWING Inject NAD+ more slowly than anything else in this guide. Thirty to sixty seconds for the full dose. Almost every unpleasant reaction people report comes from pushing the plunger too fast.

SS-31 (Elamipretide)

A mitochondria-targeted peptide that concentrates in the inner mitochondrial membrane.

10 MG

WATER TO ADD	PER UNIT	STARTING DOSE	STANDARD DOSE	UPPER END	VIAL LASTS
2 mL	50 mcg	20 units	40 units	50 units	5–10 days

U-100 SYRINGE — 40 units

WHAT IT IS

SS-31 selectively accumulates in the inner mitochondrial membrane where it binds cardiolipin, a phospholipid essential to the structure of the electron transport chain. Cardiolipin becomes disorganised and oxidatively damaged with age and disease; stabilising it improves the efficiency of energy production and reduces reactive oxygen species leakage. It is unusual among the compounds here in having a genuine regulatory approval — the FDA granted accelerated approval in 2025 for Barth syndrome, under the name Forzinity.

WHAT THE EVIDENCE ACTUALLY SHOWS

Better than most in this guide. Multiple clinical trials in mitochondrial myopathy, heart failure and Barth syndrome, and an accelerated FDA approval for a rare disease indication. The important gap is that all of it is in disease populations, not healthy people seeking a longevity effect.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Inject 20–40 units once daily, five days per week. Be aware that clinical trials used 40 mg per day — twenty times the community dose. That gap exists because 40 mg daily would consume four vials a day, not because 2 mg has been shown equivalent. Do not read the trial dose as a target, and do not read the community dose as validated.

REPORTED BENEFITS

- Improved mitochondrial efficiency and reduced oxidative stress
- Improved exercise capacity — a Phase 2 heart failure trial showed improvements in six-minute walk distance
- Reduced fatigue in mitochondrial disease populations
- Cardiovascular and renal protective effects in preclinical models

TIMING

Morning.

CYCLE

Four weeks, then reassess.

SIDE EFFECTS

- Injection site reactions — the most common finding across trials
- Headache
- Nausea

DO NOT USE IF

- Pregnancy or breastfeeding

Epithalon

A four-amino-acid bioregulator studied for telomerase activation. Used in short annual courses rather than continuously.

10 MG

WATER TO ADD	PER UNIT	STANDARD COURSE	INTENSIVE COURSE	VIAL LASTS
2 mL	50 mcg	20 units	100 units	one 10-day course

U-100 SYRINGE — 20 units

WHAT IT IS

Epithalon is a synthetic tetrapeptide developed from a pineal gland extract by Vladimir Khavinson in Russia. It is proposed to activate telomerase, the enzyme that maintains the protective caps on the ends of chromosomes. In cultured human cells it induced telomerase activity and increased telomere length by roughly 30%. It also appears to influence melatonin rhythms and pineal function.

WHAT THE EVIDENCE ACTUALLY SHOWS

The in vitro telomerase data is real. The human clinical evidence is almost entirely Russian, decades old, and difficult to evaluate against modern trial standards. Treat the longevity claims as unproven rather than disproven.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Inject 20 units daily for ten consecutive days, then stop. Repeat the course two or three times per year. The intensive Russian protocol used 5–10 mg daily for ten to twenty days, which would require five to twenty vials per course — most people run the lighter version.

REPORTED BENEFITS

- Telomerase activation and telomere lengthening in cell culture
- Improved sleep quality and normalised melatonin rhythm — the most consistently reported subjective effect
- Antioxidant activity
- Long-term Russian cohort studies reported reduced mortality, though that methodology would not meet current Western standards

TIMING

Evening, on the melatonin rationale.

CYCLE

The one product here designed around short bursts rather than continuous use. Ten days on, then months off.

SIDE EFFECTS

- Very few reported
- Occasional drowsiness, consistent with the melatonin effect

DO NOT USE IF

- Pregnancy or breastfeeding
- Active cancer — telomerase activation in the presence of a tumour is a theoretical concern worth taking seriously

Glutathione

The body's primary intracellular antioxidant, given by injection to bypass poor oral absorption.

600 MG

WATER TO ADD	PER UNIT	STANDARD DOSE	HIGHER DOSE	VIAL LASTS
2 mL	3 mg	67 units	100 units	2–3 doses

U-100 SYRINGE — 67 units

WHAT IT IS

Glutathione is a tripeptide of glycine, cysteine and glutamic acid, and the principal antioxidant operating inside cells. It neutralises reactive oxygen species, regenerates vitamins C and E, and is central to phase II liver detoxification. Oral glutathione is largely broken down in the gut, which is the entire rationale for injecting it.

WHAT THE EVIDENCE ACTUALLY SHOWS

The biochemistry is not in dispute. Clinical evidence for injected glutathione producing durable systemic benefit in healthy people is weak, and the skin-lightening use in particular has been the subject of safety warnings in several countries where it is administered at very high intravenous doses.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Inject 67–100 units two to three times per week. Because the volumes are large, intramuscular injection into the deltoid or upper outer glute is more comfortable than subcutaneous for anything above about 50 units.

REPORTED BENEFITS

- Antioxidant capacity and reduction of oxidative stress
- Support for liver detoxification pathways
- Skin brightening and more even tone, driven by inhibition of melanin production
- Immune function support

TIMING

Morning.

CYCLE

Eight weeks on, two to four weeks off.

SIDE EFFECTS

- Stinging at the injection site
- Occasional light-headedness
- Rare skin reactions, reported mainly in high-dose unregulated intravenous skin-lightening infusions

DO NOT USE IF

- Asthma — rare reports of bronchospasm
- Pregnancy or breastfeeding

WORTH KNOWING A faint yellow tint to the solution is normal. Discard it if it turns cloudy or noticeably darker.

HCG

An LH analogue used to maintain testicular function and fertility, most often alongside testosterone therapy.

- WADA PROHIBITED
- HIGHER RISK

5000 IU

WATER TO ADD	PER UNIT	WITH TRT	MAINTENANCE	FERTILITY	VIAL LASTS
5 mL	10 iu	25 units	50 units	150 units	~5 weeks

U-100 SYRINGE — **50 units = 500 iu**

WHAT IT IS

HCG mimics luteinising hormone closely enough to bind the same receptor on the Leydig cells of the testes. Exogenous testosterone shuts down the body's own LH production, and without LH signalling the testes stop producing testosterone and sperm, and atrophy. HCG substitutes for the missing signal, keeping the testes working while someone is on testosterone therapy. Its half-life is around 33 hours, which is why it is dosed every two to three days rather than weekly.

WHAT THE EVIDENCE ACTUALLY SHOWS

Well established in clinical endocrinology and urology. HCG is a prescription medicine with a long history of legitimate use for hypogonadotropic hypogonadism and male infertility. Of everything in this guide, this is among the best understood.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

For maintaining testicular function alongside testosterone therapy, inject 25–50 units two to three times per week — Monday and Thursday is the usual split. Fertility restoration protocols run far higher, at 1500–3000 iu three times weekly, often combined with other agents, and genuinely need medical supervision and semen analysis to guide them.

REPORTED BENEFITS

- Maintains testicular size and function during testosterone therapy
- Preserves fertility and sperm production, which testosterone alone suppresses
- Maintains intratesticular testosterone, not restored by injectable testosterone
- Used at higher doses to restore fertility after suppression

TIMING

Every two to three days, spaced evenly. The 33-hour half-life sets the frequency.

CYCLE

Continuous, for as long as testosterone therapy continues.

SIDE EFFECTS

- Gynecomastia — HCG raises oestrogen through aromatisation, and this is the most common problem people run into
- Acne
- Mood changes and irritability
- Water retention
- Testicular discomfort in the first weeks, usually as the testes recover volume

DO NOT USE IF

- Hormone-sensitive cancers, particularly prostate and breast
- Precocious puberty
- Pregnancy

WORTH KNOWING HCG is more fragile than the other compounds here — refrigerate immediately after mixing. Separately: the so-called HCG diet has been studied repeatedly and shown to produce no weight loss beyond the severe caloric restriction it is paired with. It is not a legitimate use of this compound.

Selank

An anxiolytic peptide developed in Russia, notable for producing calm without sedation or dependence.

5 MG

WATER TO ADD	PER UNIT	INTRANASAL	SUBCUT. DAILY	SUBCUT. 2–3×/WK	VIAL LASTS
2 mL	25 mcg	10–12 units	20 units	40 units	~10 days

U-100 SYRINGE — **20 units**

WHAT IT IS

Selank is a synthetic analogue of tuftsin, an immunomodulatory peptide fragment, stabilised with a short amino acid tail. It modulates GABA and serotonin signalling and increases BDNF expression. Its distinguishing feature is that it produces anxiolysis without the sedation, cognitive dulling, tolerance or withdrawal associated with benzodiazepines — clinical studies found no dependence in evaluated subjects.

WHAT THE EVIDENCE ACTUALLY SHOWS

Reasonable Russian clinical literature on anxiety disorders, including comparisons against benzodiazepines. Very little Western trial data. The safety signal across what exists is good.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Two routes work. Intranasally, 250–300 mcg two to three times daily, spaced four to six hours apart — draw the reconstituted solution into a clean nasal spray bottle and calibrate the spray volume. Subcutaneously, 20 units once daily in the morning, or 40 units two to three times per week.

REPORTED BENEFITS

- Reduced anxiety without sedation
- Improved focus and mental clarity, often reported as the more valuable effect
- Better stress resilience
- Increased BDNF expression, associated with neuroplasticity
- Effects are typically felt within minutes to hours of an intranasal dose

TIMING

Morning and early afternoon, doses spaced four to six hours apart.

CYCLE

Two to four weeks on, then a break. The low-frequency subcutaneous protocol runs eight weeks on, eight weeks off.

SIDE EFFECTS

- Nasal stinging or dryness with intranasal use
- Mild headache during the first few days
- Injection site irritation
- No tolerance, dependence or withdrawal observed in clinical studies

DO NOT USE IF

- Pregnancy or breastfeeding

Bacteriostatic Water

Sterile water with 0.9% benzyl alcohol. The preservative is the entire point.

10 ML

VOLUME	PRESERVATIVE	ONCE PUNCTURED	COVERS
10 mL	0.9% benzyl alcohol	28 days	several vials

WHAT IT IS

Bacteriostatic water is sterile water containing 0.9% benzyl alcohol as a preservative. That preservative inhibits bacterial growth, which is what makes it safe to puncture a vial repeatedly over several weeks. Plain sterile water has no preservative — once a vial of peptide is reconstituted with sterile water it should be used immediately or within 24 hours. For anything multi-dose, bacteriostatic water is the correct choice, and the reason the 28-day rule exists at all.

WHAT THE EVIDENCE ACTUALLY SHOWS

Standard pharmaceutical diluent. Nothing controversial here.

DOSING, BENEFITS AND CAUTIONS CONTINUED OVERLEAF →

HOW TO USE IT

Use the volume specified for each peptide in this guide. Swab the stopper before every entry. Once first punctured, treat the vial as good for 28 days.

REPORTED BENEFITS

- Allows a reconstituted vial to be used across multiple doses over weeks rather than a single day
- Compatible with every peptide in this guide
- One 10 mL vial reconstitutes several peptide vials

STORAGE

Room temperature is fine for an unopened vial. Refrigerate once punctured if you like, but it is not required.

COMPATIBILITY

Every compound in this guide reconstitutes with bacteriostatic water.

SIDE EFFECTS

- None expected from the diluent itself

DO NOT USE IF

- Never use bacteriostatic water for a newborn — benzyl alcohol is toxic to neonates. This is the one absolute restriction on the diluent itself.

WORTH KNOWING Do not confuse bacteriostatic water with sterile water for injection, saline, or sterile water for irrigation. They are not interchangeable for multi-dose use.

Reference

Quick-reference dosing, the legal position in Australia and the EU, anti-doping status, and a glossary.

Quick reference

Typical dose is the standard protocol for each product, not the maximum, and assumes the water volume shown. Full detail is in part two.

	PRODUCT	VIAL	WATER	PER UNIT	TYPICAL	HOW OFTEN
01	**BPC-157 + TB-500**	20 mg blend	4 mL	50 mcg	**10 units**	once daily
02	**KLOW Blend**	80 mg blend	5 mL	160 mcg	**20 units**	once daily
03	**GHK-Cu**	100 mg	5 mL	200 mcg	**10 units**	daily, 5 on / 2 off
04	**CJC-1295 + Ipamorelin**	10 mg blend	2 mL	50 mcg	**8 units**	nightly, 5 on / 2 off
05	**Tesamorelin**	5 mg	1 mL	50 mcg	**40 units**	once daily
06	**HGH (Somatropin)**	15 iu (~5 mg)	1.5 mL	0.1 iu	**20 units**	once daily
07	**Retatrutide**	10 mg	1 mL	100 mcg	**10–120 units**	once weekly, titrated
08	**MOTS-c**	10 mg	1 mL	100 mcg	**25–50 units**	2–3× per week
09	**SLU-PP-332**	10 mg	2 mL	50 mcg	**25 units**	twice daily
10	**NAD+**	500 mg	5 mL	1 mg	**50 units**	2–3× per week
11	**SS-31 (Elamipretide)**	10 mg	2 mL	50 mcg	**20–40 units**	daily, 5 days a week
12	**Epithalon**	10 mg	2 mL	50 mcg	**20 units**	10 days, 2–3× a year
13	**Glutathione**	600 mg	2 mL	3 mg	**67 units**	2–3× per week
14	**HCG**	5000 iu	5 mL	10 iu	**25–50 units**	2–3× per week
15	**Selank**	5 mg	2 mL	25 mcg	**20 units**	daily, or intranasal
16	**Bacteriostatic Water**	10 mL	–	–	**–**	as required

Read the dose strip

Every product page in part two carries one across the top, with the water volume and the units already worked out.

One unit = 0.01 mL

A U-100 insulin syringe holds 1 mL across 100 marks. That is the scale every number here is measured against.

28 days, then discard

The working life of any reconstituted vial, whatever is left in it.

Legal and regulatory position

Australia

Most compounds in this guide are Schedule 4 (prescription-only) substances under the Poisons Standard. Retatrutide and SLU-PP-332 are not approved for human use anywhere in the world. The Personal Importation Scheme requires a valid Australian prescription for Schedule 4 medicines, and the TGA has been increasingly active on unapproved peptide products. Products are supplied for laboratory and research use.

European Union

Regulation varies by member state, but the equivalent prescription-only classifications apply across the bloc for the same compounds. Check your own national rules.

Tested athletes

Almost everything in this guide is on the WADA Prohibited List and banned at all times, in and out of competition. Growth hormone secretagogues, HGH, tesamorelin and HCG fall under S2 (peptide hormones and growth factors). BPC-157, TB-500, retatrutide and SLU-PP-332 fall under S0 (non-approved substances). Therapeutic Use Exemptions are generally not available for substances with no regulatory approval anywhere, because a TUE requires an approved therapeutic agent. If you compete in a tested sport, none of this is available to you.

This guide

Reference information compiled from published clinical trials and established clinical protocols. It is not medical advice, it does not create a practitioner relationship, and it is not a substitute for consulting a doctor who can examine you, order bloodwork and follow you over time.

Glossary

Lyophilised

Freeze-dried. The white powder or cake in the vial before you add water.

Reconstitution

Adding liquid to lyophilised powder to make an injectable solution.

Bacteriostatic water (BAC)

Sterile water with 0.9% benzyl alcohol preservative, used for multi-dose vials.

Subcutaneous (subQ)

Into the fat layer beneath the skin. The route used for almost everything in this guide.

Intramuscular (IM)

Into muscle. Used for larger volumes, absorbed faster.

U-100 syringe

An insulin syringe marked in 100 units per millilitre. One unit equals 0.01 mL.

iu (international unit)

A measure of biological activity rather than mass. Used for HGH and HCG.

mcg and mg

One milligram equals 1000 micrograms. Confusing the two is the most dangerous arithmetic error in peptide dosing.

Half-life

The time taken for half the compound to clear. It determines how often you need to dose.

Titration

Increasing the dose in planned steps to let side effects settle at each level before moving up.

Secretagogue

A compound that causes the body to secrete something — here, growth hormone.

GHRH

Growth hormone-releasing hormone. The upstream signal that tells the pituitary to release GH.

IGF-1

Insulin-like growth factor 1. Produced by the liver in response to GH, and responsible for many of its effects.

Lipodystrophy

Damage to the subcutaneous fat layer from repeated injection into the same spot. Causes permanent dents and impairs absorption.

Visceral adipose tissue (VAT)

Deep abdominal fat surrounding the organs. Metabolically distinct from, and more harmful than, subcutaneous fat.

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Start low. Write it on the vial. Ask a doctor.

If anything in this guide is unclear, email us. We would rather answer the question twice than have you guess a concentration.

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