### INCLUSION / EXCLUSION CRITERIA FORM

**Patient ID Number**

**Form Code**

**Version**

**Visit**

**Seq#**

**Patient Initials**

**Visit Date**

---

**Instructions:** The clinician completes this form during the screening visit. Affix the participant ID label above.

### INCLUSION CRITERIA

1. Has the patient demonstrated adequate decisional capacity as determined by scoring greater than or equal to 15 on the UBACC? Yes ☐ No ☐

   Write in the UBACC score here: _____

2. Has the patient provided informed consent to participate? Yes ☐ No ☐

3. Is the patient 18-40 years of age? Yes ☐ No ☐

4. Does the patient have a diagnosis of schizophrenia or schizoaffective disorder (DSM-IV-TR), confirmed by SCID? Yes ☐ No ☐

5. Has the patient been treated with an antipsychotic medication for less than 5 years? Yes ☐ No ☐

6. Has the patient had a recent psychotic exacerbation within the month prior to study entry requiring hospitalization or an increased level of care? Yes ☐ No ☐

7. Is the patient male or female? Male ☐ Female ☐

   7a) If able to become pregnant, is the patient using an adequate method of birth control? (code X if not applicable) Yes ☐ No ☐ X

   (Please see list of adequate methods of birth control in Section 3.2.1 of the protocol).

8. Is the patient's BMI within the acceptable range? (18 kg/m² < BMI < 35 kg/m²) Yes ☐ No ☐

### EXCLUSION CRITERIA

9. Do any of the labs meet the exclusion criteria? Yes ☐ No ☐

   (Hemoglobin A1c ≥ 7% or Hematocrit < 31% or Non-HDL ≥ 190 mg/dL or Triglycerides ≥ 500 mg/dL)

10. Does the patient have any documented failure with an adequate trial of olanzapine, perphenazine or aripiprazole? Yes ☐ No ☐

   (Adequate trials last at least four weeks at a minimum dose. Minimum doses: aripiprazole 15 mg/day, olanzapine 15 mg/day, perphenazine 16 mg/day)

11. Is the patient currently being treated with olanzapine, perphenazine or aripiprazole for a duration of more than one month? Yes ☐ No ☐

12. Does the patient have a known hypersensitivity to metformin, simvastatin or benztropine? Yes ☐ No ☐
EXCLUSION CRITERIA (cont’d)

13) Does the patient have any contraindications to metformin use? .......................................................... Y  N
(Please see list of exclusionary indications in Section 3.2.2 of the protocol. Any potential contraindications must be discussed with the Project Medical Officer prior to randomization).

14) Does the patient have any other medical condition that is serious and unstable in the judgment of the investigator? ................................................................................................................................. Y  N

15) Is the patient being treated with a medication prescribed for weight loss? ........................................... Y  N

16) Does the patient have a diagnosis of diabetes mellitus or is the patient currently being treated with insulin or other diabetes medication? ........................................................................................................... Y  N

17) Is the patient pregnant or breastfeeding? ................................................................................................................. Y  N

18) Does the patient have a DSM-IV-TR diagnosis of mental retardation or delirium? ..................... Y  N

Eligibility status below will be populated in the DMS based upon the responses to the questions above. If the physician wishes to override the DMS assessment of eligibility, then a discussion between the investigator and the PMO must take place and be documented on the Randomization Form (RDM).

19) Eligibility status .................................................................................................................................................. 1 = Eligible 2 = Ineligible 3 = Pending

ADMINISTRATIVE INFORMATION

20) Staff code number of person collecting the data on this form ..........................................................