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Testosterone prescribing for women: A practical guide

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Testosterone therapy is recommended for peri- and postmenopausal women with hypoactive sexual desire disorder (HSDD) after a full biopsychosocial assessment and exclusion of other causes. Currently, women are usually prescribed male formulations at lower doses (off-label). Last year, the Medicines Healthcare products and Regulatory Authority (MHRA) approved AndroFeme®, making it the first female-specific testosterone product to be licensed in the UK. If approved by the National Institute for Health and Care Excellence (NICE), AndroFeme® may soon be available in the NHS. This article reviews how to prescribe and monitor testosterone therapy for women.

Clinical case scenario

A 53-year-old postmenopausal woman presents with a 2–3 year history of low libido, night sweats, fatigue, headaches, irritability, anxiety, low mood, generalised joint pain and stiffness, and mild vaginal dryness. She is happily married but reports a new lack of interest and enjoyment in sex (loss of libido), which she finds distressing. She is otherwise healthy and not taking any regular medication. She is prescribed hormone replacement therapy (HRT) and most of her symptoms improve, but the low libido and lack of energy persist. What would you do next?

Hypoactive sexual desire disorder

Hypoactive sexual desire disorder (HSDD)—the 'persistent or recurrent deficiency or absence of sexual fantasies and desire for sexual activity with marked distress or interpersonal difficulty' (Parish et al., 2016)—affects 12–32% of women aged 40–64 years (Parish et al., 2021). The management of women with HSDD has been described in detail elsewhere (Rowen et al., 2026). In brief, the diagnosis of HSDD should be based on a thorough clinical assessment that aims to identify biological, psychological, sociocultural and interpersonal factors that may be causing or contributing to HSDD (Table 1). Treatment should follow this biopsychosocial model, and includes non-pharmacological treatments (e.g. psychotherapies, pelvic floor rehabilitation), pharmacological therapies (non-hormonal and hormonal) or both (Figure 1).

Oestradiol and testosterone modulate female sexual desire via central nervous system and peripheral (genitourinary) effects. The sharp drop in serum oestradiol levels across the menopause transition, coupled with an age-related decline in circulating testosterone levels, is associated with HSDD and genitourinary symptoms (GSM) in peri- and postmenopausal women (Rowen et al., 2026). Symptoms include low libido, reduced arousal, reduced lubrication, dyspareunia and impaired orgasm. Other menopausal symptoms including vasomotor symptoms (VMS), insomnia, fatigue and low mood may also negatively impact sexual desire. Both local hormones (vaginal oestrogen and/or vaginal dehydroepiandrosterone (DHEA) and systemic hormone therapies (hormone replacement therapy (HRT), with or without testosterone) may therefore be needed to address sexual dysfunction in peri- and postmenopausal women (Panay, 2022).

Testosterone physiology

In reproductive-aged women, the ovaries and adrenals each contribute approximately 25% of circulating testosterone and

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Table 1. Factors that commonly affect female desire

Factors affecting female desire	Examples
Physiological	Medical comorbidities
	Genitourinary issues (e.g. vulvodynia, GSM, urinary incontinence, lichen sclerosus, female genital mutilation (FGM))
	Endocrine disorders (e.g. diabetes, thyroid disease)
	Neurological disorders (e.g. multiple sclerosis, Parkinson's disease, stroke)
	Malignant disease[a]
	Chronic pain (e.g. myalgic encephalomyelitis (ME), rheumatoid arthritis)
	Medications (e.g. selective serotonin reuptake inhibitors (SSRIs), anticholinergics, beta blockers, the contraceptive pill)
	Recent childbirth, breastfeeding, menopause
Psychological	Stress
	Low body image/self esteem
	Mental ill-health (e.g. depression, anxiety)
	Substance abuse including alcohol
	History of abuse
Sociocultural	Relationship difficulties
	Family issues
	Religious beliefs
	Cultural attitudes

[a]Sexual dysfunction is common in women undergoing cancer treatment and cancer survivors. Causes include direct damage to genitourinary tissues (surgery, radiotherapy), iatrogenic premature or early menopause (bilateral oophorectomy, chemotherapy, pelvic radiation), anti-hormone therapies (e.g. tamoxifen, aromatase inhibitors), other side effects of cancer treatment (e.g. nausea, fatigue), genital graft versus host disease, chronic inflammation and stress (reduced brain dopamine levels), psychological effects (low mood, anxiety, altered self-image, loss of autonomy), and relationship difficulties (e.g. loss of intimacy, role changes – partner as patient/carer).

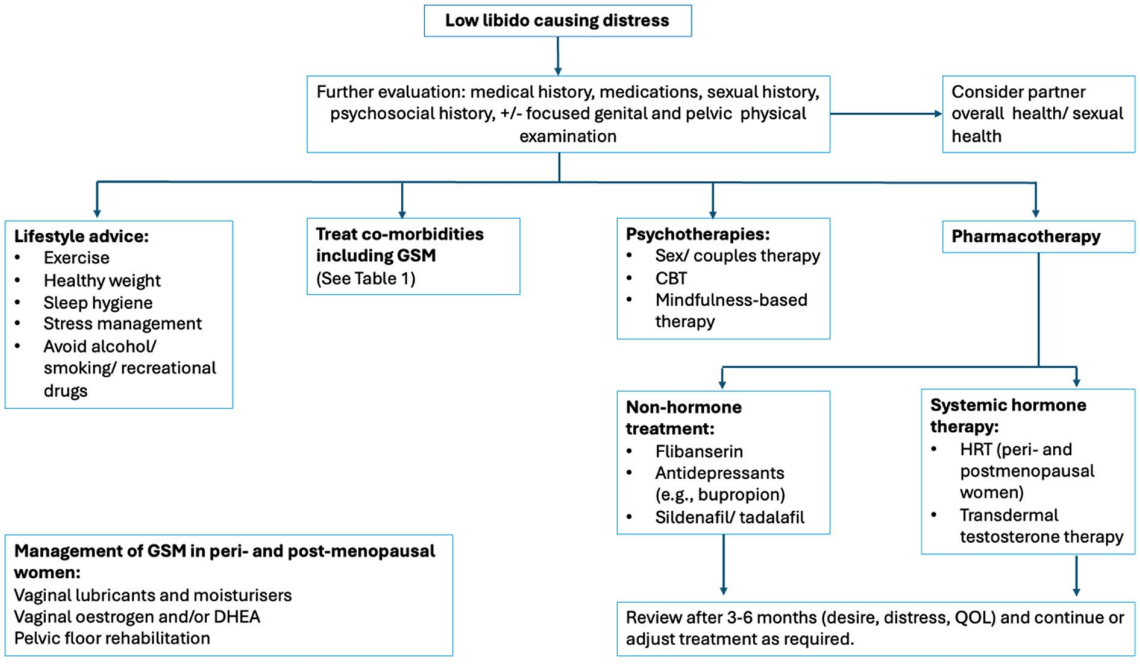
the remaining 50% is produced by peripheral conversion of ovarian- and adrenal-derived pre-androgens (androstenedione and DHEA) (Figure 2) (Parish et al., 2021). After menopause, the adrenal androgen precursors are the main source of testosterone.

Between 1% and 3% of circulating testosterone is unbound or 'free', and the remainder is bound to either sex hormone binding globulin (SHBG) (65%) or albumin (30–45%) (Parish et al., 2021). In target tissues (e.g. the brain, bone, muscles, heart and blood vessels), a small but significant proportion of testosterone is converted to dihydrotestosterone (DHT), the most potent androgen (Parish et al., 2021). Both testosterone and DHT bind to the androgen receptor leading to modulation of androgen-dependent gene expression and biological effects. Additionally, testosterone modulates many biochemical and physiological pathways via aromatisation to 17β-oestradiol, the most potent oestrogen (Parish et al., 2021).

Testosterone blood concentrations peak in adolescence and early adulthood. In premenopausal women, testosterone, oestradiol and oestrone circulate in roughly equal amounts (approximately 300–400 pmol/l) (Skiba et al., 2019). Testosterone levels decrease by 40–50% from age 18 to 60 years, then increase slightly (Skiba et al., 2019; Wang et al., 2025a). Smoking and high body mass index (BMI) are associated with higher testosterone concentrations; bilateral oophorectomy is associated with lower testosterone concentrations in surgically postmenopausal women irrespective of age (Wang et al., 2025a).

Testosterone levels also vary across the menstrual cycle, in a manner similar to oestradiol. Serum testosterone concentration is lowest in the early follicular phase (during menstruation), and highest mid-cycle (peri-ovulation) and in the luteal phase (Skiba et al., 2019). Unlike oestrogens, testosterone levels do not vary by menopausal stage (Wang et al., 2025a). Testosterone is therefore the most abundant sex steroid hormone in postmenopausal women with low oestrogen levels. DHEA and androstenedione are present at much higher concentrations but are less potent and mainly act as a circulating reservoir of precursor hormones that can be converted into testosterone, oestradiol and oestrone in peripheral tissues.

Figure 1. The management of HSDD in women. A multimodal approach is often required that includes lifestyle advice, management of co-morbidities including GSM, psychotherapies (especially if HSDD is situational, i.e. partner or context specific, if there is a significant psychiatric condition, and if there is a history of unresolved sexual trauma and/or abuse) and pharmacological therapies (hormonal and non-hormonal). In the UK, testosterone (AndroFeme®) is the only MHRA-approved medication licensed to treat HSDD (postmenopausal women on optimised HRT). In the USA, flibanserin is the only Food and Drug Admistration-approved medication for the treatment of HSDD (pre- and postmenopausal women; not licensed or authorised for use in the UK).



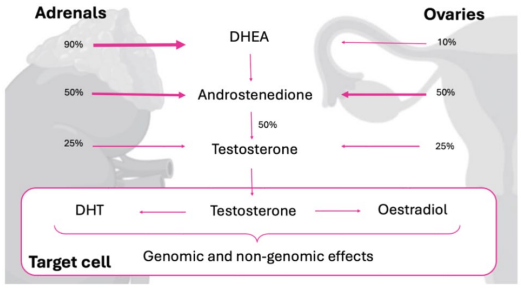
CBT, cognitive behavioural therapy; QOL, quality of life.

Testosterone for the management of HSDD

In contrast to men, a consistent correlation between low serum testosterone levels and low libido and sexual dysfunction in women has not been demonstrated. However, most studies measured testosterone concentration using immunoassay-based techniques, which are highly imprecise and unreliable when testosterone levels are low (less than 3.5 nmol/l, consistent with the reference range for testosterone in healthy pre- and postmenopausal women) (Handelsman and Davis, 2024). A recent study used liquid chromatography-tandem mass spectrometry (LC-MS/MS), the gold standard method, to measure testosterone concentration in women aged 40–69 years (Wang et al., 2025a). It found that testosterone levels decline with age and reach a nadir at the age of 58–59 years, which coincides with the peak prevalence of female sexual dysfunction (FSD) in women (55–59 years) (Wang et al., 2025b).

A systematic review and meta-analysis of 36 randomised clinical trials with 8480 participants found that testosterone therapy exerts a beneficial effect on sexual function, including satisfactory sexual event frequency, sexual desire, arousal, orgasm, pleasure, sexual responsiveness and self-image, and also reduces sexual concerns and distress in postmenopausal

Figure 2. Relative production of circulating androgens by the adrenal glands and ovaries during the reproductive years (Parish et al., 2021). The adrenals and ovaries contribute around half of circulating testosterone. The remainder is produced after peripheral conversion of testosterone precursors (DHEA and androstenedione). The adrenals additionally secrete DHEA sulphate in large amounts (not shown), a prohormone that is converted to DHEA. In target cells, testosterone is converted to DHT and oestradiol. All three hormones exert biological effects via androgen and oestrogen receptor signalling.



women (Islam et al., 2019). Based on the results of the meta-analysis, a global consensus position statement has endorsed the use of transdermal testosterone therapy for postmenopausal women with HSDD, after a formal biopsychosocial assessment and exclusion or treatment of other causes (Davis et al., 2019). Subsequently, the International Society for the Study of Women's Sexual Health (ISSWSH) has recommended that testosterone can also be used to treat HSDD in perimenopausal women (Parish et al., 2021). There are insufficient data to advocate for the use of testosterone in premenopausal women (Davis et al., 2019; Parish et al., 2021).

Both the global consensus statement and ISSWSH guideline recommend that other causes for female sexual dysfunction should be identified and addressed before testosterone is prescribed, but agree that a combined or multimodal approach may be needed (Davis et al., 2019; Parish et al., 2021). In clinical practice testosterone is often prescribed alongside other treatment strategies, because HSDD has complex and overlapping aetiologies (Rowen et al., 2026).

Can testosterone be used to treat other symptoms in peri- and postmenopausal women?

In men, testosterone deficiency results in symptoms including fatigue, sleep disturbance, low mood, anxiety, hot flushes, night sweats, poor concentration, muscle weakness, weight gain and sexual dysfunction. Testosterone is also an essential hormone for women, needed for maintenance of sexual, reproductive, metabolic, musculoskeletal, cardiovascular and brain health. However, systematic reviews of observational studies have failed to demonstrate an association between endogenous testosterone levels and low mood, cognitive dysfunction, or muscle mass and strength in women (Hemachandra et al., 2023; Sultana et al., 2023; Taylor et al., 2023). Furthermore, although limited data from observational studies suggest that testosterone therapy may have beneficial effects on menopausal symptoms including energy, mood and cognition, this has not been confirmed in randomised clinical trials (Islam et al., 2019).

Multiple factors may account for the lack of therapeutic effect on other menopausal symptoms in clinical trials. These include small sample sizes, different eligibility criteria (menopausal status, age at menopause, natural vs surgical menopause), the concomitant use of oestrogen therapy in some but not all studies, the use of different scales to measure different outcome measures and short study durations. Most trials were designed to assess the impact of testosterone on sexual function (the primary outcome); they were not designed (and lacked power) to detect an effect on other symptoms such as mood and cognitive function (secondary outcomes) (Islam et al., 2019). Finally, most studies measured serum testosterone concentration using immunoassays which, as noted previously, lack accuracy in the female range (Handelsman and Davis, 2024).

In summary, the findings of clinical trials are inconclusive and do not support a treatment effect or lack of efficacy for the relief of menopausal symptoms other than low libido (Islam et al., 2019). In clinical practice, women seldom present to a menopause clinic with HSDD alone. Menopause specialists often prescribe testosterone to improve libido, and because many women additionally report improvement in other symptoms including fatigue, sleep disturbance, low mood, anxiety, hot flushes, night sweats, poor concentration and muscle weakness. There is an urgent need for 'more adequately powered, double-blind randomised clinical trials (RCT), without selection bias and with consistent reporting of standardised outcomes, to comprehensively establish the benefits and risks of testosterone therapy for women' (Davis et al., 2019). To this end, the Evaluating the clinical and cost-effectivenesS of TEstosteronE to improve Menopause-related quality of life (ESTEEM) trial aims to determine if the addition of testosterone to standard HRT for 12 months can improve menopause-related quality of life and menopausal symptoms including sleep, memory, mood and migraine (Cardiff University Centres for Trials Research, 2025). The trial is expected to end in June 2028. Until further data are available, it must be emphasised that the only evidence-based indication for testosterone therapy for women is for the treatment of HSDD (Davis et al., 2019; Parish et al., 2021).

Testosterone prescribing: UK guidelines

The National Institute for Health and Care Excellence (NICE) menopause guideline (NG23) recommends that testosterone therapy can be prescribed for women with low sexual desire associated with menopause if HRT alone is not effective (NICE, 2015). The British Menopause Society (BMS) recommends that testosterone therapy is considered for peri- and postmenopausal women with distressing low sexual desire and low energy, particularly if HRT with adequate levels of oestrogen (± a progestogen) has not been effective (Hamoda et al., 2020; Panay, 2022).. In other words, HRT should normally be tried first (unless not wanted, not tolerated or contra-indicated), and the dose and regimen should be optimised (Glynne and Simon, 2026).

Since NICE first published its menopause guideline in 2015, testosterone gel prescriptions for women aged 40 years and over in England have increased substantially, from around 10 000 items in 2015/16 to 120 000 items in 2023/24 (+1100%) (Arnold et al., 2025). This has been associated with a 15-fold increase in NHS spend over the same time period (from £150,000 to £2.5m) (Arnold et al., 2025). Until recently, no government-approved female testosterone formulation was available in the UK. Consequently, testosterone treatment is usually initiated or recommended by a specialist in secondary care, and prescribing is transferred to the GP once the dose has been optimised (shared care agreements). However, not all local formularies include testosterone, and GPs may be reluctant to prescribe off-label medications. This has resulted in a postcode lottery of testosterone prescribing and provision for women in the NHS (Arnold et al., 2025).

AndroFeme® 10mg/mL cream is a testosterone cream that has been specifically designed for female use. Manufactured in Australia, it has been imported to the UK under special Medicines Healthcare products and Regulatory Authority (MHRA) license for use in the private sector since 2019. In

Table 2. Testosterone formulations commonly prescribed for peri- and postmenopausal women with HSDD in the UK.

Formulation	Pack details	Starting dose	Prescription duration	Cost per pack	Approximate cost per year
Testogel® 40.5 mg/2.5 g (Besins Healthcare Ltd)	30 × 2.5 g sachets	1/8 sachet daily (a 'small pea-sized amount' daily)	One sachet lasts 8 days A 30-sachet pack lasts 240 days	£39.94	£61.24
Tostran® 2% gel One pump delivers 0.5 g of gel containing 10 mg of testosterone (Kyowa Kirin Ltd)	60 g canister	One pump (10 mg) on alternate days	One canister = 120 doses lasts 240 days	£28.63	£43.52
AndroFeme® 1% cream (10 mg/ml) (Lawley Pharmaceuticals Ltd)	50 ml tube	0.5 ml daily	1 × 50 ml tube lasts 100 days	-	-

AndroFeme® is the only product licensed for postmenopausal women with HSDD; use in perimenopausal women is off-label. Other formulations are licensed for male use, and the dose must be down-titrated to achieve a female dose (off-label). A fourth formulation, Testogel® 16.2 mg/g (one pump delivers 1.25 g of gel containing 20.25 mg of testosterone), is sometimes prescribed but not recommended because female dosing is difficult to achieve (one pump every 4 days, meaning that levels fluctuate above and below the female range and are difficult to titrate).
Estimated cost of treatment is based on data published in the NHS Drug Tariff in January 2026 (NHS Business Services Authority, 2026).
AndroFeme® is not available on standard NHS prescription. A private prescription for AndroFeme® costs around £100 per 50ml tube.

August 2025, AndroFeme® was approved by the Medicines and Healthcare products Regulatory Agency (MHRA) to treat HSDD in postmenopausal women on optimised HRT (Medicines Healthcare products and Regulatory Agency, 2025). Due to be launched in the UK in late 2026, a licensed testosterone formulation may therefore soon become available in the NHS, subject to NICE approval.

Testosterone formulations and doses

The aim of treatment is to achieve testosterone concentrations within the physiological range observed in premenopausal women (Davis et al., 2019). Transdermal, body-identical testosterone formulations are therefore recommended; oral preparations, intramuscular injections and subcutaneous pellets that result in supraphysiological blood concentrations should be avoided (Davis et al., 2019; Parish et al., 2021). Compounded 'bioidentical' products manufactured in independent pharmacies are also not recommended, due to uncertain quality and a lack of evidence for efficacy and safety (Davis et al., 2019; Parish et al., 2021).

AndroFeme® comes with a syringe applicator to measure out the exact prescribed dose. The usual starting dose is 0.5 ml (0.5 mg) daily. Male testosterone formulations are prescribed off-label with the dose adjusted to achieve testosterone concentrations in the female range (Table 2) (Panay, 2022). If prescribing Testogel® 40.5 mg/2.5g gel sachets, women are usually advised to apply a small pea-sized amount of gel daily, one sachet should last 8 days (approximately 0.5 mg daily). Tostran 2% gel (20 mg of testosterone per gram of gel in a 60-g metered-dose canister) can also be prescribed. One pump delivers 0.5 g gel containing 10mg testosterone. One pump of gel must therefore be applied on alternate days to achieve a 5-mg daily dose.

Gels and creams should be applied at roughly the same time each day (or on alternate days – Tostran) to clean, dry skin on the upper outer thigh or buttock. The cream or gel should be massaged in until absorbed (approximately 30 seconds). Women can then dress but should avoid bathing, showering or swimming for at least 4 hours post-application.

Testosterone in doses far exceeding therapeutic levels may be abused for recreational purposes (competitive sport and bodybuilding) and/or for cosmetic reasons. It is therefore a schedule 4 (part II) Controlled Drug in the UK (UK Government, 2001). This means that testosterone is only available by prescription, and prescriptions are only valid for 28 days. The Department of Health recommends that prescriptions for Schedule 4 controlled drugs do not exceed a 30-day supply. However, prescriptions can exceed 30 days if there is a justifiable clinical need such as a long-term stable condition (e.g., HSDD) and a low risk of abuse (National Institute for Health and Care Excellence (NICE), 2022).

Monitoring response to treatment

Transdermal drug absorption is highly variable, and testosterone dose must therefore be tailored to the individual (some women are 'good absorbers' and only need a standard dose; others are 'poor absorbers' and need a higher dose or a different formulation to achieve therapeutic levels). Factors affecting SHBG levels can also influence testosterone bioavailability and dose requirements (Table 3). High SHBG levels bind more testosterone and reduce the amount of free, bioavailable

Table 3. Conditions associated with high and low SHBG concentrations.

Conditions associated with high SHBG concentrations	Conditions associated with low SHBG concentrations
Aging	Obesity
Chronic infections (e.g. HIV, hepatitis)	Diabetes and insulin resistance states (e.g. polycystic ovarian syndrome)
Hyperthyroidism	Hypothyroidism
Elevated oestrogen (e.g. advanced liver disease, pregnancy, alcohol consumption)	Acromegaly
Medications (e.g. thiazolidinediones, anticonvulsants, oral contraceptives, selective oestrogen receptor modulators)	Medications (e.g. glucocorticoids, tyrosine kinase inhibitors, anabolic androgenic steroids)
SHBG polymorphisms (rs6258, rs12150660)	SHBG polymorphisms (rs6257, rs6259, rs727428, rs1799941)
Extreme weight loss e.g., anorexia nervosa	Nephrotic syndrome

testosterone in the body, which can result in symptoms of testosterone deficiency. Switching women with HSDD on oral oestrogen to a transdermal oestrogen formulation can increase the amount of circulating free testosterone and may improve symptoms without the need for testosterone therapy (Panay, 2022; Parish et al., 2021).

LC-MS/MS is the gold-standard method for measuring serum testosterone concentration, but not widely available in clinical practice (Handelsman and Davis, 2024). Immunoassays are commonly used (cheaper, less labour-intensive, automated for higher throughput), but lack sensitivity at low concentrations and are subject to interference from cross reacting and interfering substances (e.g. DHEA, biotin and heterophile antibodies) (Handelsman and Davis, 2024). Furthermore, blood levels may not accurately reflect tissue levels or overall androgen status, and there is no established reference interval for testosterone in women (Handelsman and Davis, 2024)

Consequently, blood tests are of limited value. Clinical response to treatment (symptom improvement and side effects) is key, and blood monitoring is used solely to exclude high total testosterone concentrations before and during treatment. Because immunoassays have a positive bias, levels up to 50% above the upper limit of the premenopausal reference range for the assay used are generally considered acceptable. For example, if the labs upper limit is 1.6 nmol/l, levels up to 2.4 nmol/l are permissible in the absence of side effects. If levels are high but the patient has no signs of hyperandrogenism (e.g. hirsutism, acne), the test should be repeated to exclude skin contamination (Vihtamaki et al., 2004) or lab error. If very high and/or persistently elevated, interference should be suspected and the patient should be referred for further assessment and quantification of serum testosterone using LC-MS (Huang et al., 2025). The free androgen index (FAI = total testosterone × 100/SHBG) can be used to support dose decisions when SHBG levels are low or high (FAI should be between 1.5% and 10%) (Hamoda et al., 2020). Where there is clinical uncertainty, the dose should be reduced; if symptoms recur the dose can be increased back to the previously effective dose. If symptoms don't recur, the patient should continue to use the lower dose and/or consider a trial of stopping therapy (may no longer be needed).

Guidelines recommend that total testosterone is measured at baseline and 3-6 weeks after treatment initiation (Davis et al., 2019; Parish et al., 2021). Women typically start to notice improvement in sexual function 6–8 weeks after initiating treatment, with maximal effects at about 12 weeks (Parish et al., 2021). In practice, patients are therefore usually reviewed after 2–3 months, and testing can be delayed until then if more practicable (Panay, 2022).

If there is no response after 12 weeks, patients should be advised that it can take up to 6 months to see a treatment effect (Panay, 2022). If the total testosterone concentration is within the premenopausal reference range, the dose can be increased e.g. to 1.0 ml AndroFeme® cream daily, or a 'small edamame bean-sized' amount of Testogel® daily (one sachet should last 4–6 days). Higher doses or a change in formulation may be required if women are poor absorbers. The patient should be reviewed again after 6–12 weeks. If there is benefit, treatment can be continued and the patient should be reviewed every 6–12 months to assess for ongoing efficacy and androgenic side effects (Panay, 2022). If there is no benefit, treatment should be discontinued and other causes and treatment options for HSDD should be re-explored.

Side effects and safety

Testosterone therapy is usually well-tolerated and androgenic side effects are rare when testosterone levels are maintained in the premenopausal range. Compared with placebo, systemic testosterone therapy in physiologic doses is associated with mild increases in acne (7.5% vs 5%) and body/facial hair (8.6% vs 6.0%, mainly at the site of application), but not with alopecia,

clitoromegaly or voice change (Islam et al., 2019). Acne often settles with continued use (may take several months); both acne and excess hair growth resolve when treatment is discontinued.

In observational studies and clinical trials of up to 2 years of duration, no serious adverse effects have been reported (Islam et al., 2019). Clinical trials are needed to establish long-term safety.

Conclusions

Testosterone is recommended to treat HSDD in peri- and postmenopausal women. HRT should be tried first and the dose and regimen should be optimised (Glynne and Simon, 2026), especially if women have other menopausal symptoms that negatively impact libido (e.g. vasomotor symptoms, fatigue, low mood). It is also important to treat genitourinary symptoms.

Testosterone therapy can be prescribed and monitored in primary care, subject to the healthcare professional's level of expertise and available resources (Panay, 2022). If GPs lack confidence, are unable to prescribe testosterone (not supported by local formularies/ prescribing pathways), and/or if women have severe or persistent symptoms, they should be referred to a menopause specialist. Women with high levels should also be referred if assay interference is suspected (clinical context is key). It is not always necessary to wait until other factors contributing to low libido have been addressed (e.g. depression, relationship difficulties) because a multimodal treatment strategy is often needed and testosterone can be a useful adjunct to other therapies.

Demand for testosterone is increasing but provision in the UK is currently patchy. AndroFeme®, a transdermal testosterone cream, has recently been licensed to treat HSDD in postmenopausal women with persistent symptoms on optimised HRT. AndroFeme® can also be used to treat HSDD in perimenopausal women (off-label). If approved by NICE, the inclusion of AndroFeme® in local formularies will improve access, reduce prescribing variation, and support equitable, patient-centred care (NICE, 2014).

KEY POINTS

- Female sexual dysfunction is common and can significantly impair quality of life and well-being
- Testosterone significantly improves sexual desire and is recommended for the treatment of hypoactive sexual desire disorder in peri- and postmenopausal women
- Until recently, no testosterone products licensed for female use were available in the UK. Women have therefore been prescribed male formulations off-label, or AndroFeme® in private clinics (licensed in Australia in 2020)
- In 2025, the MHRA granted marketing authorisation for AndroFeme®, making it the first licensed testosterone product for female use in the UK
- If approved by NICE, AndroFeme® may soon become available in the NHS
- GPs should understand when and how to prescribe testosterone, and when to refer to a menopause specialist

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