

GLP-1 Medicines and Pregnancy Planning

Product-specific counseling and continuity of metabolic care

Learner monograph | Lisa Zahakos, RPA-C

60-minute design target. A timed learner pilot and provider credit designation remain required.

Learning objectives

1. Apply the current product-specific pregnancy and contraception instruction to a clinical situation.
2. Interpret early-exposure research without claiming either proven safety or inevitable fetal harm.
3. Select a coordinated medication transition and follow-up plan that preserves necessary metabolic care.

Case 1 Maya P plans conception



Maya P takes injectable semaglutide for weight management and hopes to conceive soon. The conversation begins with her exact medicine and goals, the clinicians who need to be involved, and the care that must continue through the transition.

Which product details and reproductive plans must you clarify before offering a timing rule? Carry that question into the first clinical section.

Start with the exact medicine, formulation, dose, indication, last dose and reproductive situation. Is the patient planning conception, seeking contraception, newly pregnant or breastfeeding? Does she have type 2 diabetes, obesity without diabetes, cardiovascular disease or another relevant indication? These details prevent a general statement about "GLP-1s" from becoming an inaccurate instruction.

Maya P is a fictional 36-year-old taking injectable semaglutide solely for weight management. She has no established diabetes and hopes to conceive next month. Current Wegovy labeling calls for discontinuation at least two months before planned pregnancy. [12] Her proposed timeline therefore needs discussion now, together with the prescriber and obstetric clinician.

Agree on the last dose, the intended conception timeline and the interim health plan. Review current glucose status, nutrition, other medicines and the patient's priorities. The task is not simply to circle a date. It is to arrange the care that continues while treatment is stopped. Explain that the planning conversation should happen before contraception is discontinued.

The current semaglutide label distinguishes some pregnancy advice by indication; this curriculum's cases concern weight management or diabetes-related transitions, not treatment of MASH with advanced fibrosis. Do not turn one case into a universal rule covering every indication. Confirm the

current prescribing information before release and at the point of care. [12]

Read the fictional case and choose the next step. The optional fully narrated recap covers the case, reasoning and clinical takeaway; an audio alternative and complete transcript are included.

Coordinate the diabetes variation

Priya is a fictional 35-year-old with type 2 diabetes, hypertension and obesity who wants to conceive. She has stopped her GLP-1 medicine on her own but has no replacement plan. She reports rising home glucose values. The medication has been stopped, but the clinical problem has not been resolved.

The Endocrine Society and European Society of Endocrinology advise discontinuation before conception in people with type 2 diabetes, with individualized timing and active glycemic management. A timely transition to appropriate therapy is needed because deterioration in glucose control is itself important for pregnancy outcomes. [11] Arrange prompt review rather than waiting for a routine follow-up several months away.

A full preconception review includes other prescribed and nonprescribed medicines, blood pressure treatment, renal status and cardiovascular disease when relevant. The maternal-fetal medicine and endocrine teams should agree who manages each part of the transition. The preventive cardiologist contributes when established disease or a complex cardiovascular regimen changes the decision.

The registered dietitian should assess current intake, nausea, eating patterns, nutritional adequacy and food access. Pregnancy planning is not a reason to prescribe extreme carbohydrate restriction or a universal supplement regimen. Coordinate the nutrition plan with glucose monitoring and the medical treatment plan. Pregnancy, lactation and weight-loss treatment have different nutritional contexts.

A usable transition note

Document the exact product and last dose, the patient's intended timeline, who will make the medication decision and how ongoing glycemic care will be provided when diabetes is present. Confirm that the receiving clinician accepts the plan. Example scheduling checks are local workflow choices, not universal guideline intervals.

Use the worked example as a reference, not a required writing task: "Medication and reproductive timeline verified. Prescribing clinician owns interim glucose care. Preconception visit arranged. Patient knows whom to contact if readings, symptoms or plans change."

Worked comparison: two plans that sound complete

Maya's first draft says, "Stop the medicine and ask obstetrics about pregnancy." Her revised draft records the product and indication, the last-dose plan, the intended conception timeline, and who will answer questions before the obstetric visit. The second draft is more usable because another clinician can tell which decision has been made and which remains open. It does not presume that a referral has transferred responsibility.

A transition is a sequence of decisions

For the diabetes variation, separate three tasks: establish the patient's current condition; agree on a treatment transition; confirm that the follow-up actually occurs. Rising glucose requires clinical interpretation alongside symptoms, available readings, current medicines and access to care. The vignette does not contain enough information to select a dose or prescribe a replacement regimen. The treating team must make that decision. [11]

Close the loop before the patient leaves

In this original workflow example, the prescribing office contacts the receiving team and identifies an interim clinician. The patient receives a single written next-step summary and a contact route if the appointment cannot be obtained. The team verifies that the patient can obtain the agreed treatment and monitoring supplies. These are practical checks for implementation, not additional learner assignments or universal guideline deadlines.

Teach-back that tests the plan

Instead of asking "Do you understand?", ask Maya to explain when she will contact the prescriber and what she will do if her pregnancy plans change. In Priya's variation, ask whom she will contact about rising readings while the referral is pending. A correct explanation reveals whether the plan is understandable; an uncertain answer is a reason to clarify it. Document the agreed plan without making the patient responsible for resolving disagreements between offices.

Maya P uses contraception and is not pregnant. She asks which stopping interval applies to her injectable semaglutide. Which guidance fits the product and indication in this case?

- A. Arrange preconception review and stop injectable Wegovy one month before trying.
- B. Continue until the first missed period, with prompt medication review at that point.
- C. Use a four-week interval after the last dose based on tirzepatide contraception guidance.
- D. Stop Wegovy at least two months before the planned pregnancy and coordinate preconception care.

Best answer: D. For this weight-management scenario, the Wegovy instruction is to stop at least two months before planned pregnancy. Another product's contraception precaution is not a substitute for this interval. [12]

In another variation, Priya has type 2 diabetes controlled with a GLP-1 receptor agonist. She plans pregnancy and proposes stopping treatment until her first prenatal visit. Which plan best addresses this change?

- A. Stop the GLP-1 medicine before trying and review glucose treatment at the first prenatal visit.
- B. Coordinate discontinuation, alternative glycemic treatment and monitoring before conception.
- C. Stop before trying and arrange treatment review only if home readings move outside target.
- D. Continue the current regimen while arranging pregnancy care and stop after pregnancy is confirmed.

Best answer: B. Discontinuation must be paired with active glycemic care and a coordinated transition. Triage current symptoms and readings; the treating clinician sets the response and review interval. [11]

Carry into practice

Verify exact product indication and intended conception timeline.

Coordinate product-specific discontinuation with ongoing care.

Use teach-back and an accepted preconception handoff.

Case 2 Leah and Sofia need product specific contraception advice



Leah is a fictional 32-year-old starting tirzepatide for obesity. She uses an oral hormonal contraceptive and does not want to become pregnant. She assumes the medication discussion is finished once nausea and injection technique have been reviewed.

The current Zepbound label advises switching to a nonoral contraceptive method or adding a barrier method for four weeks after initiation and for four weeks after each dose escalation. [13] Discuss the available options without coercion and make sure Leah understands that the four-week period can recur when a dose is increased.

Document the method she chooses and the date it begins. At the next planned dose change, revisit the instruction rather than assuming the original counseling covers the new interval. If she reports missed contraception, a possible pregnancy or concerns about her method, arrange timely clinical advice. A medication education handout should not substitute for access to that advice.

Avoid applying this exact rule to all GLP-1 medicines or to every type of contraception. Ask the pharmacist to confirm product-specific interactions when the medication list is complex. The case tests whether the learner recognizes a specific counseling requirement, not whether the patient can memorize a long list of adverse effects.

Lactation requires a separate discussion. Oral and injectable semaglutide have different considerations. Current tirzepatide labeling reports low or undetectable transfer in a single-dose

lactation study, with no available infant-effect or milk-production data. [12,13] A small pharmacokinetic study does not answer every clinical safety question, particularly for a young or medically vulnerable infant. The current Wegovy label advises against breastfeeding during treatment with oral tablets because its absorption enhancer, SNAC, and/or its metabolites may accumulate in infants. This instruction does not automatically apply to the injection. Foundayo is not recommended for nursing women; human milk and infant-effect data are unavailable. Review the maternal indication, infant context and alternatives with the treating team. [12,23]

A different product changes the instruction

Sofia is a fictional 31-year-old starting orforglipron for obesity. She uses an oral hormonal contraceptive and does not want pregnancy. A copied instruction in her chart says “use backup for four weeks.”

Sofia’s chart needs a product-specific correction: the Foundayo instruction uses 30 days after initiation and each escalation, rather than a rounded four weeks. Confirm her chosen method and document the dates. An oral medicine is not exempt from reproductive counseling or interaction review. Ask what she will do if a dose change or a possible pregnancy occurs. [23]

Scenario	Instruction to verify
Wegovy for the planned weight-management pregnancy case	Stop at least two months before planned pregnancy. [12]
Zepbound and oral hormonal contraception	Nonoral method or additional barrier for four weeks after initiation and each escalation. [13]
Foundayo and oral hormonal contraception	Nonoral method or additional barrier for 30 days after initiation and each escalation. [23]

Use dates without confusing the questions

A planned-pregnancy stopping interval and a temporary contraception precaution answer different questions. In the clinical record, name the question first, then record the product and the interval. Let the patient choose among appropriate contraceptive options without coercion. If a possible pregnancy or lapse is reported, provide timely individualized advice rather than waiting for the next routine titration visit. [11]

Worked example: the dose-change visit

Leah returns for a dose increase. A chart banner says “contraception discussed,” but it does not identify the method, product, dose-change date or applicable interval. The clinician verifies that she still uses an oral hormonal method, checks the current tirzepatide instruction, discusses suitable choices and documents the plan for this escalation. The earlier counseling is relevant history; it does not show that the new interval has been addressed. [13]

A calendar is an implementation aid

The team places the dose-change date and the relevant precaution interval together in the after-visit plan. If the titration date changes, the plan is updated. For Sofia, the orforglipron interval is recorded in days rather than copied from another product’s week-based instruction. This distinction is a label-reading exercise, not a claim that these drugs have been compared for contraceptive outcomes. The prescriber or pharmacist should resolve uncertainty before the patient relies on a copied instruction. [13,23]

Respect preferences and practical barriers

Ask what matters to the patient about the available options and whether she can obtain and use the selected method. Discuss concerns in private when appropriate. A person may decline a proposed method; that calls for further shared discussion and an individualized plan, not a judgment about adherence. The worked example measures the clinician’s counseling decision, not the patient’s willingness to accept a particular contraceptive method.

When the question changes to breastfeeding

Build a separate question list: Which exact product and formulation? What is the maternal indication? What infant context matters? What evidence describes milk transfer, and what evidence describes infant effects? Write “not measured” when an outcome is unavailable instead of turning a low concentration into a safety conclusion. Review current product-specific advice with the treating team. This separation helps explain why a pregnancy-planning interval does not answer a lactation question. [12,13,23]

Consider a separate variation: Leah is taking tirzepatide as Zepbound, uses an oral hormonal contraceptive, and does not want pregnancy. Her prescriber is increasing the dose. She asks whether taking the pill at a different time is enough. What counseling is supported by the current Zepbound label?

- A. Use a non-oral method or add a barrier for four weeks after initiation and each escalation.
- B. Use backup contraception for four weeks when treatment starts, without repeating it after escalation.
- C. Use backup contraception for seven days after initiation and after each dose increase.
- D. Separate the contraceptive tablet from the injection by twelve hours during escalation.

Best answer: A. Zepbound specifies a nonoral method or added barrier for four weeks after initiation and each escalation, including a new increase after earlier precautions were completed. [13]

In a separate variation, Sofia starts Foundayo for obesity while using oral hormonal contraception. She assumes an oral medicine needs no contraceptive precaution. Which instruction matches the July 2026 label?

- A. Use an added barrier for 30 days when treatment starts, then stop the precaution.
- B. Use a non-oral method or add a barrier for 30 days after initiation and every escalation.
- C. Use an added barrier for seven days after initiation and every escalation.
- D. Use additional contraception if GI symptoms interfere with the oral contraceptive.

Best answer: B. Foundayo specifies 30 days after initiation and each escalation. Keep that interval distinct from the four-week tirzepatide instruction. [23]

Carry into practice

Confirm the route of contraception and exact medicine.

Record the chosen method and the start and end dates.

Revisit the instruction at every relevant escalation.

Case 3 Nora reports an unexpected pregnancy exposure



Nora is a fictional 34-year-old who reports a positive pregnancy test after using semaglutide for weight management. She is frightened and asks whether she has harmed the pregnancy. Obtain the exposure dates, formulation, indication, other medicines, symptoms and available glycemic history. Arrange prompt obstetric and prescribing-team review.

Brown and colleagues used claims data to emulate continued versus noncontinued GLP-1 dispensing into the first trimester. The adjusted risk ratio for nonlive birth was 1.09, with a 95% confidence interval of 0.98-1.23. Estimates for major congenital malformations and small-for-gestational-age birth were imprecise and compatible with clinically important differences. Dispensing is not direct observation of ingestion, and residual confounding remains possible. [14]

These findings can support a measured conversation after an inadvertent exposure. They do not establish intentional use as safe, and they do not prove that an individual pregnancy has been injured. Avoid a yes-or-no answer the evidence cannot support. The next step is a clinical assessment and a plan, not an internet verdict.

For Nora's weight-management indication, follow the current product instruction to discontinue when pregnancy is recognized. [12] Explain how the team will assess her health and arrange appropriate prenatal care. Offer information about the relevant pregnancy exposure registry through the clinical team. An exposure alone is not a basis for an automatic recommendation about pregnancy termination.

Patient language: "I understand why this worries you. The available studies cannot give us a guarantee, but the exposure does not by itself tell us that something is wrong. Let's review the medicine and timing, follow the current guidance, and arrange the care you need." This is an original counseling example for faculty review.

Use the research without turning it into a guarantee

The Brown study is a claims-based target-trial emulation, not a randomized trial of planned treatment during pregnancy. The exposure definition, comparison group and outcome ascertainment all affect interpretation. A nonsignificant estimate does not demonstrate equivalence. The estimate cannot answer whether this particular pregnancy has been affected. [14]

Respond to the actual encounter

Nora reports using semaglutide for weight management and a positive pregnancy test. Confirm the product, formulation, dose and dates, but do not delay appropriate care while reconstructing every detail. Follow the current label for the indication and arrange prompt obstetric and prescribing-team assessment. If diabetes is present, the plan also needs active glucose management. Severe or concerning symptoms change urgency and require clinical assessment. [11,12]

A practical conversation

"The exposure alone does not tell us what will happen. The studies have important limits, so I cannot promise no risk or predict harm. We will review the medicine and timing, follow the current guidance and arrange the care you need." Ask what worries Nora most and check that she understands the next contact. This is an original teaching conversation, not a consent form.

Make the handoff explicit

The obstetric clinician evaluates pregnancy-specific care; the prescribing or diabetes team manages the metabolic transition; the RDN supports feasible nutritional care. Actual clinical roles must be agreed, not inferred from a referral. Document who owns care while appointments are pending. The patient should not have to coordinate contradictory medication instructions herself.

Review nutrition in its current context. A restrictive weight-loss plan is not automatically appropriate during pregnancy or lactation. Ask about usual intake, nausea, food access and the glucose-monitoring plan, and coordinate advice with the treating team. Do not provide universal supplement or medication doses from an incomplete vignette. [1,11]

Worked appraisal: what the estimate can tell you

Consider the reported relative-risk estimate and confidence interval as a range of effects compatible with the study's data and assumptions. The result is not a probability assigned to Nora. A point estimate close to one can coexist with uncertainty that matters clinically. Ask whether the outcome, comparison group and exposure definition match the question the patient is asking before translating a study into counseling. [14]

Separate three statements in the conversation

First, explain what is known about the reported exposure: the product, reason for use and available dates. Second, explain what remains uncertain about pregnancy outcomes. Third, state the action that will happen now. Keeping these statements separate avoids using a reassuring tone as a substitute for a care plan. It also prevents the product instruction to discontinue from being heard as proof that an individual pregnancy has been harmed.

An original handoff example

"Nora reports a positive pregnancy test after weight-management semaglutide exposure. The prescribing clinician is reviewing the product-specific instruction and current health needs. Obstetric review has been requested, with the receiving team and contact route documented. The patient has been told how to reach us if she cannot obtain the visit." Complete the actual exposure details and clinical plan in the patient's medical record. This example is a communication structure, not a universal treatment order.

Judge the quality of the completed visit

A useful encounter ends with an answer to four practical questions: What changes today? Who owns the next clinical decision? How will the patient reach that person? How will the originating office learn that follow-up occurred? These questions remain relevant even when the research is incomplete. For the activity, read the example and apply the reasoning in the existing decisions; no additional question or written submission is required.

Nora has a positive pregnancy test after taking semaglutide solely for weight management. Which response best fits?

- A. Continue the next dose while waiting for a routine prenatal visit because available observational data are reassuring.
- B. Discontinue according to the current label and arrange prompt clinical review, without predicting fetal harm from exposure alone.
- C. Stop treatment and provide reassurance from the observational estimate without arranging exposure-specific clinical review.
- D. Arrange specialist referral but leave the next-dose decision open until every exposure date is confirmed.

Best answer: B. Follow the indication-specific instruction and preserve appropriate care. Exposure alone does not establish an individual outcome. [12,14]

Which statement best communicates the early-exposure evidence?

- A. Explain that an adjusted estimate near the null gives an individualized estimate of her pregnancy outcome.
- B. Use the nonsignificant finding as evidence that exposed and unexposed pregnancies have equivalent outcomes.
- C. The available data cannot predict an individual outcome; explain the uncertainty and the agreed next clinical step.
- D. Present the study's upper relative-risk limit as her absolute probability of an adverse outcome.

Best answer: C. Distinguish observational association, uncertainty and individual prediction. A clear action plan supports counseling without unsupported reassurance or alarm. [14]

Carry into practice

Review exposure and current maternal health.

Follow the product-specific instruction and preserve necessary care.

Explain uncertainty and confirm the accepting clinical team.

References

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