FTM Gender Affirming Therapy

Aotearoa New Zealand PATHA Gender Affirming Hormone Therapy Guidelines (2025) and the earlier Primary Care Gender Affirming Hormone Therapy Initiation Guidelines (2023).

The goal is to achieve **physiological adult male serum testosterone concentrations (approximately 10–30 nmol/L)** while titrating according to clinical response, serum levels, and adverse effects.

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Formulation	Starting Dose	Typical Maintenance Dose	Administration	Monitoring Timing	Major Advantages	Important Considerations
Testosterone cypionate (Depo-Testosterone®)	**50–100 mg IM every 2 weeks** or **25 mg SC weekly**	**100–200 mg IM every 2 weeks** or **50 mg SC weekly**	IM or SC (SC suitable for self-injection)	Check testosterone **midway between injections**	Flexible dosing, inexpensive, self-injection possible	More peak–trough variation than long-acting preparations
Testosterone esters (Sustanon® 250 mg/mL)	**125 mg IM every 3 weeks**	**250 mg IM every 3 weeks**	IM	Midway between injections	Widely available, self-injection possible	Contains **arachis (peanut) oil**—avoid in significant peanut allergy
Testosterone undecanoate (Reandron®)	**750–1000 mg IM**, with **second dose at 6 weeks**	**750–1000 mg IM every 10–12 weeks**	Deep IM (health professional administered)	Just prior to next injection (trough)	Stable testosterone concentrations, fewer injections	**Not suitable for self-administration** due to rare risk of pulmonary oil microembolism
Testosterone gel (Testogel®)	**1 pump daily**	**2 pumps each morning**, titrating up to **4 pumps daily** if required	Transdermal	Measure testosterone after reaching steady state (blood sampling several hours after morning application according to local laboratory guidance)	Avoids injection peaks/troughs; easy dose adjustment	Risk of **skin-to-skin transfer** until dry; wash hands after application
Testosterone patch *(not PHARMAC funded)*	Usually 2.5–5 mg/day	**7.5 mg/day**	Transdermal	After steady state	Stable serum concentrations	Skin irritation common; limited availability

Practical Prescribing Pearls (PATHA)

- **Start at approximately half the usual maintenance dose** and titrate according to patient goals and serum testosterone.
- Aim for **physiological male testosterone levels (approximately 10–30 nmol/L)** rather than maximal dosing.
- Amenorrhoea is expected within **3–6 months**; persistent bleeding should prompt assessment of testosterone levels and consideration of additional menstrual suppression if needed.
- Testosterone **is not contraceptive**—discuss contraception whenever pregnancy is possible.
- The most common dose-limiting adverse effect is **erythrocytosis**, making regular full blood count monitoring essential.