Wahine Health
GYNECOLOGY CARE FOR MAUI

PATIENT EDUCATION
HORMONE THERAPY

Testosterone for women, *honestly.*

What it can do, what it can't, and every way to take it — plainly explained.

Yes — testosterone is a women's hormone, too: your ovaries and adrenals have made it your whole life, and by your forties levels are roughly half what they were at twenty. **The best-established evidence supports testosterone for low sexual desire that genuinely bothers you (HSDD) after menopause;** research on its roles in muscle, bone, and cognition is active and emerging, though not yet conclusive. With no FDA-approved testosterone for women in the U.S., every option below is either compounded for you or an off-label male product at about one-tenth dose.

Cost tiers: $ under ~$30/mo · $$ ~$30–100/mo · $$$ often $100+/mo
Because no women's product is FDA-approved, insurance rarely covers testosterone for women — most routes are cash-pay. Discount cards help on the generic gel.

Compounded cream — $$

OUR PREFERRED ROUTE — AND OUR PATIENTS'

True female-strength cream — designed for a woman's physiology, not an eyeballed fraction of a men's product.

Where it goes: a measured amount to the outer thigh or lower abdomen daily. Wash hands after; let dry before skin-to-skin contact.

Dosing flexibility: the widest of any route — strength adjusted in small increments against your response and levels, often within days.

Good to know: no alcohol-gel odor, easier to adjust and monitor — the option most requested by our patients and most often prescribed here. Cash-pay.

Compounded troche — $$

A testosterone lozenge tailored to your prescription — the compounded route with no topical at all.

Where it goes: tucked between cheek and gum, where it dissolves slowly — nothing applied to skin, no transfer concern.

Dosing flexibility: strength tailored like the cream; absorption varies more person to person, so we lean on your response and follow-up levels.

Good to know: the choice for wāhine who'd rather skip creams entirely — travel-friendly and discreet. Cash-pay.

Male-label gel, micro-dosed — $

Generic 1% testosterone gel — the men's product, used off-label at about one-tenth the dose: a small, measured daily dab.

Where it goes: lower abdomen, upper buttock, or outer thigh. Wash hands after; let it dry and cover the site before skin-to-skin contact.

Dosing flexibility: adjustable, but measuring a tiny dab precisely is the challenge — we titrate by your levels and your response, not the label.

Good to know: generic and cheap with a discount card, and the route international guidelines cite. Downsides: a noticeable alcohol odor, and imprecise micro-dosing — why most of our patients choose the compounded cream above.

Injections — $

Testosterone cypionate given as a small intramuscular or subcutaneous injection — a route borrowed from men's medicine.

Where it goes: into the muscle or fat of the thigh or hip, typically weekly.

Dosing flexibility: dose and interval adjust — but levels spike after each injection and fall before the next, and even small doses can overshoot.

Good to know: inexpensive, but international guidance cautions against injections for women because of those swings — if used at all, we monitor closely.

Pellets — $$$

Implants placed under the skin, releasing testosterone for months — heavily marketed elsewhere; not offered at Wahine Health.

Where they go: under the skin of the hip area, in a brief procedure — at other practices.

Dosing flexibility: none once placed — pellets can't be removed or turned down, and whatever the dose does, you live with it for months.

Good to know: major society guidance recommends against pellets for women — and it's why we don't offer them. If you've had pellets elsewhere or are weighing them, bring your questions; we'll walk through the trade-offs honestly.

Whichever route: monitoring

Not an option — the guardrail around all of them.

What we check: a baseline level before starting, again at about eight to ten weeks, then periodically as indicated — dose optimized to your individual symptoms and response, with levels as our safety guardrail.

The timeline: desire changes build over about twelve weeks. We reassess at three to six months — and if it isn't helping, the honest move is to stop.

Good to know: acne, oily skin, or new facial hair are dose signals — caught early, they reverse with adjustment. Voice changes may not, which is why side-effect signals, not a number, set the ceiling.

About compounding, plainly: compounded preparations aren't FDA-approved products; they're prepared for an individual patient by licensed pharmacies under federal 503A/503B rules — a regulatory gap, not a verdict on the medicine. Ours come from a highly regarded Maui compounding pharmacy we work with closely.

The evidence picture, *honestly.*

What the evidence actually supports.

The international consensus on testosterone therapy for women supports one indication: hypoactive sexual desire disorder — low desire that persists and genuinely bothers you — after menopause. For that, trial data show meaningful benefit. It's a real tool for a real problem, prescribed for the right reason.

Where the evidence is still emerging.

Beyond desire, testosterone's roles in muscle, bone, and cognition are a genuinely active area of research — emerging data suggest these effects deserve serious attention, and we follow that literature closely, though it isn't yet conclusive enough to be the sole reason to start therapy. And if fatigue or low mood is the main story, sleep, thyroid, iron, medications, and life context still deserve the first look — finding your actual answer matters more than reaching for a popular one.

Treating you, not a lab number.

Here's an honest lab secret: "normal ranges" for women's testosterone are poorly standardized, and assays are imprecise at female levels — those printed ranges weren't built to guide therapy. So we dose to *you*: your symptoms, your benefits, your side effects. Optimized for one wāhine may sit above a lab's printed range — and that's a clinical judgment we make together, with periodic levels and side-effect signals as the real guardrails.

Why we don't offer pellets.

Once placed, pellets can't be removed or turned down for months — whatever the dose does, you live with it. International guidance recommends against them for women, and they run counter to how we practice: small, steerable adjustments guided by your response and your levels. Adjustable daily routes let us steer; implanted ones don't.

Topical safety, briefly.

Cream and gel both transfer by touch until absorbed. Apply to a site clothing will cover, wash your hands after, and let it dry fully before skin-to-skin contact with keiki, pets, or partners. The troche sidesteps all of this — one reason some wāhine choose it.

A fair trial, then an honest call.

Desire changes build gradually over about twelve weeks. We reassess together at three to six months: if it's helping, we continue with periodic monitoring; if it isn't, we stop — and keep looking. Staying on a hormone that isn't working is the one outcome we won't choose.

Questions worth bringing to your visit

- Does what I'm experiencing fit HSDD — or something else?
- What baseline labs do we check, and when do we recheck?
- Cream or troche — which fits my routine better?
- What changes should I expect, and by when?
- What would tell us the dose needs adjusting?
- What will this cost, since insurance rarely covers it?

Wahine Health · *Gynecology Care for Maui*
wahinehealth.com · 808-879-1859 · @wahinehealth

SCAN TO SAVE
this handout to your phone

Wondering if this *is* perimenopause? Take our free, private 3-minute symptom check-in: wahinehealth.com/gynecology-blog/perimenopause-quiz