THE PIVOTAL PROTOCOL – EDUCATIONAL REFERENCE SERIES

Peptide Timing Workbook

A complete timing and cycle reference guide for members of The Pivotal Protocol curriculum. Templates, schedules, and frameworks for structuring your educational understanding of compound timing.

Educational purposes only. Nothing in this document constitutes medical advice, clinical recommendation, or treatment protocol. All compound references are for educational and research literacy purposes. Consult a licensed physician before making any health-related decisions. The Pivotal Protocol is an education and teaching operation.

1. The Fasted Window: Why Timing Matters for GH Secretagogues

Growth hormone secretagogues (GHS) - including GHRPs and GHRHs - stimulate GH release by acting on receptors in the pituitary and hypothalamus. The magnitude of the resulting GH pulse is significantly modulated by the metabolic environment at the time of administration.

The Mechanism

Elevated blood glucose and elevated circulating insulin both suppress somatostatin tone. Somatostatin is an inhibitory neuropeptide that dampens GH release. When insulin is high (post-meal state), somatostatin activity rises and the GH pulse generated by a secretagogue is blunted - sometimes dramatically.

Practical Implication

- A fully fasted state (minimum 2 hours post-meal, ideally 3-4 hours) is the target window for GH-axis peptides
- Morning dosing before breakfast is the most consistently clean window for most individuals
- Post-training dosing (30-60 min post-workout, before eating) is a second viable fasted window
- Bedtime dosing requires dinner at least 2-3 hours prior
- Fat alone has minimal insulin impact; a small amount of fat near the dosing window is less disruptive than carbohydrates

Key Principle:

2. Injection Timing by Compound Class

COMPOUND CLASS	EXAMPLES	PREFERRED WINDOW	RATIONALE
GH Secretagogues (GHRPs)	Ipamorelin, GHRP-2, GHRP-6	Morning fasted; post-training fasted; bedtime	Maximize GH pulse by minimizing insulin interference
GHRH Analogs	CJC-1295 no DAC, Sermorelin, Tesamorelin	Morning fasted; bedtime	Act on pituitary directly; pulsatility preserved in fasted state
GLP-1 Class	Semaglutide, Tirzepatide	Any time, SubQ; weekly cadence typical	Long half-life; meal timing irrelevant for absorption
Recovery Peptides	BPC-157, TB-500	Post-training or bedtime	Tissue repair signaling; meal timing not mechanistically critical
Fat-Selective Peptides	AOD-9604	Morning fasted	GH fragment; same somatostatin considerations apply
Longevity / Mitochondrial	Epithalon, SS-31, MOTS-c	Morning; flexible	No direct GH axis interaction; timing less critical
Neuropeptides	Semax, Selank, Dihexa	Morning, pre-cognitive task	Nootropic effect alignment with peak cognitive demand window
Sleep Peptides	DSIP (Delta Sleep-Inducing Peptide)	30-60 min before intended sleep	Targets delta sleep induction; timing tied to sleep onset

3. Cycle Length Reference Table

COMPOUND	CLASS	TYPICAL ON-PERIOD	TYPICAL OFF-PERIOD	NOTES
Ipamorelin	GHRP	8-12 weeks	4-8 weeks	Well-tolerated; longer cycles studied
CJC-1295 (no DAC)	GHRH analog	8-12 weeks	4-8 weeks	Typically paired with Ipamorelin
CJC-1295 (with DAC)	GHRH long-acting	8-12 weeks	4-8 weeks	Once or twice weekly dosing; depot effect
Sermorelin	GHRH analog	12-24 weeks	4-8 weeks	Often used in longer, gentler protocols
Tesamorelin	GHRH analog	12-26 weeks	4-8 weeks	Most human data of any GHRH analog
GHRP-2	GHRP	8-12 weeks	4-8 weeks	Potent; more cortisol/prolactin signal than Ipamorelin
GHRP-6	GHRP	8-12 weeks	4-8 weeks	Strong hunger drive; ghrelin agonism pronounced
BPC-157	Recovery	4-12 weeks	4-8 weeks	Injury-specific protocols may be shorter; flexible
TB-500	Recovery	4-12 weeks	4-8 weeks	Often run parallel to BPC-157

COMPOUND	CLASS	TYPICAL ON-PERIOD	TYPICAL OFF-PERIOD	NOTES
AOD-9604	GH fragment	12 weeks	4-8 weeks	Limited human data; research context
Epithalon	Telomere/ longevity	10-20 days (course)	4-6 months	Short courses repeated periodically
SS-31	Mitochondrial	4-12 weeks	4-8 weeks	Mostly animal data; human trials ongoing
MOTS-c	Mitochondrial peptide	4-8 weeks	4 weeks	Emerging; human data limited
Semax	Neuropeptide	2-4 weeks	2-4 weeks	Cyclical use; tolerance considerations
Selank	Neuropeptide / anxiolytic	2-4 weeks	2-4 weeks	Well-tolerated; may run alongside Semax or alternate
Dihexa	Nootropic peptide	1-3 weeks	4+ weeks	Extremely potent; minimal human data; caution warranted
DSIP	Sleep / recovery	1-4 weeks	Variable	Situational; not typically long-cycled

4. Weekly Dosing Schedule Builder Template

Use this 7-day grid to map your compound timing windows. Each compound occupies one row. Mark each day with: AM (morning fasted), PM (post-training), BT (bedtime), or leave blank for rest day.

WEEKLY COMPOUND SCHEDULE - TEMPLATE							
Compound	MON	TUE	WED	THU	FRI	SAT	SUN
_____							
_____							
_____							
_____							
_____							
Notes	AM = morning fasted | PM = post-training | BT = bedtime | blank = rest day						

5. Stacking Timing Conflicts: What Can Share a Window

WINDOW	CAN BE CO-ADMINISTERED	AVOID COMBINING
Morning Fasted	GHRP + GHRH analog (synergistic); Semax; AOD-9604	Anything followed immediately by carbohydrate-rich meal
Post-Training	BPC-157 + TB-500; GHRP + GHRH if still fasted	GH peptides if post-workout nutrition already consumed
Bedtime	GHRP + GHRH; DSIP; Selank (anxiolytic benefit)	Semax (stimulating neuropeptide; may disrupt sleep onset)
Any Time	GLP-1 class; recovery peptides (BPC-157 non-fasted acceptable)	Pairing two stimulating neuropeptides in same window without washout

Neuropeptide stacking note:

6. The Pulse Model: Mimicking Natural GH Pulsatility

Endogenous GH is released in discrete pulses, predominantly during slow-wave sleep and in the post-exercise fasted state. The largest pulse occurs within the first 90 minutes of sleep (the delta sleep window). Smaller secondary pulses occur in early morning fasting and approximately 3-4 hours after the sleep pulse.

Pulsatility Principles

- Continuous GH elevation suppresses natural pulsatility via negative feedback. Secretagogues work best when dosed to mimic discrete pulses, not continuous elevation.
- The GHRH + GHRP combination is synergistic: GHRH sets the amplitude ceiling; GHRP amplifies the pulse and suppresses somatostatin simultaneously.
- Spacing doses minimum 3 hours apart preserves receptor sensitivity and avoids desensitization.
- CJC-1295 with DAC creates a sustained GHRH background elevation - this alters the pulsatile model and is a distinct pharmacological approach from short-acting GHRH analogs.

Dosing Frequency Models (Educational)

MODEL	FREQUENCY	WINDOWS	PROFILE
Pulse Mimicry	2-3x daily	AM + post-training + BT	Most physiologic; requires schedule discipline
Single Pulse	1x daily	Bedtime (preferred) or AM	Simplified; targets largest natural pulse window
Long-Acting	1-2x weekly	Any SubQ	CJC with DAC model; background elevation pattern

7. Insulin Interference: Carbohydrates Before GH Peptide Doses

The insulin-GH antagonism is one of the most clinically documented interactions in endocrinology. For educational understanding:

- Post-prandial insulin peaks at 30-90 minutes after a carbohydrate-containing meal
- Insulin elevation increases somatostatin tone, which gates GH release
- A GH secretagogue administered during peak insulin will generate a blunted or absent pulse
- Fasting window needed: 2 hours minimum; 3-4 hours is more reliable
- Protein meals raise insulin modestly; fat meals minimally
- Black coffee without additives does not meaningfully affect insulin and is generally compatible with a fasted dosing window

8. Sleep Peptide Timing: The Delta Sleep Window

The delta sleep window refers to the first 90-minute sleep cycle, during which slow-wave (delta) sleep predominates. This is the physiologically dominant GH pulse window in healthy adults. Educational context:

- DSIP is named for its proposed role in promoting delta-wave sleep; human data is limited and mixed
- GHRP/GHRH combinations dosed at bedtime leverage this natural GH pulse window
- Ideal bedtime window: 30-60 minutes after dinner (ensuring partial fasting), and 15-30 minutes before sleep onset
- Any compound with stimulating nootropic activity (Semax, Dihexa) is contraindicated in this window due to arousal effects
- Selank, with its anxiolytic profile, may complement sleep-window dosing

9. Monthly Cycle Calendar Template

Mark each day with compound initials in the appropriate cell. Use: **ON** (active), **OFF** (rest), or leave blank.

MONTH: _____ YEAR: _____ CYCLE WEEK: ____ OF ____							
WEEK	MON	TUE	WED	THU	FRI	SAT	SUN
Week 1							
Week 2							
Week 3							
Week 4							

10. End-of-Cycle Tapering: When It Applies and When It Does Not

Unlike anabolic steroids, most research peptides do not require a structured post-cycle taper to restore endogenous hormone production because they work through receptor stimulation rather than exogenous hormone replacement.

Compounds Where Tapering Is Not Generally Indicated

- BPC-157, TB-500 (no hormonal axis; cessation is clean)
- Epithalon (short courses; cessation is standard practice)
- Semax, Selank (neurological; gradual wind-down is practical, not mandatory)
- MOTS-c, SS-31 (no known feedback loop requiring taper)

Compounds Where Gradual Off-Ramp Merits Consideration

- GHRP/GHRH combinations used for extended periods: some educational frameworks suggest reducing frequency (e.g., from 3x to 1x daily for 1-2 weeks) rather than abrupt cessation, to allow receptor sensitivity normalization
- CJC-1295 with DAC: the depot effect means cessation is gradual by nature due to pharmacokinetics

11. Lab Timing: When to Draw IGF-1 Relative to Last Dose

COMPOUND CLASS	RECOMMENDED DRAW TIMING	NOTES
GH Secretagogues (all)	Trough: 24+ hours after last dose for clean baseline; mid-cycle: 4-6 weeks into cycle for on-protocol IGF-1	IGF-1 reflects 24-72hr integrated GH output; single-dose effects are smoothed
CJC with DAC	Mid-cycle draw; 3-4 days after dose to capture plateau-phase IGF-1	Long half-life makes trough less meaningful in short timeframes
Baseline (pre-cycle)	Minimum 2 weeks off all GH-axis peptides	True baseline requires full washout

12. Travel and Schedule Disruption: Adapting a Protocol

- **Crossing time zones:** anchor dosing to local fasted windows, not home-time-zone clock. The physiological requirement is meal/insulin state, not clock time.
- **Travel day itself:** airport meals and disrupted eating make GH peptide timing unreliable. Skipping one day on travel day is a pragmatic choice.
- **Hotel mini-fridge stability:** reconstituted peptides require refrigeration. Lyophilized (powder) form is more stable for travel; reconstitute on arrival.
- **Short trips (1-3 days):** simplify to once-daily bedtime dosing rather than attempting full 3x schedule.
- **Extended travel (7+ days):** maintain schedule in local time; allow 2-3 days of circadian adjustment before expecting full efficacy.

13. Missed Dose Protocol

> **Core principle:** Never double dose to compensate for a missed injection. Skip and resume normal schedule at next dose.

By Compound Type

- **Short-acting GH peptides (daily/EOD):** If a dose is missed, skip it entirely. Resume next scheduled dose.
- **CJC with DAC (weekly):** If missed by 1-2 days, dose when remembered and adjust next dose date accordingly.
- **BPC-157 / TB-500:** Missing one dose has minimal cumulative impact. Resume next day.
- **Epithalon (course-based):** If mid-course, resume same day if remembered before sleep. Do not extend the course to make up for missed days.
- **Semax / Selank:** Skip missed dose. These are not therapeutically time-sensitive in the same way as GH-axis compounds.

14. Cycle Logging Template: Daily Tracking Sheet

FIELD	ENTRY	FIELD	ENTRY
Date		Cycle Day	
Compound(s) dosed		Window(s)	
Last meal before AM dose		Hours fasted	
Training today?		Post-training dose?	
Energy (1-10)		Sleep quality (1-10)	
Mood (1-10)		Recovery (1-10)	
Notable effects		Side effects	
Labs drawn today?		Physician contact?	
Notes			

15. 12-Week Master Schedule Template

WEEK	PHASE	COMPOUNDS ACTIVE	KEY LAB OR CHECK-IN	NOTES
Pre-cycle	Baseline	None	Full baseline panel: IGF-1, CBC, CMP, hormones, fasted glucose	2+ weeks off GH peptides before draw
Week 1	Introduction	Compound A only	None	Single compound; observe baseline response
Week 2	Introduction	Compound A	None	Note any side effects before adding
Week 3	Add Layer	A + Compound B	None	Add second compound; one variable at a time
Week 4	Add Layer	A + B	Subjective check-in; physician communication recommended	
Week 5	Active	A + B (+ C if indicated)	None	
Week 6	Active	Full stack	**Mid-cycle labs: IGF-1, fasted glucose, hormones**	Key decision point; adjust or maintain
Week 7	Active	Full stack	None	Review lab data with physician
	Active	Full stack	None	

WEEK	PHASE	COMPOUNDS ACTIVE	KEY LAB OR CHECK-IN	NOTES
Week 8				
Week 9	Active	Full stack	None	
Week 10	Active	Full stack	None	
Week 11	Wind-Down	Reduce frequency if tapering	None	
Week 12	Final	Last doses	**End-of-cycle labs: full repeat panel**	Compare to baseline and week-6 draw
Weeks 13–16	Off-Cycle	None	Post-cycle lab at week 16 (4 weeks post-cessation)	Document recovery baseline

16. Physician Communication Timeline

- **Pre-cycle:** Share intent, obtain baseline labs, confirm no contraindications
- **Week 4:** First subjective check-in; report any unexpected effects
- **Week 6:** Mid-cycle lab review; primary clinical decision point for the cycle
- **Week 12:** End-of-cycle labs; discuss results and next-cycle planning
- **Week 16:** Post-cycle recovery labs; confirm return to baseline
- **Any time:** Red-flag symptoms warrant immediate contact (see Guide 4 for red-flag lab values)

17. Adjustment Decision Tree

Feel significantly better, labs within range → Maintain current protocol. Document. Plan end-of-cycle lab at expected timeframe.

Feel no change at 4 weeks, labs normal → Review timing compliance first (fasted windows). If timing is correct, discuss with physician. Do not increase dose impulsively.

Feel worse (fatigue, water retention, sleep disruption) → Reduce to single compound. Identify culprit before continuing. Physician consult recommended.

IGF-1 elevated above range at mid-cycle → Reduce frequency or dose per physician guidance. Do not continue at current dose pending physician review.

IGF-1 unchanged from baseline at mid-cycle → Check product quality, reconstitution, storage, and injection technique before adjusting dosing. Review fasted window compliance.

Labs flagged (glucose, liver enzymes, thyroid) → Pause protocol. Physician consult. Do not restart until clearance.

18. The Off-Cycle Protocol

The off-cycle period serves two functions in the educational model: receptor sensitivity restoration and physiological baseline recovery. What is typically maintained during an off-cycle:

- **Recovery peptides (BPC-157, TB-500):** May be continued during off-cycle from GH-axis compounds, as they act through independent mechanisms
- **Neuropeptides:** If cycling, off-cycle from GH axis does not require off-cycle from Semax or Selank separately (follow their own cycle windows)
- **Longevity compounds:** SS-31, MOTS-c may be continued or cycled independently
- **GH secretagogues:** Full off-cycle period. No GHRPs, GHRHs, or AOD-9604 during the defined break.

19. Stacking Sequence: Introducing Compounds One at a Time

Introducing multiple compounds simultaneously makes it impossible to identify the source of any effect (positive or negative). The standard educational framework:

1. Start with one compound. Run for minimum 2 weeks before adding anything.
2. Add the second compound. Observe for 1-2 weeks before adding a third.
3. Never add a fourth compound before the three-compound stack is established and stable.
4. If a side effect emerges, remove the most recently added compound first and observe.
5. Compounds with overlapping timing windows should be differentiated by at least 30 minutes if uncertain about compatibility.

20. The Monthly Optimization Review

At the end of each month on-cycle, a structured review session should inform next-month decisions:

Data Points to Collect

- Average subjective scores (energy, sleep, mood, recovery) from daily log - computed weekly average
- Body composition trend (weight, waist circumference, visual assessment)
- Training performance trend (output, recovery time, joint comfort)
- Lab values if mid-cycle draw occurred this month
- Compliance rate: what percentage of planned doses were administered in correct fasted windows

Decision Framework

DATA SIGNAL	DECISION
Positive response + labs normal + compliance high	Maintain. No changes.
Positive response + compliance was low	Maintain compound selection; improve timing discipline before attributing effect to dose level
Neutral response + compliance high + labs normal	Discuss with physician. Consider whether compound selection matches goals.
Any negative lab flag	Pause. Physician consult. Do not optimize toward a problem

Next Cycle Planning Checklist

- Off-cycle length defined?
- Post-cycle labs scheduled?
- Recovery labs (4 weeks post-cycle) scheduled?
- Compound selection for next cycle decided with physician input?
- Supply secured before cycle start (not mid-cycle)?
- Physician communication scheduled for cycle start?

All compound references are for research literacy and educational context only. Consult a licensed physician before any health decision.