



Feminizing Hormone Therapy Checklist

UCSB Student Health policy is to optimize accessibility of transition care without sacrificing quality of care. The following checklist is intended to guide the prescription process to ensure that the patient is well-informed about their personal risk, the options and resources available to them, and how the process of medical transition works. This advising process is intended to empower patients to make the best decision for themselves and assess the patient's ability to provide informed consent (UCSF's standards are "able to understand risks, benefits, alternatives, unknown, limitations, and risks of no treatment"); the process should be as transparent as possible.

- Answer any questions the patient has about medical transition. FAQ handouts are available. The informed consent form can also be a useful tool for initial counseling.
- Take a baseline metabolic panel. This will make it possible to evaluate risk to kidneys and liver, and to track hormone levels—metabolic panels are typically reassessed at 3 months, 6 months, and annually thereafter.
Patient is usually asked to fast 10-12 hours before collection.
- Screen for contraindicating factors:
 - **History of estrogen-dependent cancer (most often breast cancer)**
 - Migraines
 - Seizures
 - Smokes cigarettes
 - Blood clots that could or did travel to lungs
 - Strong family history of breast cancer or other estrogen-responsive cancers
 - Kidney or liver disease
 - Heart disease or heart valve problems
- Discuss complicating social factors:
 - Is the patient out to family, friends, partner, employer, or instructors? Is there a plan to come out? How does the patient think people will respond to the news?
 - Does the patient depend on parents financially? Is there a fear of financial support diminishing as a result of transition? Does the patient have a plan in this case?
 - Is the patient seeing a therapist? This is not required but if no, recommend short-term therapy during medical transition.
 - Does the patient have any fears or worries associated with transitioning or beginning hormones?
- Review informed consent document with patient, incorporating evaluation from metabolic panel, family history, and any other relevant screenings. This document does not have to be signed, but should be reviewed carefully prior to starting hormones to



ensure that the patient has an accurate sense of what hormone therapy entails. The patient should receive a copy of the informed consent form.

- Discuss delivery options:
 - Transdermal patches: usually changed once or twice a week, must be worn all the time
 - Pills: inexpensive and convenient, increased risk of serious side effects with smoking or age over 35
 - Injection: inexpensive, but harder to keep estrogen levels stable (which can increase certain side effects)
 - Less-common options include creams and gels, but these may be more expensive or more difficult to find.
- Begin prescribing. UCSF dosing recommendations attached.
- Follow-up appointments (3mo, 6mo, then annual):
 - Evaluate changes in testosterone and estrogen levels
 - Monitor risk to kidneys and liver
 - Inquire about ongoing social risk factors and recommend resources as appropriate
 - UCSF follow-up guidelines attached.

More information on masculinizing therapy can be found in the UCSF Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People:

<http://transhealth.ucsf.edu/trans?page=guidelines-masculinizing-therapy>



Hormone	Initial-low ^b	Initial	Maximum ^c	Comments
Estrogen				
Estradiol oral/sublingual	1mg/day	2-4mg/day	8mg/day	if >2mg recommend divided bid dosing
Estradiol transdermal	50mcg	100mcg	100-400 mcg	Max single patch dose available is 100mcg. Frequency of change is brand/product dependent. More than 2 patches at a time may be cumbersome for patients
Estradiol valerate IM ^a	<20mg IM q 2 wk	20mg IM q 2 wk	40mg IM q 2wk	May divide dose into weekly injections for cyclical symptoms
Estradiol cypionate IM	<2mg q 2wk	2mg IM q 2 wk	5mg IM q 2 wk	May divide dose into weekly injections for cyclical symptoms
Progestagen				
Medroxyprogesterone acetate (Provera)	2.5mg qhs		5-10mg qhs	
Micronized progesterone			100-200mg qhs	
Androgen blocker				
Spirolactone	25mg qd	50mg bid	200mg bid	
Finasteride	1mg qd		5mg qd	
Dutasteride			0.5mg qd	

a. Available as standard U.S. Pharmacopia (USP) as well as compounded products

b. Initial-low dosing for those who desire (or require due to medical history) a low dose or slow upward titration.

c. Maximal effect does not necessarily require maximal dosing; as such maximal doses do not necessarily represent a target or ideal dose. Dose increases should be based on patient response and monitored hormone levels.



Test	Comments	Baseline	3 months*	6 months*	12 months*	Yearly	PRN
BUN/Cr/K+	Only if spiro used	X	X	X	X	X	X
Lipids	No evidence to support monitoring at any time; use clinician discretion	Based on USPSTF guidelines					X
A1c or glucose	No evidence to support monitoring at any time; use clinician discretion	Based on USPSTF guidelines					
Estradiol			X	X			X
Total Testosterone			X	X	X		X
Sex Hormone Binding Globulin (SHBG)**			X	X	X		X
Albumin**			X	X	X		X
Prolactin	Only if symptoms of prolactinoma						X

* In first year of therapy only

** Used to calculate bioavailable testosterone; monitoring bioavailable testosterone is optional and may be helpful in complex cases (see text)