

THE
peptide.
BRIEF

The Perimenopause Peptide Decision Guide

Which peptides have real evidence, which don't, and the order that actually matters.

The no-hype guide to peptides, hormones, and feeling like yourself again.

Start here

If you're reading this, you've probably been told that peptides are the missing piece — the thing that finally fixes the weight that won't budge, the sleep that won't come, the skin that suddenly looks tired. Maybe a podcast host swears by them. Maybe a clinic sent you a glossy menu.

Here's the promise of this guide: no hype, and no fear-mongering either. Some of these compounds have genuinely good evidence. Some have almost none. And the single most important factor in whether peptides help you isn't which peptide you pick — it's what you do first.

The one idea to take away

Peptides are not step one. They are something you layer on top of a foundation that's already working. Get that order wrong and even a well-evidenced peptide is money — and risk — spent on the wrong thing.

The order that actually matters

Think of it as three layers, built in sequence. You don't skip ahead.

Layer 1 — The foundation

Sleep, protein, strength training, stress, alcohol. Unglamorous, free, and the highest-leverage thing you can do in midlife. No peptide compensates for a missing foundation. Clinicians who work with peptides are blunt about this: optimizing the fundamentals first is non-negotiable, and peptides are meant to augment an already-optimized system, not paper over the gaps in one.

Layer 2 — The hormones

For many women in perimenopause, hormone therapy is the layer that changes everything — and it's the one most often skipped in favor of something newer. The emerging research is striking: hormones and certain peptides appear to work better together than either alone. Settle this layer, with a clinician, before reaching for the next one.

Layer 3 — The peptides

Only here — foundation handled, hormones addressed — do peptides earn their place. And even then, only the ones with evidence behind them. The rest of this guide is about telling those apart.

Dr. Mary Pines' analogy

Hormones are a loudspeaker; peptides are a precise text message. You don't send the text message hoping it will do the loudspeaker's job.

How to read a peptide claim

Before the individual verdicts, one skill that protects you more than any single fact: knowing what kind of evidence you're looking at. Almost every overstated peptide claim collapses on one of these distinctions.

- Animal vs. human. "Shown to regenerate tissue" almost always means in rats. Rodent results are a reason to study something in people — not a reason to conclude it works in people.
- Pilot study vs. real trial. A glowing result in 12 people with no comparison group is a signal, not a verdict. The number that matters is whether there's a randomized, placebo-controlled trial.
- Topical vs. injected. A peptide with good evidence in a face cream tells you nothing about its safety injected.
- FDA-approved vs. compoundable vs. gray-market. Three completely different categories of oversight and quality control, routinely blurred into the single word "peptide."

The one-line red-flag test

If a provider can't or won't tell you exactly where their peptides come from, walk away. Sourcing transparency is the whole game.

The peptides, honestly assessed

Four of the names you'll hear most, each with a plain verdict. "Evidence" here means human evidence specifically.

GLP-1s (semaglutide, tirzepatide)

The strongest evidence on this list — and, technically, the peptide you may already know. **These are FDA-approved medications with large randomized trials behind them.**

Verdict	Strong, FDA-approved. The best-evidenced option here.
What it does	Reduces appetite and "food noise," slows digestion, improves insulin sensitivity.
Women's data	Works as well after menopause as before — roughly 20–23% body-weight reduction across pre-, peri-, and postmenopausal women in large trial analyses.
The HRT angle	Emerging studies suggest adding hormone therapy increases weight loss meaningfully versus a GLP-1 alone — the layers working together.
The catch	Women report nausea at notably higher rates than men at standard doses. Lower, slower dosing is often the smarter entry. This is a clinician conversation, not a DIY one.

GHK-Cu (copper peptide)

The best-evidenced peptide for skin — with a sharp line between what it's proven to do and what it's sold to do.

Verdict	Good evidence — topically, for skin. Decades of published research.
What it does	Signals your own skin to rebuild collagen. Human trials show measurable gains in collagen density, firmness, and fine lines over ~12 weeks.
Where it's overstated	Hair growth and weight loss claims are not supported by solid clinical evidence. Treat those as marketing.
The catch	The strong evidence is for topical use. Don't pair it in the same routine with strong vitamin C or retinol — it blunts the effect.

BPC-157

The clearest example of the hype-versus-evidence gap on this list. Enormous online enthusiasm; **almost no human evidence.**

Verdict	Investigational. Promising in animals; human data is extremely thin.
The reality	As of 2026, only a handful of small human pilot studies exist — fewer than ~30 subjects total, none randomized or placebo-controlled.
Safety	Genuinely unknown in humans. There are no proper safety or pharmacokinetic studies, so "no reported side effects" reflects how little it's been studied, not a

	clean bill of health.
Honest take	“Promising animal data” describes thousands of compounds that later failed in people. For healthy women seeking recovery or anti-aging, the responsible move is to wait for real trials.

Sermorelin & NAD+

Frequently bundled into longevity menus. Each sits in a different evidence place, and neither is a foundation.

Sermorelin	Prompts your body's own growth-hormone release. Has a longer clinical history than the frontier peptides, but quality evidence specifically in perimenopausal women is limited. A clinician-supervised option, not a starting point.
NAD+	Heavily marketed for energy and aging. Mechanistically interesting, but human outcome data is early and far less settled than the marketing implies. Promising area to watch — not a proven fix.

The regulatory picture

As of June 2026 — this section dates faster than the rest

Regulation here is moving quickly. Treat the specifics below as a snapshot, not a permanent state of affairs, and confirm current status with your clinician before acting.

Why this matters to you as a buyer: a peptide's legal and oversight status directly determines its quality, sourcing, and whether anyone is accountable for what's in the vial.

What's happening

- A U.S. FDA advisory committee is reviewing several peptides (BPC-157 among them) for compounding access at a hearing scheduled for late July 2026. A favorable review would be a milestone — not an immediate green light; rulemaking takes time well beyond the vote.
- History counsels caution: every peptide this committee reviewed in 2024 was turned down, including ones with stronger track records than most of today's candidates.
- In April 2026, the UK's medicines regulator opened an investigation into peptide clinics making health claims — with BPC-157 named first. A reminder that the regulatory wind isn't blowing in only one direction.

What it means for you

"Available to buy" and "proven and approved" are not the same thing — and right now, for most frontier peptides, there's a wide gap between the two. The legal status tells you about oversight. It does not tell you the compound works.

Your decision checklist

Before saying yes to any peptide, run these five questions:

1. Is my foundation actually handled? Sleep, protein, strength, stress, alcohol — honestly.
2. Have I addressed hormones with a clinician first?
3. Is there human evidence for this specific peptide — or just animal studies and testimonials?
4. Do I know exactly where it's sourced and who's accountable for quality?
5. Is a qualified clinician supervising — dose, interactions, monitoring?

The bottom line

The women who do best with peptides aren't the ones who chase every new molecule. They're the ones who build the foundation, settle the hormones, and then add the one or two well-evidenced peptides that fit their actual goal. Order first. Molecule second.

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This guide is educational and is not medical advice. Peptides, hormone therapy, and GLP-1 medications carry real risks and interactions. Always consult a qualified clinician before starting, stopping, or changing any treatment. Information is current as of June 2026 and the regulatory landscape in particular may have changed since.