Why Peptides Are Having a Moment in the UK

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Market Growth, UK Regulation and How to Be a Careful Buyer. 2026 Edition

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Part I: The UK Peptide Moment

Chapter 1: Four Categories, One Word

"Peptide" is one word doing the work of four very different UK markets. A buyer who types it into a search engine in 2026 could be looking for a prescription weight-management medication, a research chemical sold for laboratory use, a skincare ingredient, or a food supplement. These four categories sit under four different UK regulators, carry four different legal statuses, and call for four different sets of questions before you buy.

- Prescription GLP-1 medications (tirzepatide, semaglutide, liraglutide) are Prescription Only Medicines, regulated by the MHRA and dispensed through GPhC-registered pharmacies.
- Research peptides (such as BPC-157, TB-500, Ipamorelin) are sold under "research use only" framing and sit outside the medicines tier when no health claims are made.
- Cosmetic peptide skincare is regulated under the UK Cosmetics Regulation 2013, not the MHRA.
- Ingestible collagen is a food supplement, regulated by the Food Standards Agency.

What unites these four categories is the word on the label. Almost nothing else does. The chapters that follow take each on its own terms: its regulator, its legal status, its supply chain, and the signals a careful buyer should read.

Chapter 2: What Is Driving the Interest

The UK peptide market in 2026 looks nothing like it did five years ago. A category that was niche, dominated by a small number of research peptide retailers serving academic and laboratory customers, and a cosmetics ingredient found mostly in premium serums, has become the subject of mainstream consumer interest, significant regulatory attention, and a growing editorial conversation about what the UK rules actually say.

PeptideClear UK's editorial observation, drawn from reviewing publicly available search trend data, the volume and breadth of UK media coverage, and the growth in the number of UK-facing retailers and clinics in each category, is that four distinct forces have converged:

GLP-1 prescription medications. The NHS approved tirzepatide (Mounjaro) for weight management in December 2024 under NICE TA1026, following earlier approvals for semaglutide (Wegovy) and liraglutide (Saxenda). The phased NHS rollout, beginning with the highest-need cohort from June 2025 and widening in later phases on an NHS

England timetable, has brought prescription GLP-1 medications into mainstream public awareness at a pace that outstripped the regulatory and educational infrastructure around them. A corresponding private market grew alongside the NHS route, with many UK clinics and online pharmacies entering the space in 2024 and 2025. The ASA's September 2025 enforcement notice on consumer-facing GLP-1 advertising reflects how quickly the market matured and how quickly regulators had to respond.

Research peptides. The UK research peptide retailer market expanded in the same period, selling peptides such as BPC-157, TB-500, Ipamorelin, and MOTS-c under "research use only" framing. These are not medicines. They hold no UK marketing authorisation. They sit outside the MHRA medicines tier when sold without health claims. Interest in them, from academia, from bodybuilding communities, from people aware of their preclinical literature, has grown. So has the number of UK retailers, the variance in quality practice, and the MHRA's attention to retailers that blur the line between "research use only" labelling and therapeutic marketing.

Cosmetic peptide skincare. Peptides have been ingredients in cosmetic formulations since at least the early 2000s, and GHK-Cu (Pickart, 1973) has a decades-long cosmetic literature. In 2024 to 2026 the cosmetic peptide category has grown rapidly as a skincare ingredient class in UK retail, with Cult Beauty, LookFantastic, Boots, and Holland and Barrett all expanding peptide ranges. The category is regulated by the UK Cosmetics Regulation 2013, not the MHRA, and operates under different rules from either prescription medicines or research chemicals.

Ingestible collagen. The UK ingestible collagen market, hydrolysed collagen supplements, grew through the same period, driven by social media interest in skin elasticity, joint support, and gut health applications. Collagen supplements are food supplements, regulated by the Food Standards Agency, not the MHRA. They sit in a category with lighter regulatory requirements and correspondingly wider variation in product quality and transparency.

What these four categories share is a word: "peptide". Beyond that word, their regulatory regimes, their legal status, their supply chains, and the standards buyers should apply to each differ substantially. This book is about those differences.

Who this book is for

This book is for UK consumers, journalists, healthcare students, and researchers who want to understand what the UK rules actually say about peptides, in each of the four categories, and what that means for a buyer trying to distinguish between a well-run seller and a poorly-run one. It is not a guide to using any peptide. It is a guide to the regulatory terrain, the quality signals, and the questions worth asking.

A note on scope

PeptideClear UK publishes across four peptide categories. This book draws primarily on PeptideClear's regulatory and consumer-awareness editorial in the two categories where the regulatory story is most complex and where buyer risk is highest: prescription GLP-1 medications and UK research peptides. Cosmetic peptide skincare and collagen supplements are covered in the context of regulatory framing but are not the primary focus.

Part II: The UK Rules

Chapter 3: How MHRA Classifies Medicines

UK medicines are classified into three tiers: Prescription Only Medicine (POM), Pharmacy (P), and General Sales List (GSL).

MHRA medicines classification

The Medicines and Healthcare products Regulatory Agency (MHRA) classifies licensed UK medicines into three tiers, set out in the Human Medicines Regulations 2012. The classification determines who can prescribe or sell the medicine, where the supply can happen, and what advertising is permitted.

The three tiers

- Prescription Only Medicine (POM): requires a prescription from a qualified prescriber. Dispensed through a pharmacy. Cannot be advertised to the public. All licensed GLP-1 weight-management medications are POM.
- Pharmacy medicine (P): sold only by or under the supervision of a pharmacist. No prescription required. Can be advertised with restrictions. Examples: orlistat 60 mg (Alli), some emergency contraception.
- General Sales List (GSL): sold in any retail outlet without pharmacist supervision. Lowest tier. Examples: paracetamol 500 mg in pack sizes up to 16, low-dose ibuprofen.

Reclassification

MHRA can reclassify a medicine downward (POM to P, P to GSL) when sufficient real-world safety data has accumulated. Orlistat moved from POM to P in 2009. No GLP-1 weight-management medication has been reclassified, and the MHRA's stated position, per its classification documentation, is that the risk profile it cites (including pancreatitis, gallbladder events, and hypoglycaemia in people with diabetes) does not support P-tier supply.

What sits outside the tiers

Food supplements (collagen, vitamins, minerals) are regulated by the Food Standards Agency (FSA), not the MHRA. Cosmetic products (peptide serums) are regulated under the UK Cosmetics Regulation 2013. Research peptides without UK marketing authorisation sit entirely outside the medicines classification when sold under "research use only" framing.

Chapter 4: ASA and Advertising: What Cannot Be Said

The Advertising Standards Authority enforces the CAP code on UK advertising. POM weight-loss medications cannot be advertised to the public.

ASA rules on weight-loss advertising

The Advertising Standards Authority (ASA) enforces the Committee of Advertising Practice (CAP) code on UK advertising. Prescription-only medicines (POMs) cannot be advertised to the public under CAP rule 12.12. Tirzepatide (Mounjaro), semaglutide (Wegovy) and liraglutide (Saxenda) are all POMs. The ASA issued an enforcement notice in September 2025 tightening the application of these rules to consumer-facing GLP-1 advertising.

What is not allowed

- · Naming a POM weight-loss medication in consumer advertising.
- · Before-and-after imagery linked to a named POM medication.
- · Pricing the medication directly in social or search advertising.
- · Promotional codes or discount offers for POM weight-loss medications.
- · Influencer endorsements of named POM medications.

What is allowed

- · Generic advertising of a weight-management clinic or service (“medical weight loss programme”) without naming the medication.
- · Editorial commentary on the medications themselves (this publication is informational commentary, not a medicine advertisement).
- · Pharmacy advertising of services, with conservative wording.
- · Healthcare professional-facing communications (not consumer-facing).

Why the September 2025 enforcement notice mattered

The ASA confirmed that many UK clinic and pharmacy ads naming Mounjaro and Wegovy in search and social were in breach. Several major clinics paused consumer ads while compliance reviews ran. By Q1 2026 most UK clinics had restructured advertising around generic “GLP-1” or “medical weight loss” framing, with the named medication only appearing post-consultation on the prescriber side.

Chapter 5: Research-Use-Only Framing: What It Does and Does Not Authorise

The regulatory wording under which research peptides are sold in the UK. What it does and does not authorise, why the framing matters, and where it sits.

"Research use only" framing

Research peptides without UK marketing authorisation (BPC-157, TB-500, Ipamorelin, Sermorelin, Tesamorelin, MOTS-c and many others) are sold by UK retailers under a "research use only, not for human or animal consumption" framing. This wording is what positions the product outside the Human Medicines Regulations 2012 medicines tier.

What the framing does

- · Marks the product as not intended for use as a medicine.
- · Removes therapeutic claims from the product page (no "treats", "cures", "improves").
- · Positions the supplier as a chemical retailer, not a pharmacy or prescriber.
- · Keeps the product outside the MHRA medicines licensing regime.

What it does not authorise

- · It does not authorise human use of the peptide. The framing is the opposite of that.
- · It does not exempt the retailer from making honest descriptive claims; misleading purity claims would still be in scope of consumer protection law.
- · It does not place the product in any positive regulatory category. The product sits outside the medicines tier rather than inside any other tier.

When the framing fails

A retailer adding any therapeutic claim (for example, any claim that a peptide treats, heals or improves a named condition in humans) immediately puts the product in scope of the Human Medicines Regulations 2012, which means selling an unlicensed medicinal product. MHRA enforcement action against UK retailers in 2024 to 2025 has focused on exactly this pattern: research-use-only labelling on the product page but therapeutic claims in the marketing copy elsewhere on the site.

Why this matters to readers

The research-use-only framing is meaningful: it sets the regulatory context that the peptide is not approved for human use in the UK. PeptideClear treats all research peptide content as encyclopedia information about the molecule and the literature, not as guid-

ance for human use. We do not publish dosing protocols, missed-dose advice, or human-use instructions for research peptides.

Chapter 6: Compounded vs Licensed GLP-1: the UK Position

Compounded GLP-1 (custom-mixed semaglutide or tirzepatide) is common in the US but not part of routine authorised UK supply (unlicensed Specials aside).

Compounded vs licensed GLP-1

Compounded GLP-1 is semaglutide or tirzepatide active ingredient mixed into custom formulations by a non-manufacturer, typically a specialist compounding pharmacy. In the US, compounded GLP-1 was widely available during 2023 to 2024 when FDA shortage lists allowed it. In the UK, compounded GLP-1 is not part of routine authorised supply; unlicensed compounding is limited to bespoke Specials prepared for an individual patient under strict regulatory exemptions, not routine commercial supply. PeptideClear does not list or recommend compounded sources.

What “licensed” means in the UK

Licensed UK GLP-1 medications are tirzepatide (Mounjaro, Eli Lilly), semaglutide (Wegovy and Ozempic, Novo Nordisk), and liraglutide (Saxenda and Victoza, Novo Nordisk). Each holds a UK MHRA marketing authorisation and is supplied in pre-filled pens or single-use vials manufactured by the licence holder. Cold-chain logistics from manufacturer to UK pharmacy are validated and documented.

Why compounded is not legal UK supply

- · Compounded mixtures are unlicensed medicinal products under the Human Medicines Regulations 2012.
- · UK Specials manufacturing licence is needed to prepare unlicensed medicines, and is granted for specific patient needs, not routine supply.
- · The active ingredient source matters: licensed manufacturers produce semaglutide and tirzepatide to GMP standard with full chain of custody. Compounded sources may not have this.
- · MHRA enforcement focus 2024 onwards has targeted UK retailers and pharmacies offering compounded supply.

What to verify before purchase

A UK pharmacy supplying GLP-1 should be able to confirm: GPhC registration number, the medication brand name (Mounjaro or Wegovy or Saxenda, not “semaglutide compound”), the manufacturer (Eli Lilly or Novo Nordisk), batch number traceability, and validated cold-chain delivery. If a supplier is vague on any of these, the product is unlikely to be licensed UK supply.

Chapter 7: WADA and Tested Athletes

The World Anti-Doping Agency prohibits several research peptides under section S2 (peptide hormones, growth factors).

WADA prohibited list and peptides

The World Anti-Doping Agency (WADA) publishes an annually-updated list of prohibited substances. Several research peptides commonly sold in the UK appear on it under section S2 (peptide hormones, growth factors and related substances). Tested athletes under UK Anti-Doping (UKAD), British Olympic Association or international federation jurisdiction must avoid these peptides regardless of context.

Research peptides commonly on the list

- · BPC-157 (also captured under section S0, non-approved substances).
- · TB-500 (thymosin beta-4 fragment).
- · MOTS-c (prohibited under section S4.4, metabolic modulators, rather than S2).
- · Ipamorelin and related GHRPs (GHRP-2, GHRP-6, hexarelin).
- · CJC-1295 and other GHRH analogues.
- · Tesamorelin and Sermorelin (as GHRH analogues).
- · IGF-1 and IGF-1 LR3.

SARMs specifically

Selective Androgen Receptor Modulators (Ostarine, LGD-4033, RAD-140, Andarine) are prohibited under section S1.2 (other anabolic agents), not S2. Tested athletes choosing a UK research peptide retailer should consider whether the retailer also sells SARMs; even purchasing the peptide alongside SARMs raises evidentiary concerns in an investigation.

In and out of competition

These substances are prohibited at all times (in and out of competition). There is no detection-free or “wash-out” interval for a tested athlete; metabolite detection windows extend well beyond any use period, and any positive test is a violation.

Therapeutic use exemptions (TUEs)

Some prohibited substances can be used with a Therapeutic Use Exemption when there is a documented medical need. The S2 peptides listed above almost never qualify because they have no UK marketing authorisation as medicines; there is therefore no licensed therapeutic use for which an exemption could apply.

Chapter 8: NHS Access: the Three-Cohort Rollout

NHS England is rolling Mounjaro out for weight management in phased cohorts by BMI and comorbidity count, over a period of up to 12 years. Cohort 1 live since June 2025; Cohort 2 from 23 June 2026.

NHS GLP-1 access

NHS England is rolling out tirzepatide (Mounjaro) for weight management in phased cohorts defined by BMI threshold and the number of weight-related comorbidities, prioritised by clinical need and reaching the full eligible population over a period of up to 12 years. The phasing is set out in the NICE technology appraisal TA1026 (2024) and the NHS England interim commissioning guidance, and is operationalised by Integrated Care Boards (ICBs) at different paces across England.

The phased cohorts

- Cohort 1 (live since June 2025): BMI 40+ (37.5+ with ethnicity adjustment) and four or more weight-related comorbidities.
- Cohort 2 (from 23 June 2026): BMI 35 to 39.9 (32.5 to 37.4 with ethnicity adjustment) and four or more weight-related comorbidities.
- Later phases: NHS England extends eligibility progressively after June 2026, prioritised by clinical need, with the full eligible population (around 3.4 million people) reached over a period of up to 12 years. The criteria and timing for cohorts beyond June 2026 have not yet been finalised by NHS England, so check the current NICE TA1026 and NHS England guidance for the latest position.

What counts as a comorbidity

Weight-related health conditions defined in NICE TA1026: type 2 diabetes, hypertension, dyslipidaemia (raised cholesterol or triglycerides), obstructive sleep apnoea, cardiovascular disease (including heart failure and ischaemic heart disease).

Ethnicity-adjusted BMI

NICE recommends a 2.5 kg/m² downward adjustment of the BMI threshold for South Asian, Chinese, Black African, and African-Caribbean populations, reflecting higher metabolic risk at lower BMI in those populations.

ICB pace variation

The 42 English ICBs operate at different paces. Some launched Cohort 1 immediately in June 2025; others took six to twelve months to commission specialist weight management services to manage referrals. PeptideClear tracks the rollout status on the ICB rollout tracker page.

Chapter 9: NICE TA1026: the Framework in Detail

NICE Technology Appraisal 1026 (2024) is the UK guidance defining who qualifies for NHS Mounjaro under the phased rollout.

NICE TA1026

NICE Technology Appraisal 1026 was published in December 2024. It is the UK authoritative document governing tirzepatide (Mounjaro) availability through NHS England for weight management. It defines the BMI thresholds, comorbidity requirements, ethnicity-adjusted thresholds, the phased cohort rollout, and the criteria for continuation or discontinuation.

Headline eligibility framework

Eligibility is defined by BMI and comorbidity count and is rolled out in phases, prioritising the highest clinical need first, with the full eligible population reached over a period of up to 12 years. Cohort 1 (BMI 40+, 37.5+ with ethnicity adjustment, and four or more weight-related comorbidities) has been live since June 2025. Cohort 2 (BMI 35 to 39.9, 32.5 to 37.4 with ethnicity adjustment, and four or more comorbidities) opens from 23 June 2026. The criteria and timing for cohorts beyond June 2026 have not yet been finalised by NHS England, so check the current guidance. Ethnicity-adjusted thresholds (a 2.5 kg/m^2 downward adjustment) apply throughout.

Comorbidities that count

- · Type 2 diabetes.
- · Hypertension.
- · Dyslipidaemia (raised total cholesterol, raised LDL, or raised triglycerides).
- · Obstructive sleep apnoea.
- · Cardiovascular disease (ischaemic heart disease, heart failure, established stroke risk).

Continuation and discontinuation criteria

NICE TA1026 includes a continuation review at month 6: it recommends assessing whether at least 5 percent of baseline weight has been lost on the highest tolerated dose, and deciding whether to continue treatment in light of the clinical benefits and risks. NICE frames this as a clinical decision point, not an automatic discontinuation. This review does not apply to private prescribing; private patients and prescribers set their own continuation criteria.

Why TA1026 is structured around weight management rather than diabetes

Tirzepatide is also available on a separate NHS pathway for type 2 diabetes, governed by its own NICE technology appraisal that is distinct from the weight-management appraisal TA1026. A patient may qualify for tirzepatide on the diabetes pathway under different criteria from the weight-management pathway. The two pathways are commissioned separately by ICBs.

Chapter 10: Tier 3 and Tier 4 NHS Weight Management Services

The NHS weight management framework runs in four tiers. Tier 3 is specialist multi-disciplinary support; Tier 4 is bariatric surgery.

Tier 3 and Tier 4 NHS weight management

The NHS England weight management framework has four tiers escalating from population-level prevention to bariatric surgery. NHS Mounjaro under NICE TA1026 is commissioned at Tier 3 (specialist multi-disciplinary services). Tier 4 is the surgical pathway for severe obesity not adequately addressed at Tier 3.

The four tiers

- Tier 1: universal population-level prevention (public health campaigns, community programmes).
- Tier 2: community-level weight management services (commercial providers, group programmes, GP-led lifestyle interventions).
- Tier 3: specialist multi-disciplinary clinics for severe obesity. Dietitian, psychologist, physiotherapist, and prescribing clinician. NHS GLP-1 prescribing happens here.
- Tier 4: bariatric surgery (gastric sleeve, gastric bypass, gastric band) plus pre- and post-operative support.

Why GLP-1 commissioning sits at Tier 3

Under the NICE TA1026 framework, GLP-1 medications for weight management are commissioned alongside ongoing clinical review, dose titration, and structured lifestyle programming, and are subject to the NICE TA1026 continuation criteria. The multi-disciplinary structure of Tier 3 services reflects that commissioning rationale.

Tier 4 escalation pathway

Patients who do not achieve sufficient weight loss at Tier 3 (medication plus programme) can be escalated to Tier 4 for bariatric surgery assessment. NICE guidance on bariatric surgery (NG7, updated for the GLP-1 era) considers whether the patient has trialled Tier

3 medication adequately first. The two pathways are complementary, not competing.

Chapter 11: Specialist Weight Management Services

NHS tier-3 service providing multi-disciplinary support for severe obesity. The commissioning route through which NHS Mounjaro is delivered in most ICBs.

Specialist Weight Management Service (SWMS)

A Specialist Weight Management Service is an NHS multi-disciplinary clinic providing structured support for severe obesity. Commissioned at ICB level, sometimes referred to as a tier-3 service in the NHS weight management framework. In most ICBs, the SWMS is the route through which NHS Mounjaro is prescribed under NICE TA1026.

What an SWMS does

- · Clinical assessment of obesity severity and weight-related comorbidities.
- · Dietitian, psychologist, and physiotherapist input within a 12-month programme.
- · Prescribing of GLP-1 medications (Mounjaro, Wegovy, Saxenda) when clinically indicated and the patient meets the relevant cohort criteria.
- · Bariatric surgery referral pathway as the tier-4 escalation.
- · Continuation review at 6 months against the NICE TA1026 stopping rule (5 percent loss from baseline).

How you get referred

GP confirms eligibility against the current rollout cohort (BMI and comorbidity count, ethnicity-adjusted where applicable) and submits the referral. The SWMS triages the referral against capacity. Wait times vary materially between ICBs from weeks to many months. Some ICBs commission specialist services across multiple acute trusts to spread the demand.

Why SWMS capacity is the binding constraint

At the time of writing, NHS England guidance pointed to specialist-service capacity, rather than national medication supply, as the principal constraint in many regions. The binding constraint on NHS GLP-1 access in 2026 is SWMS capacity, particularly in ICBs that did not pre-commission additional dietitian and psychologist capacity ahead of Cohort 1 going live in June 2025. NHS England has issued commissioning guidance on capacity expansion, but the ramp varies materially by ICB.

Chapter 12: MHRA Yellow Card: Pharmacovigilance in Practice

The UK system for reporting suspected adverse drug reactions. Patients and clinicians can submit at yellowcard.mhra.gov.uk.

MHRA Yellow Card scheme

The Yellow Card scheme is the UK system for reporting suspected adverse drug reactions, side effects, defective products, and counterfeit medicines. Run by the MHRA since 1964 (originally named after the yellow paper form), now operated online at yellowcard.mhra.gov.uk. Reports are accepted from anyone (patients, carers, healthcare professionals).

What to report

- · Any suspected side effect, even if the link to the medication is uncertain.
- · Side effects from over-the-counter medicines, prescribed medicines, herbal remedies, vaccines, e-cigarettes.
- · Counterfeit, suspected counterfeit, or substandard medicines.
- · Defective medicines (mislabelled, contaminated, damaged).
- · Medical device problems alongside medicines.

Why it matters for GLP-1 medications

GLP-1 weight management medications carry a Black Triangle (▼) on UK packaging and patient information leaflets. This indicates the medication is under additional MHRA monitoring because real-world safety data is still accumulating beyond the pivotal trial population. Yellow Card reports for any side effects on these medications carry particular weight in the safety surveillance system.

How to submit

Direct online at **yellowcard.mhra.gov.uk**. The form takes 10 to 15 minutes. The MHRA app is also available on iOS and Android. Patients do not need to consult their prescriber first; reports can be submitted independently.

Where the data goes

MHRA aggregates Yellow Card reports and uses the data to update SPCs, issue Drug Safety Updates, and inform regulatory action. Reports do not trigger personal medical follow-up; they are pharmacovigilance, not patient care. For personal medical concerns, contact your prescriber alongside any Yellow Card report.

Chapter 13: Patient Information Leaflets: the Authoritative Document

The leaflet inside every UK medicine box. The authoritative source on dosing, side effects, missed-dose advice.

Patient Information Leaflet (PIL)

The Patient Information Leaflet is the folded paper leaflet inside every UK medicine box. It is the legally-required authoritative document on dosing, side effects, contraindications, missed-dose advice, and how to recognise a serious adverse reaction. PILs are produced by the marketing authorisation holder (the licence-holding manufacturer) and approved by the MHRA. They take precedence over web content, app content, and clinic advice.

What a PIL must include

- · What the medicine is and what it is used for (the licensed indication).
- · What you need to know before taking it (contraindications, warnings).
- · How to take it (dose, frequency, route, what to do for a missed dose).
- · Possible side effects, grouped by frequency (very common, common, uncommon, rare, very rare).
- · How to store the medicine.
- · What the medicine contains and what the packaging looks like.
- · How to report side effects via Yellow Card.

Why PIL trumps other sources

The PIL is the document the regulator approved as patient-facing safety information for that specific medication batch. Marketing copy, clinic advice, app notifications, and editorial content (including this site) are downstream of the PIL. When PIL guidance and a clinic's app advice conflict, the PIL is the primary public reference (a prescriber may lawfully depart from it in an individual case).

Where to find a PIL outside the box

Every UK-licensed medicine has its current PIL published at the electronic Medicines Compendium (emc.medicines.org.uk). Search by brand name (Mounjaro, Wegovy, Saxenda) or active ingredient. The same site holds the SmPC (the prescriber-facing equivalent).

Part III: Why Quality and Trust Vary

Chapter 14: Certificates of Analysis: What They Prove and Do Not Prove

A CoA is a third-party lab document confirming purity, identity, and sometimes additional properties of a chemical sample.

Certificate of Analysis (CoA)

A CoA is a document from a third-party analytical lab confirming the purity, identity, and (depending on scope) additional properties of a chemical sample. For research peptides, the minimum is a CoA covering HPLC purity and mass-spectrometry identity. UK retailers either include the CoA with each order or make it available on request.

What a strong CoA covers

- · The molecule's identity, confirmed by mass spectrometry.
- · Purity percentage by HPLC, with the gradient and method documented.
- · Batch or lot number, linked to the physical vial.
- · Date of testing and lab name.
- · Optionally: endotoxin (for human-grade material), heavy-metals testing, residual solvents.

What a CoA does not prove

- · Sterility (separate test, usually direct culture).
- · Biological activity (no analytical proxy; activity is established in cell or animal models, not in vials).
- · That this specific vial is the one the CoA describes (only batch traceability links them).
- · Long-term storage stability (a separate stability test).

Provided-with-order vs on-request

Provided-with-order CoA arrives in the package or by email automatically; the customer does not need to ask. On-request CoA is sent if the customer emails the retailer, typically within 1 to 3 working days. Either is acceptable. Provided-with-order is the higher-confidence default and scores higher in editorial ranking.

Chapter 15: HPLC Purity: What 99%+ Does and Does Not Mean

High-Performance Liquid Chromatography measures peptide purity by separating components and reading the proportion of the named peptide.

HPLC purity

HPLC (High-Performance Liquid Chromatography) is a lab technique that separates the components of a sample by chemical property (typically polarity or hydrophobicity) and reads the relative proportion of each. For peptides, "99% HPLC purity" means the named peptide accounts for at least 99 percent of the total peptide content of the sample. It is the standard purity claim for research peptide retailers.

What HPLC proves

- · The proportion of the named molecule in the sample (relative to other detectable peptide content).
- · The absence of major synthesis by-products at the stated purity threshold.
- · Repeatability when the same sample is tested again.

What HPLC does not prove

- · Biological activity. A 99% pure dead peptide is still 99% pure.
- · Sterility. Sterility is a separate analytical test, often using direct culture or rapid microbial detection.
- · Correct labelled dose. Dose accuracy requires a separate quantitative analytical test, not just purity percentage.
- · Endotoxin content. Endotoxin testing uses LAL or recombinant Factor C, not HPLC.
- · The molecule is what the label says it is, on its own. HPLC tells you the proportions; mass spectrometry confirms the identity by molecular mass.

Mass spectrometry as the sister test

Mass spectrometry (MS) measures the mass-to-charge ratio of a molecule, which lets a lab confirm the identity of the named peptide. A Certificate of Analysis that pairs HPLC purity with MS identity is meaningfully stronger than HPLC alone. UK retailers including my-peptides and Nooku tend to publish both; others publish HPLC only.

Chapter 16: How Peptides Are Made: Solid-Phase Synthesis Explained

The Merrifield 1963 method for building peptides one amino acid at a time on an insoluble resin. Why peptide cost scales non-linearly with amino acid length.

Solid-phase peptide synthesis (SPPS)

Solid-phase peptide synthesis is the standard manufacturing method for research peptides and many medicines. Bruce Merrifield published the method in 1963 and won the 1984 Nobel Prize in Chemistry for it. Amino acids are added one at a time to a growing chain anchored to an insoluble resin, with chemical wash steps between additions to remove unreacted material.

How the chain grows

- · First amino acid attached to the solid resin (typically polystyrene-based).
- · N-terminus protecting group removed by acid or base wash.
- · Next protected amino acid coupled to the exposed terminus.
- · Cycle repeats: wash, deprotect, couple, wash, deprotect, couple.
- · Final cleavage releases the peptide from the resin and removes side-chain protecting groups.
- · HPLC purification separates the target peptide from incomplete sequences and side-products.

Why cost scales non-linearly

Each cycle has an efficiency rate, typically 99%+. At 99% per cycle, a 30-amino-acid peptide retains only about 74% of the full-length product after synthesis (0.99 to the power 30). The shorter the peptide, the higher the yield, the lower the cost per gram. A 5-amino-acid peptide is dramatically cheaper per gram than a 44-amino-acid peptide. This is why Tesamorelin (44 aa) costs 2 to 3 times Sermorelin (29 aa) per equivalent quantity to synthesise, and Ipamorelin (5 aa) is among the cheapest.

Why purification matters

The HPLC purification step is where retailer-grade purity is determined. A 99%+ HPLC purity claim on a 30-amino-acid peptide means the retailer is purifying away the truncated sequences that the synthesis process inevitably produces. This is why the per-gram cost of a high-purity 30+ amino acid research peptide is substantially higher than the per-gram cost of a short peptide.

Chapter 17: Storage and Handling

Most research peptides arrive lyophilised (freeze-dried) and stable at room temperature for short periods.

Peptide storage and handling

Most research peptides arrive lyophilised (freeze-dried) as a white powder under partial vacuum in a sealed glass vial. In this state, peptides are reasonably stable at room temperature for short transit and substantially more stable when refrigerated or frozen. Once a lyophilised peptide is reconstituted into solution, its stability drops sharply. The preparation, reconstitution and any handling of research peptides for use fall outside the scope of this editorial, which covers the molecule, its storage as a powder, and its UK regulatory status only.

Why peptides ship lyophilised

Water is the main driver of peptide degradation. Freeze-drying removes the water and locks the peptide in a stable amorphous state. Lyophilised peptides typically survive 24 to 48 hours at ambient temperature with negligible degradation, which makes ordinary UK courier delivery practical. Without lyophilisation, peptides would require refrigerated transit and have far shorter shelf lives.

Lyophilised storage

- · Refrigerated (2 to 8°C): typically stable for 6 to 12 months for most peptides.
- · Frozen (minus 18°C or colder): often stable for 12 to 24 months.
- · Room temperature: stable for short periods (days to weeks), then progressive degradation.

After reconstitution

Reconstituted peptide solutions are markedly less stable than the lyophilised powder. Detailed reconstitution and in-use handling are operational steps that fall outside this editorial, which is limited to powder storage and regulatory context. This book does not provide preparation, reconstitution, or human-use instructions for research peptides.

Cold-chain for GLP-1 medications

Licensed GLP-1 medications (Wegovy, Mounjaro, Saxenda) are pre-filled pen injectors that ship under cold chain (2 to 8°C). Once in the user's fridge, they remain stable for the labelled shelf life. Once at room temperature, the manufacturer-specified out-of-fridge window is typically 21 to 30 days depending on the product (for example Mounjaro 21 days, Wegovy 28 days, Saxenda 30 days); always follow the product's Patient Information Leaflet. UK pharmacies dispensing GLP-1 maintain validated cold-chain logistics; this is one of the GPhC requirements.

Chapter 18: Cold Chain for GLP-1 Medications

Licensed GLP-1 medications ship under refrigerated cold chain (2 to 8°C). Why this matters, what validated cold-chain logistics look like, and the.

Cold chain for GLP-1 medications

Licensed GLP-1 medications (Mounjaro, Wegovy, Saxenda) require refrigerated storage at 2 to 8°C from manufacturer to patient. UK pharmacies dispensing GLP-1 must maintain validated cold-chain logistics; this is one of the operational requirements for a GPhC-registered pharmacy supplying these medications.

Where cold chain breaks matter

- · Manufacturer warehouse to wholesaler: validated refrigerated transport.
- · Wholesaler to pharmacy: validated refrigerated transport.
- · Pharmacy storage: temperature-monitored refrigeration with documented out-of-fridge events.
- · Pharmacy to patient: insulated packaging with ice packs and a temperature indicator, typically 24-hour next-day delivery.
- · Patient receipt: into the fridge promptly; manufacturer-specified out-of-fridge windows vary by medication.

Out-of-fridge windows (manufacturer-specified)

- · Mounjaro (tirzepatide): up to 21 days at room temperature (below 30°C) once removed from the fridge.
- · Wegovy (semaglutide): up to 28 days at room temperature (below 30°C) once removed from the fridge.
- · Saxenda (liraglutide): up to 30 days at room temperature (below 30°C) once removed from the fridge.

Beyond these manufacturer windows, the medication should not be used. Refrigerator failures and household power cuts are common reasons patients need to discuss replacement supply with their pharmacy or clinic.

Cold-chain failures and what to do

If the package arrives warm, the ice packs are fully melted with no remaining cold, or the temperature indicator shows a breach, contact the supplying pharmacy before using the medication. A reputable UK pharmacy will replace the supply at no cost. Documentation of the issue (photo of the package and indicator on arrival) supports the claim.

Chapter 19: Pen vs Vial: UK GLP-1 Delivery Formats

UK licensed GLP-1 medications are delivered in pre-filled pens or single-use vials. The two formats differ on dose control, ease of use, and waste.

Pen vs vial GLP-1 delivery

UK licensed GLP-1 medications are delivered to patients in two formats: pre-filled multi-dose pens (KwikPens) and single-use pre-filled vial-and-syringe formats. The format affects dose precision, ease of use, packaging waste, and storage logistics. Current UK Mounjaro delivery shifted from vials to KwikPens during 2024 to 2025.

Pre-filled pens

- · KwikPen for Mounjaro: multi-dose pen with dial-set dose selection across the licensed dose range.
- · Wegovy FlexTouch: weekly disposable single-use pen pre-set to one of the licensed titration steps.
- · Saxenda FlexTouch: multi-dose pen, dial-set within its licensed dose range.
- · Advantages: ease of use, error reduction, easier travel.
- · Disadvantages: higher unit cost for the manufacturer, more plastic packaging.

Single-use vials

- · Tirzepatide single-use vial format: still available in the US through some compounding sources; not the current UK route.
- · Advantages: cheaper unit cost, theoretical dose flexibility.
- · Disadvantages: requires the patient to draw up the dose accurately each time, increases dose-error risk, more clinical training required.

Current UK position

Eli Lilly transitioned UK Mounjaro supply from vials to KwikPens during 2024 to 2025 to align with the rest of the UK GLP-1 market and reduce dose-error rates in real-world use. Novo Nordisk Wegovy has been pen-only in the UK since launch. Saxenda is multi-dose pen. UK pharmacies dispense whatever format is licensed; vial-format GLP-1 is not a routine UK option.

Chapter 20: UK Peptide Manufacturing: the Named-Facility Context

Where UK peptides are actually synthesised. MHRA-regulated CDMOs, named manufacturers like Almac, Sterling, and Biosynth Pepceuticals, and how to read the named-lab signal on a retailer Certificate of Analysis.

UK peptide manufacturing explained: who actually makes the molecules

If you are researching UK research-peptide retailers, the question that decides trust is whether the vial in the box originated at a named, regulated facility, or at an unnamed one. The PeptideClear CoA Trust Index uses that distinction as its central signal. This page explains what "named lab" actually means in the UK context: who the real UK peptide manufacturers are, how peptides get made, and why a retailer that can name its synthesis source is operating on different ground from one that cannot.

The three Tier 1 UK manufacturers profiled here (Almac, Sterling, Biosynth Pepceuticals) supply pharmaceutical-grade Active Pharmaceutical Ingredients (APIs) to global pharma and biotech. None of them sells to consumers. None of them ships research vials. The point of naming them is to give you a reference for what "real" UK peptide manufacturing looks like, so that the named-lab disclosure on a retailer page becomes legible rather than abstract.

How peptide manufacturing actually works in the UK

Almost all commercial peptides shorter than around 70 amino acids are made by solid-phase peptide synthesis (SPPS), the Merrifield method first published in 1963. Amino acids are added one at a time to a chain anchored on an insoluble resin, with wash and deprotection cycles between additions. Final cleavage releases the chain. HPLC purification removes truncated sequences and side-products. Mass spectrometry confirms identity.

Pharmaceutical-grade peptide manufacturing in the UK happens under the same regulatory regime as any other Active Pharmaceutical Ingredient: it is overseen by the Medicines and Healthcare products Regulatory Agency (MHRA), conducted under Good Manufacturing Practice (GMP), and the facilities are periodically inspected. A facility holding a Manufacturer's Authorisation for Investigational Medicinal Products (MIA(IMP)) can supply clinical-trial material. Multi-kilogram commercial supply requires further demonstrated capability. Most UK CDMOs (Contract Development and Manufacturing Organisations) operate at both research and GMP grades, with the GMP arm sitting under documented MHRA inspection cycles.

Research-grade peptide synthesis (for academic labs, biotech R&D, in vitro work) sits outside that pharmaceutical regulatory perimeter but uses the same chemistry. Several UK labs publish ISO 9001 quality systems and ISO/IEC 17025 testing accreditation as the research-grade quality floor. Neither tier touches a consumer market: pharma-grade material goes into prescription medicines, research-grade goes into laboratories. The grey-market research-peptide retailer space is downstream of both, and the supply chain back into named UK synthesis is rarely disclosed.

The three named UK peptide manufacturers we reference

These are the UK facilities whose published credentials, scale, and customer base are clearest. They are the reference points PeptideClear uses when the CoA Trust Index measures whether a retailer's synthesis source is verifiable.

Almac Group · Craigavon, Northern Ireland

Almac Group is a global CDMO with heritage dating to 1968 (operating as Almac Group since 2002) and Northern Ireland headquarters in Craigavon. Almac Sciences, the chemical development and API arm, opened an expanded 28,000 square foot GMP peptide facility in 2024, capable of producing peptides longer than 70 amino acids including vaccine peptide cocktails. Almac is MHRA-inspected and serves more than 600 pharma and biotech customers. Publicly disclosed product launches Almac has supported include Agios Pharmaceuticals' Pyrukynd (mitapivat, approved for pyruvate kinase deficiency), Sanofi's Tzield (teplizumab, the first disease-modifying therapy for type 1 diabetes), and PTC Therapeutics' Upstaza (eladocagene exuparvovec, a gene therapy for AADC deficiency). When pharmaceutical companies need a named UK peptide manufacturer to put on regulatory submissions, Almac is one of the names that appears.

Sterling Pharma Solutions · Cramlington, Northumberland

Sterling Pharma Solutions is a UK-headquartered CDMO at Dudley Lane, Cramlington, with six facilities and more than 1,350 staff. Sterling's peptide capability covers more than 25 years of synthesis experience with chain lengths up to 40 amino acids, full SPPS, downstream purification, and analytical method development. The company trademarked the term PDMO (Pharmaceutical Development and Manufacturing Organisation) in 2020 to differentiate its end-to-end small-molecule, ADC, and peptide service. Sterling is MHRA-regulated and operates at clinical and commercial scale. Its named-customer roster is not publicly itemised (typical for CDMOs supplying branded pharma) but the scale, the Northumberland headquarters, its long operating history, and the published 40-amino-acid peptide capability are the credibility hooks.

Biosynth Pepceuticals · Leicester, England

Pepceuticals Ltd is the UK GMP peptide arm of Biosynth, acquired in September 2023. The Leicestershire facility (Enderby, Feldspar Close) covers 10,000 square feet across eight cGMP laboratories. Pepceuticals is an MHRA-approved API manufacturer holding MIA(IMP) certification, supporting multi-kilogram GMP peptide synthesis from early clinical trials through to commercial supply. A £2 million facility investment expanded capacity post-acquisition. Biosynth also operates Cambridge Research Biochemicals in Billingham, Teesside (acquired May 2023), which handles complex peptide chemistry, fluorescent labelling, and antibody tools at the research grade. For UK readers, Pepceuticals is the most geographically placeable of the three: an East Midlands GMP peptide facility, MHRA-inspected, currently shipping commercial-grade peptide APIs.

Smaller named UK peptide labs

Three more UK labs sit one rung down in scale but contribute to the picture of a real UK peptide synthesis industry. AltaBioscience (37 Walkers Road, Redditch, B98 9HE, Companies House 07278564) is a 1973-founded peptide and amino-acid-analysis lab, ori-

ginally a University of Birmingham spin-out, now UKAS-accredited under ISO 9001:2015 and ISO/IEC 17025:2017 for testing. It serves pharma, academia, biotech, contract manufacturers, and the food industry.

Isca Biochemicals (26 Hanover Road, Exeter, EX1 2TL, incorporated October 2012) is the spin-out of the former Biomol peptide manufacturing arm. It runs custom synthesis alongside a publicly visible research-grade catalogue covering antimicrobial peptides, neuropeptides, FRET substrates, and kinase reagents. The combination of a named address, 13-year incorporation, and an open catalogue gives it stronger named-lab credibility than most grey-market retailers.

Cambridge Research Biochemicals (Billingham, Teesside), the Biosynth research-grade UK subsidiary, handles complex peptide chemistry, fluorescent labelling, and antibody conjugation. Mentioned alongside its sister facility Pepceuticals when the UK Biosynth footprint is the topic, although Pepceuticals (Leicester) is the GMP headline.

UK peptide-adjacent suppliers we do not include

Two UK companies came up in supplier research that we deliberately exclude from named-lab editorial because the framing would mislead a reader. Activotec (Cambridge) is primarily a peptide-synthesizer hardware vendor: it sells the machines (Activo-Darwin, Activo-P11) that other labs use to perform SPPS. It does run a small custom synthesis service, but characterising it as a UK peptide manufacturer would conflate equipment vendor with manufacturer.

Isomerase Therapeutics (Chesterford Research Park, Cambridge, Companies House 08335008) is a recombinant peptide and synthetic-biology service: it produces peptides via engineered microbes (cell-free and cell-based bioprocesses) rather than by chemical SPPS. It is a credible UK company but is solving a different problem in a different chemistry, and naming it alongside SPPS CDMOs would confuse the supply-chain picture readers come here to clarify.

What this means when you read a Certificate of Analysis

The named-lab signal on a UK research peptide retailer page is rarely “manufactured at Almac”. Almac, Sterling, and Pepceuticals supply branded pharma APIs, not unbranded research vials. The named-lab signal that actually matters at the consumer end is whether the third-party testing laboratory on the Certificate of Analysis can be verified, and whether per-batch CoAs are published rather than a one-off CoA image being reused.

What the existence of named UK manufacturers does tell you is what the regulated baseline looks like. MHRA inspection. GMP facilities. Manufacturer’s authorisations under documented numbers. Multi-kilogram audited batches. If a retailer cannot name where its peptides are synthesised, that gap is the gap: established UK peptide manufacturing is named, regulated, and inspected, and consumer-facing retailers that originate downstream of that regime should be able to describe their own supply chain in comparable detail.

Related reading: CoA Trust Index · UK research peptide retailers compared · Solid-phase peptide synthesis (SPPS) explained · Certificate of Analysis explained · HPLC purity.

Research-use-only framing. PeptideClear is an editorial comparison and information service. The UK manufacturers named on this page do not sell to consumers and have no commercial relationship with PeptideClear. Editorial commentary based on publicly available information at the time of review.

Part IV: How to Be a Careful Buyer

Chapter 21: A Framework for Each Category

Being a careful buyer in the UK peptide market means asking different questions depending on which category you are in. The four categories have four different regulatory regimes, four different trust signals, and four different risk profiles.

This part draws together the consumer-awareness threads from Parts II and III into a practical summary.

Prescription GLP-1 medications: what to check

If you are accessing GLP-1 medications through a private route (because you do not yet qualify for the NHS rollout, or because you prefer the speed and convenience of private), the following signals separate a well-run provider from a poorly-run one:

GPhC registration. Every UK online pharmacy that dispenses prescription medications must hold a GPhC registration number. The GPhC register is publicly searchable at pharmacyregulation.org. An online pharmacy without a GPhC registration number is not a legitimate UK pharmacy.

Named prescriber. A UK clinic or pharmacy prescribing a POM medication must have a named, GMC-registered (or NMC-registered for prescribing nurses) prescriber. Anonymous prescribing is a red flag.

Brand and manufacturer. Licensed UK GLP-1 medications are Mounjaro (tirzepatide, Eli Lilly), Wegovy (semaglutide, Novo Nordisk), and Saxenda (liraglutide, Novo Nordisk). Any supplier offering “semaglutide compound”, “tirzepatide compound”, or unnamed-source GLP-1 is not supplying licensed UK medication. Compounded GLP-1 is not part of routine authorised UK supply (the lawful Specials route aside).

Cold-chain delivery. GLP-1 medications require refrigerated transit. A legitimate UK pharmacy will use validated cold-chain packaging with ice packs and a temperature indicator.

Transparent pricing and cancellation terms. Published, itemised pricing and documented cancellation terms are a baseline for any regulated UK healthcare provider.

Research peptides: what to check

Research peptides sit outside the UK medicines tier when sold without health claims under "research use only" framing. They are not approved for human use. The buyer-awareness question is not about efficacy, PeptideClear does not comment on efficacy, but about product quality signals.

Certificate of Analysis. A CoA from a named third-party laboratory is the primary quality signal. The CoA should cover HPLC purity and mass spectrometry identity. Per-batch CoAs are stronger than a single image displayed for all products.

Named laboratory. A retailer able to name its third-party testing laboratory is operating more transparently than one that cannot. The PeptideClear CoA Trust Index scores UK retailers on this signal.

Research-use-only framing. A retailer that maintains consistent "research use only, not for human or animal consumption" framing across its site and marketing is operating within the legal framing. A retailer whose product pages say "research use only" but whose social media posts make therapeutic claims is not.

WADA status. Tested athletes need to check the current WADA Prohibited List before purchasing any research peptide. Several commonly sold UK research peptides are prohibited substances for tested athletes.

The NHS as a baseline

For GLP-1 medications, the NHS route, when you qualify under the phased NICE TA1026 rollout, is the safest and most regulated access route. NHS-supplied Mounjaro is dispensed by a GPhC-registered pharmacy, under a GMC-registered prescriber, through a specialist weight management service, with ongoing clinical review. Private routes involve varying levels of clinical oversight; the PeptideClear methodology documents the minimum criteria we require before listing a clinic or pharmacy.

For people who do not yet qualify for the NHS route, the private market is legal and widely used. The questions above apply.

Where regulation sits

The UK peptide market in 2026 is not a regulatory vacuum. Prescription GLP-1 medications are among the most regulated consumer products in the UK: POM status, MHRA marketing authorisation, GPhC pharmacy requirement, ASA advertising rules, Black Triangle pharmacovigilance. Research peptides occupy a narrower and more contested regulatory space: outside the medicines tier when framed correctly, subject to consumer protection law throughout, and within MHRA enforcement scope when a retailer makes health claims. Cosmetic peptides are regulated products under UK cosmetics law. Collagen supplements are food supplements under FSA rules.

The variation, and the consumer-awareness gap, is not about whether regulation exists. It is about whether buyers know which regime applies to what they are looking at, and what signals to read.

Chapter 22: How PeptideClear Compares Providers

Methodology used by PeptideClear to compare UK GLP-1 clinics, online pharmacies, and access routes. Criteria-based, transparent, refreshed quarterly.

Methodology

PeptideClear publishes editorial comparison across four UK peptide categories: cosmetic skincare peptides, ingestible collagen, research peptides, and prescription GLP-1 weight loss. Each category has its own methodology page because the regulatory regimes differ (cosmetic, food supplement, research-use-only chemical, and POM medicine respectively). The shared framework below covers source-tier ranking, comparison criteria, refresh cadence (quarterly), and a documented conflict-of-interest position. Editorial byline: Oliver Mackman. We are not a pharmacy and not a clinic.

Methodology by category

- · GLP-1 clinics and online pharmacies, licensed prescription medicines (semaglutide, tirzepatide). GPhC + GMC + trading-history criteria.
- · Research peptides, research-use-only chemicals. CoA Trust Index criteria. Linked to the CoA Trust Index.
- · Cosmetic peptide skincare, licensed topicals. INCI position, formulation transparency, clinical-claim substantiation.
- · Collagen supplements, food-supplement category. Source, dose, peer-reviewed substantiation.
- · Longevity clinics, emerging UK private-clinic tier.

The detail below is the shared framework that all five category methodologies apply.

Criteria for clinic and pharmacy listings

- · UK-licensed pharmacy (GPhC registration verified)
- · Prescriber on payroll or under contract (named, not anonymous)
- · Published, transparent pricing
- · Published switching, pause, and cancellation terms
- · At least 12 months of UK trading history
- · Published, transparent complaints and cancellation handling
- · No grey-market or compounded GLP-1 supply
- · Cold-chain delivery infrastructure for tirzepatide and semaglutide

Comparison criteria (per clinic / pharmacy profile)

- · Onboarding (questionnaire vs full clinical consultation)
- · Coach, app, and check-in cadence
- · Cost per typical month at a typical maintenance dose
- · Switching policy (Wegovy to Mounjaro and vice versa)
- · Pause and cancellation terms
- · Maintenance-dose policy at goal weight
- · HRT-aware or fertility-aware co-prescribing, where offered (a listing criterion, not a clinical recommendation)
- · UK delivery coverage
- · Transparency of published pricing, terms, and registration

Refresh cadence

Clinic and pharmacy profiles are refreshed quarterly or whenever a partner notifies us of a material change (price, policy, registration).

Conflict of interest

Some clinics and pharmacies on the site are referral partners. Inclusion in the directory is not contingent on a referral relationship. Our editorial framework is documented in our editorial policy; our funding model in how we are funded.

Chapter 23: The CoA Trust Index: How We Score Retailers

Editorial comparison of how every UK research peptide retailer handles Certificates of Analysis. Per-batch publishing, third-party lab partner, gating method.

How UK peptide retailers handle Certificates of Analysis

The PeptideClear CoA Trust Index is the UK reference for how every research-peptide retailer handles Certificates of Analysis. It scores UK retailers across six observable signals: per-batch CoA publishing, gating method (open, email, login, image, or absent), third-party laboratory partner naming, QR-verifiable batch lookup, dedicated CoA URL, and public stance on third-party testing. Retailers whose UK Companies House entity showed as dissolved at the time of our review are tiered red regardless of score (verify current registration at Companies House). The retailer scoring resolves to green (CoA:

strong), amber (CoA: partial), and red (CoA: weak or closed). Editorial commentary based on publicly available information at the time of review. Compiled by Oliver Mackman, editorial director, PeptideClear.

CoA: strong

Per-batch publishing, third-party lab named, no email gate or open subdomain.

CoA: partial

Some signal (per-batch claim or gated CoA), but gaps on transparency, lab naming, or accessibility.

CoA: weak / closed

No accessible CoA, no publicly identifiable third-party testing, or a registered entity that showed as dissolved at the time of review.

↓

Full comparison

Scroll the table horizontally

Retailer | CoA tier | Access | Lab partner | Per-batch | QR verifiable | Founded | Companies House |

How we score CoA practice

We score each UK research peptide retailer on six observable signals. Score thresholds set the tier (green ≥ 5, amber 2 to 4, red below 2). Retailers whose Companies House entity is dissolved are auto-tiered red regardless of score.

Positive signals

- · +2 Per-batch CoA published (not just one-off)
- · +2 Open access (no email, login, or form gate)
- · +2 QR-verifiable directly to a named third-party lab
- · +1 Named third-party lab partner
- · +1 Dedicated CoA URL or subdomain

Negative signals

- · -2 No publicly identifiable third-party CoA testing at time of review
- · -1 CoA gated behind email request
- · -1 CoA practice undisclosed or unverified

- · Auto-red Registered entity shown as dissolved at Companies House at time of review

Scores are editorial commentary based on publicly available information at the time of review. PeptideClear does not laboratory-test peptides or audit labs directly. Read our full methodology and how we are funded. CoA links

Named UK manufacturers we reference

Real UK peptide manufacturing happens under MHRA inspection at named facilities. The three we cite across PeptideClear editorial as the reference point for “named lab”:

- · Almac Group (Craigavon, Northern Ireland): MHRA-inspected, 600+ pharma customers, named launches Agios Pyrukynd, Sanofi Tzield, PTC Upstaza.
- · Sterling Pharma Solutions (Cramlington, Northumberland): UK CDMO, 25+ years peptide synthesis, 40-amino-acid capability.
- · Biosynth Pepceuticals (Leicester): MHRA-approved API manufacturer, 8 cGMP labs, multi-kilogram commercial supply.

None sells to consumers. They are the contrast point for what established UK peptide manufacturing looks like. Read the full explainer.

Why this matters

Every UK research peptide retailer claims purity. A small minority publish per-batch Certificates of Analysis from a named third-party laboratory. That is one of the few objective signals a buyer can verify independently before buying.

This page exists because no UK retailer can honestly compare its own CoA practice against the rest of the segment. We do that here, in one place, updated monthly.

Research peptide encyclopaedia entries

CoA quality matters most when a compound has a substantial research literature. These are the compounds with the most-cited UK retailer stock and preclinical literature.

BPC-157

Most discussed research peptide. Animal data only. Encyclopedia entry.

TB-500

Thymosin beta-4 fragment. Preclinical connective tissue literature.

GHK-Cu

Copper-binding tripeptide. In-vitro and preclinical literature. Also in cosmetics.

Ipamorelin

Growth hormone secretagogue. Novo Nordisk Phase II, discontinued.

Sermorelin

GHRH analogue. Geref withdrawn US 2008. No UK marketing authorisation.

MOTS-c

Mitochondrial-derived peptide. Nature Communications 2020. Mouse data.

Chapter 24: PeptideClear Editorial Standards

How PeptideClear researches, sources, fact-checks, and signs off content. NICE, MHRA, NHS guidance. Single editorial byline (Oliver Mackman) for non-clinical.

Editorial policy

Sources we lead with

- · NICE technology appraisals (TA1026 for tirzepatide; relevant guidelines for related medications)
- · NHS England commissioning guidance and ICB statements
- · MHRA enforcement notices, drug-safety bulletins, and Yellow Card data
- · Patient Information Leaflets (PILs) from Eli Lilly (Mounjaro) and Novo Nordisk (Wegovy, Ozempic)
- · British National Formulary (BNF) for prescribing reference
- · Peer-reviewed clinical trial publications (SURMOUNT, STEP, SELECT)
- · The Pharmaceutical Journal, Health Foundation, BHF, Diabetes UK

Sources we use carefully

- · UK private clinic and pharmacy materials (we cite for pricing and policy, not clinical claims)
- · International sources (US FDA, European EMA) where they pre-date UK guidance
- · Peer review with caveats

Sources we do not use

- · Reddit, Mumsnet, and other unverified user forums for clinical claims
- · Brand blogs as the primary source for clinical claims
- · Influencer or anecdotal content
- · US bodybuilding-forum dosing protocols
- · Compounded or grey-import GLP-1 sources

No personal medical advice

PeptideClear does not publish dose-specific scenarios, individual symptom-triage run-books, or content that assumes the role of a clinician. Editorial framing is comparison, encyclopedia, and commentary. Where readers need clinical decisions (eligibility, dose changes, side-effect management, switching), the page directs to a UK clinic or pharmacy partner whose prescriber takes that role.

ASA / CAP code awareness

PeptideClear publishes editorial in line with the Advertising Standards Authority and the CAP code, particularly the rules governing health claims and the promotion of Prescription Only Medicines (POM). We do not name POM weight-loss medications in comparison-advertising contexts. We do not show before/after imagery. We do not target individual symptoms with branded medication references. While PeptideClear is not a regulated healthcare provider, UK advertising and consumer-protection rules (including the CAP Code) still apply to our commercial communications, and we hold ourselves to those standards.

MHRA awareness

The Medicines and Healthcare products Regulatory Agency regulates UK medicines and medical devices. PeptideClear is not a manufacturer, importer, or distributor of medicines, and we are not regulated by the MHRA. We monitor MHRA enforcement notices, drug-safety bulletins, and Yellow Card data and update affected editorial pages when MHRA guidance changes. We do not publish content that promotes compounded or grey-import medicines, including grey-route GLP-1.

No before/after imagery

We do not publish before/after weight-loss photos. The Advertising Standards Authority (ASA) treats them as misleading on POM advertising for GLP-1 medication. We agree.

No specific medication recommendations

We compare licensed routes (NHS, private clinic, online pharmacy). We summarise typical clinical practice. We do not recommend a specific medication, dose, or product to a specific person. Your prescriber does that, after a consultation.

Refresh cadence

Category and product comparison pages are refreshed when retailers, clinics, or regulatory guidance materially change. NICE, MHRA, NHS, and ASA notices trigger an immediate review of any affected page.

Corrections

Errors are corrected within 5 working days of being notified. Material corrections add a dated correction note to the page footer. Email hello@peptideclear.co.uk.

Chapter 25: How PeptideClear Is Funded

PeptideClear is funded by referral fees from clinic and pharmacy partners when readers click through and complete a consultation.

How we are funded

PeptideClear is funded by referral fees from clinic, pharmacy, retailer, and brand partners. When a reader clicks through to a partner and completes a consultation, signup, or purchase, the partner pays us a one-off referral fee. The fee ranges from £20 to £150 per converted referral depending on the partner and the action.

What this means in practice

- · You pay nothing to use PeptideClear.
- · Information on the site is free and accessible without registration.
- · When a partner pays us, the price you pay them is unchanged. The fee comes out of the partner's marketing budget, not from your pocket.
- · We never share your data with a partner you have not chosen to
- · We disclose referral relationships inline on every commercial page.

Categories of commercial relationship

- High-touch GLP-1 clinics: Numan (published £100/£100 referral programme), Voy, Manual, Juniper. Referral fees are typically £80 to £150 per converted patient.
- Low-touch GLP-1 pharmacies: Phlo, Pharmacy2U, SimplyMeds, Boots Online Doctor, Asda Online Doctor. Referral fees vary; some partners have active affiliate programs, others do not.
- Research peptide retailers: my-peptides, Pure Peptides UK, Nooku, Direct Sarms, Aquila Peptides, Pinnacle Peptides. Where referral programs exist, they typically pay £15 to £40 per conversion.
- Cosmetic peptide and collagen retailers: via Awin (Cult Beauty, LookFantastic, Boots, Holland and Barrett, Space NK) and direct brands (Bare Biology, Vital Proteins). Standard affiliate commission rates typically 5 to 15 percent.
- UK longevity clinics: no UK longevity clinic currently runs an affiliate programme that we participate in. All longevity clinic editorial is unsponsored.

What we do not do

- · We do not run third-party display advertising on the site.
- · We do not sell your data to any partner or third party.

- · Our published methodology, not commercial terms, determines which clinics, pharmacies, or retailers appear in rankings. Listing is gated by that methodology.
- · We do not write favourable copy in exchange for higher referral fees.
- · We do not accept payment to remove negative editorial.
- · We do not promote compounded GLP-1, grey-import medication, or unlicensed sources of POM medications regardless of partner offer.

Listed but not paid

Some UK clinics, pharmacies, retailers, and brands appear on the site without an active referral relationship. Inclusion is gated by our methodology, not by whether the partner pays. Where a partner has refused affiliate access (or where we have declined theirs because of regulatory or ethical concerns), we still list when the methodology floor is met.

Two examples

- · At least two ranked research peptide retailers in 2026 do not run affiliate programmes we participate in. They are ranked on the same criteria as those that do.
- · No UK longevity clinic currently has an affiliate relationship with PeptideClear. The full longevity clinic ranking is editorial-only.

Inline disclosure

Every commercial page on the site (where a click-through to a partner is the primary CTA) carries an inline affiliate disclosure adjacent to that CTA. This is more conservative than the ASA-required minimum, which is page-level disclosure. We use inline disclosure because it makes the commercial relationship visible at the decision point, not buried at the bottom of the page.

If a fee structure changes

Material changes to commercial relationships (a new partner added, an existing partner removed, a substantial change to the fee structure) are documented in editorial sign-off notes and visible to readers through the per-page “last reviewed” dates. We do not change a ranking position because a fee changes. We may add or remove a partner if regulatory status changes (loss of GPhC registration, MHRA enforcement action, etc).

About the Author

Oliver Mackman is Director of Best Business Loans Ltd, which operates PeptideClear UK (peptideclear.co.uk), an independent UK editorial and comparison hub covering the UK peptide market. He oversees PeptideClear’s editorial standards, which are reviewed against MHRA guidance, ASA CAP code requirements, and Trading Standards principles. He is a registered officer of Best Business Loans Ltd (company number 16833937). PeptideClear UK publishes commentary and comparison across four UK peptide categor-

ies: cosmetic skincare peptides, ingestible collagen, research peptides, and prescription GLP-1 routes. All editorial is general commentary; PeptideClear is not a pharmacy, not a clinic, and does not prescribe or dispense medicines.

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PeptideClear UK (peptideclear.co.uk) is an independent editorial and comparison service for the UK peptide market. Operated by Best Business Loans Ltd (company number 16833937), PeptideClear UK publishes regulatory explainers, market commentary, and buyer-awareness guides across cosmetic peptide skincare, ingestible collagen, research peptides, and prescription GLP-1 access routes. PeptideClear UK is not a pharmacy, not a clinic, and holds no pharmaceutical licences. It is not regulated by the MHRA, GPhC, or GMC. It reviews and compares regulated parties; it is not itself regulated as a healthcare provider.

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References and Sources

The following primary sources are cited or drawn upon in this publication. All are publicly available as of May 2026.

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(peptideclear.co.uk/coa-trust-index/) - PeptideClear how we are funded (peptide-clear.co.uk/how-we-are-funded/)

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