

Diabetes Technology & Pregnancy

Guide for Obstetricians



Diabetes in pregnancy is becoming more common, with nearly 20% of births affected by either gestational diabetes or overt and pre-existing diabetes globally.¹ At the same time, diabetes management is evolving rapidly to include the use of technologies like continuous glucose monitoring (CGM) and automated insulin delivery (AID).

The 2026 ADA Standards of Care recommend that diabetes devices be offered to all people with diabetes.² However, there has been limited guidance on the use of technologies during pregnancy due to insufficient research, particularly in type 2 and gestational diabetes. Still, emerging research has shown that CGM and AID can benefit both clinical and self-management of diabetes during pregnancy.

New Expert Recommendations

In 2026, a groundbreaking [international consensus statement](#) was published in *The Lancet Diabetes & Endocrinology*, providing recommendations to guide the application of CGM and AID to manage type 1, type 2, and gestational diabetes during pregnancy.

The consensus was **endorsed by 24 international medical associations**, including American Association of Clinical Endocrinology, Association of Diabetes Care and Education Specialists, European Board and College of Obstetrics and Gynaecology, and International Federation of Gynaecology and Obstetrics, and supported by American College of Obstetrics and Gynecology.

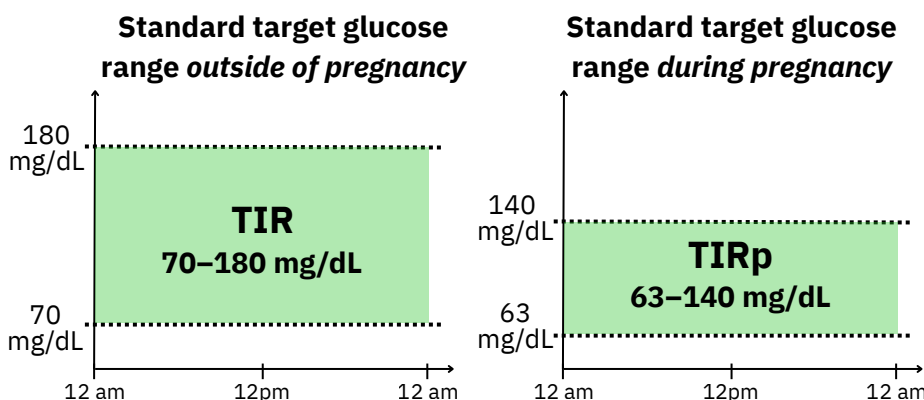
Role of Obstetricians

Obstetricians play a central role in care for diabetes and pregnancy, often from the point of diagnosis in overt diabetes and GDM. Ideally, managing diabetes in pregnancy involves coordination between primary care, endocrinology, obstetrics, maternal-fetal medicine, diabetes care and education, pharmacy, midwifery, dieticians, and other individualized support as appropriate.

While you may not be responsible for managing every detail in this document, being aware of these recommendations can help you provide consistent, up-to-date counsel—from preconception counseling through labor and delivery.

Target Glucose Ranges

CGM generates detailed, actionable metrics that show the full picture of diabetes management. One of these metrics is **time in range**. The recommended target range is more narrow in pregnancy:



Consensus Glycemic Targets

The chart below does not list all glycemic targets for diabetes in pregnancy, only those established or featured by the consensus recommendations.

	T1D	T2D	GDM
Planning Pregnancy	>70% TIR; >70% TIRp if possible (A) A1C <7.0%; <6.5% if possible. (A)	A1C <6.5%; <6.0% if possible ^{5,6}	N/A
During Pregnancy	>70% TIRp ⁴	>80% TIRp (E)	>90% TIRp (E)
Intrapartum	>70% TIRp	No recommendation given	No recommendation given
Postpartum	>70% TIR	>70% TIR ^{4,7}	N/A

Each recommendation is assigned a level of supporting evidence (**A, B, C, or E** for expert opinion). Citations included are not intended to be comprehensive—please see the full [consensus statement](#) for greater detail.

Recommendations for Device Use

Type 1 Diabetes

CGM

- Optimize glycemia using CGM when planning pregnancy to reduce the risk of complications.^{6,8} (A)
- Use CGM during pregnancy with T1D. CGM use in T1D pregnancy is associated with improved neonatal health outcomes (including reduced LGA infants, NICU admissions, and severe neonatal hypoglycemia), reduced hypertensive disorders of pregnancy, and is cost-neutral or cost-saving compared to SMBG testing for T1D.⁹⁻¹² (A)

AID

Systems vary significantly. Device selection is recommended as follows:

- Initiate AID prior to pregnancy to optimize preconception glycemia.³ Note recommendations for device use *in* pregnancy below, to ideally avoid the need to switch after conception. (A)
- If possible, choose a system that has **1)** evidence from an RCT *in pregnancy*, **2)** proven clinically relevant benefit ($\geq 5\%$ daily TIRp improvement) compared to standard insulin therapy + CGM and **3)** pregnancy-specific glucose target settings and/or algorithm that can adapt to changes in insulin sensitivity/is pregnancy-specific. . These systems can support TIRp, improve overnight glycemia, reduce hypoglycemia, and ease burden for the user.¹³⁻¹⁵ (A)
- If a preferred AID system is not available, consider using a system with RCT evidence of clinically relevant glycemic benefits *outside of pregnancy*, with assistive settings and techniques and support from an experienced healthcare team. (B) Systems with an appropriately low glucose target setting and/or evidence of $\geq 5\%$ daily improvement in TIRp are preferred. (E) Tables 2 and 3 in the consensus statement include specific setting recommendations for AID systems during [pregnancy](#) and [intrapartum](#).
- Use of AID can be continued during labor and delivery to help maintain tight glycemia without increased risk of hypoglycemia.^{16,17} (B)
- AID can safely be used postpartum, and improves glycemia compared to standard insulin delivery.¹⁸⁻²⁰ (A)
- During the 3rd trimester, provide pregnant individuals and their hospital team with instructions for managing AID system during labor, delivery, and postpartum. (E)

Automated Insulin Delivery (AID)

AID systems use an algorithm, insulin pump, and CGM sensor to provide glucose-responsive insulin delivery with user-initiated pre-meal insulin boluses. Distinct from older forms of pump technology, which operate primarily on pre-programmed settings and do not automatically adjust for glucose levels.

Continuous Glucose Monitoring (CGM)

CGM tracks glucose in the interstitial fluid, providing updated levels to the user every 1 to 5 minutes. CGM allows users and their care teams to see the full picture of diabetes management—including variability, hypo- and hyperglycemic episodes, patterns, and more.

Type 2 Diabetes

- CGM can be a useful tool when preparing for pregnancy with type 2 diabetes, supporting positive changes to weight and fitness, TIR, TIRp, A1C, hypoglycemia, and other health outcomes.²¹⁻²⁷ (B)
- CGM can be offered during pregnancy with type 2 diabetes based on available resources and individual preferences. More evidence is needed to determine how CGM may impact pregnancy outcomes in type 2 diabetes. (E)
- Use capillary blood glucose testing during all pregnancies with T2D, and provide education to support consistent use. (A)

Gestational Diabetes

- CGM can be offered during pregnancy with gestational diabetes, based on available resources and individual preferences. More evidence is needed to determine how CGM may impact pregnancy outcomes in gestational diabetes, though some recent trials suggest CGM can improve glycemic management in GDM and many individuals with GDM prefer CGM.²⁸⁻³⁰ (E)
- Use capillary blood glucose testing for all women with GDM, and provide education to support consistent use. (A)

Practical Pearls

1 Preconception Counseling

- **Glycemic goals:** Discuss the recommended targets for prior to conception and during pregnancy to help ease the transition to more intensive diabetes management. Remember the targets for time in pregnancy range (none are 100%!) and stress progress over perfection—every 5% increase in TIR is beneficial!^{30,31}
- **Treatment tools:** Review current treatment plan and suitability for pregnancy. If applicable, advance planning can allow patients to get established with an AID device that is well-suited for pregnancy prior to conception and avoid the need to switch amidst the other changes and stressors of pregnancy.

2 After Pregnancy is Confirmed

- **Listen and validate:** Managing diabetes is already a complex, full-time job, but narrower TIR targets, added pressure, and unknown factors of pregnancy can intensify distress. Checking in on someone's overall wellbeing can set the tone for more productive, collaborative problem-solving.
- **Care team coordination:** Establish who will be primarily responsible for supporting diabetes management throughout the pregnancy (is it you, or an endocrinologist, PCP, or MFM?) Refer to specialized support as needed, based on diabetes management self-efficacy and care team experience with technology. Coordination within the care team can help reduce time spent clarifying conflicting advice, sharing and reviewing device data, and more.
- **Leverage data:** Glucose and insulin delivery data from CGM and AID can provide helpful detail and context alongside finger stick logs. Plus, it can be shared remotely in real-time, allowing for adjustments in-between visits as necessary. This can decrease the burden of additional in-person visits.
- **Prepare for delivery:**
 - Instructions for diabetes management: well in advance of delivery, discuss whether use of CGM and AID will be continued during labor and delivery and how insulin dosing should be adjusted (if applicable). Provide written instructions for both the pregnant individual and the hospital team. Evidence supports continuation of AID during labor and delivery, demonstrating improved glycemia and more TIR.^{15,16}
 - Postpartum prep: For AID systems with setting-based algorithms, create a 'postpartum profile' with weakened basal rates, insulin-to-carb ratios and correction (or sensitivity) factors to be activated before or immediately after delivery. The general principles for these settings are as follows:
 - If pre-pregnancy pump settings were optimized and are known, then adjust all settings to be at least 20% weaker than the pre-pregnancy setting (more for breastfeeding).
 - Alternatively, use settings that are at least 50% less aggressive than the end of pregnancy pump settings.
 - Pack extra supplies: Instruct tech users to pack extra supplies if planning to continue use of CGM and AID during labor and delivery, as inpatient hospitals do not stock these items. Items to pack include: infusion sets, cartridges, and sensors.

3 Labor and Delivery

Activate 'postpartum profile' (or reduce insulin delivery) just before or immediately after delivery, depending on glucose levels, mode of delivery and individualized provider guidance.

4 Postpartum

Prevent postpartum hypoglycemia: for insulin users, insulin needs drop suddenly immediately after delivery of the placenta. Remind and assist AID users to activate a pre-set postpartum profile or manually adjust settings right away.

More Resources

- [AID systems](#) - learn more about each system's unique features, evidence, and recommended settings for pregnancy
- [Recommended AID settings intrapartum and postpartum](#)
- [A1C in Pregnancy](#) - more on how pregnancy affects A1C accuracy
- [CGM Guide](#) - to discuss available options
- [AGP Report Guide](#) - quick guide to interpreting CGM data
- [Healthcare Professional Toolkit](#) - more tips and tricks on integrating CGM into your practice
- [CGM billing codes](#)
- [Remote CGM data interpretation billing codes](#)
- [DME v. Pharmacy Benefits Guide](#) - for help accessing diabetes tech
- [CGM and AID Use - Practical considerations for obstetricians](#)

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