

CONVERSATIONS

Karthik Achari, Clinician and Founder PepMD

Interview by Sheldon Baker

The FDA's ongoing review of several high-profile peptides and what this pivotal moment could mean for the future of peptide medicine

As federal regulators evaluate whether peptides such as BPC-157, TB-500, Semax, and others should remain eligible for compounding, healthcare providers, patients, and the wellness industry are closely watching the outcome.

Clinician Karthik Achari had the opportunity to deliver public comment during the FDA's July 2026 Pharmacy Compounding Advisory Committee meeting. His participation gave him a firsthand perspective on the scientific, clinical, and regulatory discussions shaping the future of peptide medicine.

Achari is the founder of PepMD, an independent standards body developing the credentialing and trust infrastructure for peptide medicine launched in January 2026. PepMD claims to be the first organization to bring clinician credentialing, pharmacy recognition, and research site authorization together under a single standard. A clinician by training, Achari is currently completing Bradley University's Doctor of Nursing Practice, Family Nurse Practitioner program. His background spans pharmaceutical and peptide manufacturing and distribution as well as precision diagnostic medicine, which is where he saw the gaps in oversight firsthand. (*Altern Ther Health Med*. 2026;32(5):4-5).

Sheldon Baker is an InnoVision contributing editor. His freelance editorial content can also be found in several lifestyle publications, and as CEO of Baker Dillon Group LLC, he has created numerous brand marketing communications and public relations campaigns for health and wellness organizations. Contact him at Sheldon@NutraInk.com.

Alternative Therapies in Health and Medicine (ATHM): What does the FDA's review actually mean, and not mean, for patients seeking peptide therapies?

Karthik Achari: Less than most of the coverage suggests. What happened was a non-binding recommendation from an advisory committee about the 503A bulk drug substances list. Advisory committees advise, and FDA still has to do the rest.

For anything to actually change, the agency has to complete formal notice-and-comment rulemaking, and that usually runs well over a year. There's a wrinkle, though. FDA can use enforcement discretion in the interim, which is what happened with compounded GLP-1s during the shortages. So, I wouldn't treat the timeline as fixed.

What it doesn't mean is that any of these compounds are approved, or proven, or available. A patient's situation last week is the same as it was the week before. And none of it touched the question of who's qualified to prescribe these.

ATHM: What were the key takeaways from the committee meeting, and what should healthcare providers be watching for next?

Mr. Achari: The margins. Most of the votes came down to one or two members, and one of the seven didn't pass at all. That's a divided committee working from thin evidence, which is roughly what you'd expect given what was in front of them.

The other thing is that FDA's own scientists had recommended against all seven in the briefing documents, and the committee went a different way. However you read that, it tells you the evidence base is contested rather than settled.

For providers, watch the rulemaking docket. Separately, watch whether enforcement discretion shows up before a final rule, because those are two different tracks on two different clocks. I'd also pay attention to what fills the gap in the meantime. Nothing currently verifies that a prescriber has had any peptide-specific training.

ATHM: How could this affect the future of personalized medicine, regenerative therapies, and metabolic health?

Mr. Achari: I'd push back a little on the framing, because there wasn't a decision. It was a recommendation. On the broader question, the classification fight is genuinely unresolved. Peptides sit awkwardly across the supplement, biologic, and drug frameworks. They're amino acid chains, and reasonable people disagree about which box they belong in.

I'm not sure the classification is what determines the outcome, though. What determines it is whether the field builds any capacity to learn from what's already happening. Right now, a patient somewhere gets better on one of these compounds, a clinician notices, and then that observation just evaporates. It never becomes evidence. That's the part I'd fix first.

ATHM: There's a difference between regulated peptide therapies, compounded medications, and unregulated products sold online.

Mr. Achari: There is, and the distinctions matter more than most people realize.

An FDA-approved product has a known identity, potency, and sterility profile, a manufacturer with a regulatory file, and someone accountable if something goes wrong. A compounded medication requires a prescription and comes from a licensed pharmacy that gets inspected. That's a real bar. Though state licensure is a floor with wide variance rather than a single standard, and there's no peptide-specific requirement layered on top of it.

The third category has none of that. No prescriber, no pharmacy, no accountability, often no real idea what's in the vial. And I want to be direct about one thing, because it comes up constantly. A certificate of analysis speaks to identity. It says nothing about sterility or endotoxin, and those are the things that actually hurt people. A consumer can't test their way around that.

ATHM: Can clinicians balance innovation with evidence-based medicine as peptide use continues to grow?

Mr. Achari: I think so, but being careful on your own doesn't get you there. It has to be structural. The problem isn't a shortage of patient experience. It's a shortage of patient experience that never becomes trustworthy evidence. Thousands of people are being treated right now and almost none of it is documented in a way anyone can learn from. That part is fixable. If prescribing happens under a formal protocol with IRB governance and structured outcomes documentation, the same clinical activity that currently produces anecdotes starts producing data instead. The clinician isn't doing anything differently. The information just doesn't disappear.

ATHM: Ozempic is itself a peptide, so comparing peptides to Ozempic relies on a false premise. Your thoughts.

Mr. Achari: You're right, and I'm glad you raised it. Semaglutide is a peptide. So is insulin. So is a good portion of the modern pharmacopoeia which means the word carries almost no information about risk. It's a description of molecular structure. The distinction people are actually reaching for is between compounds with a completed regulatory file and compounds without one. The confusion does real damage, because it lets an approved medication with years of trial data and something sold as research-use-only sit in the same conversational category when the only thing they share is chemistry.

ATHM: Why is oversight critical as demand for peptide therapies increases?

Mr. Achari: I'd frame it a bit differently, since prescribing here isn't limited to physicians. The question is whether the prescriber is qualified. Being authorized to prescribe a peptide and being qualified to prescribe one are two different things, and nothing in the current system tells you which is which. A license tells you someone met their state's requirements to practice. It says nothing about whether they've had an hour of training on the compound they're about to prescribe.

A committee vote doesn't close that gap, and neither will a rule. It's a different kind of problem and it needs building rather than deciding.