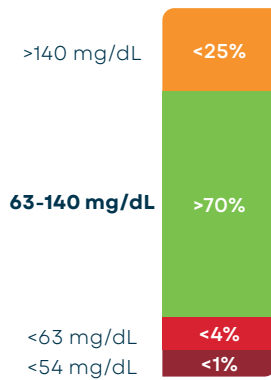


Guidance for Management of Type 1 Diabetes During Pregnancy¹

The American Diabetes Association² and Lancet international consensus³ offer guidance for management of diabetes during pregnancy, including nutrition, exercise, and lifestyle management strategies.

Diabetes in Pregnancy CGM Target Time in Range (mg/dL)



Blood Glucose Target Range for People with Diabetes During Pregnancy

Fasting
<95 mg/dL

One hour
postprandial
<140 mg/dL

Two hours
postprandial
<120 mg/dL

Pregnancy A1c Target

<6% if can be achieved without significant hypoglycemia

HOW TO ACHIEVE HIGHER TIME IN PREGNANCY RANGE WITH CONTROL-IQ+¹

Control-IQ+ showed an adjusted difference of +12.5% Time in Range for pregnancy (63-140 mg/dL) compared to standard insulin therapy + CGM in pregnant women with type 1 diabetes.¹

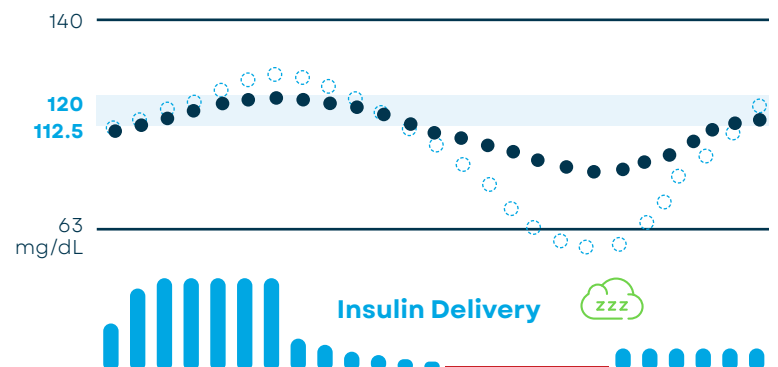


Control-IQ+ does not need a "pregnancy-specific target" setting because it uses **Basal Rates, Carb Ratio, Correction Factor, and Sleep Activity** to achieve higher time in pregnancy range and lower mean glucose.

STEP 1: USE SLEEP ACTIVITY 24 HOURS PER DAY

- Sets the lowest target glucose values
- Insulin delivery increases when 30-minute glucose is predicted to be above 120 mg/dL
- Optional use of a higher target range for exercise (Regular or Exercise Activity)

In the Control-IQ+ settings menu, Weight and Total Daily Insulin usually do not need to be routinely updated during pregnancy.



STEP 2: MAKE SETTINGS ADJUSTMENTS BASED ON GLYCEMIA*

Reassess settings every two weeks or sooner if hyperglycemic or hypoglycemic. Refer to last 1-2 weeks of insulin delivery to calculate settings (e.g., TDI = 30u, Basal = 14u)

| Insulin summary | | |
|--------------------|----------|----------|
| Average daily dose | 30 units | |
| Basal | 47 % | 14 units |
| Bolus | 53 % | 16 units |

| | Early Pregnancy | After 20 Weeks | Postpartum ³ |
|---|--|---|---|
| Basal Rate | Program to be approximately equal to the average basal delivered in the previous 1-2 weeks | Program to be approximately 20% higher than average basal delivered in the previous 1-2 weeks | Option A: Consider reducing insulin settings 50% or more compared with late third trimester settings Option B: Refer to pre-pregnancy settings and consider 33% reduction for basal rate, 20% reduction for Carb Ratio and Correction Factor |
| Correction Factor (Lower Number = Stronger) | At least as strong as 1620 divided by TDI in the previous 1-2 weeks (mg/dL) | At least as strong as 1620 divided by TDI in the previous 1-2 weeks (mg/dL) | |
| Carb Ratio (Lower Number = Stronger) | At least as strong as 400 divided by TDI (units/g) | At least as strong as 400 divided by TDI, sometimes as strong as 250 divided by TDI, especially for breakfast (units/g) | Further reductions may be needed in women who are breastfeeding |

*Individualize as needed. During the first trimester sensitivity to insulin may increase. Later in pregnancy insulin resistance rises.

STEP 3: BOLUS CONSIDERATIONS

Encouraged timing for pre-prandial insulin administration as needed:



10-15 minutes before meal in 1st trimester



20-30 minutes before meal in 2nd trimester

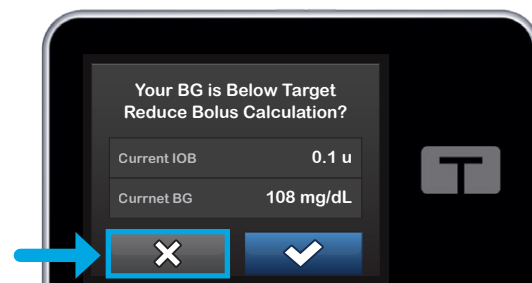


30-45 minutes before meal in 3rd trimester

IMPORTANT: Set **Max Bolus** to 25% higher than highest needed bolus dose. For those who need the highest bolus dose, set **Max Bolus** to 25 units to accommodate larger calculated doses. Ensure if bolus exceeds 25 units that the remaining insulin is delivered.

Decline prompt to reduce bolus when glucose is under 110 mg/dL.

Consider other ways to optimize boluses for insulin resistance late in pregnancy, including nutrition or postmeal short periods of exercise.^{2,3}



Click on "x" when asked to reduce bolus correction

References: 1. Donovan LE, et al. Closed-Loop Insulin Delivery in Type 1 Diabetes in Pregnancy: The CIRCUIT Randomized Clinical Trial. *JAMA*. 2025;334(24):2176-2185. 2. American Diabetes Association Professional Practice Committee for Diabetes. 15. Management of Diabetes in Pregnancy: *Standards of Care in Diabetes-2026*. *Diabetes Care*. 2026;49(Supplement_1):S321-S338. 3. Benhalima K, et al. Application of continuous glucose monitoring and automated insulin delivery technologies for pregnant women with type 1, type 2, or gestational diabetes: an international consensus statement. *Lancet Diabetes Endocrinol*. 2026;14(2):157-177.

Important Safety Information: RX ONLY. Tandem insulin pumps are intended for the subcutaneous delivery of insulin, at set and variable rates, for the management of diabetes mellitus in persons requiring insulin. Tandem insulin pumps with Control-IQ+ technology are intended for the management of type 1 diabetes in individuals 2 years of age and greater and of type 2 diabetes in persons 18 years of age and greater. Control-IQ+ technology is intended for use in pregnancy complicated by type 1 diabetes mellitus, provided the linked CGM system is suitable for use in pregnancy. Users of the pump and Control-IQ+ must: use the insulin pump, iCGM, and all other system components in accordance with their respective instructions for use. Failure to follow these instructions for use could result in an over delivery or under delivery of insulin. This can cause hypoglycemia (low BG) or hyperglycemia (high BG) events. Visit tandemdiabetes.com/safetyinfo for additional important safety information.

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