Leading a New Paradigm in Cardiovascular Health Management

INVESTOR PRESENTATION

June 2016

NASDAQ: AMRN
Forward-looking statements

This presentation contains forward-looking statements, such as those relating to the commercial potential of Vascepa®, Amarin’s product development, clinical and regulatory efforts and timelines, potential FDA approvals, intellectual property, cash flow, and other statements that are predictive in nature and that depend upon or refer to future events or conditions, including financial guidance and milestones. These statements involve known and unknown risks, uncertainties and other factors that can cause actual results to differ materially. Investors should not place undue reliance on forward-looking statements, which speak only as of the presentation date of this presentation. Please refer to the “Risk Factors” section in Amarin’s most recent Annual Report on Form 10-K and Quarterly Report on Form 10-Q filed with the SEC for a more complete description of risks of an investment in Amarin.

Presentation is for investors (not drug promotion)

This presentation is intended for communication with investors only. Nothing in this presentation should be construed as promoting the use of Amarin’s product or product candidates.
Today: Annualized revenues >$100M and growing

- Lead product Vascepa® uniquely positioned for statin-treated patients with persistent high triglycerides
- Revenues of $82M in 2015, up 51% vs. 2014
  - Q1’16 revenues $25.3M, up 63% vs. Q1’15
- Expect to enter 2017 cash flow positive from commercial operations (excluding outcomes study costs)

Upcoming: REDUCE-IT cardiovascular outcomes data on Vascepa as add-on to statin therapy

- Studying at-risk patients with persistent elevated triglycerides, a large population which lacks proven therapy
- >20,000 patient years of study already accumulated
- Achieved enrollment target of 8,000 patients
- Cardiovascular (CV) events driven study
  - Interim look by independent Data Monitoring Committee expected in Sept/Oct 2016 based on ~60% of target events
  - Onset of final target event likely in 2017; published results 2018
### Vascepa Clinical Trials: Track Record of Success

<table>
<thead>
<tr>
<th>Trial Name</th>
<th>Design Phase</th>
<th>Enrollment Phase</th>
<th>Study Phase</th>
<th>Results Evaluation and Publication</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARINE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Completed successfully</td>
</tr>
<tr>
<td>ANCHOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Completed successfully</td>
</tr>
<tr>
<td>REDUCE-IT</td>
<td></td>
<td></td>
<td></td>
<td>60% interim Sept/Oct 2016; onset of last CV event 2017; publication of completed study results 2018</td>
<td></td>
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</tbody>
</table>

- **MARINE**: Demonstrated efficacy as an adjunct to diet to reduce triglyceride (TG) levels in patients with severe (≥500 mg/dL) hypertriglyceridemia, leading to FDA approval
- **ANCHOR**: Demonstrated efficacy in treating patients who, despite statin therapy, have high TG levels (200 to 499 mg/dL), indication not approved by FDA, promotion permitted
- **REDUCE-IT**: Ongoing cardiovascular (CV) outcomes study evaluating potential to reduce residual CV events in statin-treated patients with persistently high triglycerides
- **Other**: Multiple potential other indications could be advanced further post REDUCE-IT
Large Underpenetrated Market Opportunities

U.S. Adult Population Stratified Based on TG Levels

- 150 Million People
- 34 Million People
- 36 Million People
- 3.8 Million People

*Current indication for Vascepa; same as Lovaza®
Source: Datamonitor and Archives of Internal Medicine, 2009;169(6):572-578

Only 3.6% Treated with Rx Meds

>100M People in Top 7 Global Markets for Initially-Targeted Indications
Vascepa Results Show Broad Lipid Level Improvement

**MARINE Trial:**
Phase 3 median placebo-adjusted 12 week results for Vascepa 4g/day dose in patients with very high TGs (≥500 mg/dL)

**ANCHOR Trial:**
Phase 3 median placebo-adjusted 12 week results for Vascepa 4g/day dose in patients on statin therapy with high TGs (200 to 499 mg/dL)

- Primary TG-lowering endpoint achieved
- Favorable effect on other clinically relevant endpoints
- Favorable safety and tolerability profile
  - Use with caution in patients with known hypersensitivity to fish and/or shellfish.
  - Only reported adverse reaction across the clinical profile for Vascepa with an incidence >2% and greater than placebo in Vascepa-treated patients was arthralgia (2.3% for Vascepa, 1.0% for placebo)

*All statistically significant results, except LDL-C reduction in MARINE Trial

Ref: American Journal of Cardiology 2012;110:984-992
"Vascepa showed significant improvements in several biomarkers of cardiovascular health."

Harold Bays, M.D.
Medical Director of Louisville Metabolic and Atherosclerosis Research and Principal Investigator of the MARINE trial
Approved drug following two successful Phase 3 studies in >900 patients
Marketed since 2013
No LDL-C increase and safety comparable to placebo

Typical Fish Oil Supplement
EPA 18% + various other

1st Generation Rx Omega-3 Therapy
A Complex Mixture of Fatty Acids
Ethyl-EPA (465mg)  
Ethyl-DHA (375mg)
Other (160mg)

VASCEPA
Icosapent Ethyl (Pure Ethyl-EPA)

Ethyl-EPA (≥960mg)
Other (≤40mg)

- Classified as food (supplement)
- Not intended to treat disease
- Potential safety concerns, unknown efficacy
- High cost if used in amounts to try to achieve omega-3 levels provided by pharmaceutical grade-omega-3s; little impact on lipid levels at recommended dose

Approved drug based on studies of 84 patients
Marketed since 2005 (generic)
Median placebo adjusted LDL-C increase of 49% in FDA label for very high TG patients

Only Pure EPA Product Available in the US
Considerable growth opportunity remains vs. prior generation therapies
No competitive therapy has completed a successful outcomes study
With limitations of prior generation therapies, <5% of patients with high TGs after statin therapy are treated

Source: Symphony Health Solutions, PHAST
Launched in 2013 as an adjunct to diet to reduce TG levels in patients with severe (≥500 mg/dL) hypertriglyceridemia

- Population: **3.8 million patients have very high TGs**

Promotion expanded in Q3’15 to include high TGs despite statin therapy

- Population: **36 million patients have high TGs**

Marketed in U.S. via 130 specialty sales reps

- Co-promotion partner Kowa Pharmaceuticals America doubles number of Vascepa sales calls

Vascepa Net Revenues (millions)

2012 2013 2014 2015

Q1’16 net revenues up 63% vs. Q1’15
Commercial Business Improving Beyond Revenue Growth

Gross margin percentage improving
- 73% gross margin in Q1’16; 66% for all of 2015

Sales productivity improving
- >50% prescription growth for past 9 quarters while sales force size kept flat
- Targeted sales effort by Amarin’s 130 U.S. sales reps
  - Co-promotion arrangement with Kowa Pharmaceuticals America doubles sales calls

Managed care coverage growing
- >140 million lives covered by payers on tier 2 unrestricted
- WAC price $234/month (120 capsules); net price parity to omega-3 generics for most payers

Sustainable business
- Revenue growth and cost efficiency positions commercial business to be cash flow positive entering 2017 (independent of REDUCE-IT opportunity)
- Robust patent portfolio with terms expiring in 2030, complemented by NCE status

International expansion opportunities
- Partner seeking approval for Vascepa in China
- Amarin considering partnering opportunities for Vascepa in other global markets
Cardiovascular Disease: #1 cause of death in the United States

- >700,000 people die of heart disease in the United States every year
  - Represents ~1 in every 3 deaths (AHA Heart and Stroke Statistics)
- Heart attacks, stroke and other CV disease are expensive to treat
  - Estimated annual total cost of >$300 billion

Standard of care first therapy beyond diet and exercise: Statins

- $40.2 billion annual market at its height
- Statins target LDL-C and are reported to have other “pleiotropic” effects such as:
  - Improving endothelial function
  - Enhancing the stability of atherosclerotic plaques
  - Decreasing oxidative stress and inflammation
- Statins consistently lower coronary heart disease risk by up to 25 to 40%
  - Up to 60% to 75% residual risk
Goal: Additional CV Risk Reduction After Statins

Challenge

- Science of lipid management is complex and evolving
- Many therapies that decrease TGs also increase LDL-C, “bad” cholesterol

Unsuccessful solution studied: HDL-C as independent biomarker

- Multiple failed outcome studies with “good cholesterol” as patient selection criteria
  - Subset data in certain of these studies suggested benefit for patients who had low HDL-C and high TGs and the therapy administered lowered TGs
  - No benefit for TG lowering in the full cohort, including patients without high TGs

Opportunity unstudied: TGs persistently high after statin therapy

- Patients with persistent high TGs after statin therapy not studied prospectively
- Data suggest CV risk increases with higher TG levels
- TG lowering combined with pleiotropic effects and without increasing LDL-C likely better than TG lowering alone
Goal: Additional CV Risk Reduction After Statins

Limited success in prior CV outcomes studies with statin add-on therapies

- **Ezetimibe** (IMPROVE-IT):
  - **No benefit** after considering incomplete trial data
  - Focus on additional LDL-C lowering, other lipid reductions

- **Fenofibrate** (ACCORD-Lipid)
  - **No benefit** in general population of low HDL-C patients, despite TG lowering
  - Benefit trend seen in high TG, low HDL-C subset population

- **Niacin**: HDL-C increase focus (AIM-HIGH and HPS2-THRIVE)
  - **No benefit** in AIM-HIGH general population of low HDL-C patients, despite TG lowering
  - In AIM-HIGH, benefit trend seen in high TG, low HDL-C subset population
  - No benefit in the HPS2-THRIVE population with half of the patients having low HDL-C

- **Low dose omega-3**: meta-analysis and studies of omega-3, 6, 9s (including DHA) mixtures
  - **Negligible benefit** on outcomes or on lipid levels at low doses
  - No study prospectively enrolled patients with high TG levels

**Exception**: 19% to 53% risk reduction in Japan-based study

- **Ethyl-EPA** (JELIS):
  - Benefit shown in general population of low-dose, statin-treated patients
  - Greater benefit in patient subpopulation with high TG and low HDL-C
### Favorable Effects Observed in Patients with Baseline TG $>150$ mg/dL and low HDL-C in Outcomes Studies: Suggests* Double Digit Relative Risk Reduction (RRR) on Top of Statin Therapy

<table>
<thead>
<tr>
<th>Trial Publication Year</th>
<th>Therapy</th>
<th>Subgroup Size (N)</th>
<th>Statin Use Throughout</th>
<th>Subgroup Published</th>
<th>Endpoint</th>
<th>Subgroup RRR (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>JELIS 2007</td>
<td>EPA</td>
<td>957</td>
<td>Yes</td>
<td>TG $\geq 150$ mg/dL HDL-C $\leq 40$ mg/dL</td>
<td>Expanded MACE</td>
<td>-53% (0.043)</td>
</tr>
<tr>
<td>ACCORD-Lipid 2010</td>
<td>Fenofibrate</td>
<td>941</td>
<td>Delayed start (inflates starting baselines)</td>
<td>TG $\geq 204$ mg/dL HDL-C $\leq 34$ mg/dL</td>
<td>MACE</td>
<td>-31% (0.0567)</td>
</tr>
<tr>
<td>AIM-HIGH 2011</td>
<td>Niacin ER</td>
<td>523</td>
<td>Yes</td>
<td>TG $\geq 200$ mg/dL HDL-C $&lt;32$ mg/dL</td>
<td>Expanded MACE</td>
<td>-36% (0.032)</td>
</tr>
<tr>
<td>HPS2-THRIVE 2013</td>
<td>Niacin + Laropiprant</td>
<td>4,362</td>
<td>Yes</td>
<td>TG $\geq 151$ mg/dL HDL-C $&lt;35$ mg/dL</td>
<td>Major vascular events</td>
<td>No significant difference</td>
</tr>
</tbody>
</table>

* Primary CV risk reduction endpoint was not achieved in ACCORD-Lipid, AIM-HIGH and HPS2-THRIVE
Elevated TGs More Prevalent than Elevated LDL-C

Tens of millions of people have lipid disorders
- 13.1% of U.S. adults have elevated LDL-C
- 25.1% of U.S. adults have above normal TGs

Lipid disorders contribute to pancreatitis, heart disease, atherosclerosis and other health issues

Vascepa CV outcomes study in statin-treated patients with elevated TGs uniquely positioned for success
- Lowers TGs without increasing LDL-C
- Provides beneficial effects on broad spectrum of lipid markers and likely conveys other/pleiotropic effects
- Despite uncertainty created by other outcomes studies, extensive epidemiological, genetic and clinical data in peer-reviewed literature support hypothesis of positive CV outcomes effect from Vascepa in treating patients who despite statins have high TGs
- Safety comparable to placebo

![LDL-C and TG Prevalence in Adults (U.S.)](Source: NHANES 2009-2012)
Epidemiological, genetic, and clinical data suggest that TGs and the lipoproteins that carry them are within the causal pathway of CV disease, and that treating elevated TGs may result in reduced CV risk. More study needed.
Genetic Studies: TG Levels Predict Heart Disease (CHD)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>CHD Risk Effect Size</th>
<th>Perspective</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TG</td>
<td>0.40</td>
<td><em>Genes regulating TG and LDL-C levels are comparably strong predictors of CHD</em></td>
<td>&lt;&lt;&lt;0.0001</td>
</tr>
<tr>
<td>LDL-C</td>
<td>0.39</td>
<td></td>
<td>&lt;&lt;&lt;0.0001</td>
</tr>
<tr>
<td>HDL-C</td>
<td>0.04</td>
<td>HDL-C is weak predictor</td>
<td>0.32</td>
</tr>
</tbody>
</table>

Modified from:
Japan: Ethyl-EPA Reduced Coronary Events 19% to 53% on Top of Statin Therapy in Outcomes Study (JELIS)

Patients Randomized to Statin Alone or Statin + Ethyl-EPA (Epadel) and Followed for 5 Years with Comparison of Cumulative Incidence of Major Coronary Events

**TOTAL COHORT**
No pre-specified minimum TG level

**SUBGROUP**
TG>150 mg/dL and HDL<40 mg/dL

P value adjusted for age, gender, smoking, diabetes, and hypertension.
CI=confidence interval.


“Enriched” patient population in REDUCE-IT

- REDUCE-IT: all patients have elevated TGs and other CV risk factors despite statin therapy
  - Mean and median baseline TGs >200 mg/dL and ~1/2 of patients expected to also have low HDL-C
  - Fewer CV events likely classified as unstable angina in REDUCE-IT due to higher risk patient population and advances in medicine which better separate patients with unstable angina, which is a more subjective endpoint, from patients with myocardia infarction, a hard MACE endpoint

- JELIS: many patients had normal TG levels and a 19% risk reduction was achieved
  - Published subgroup with 53% risk reduction population had TG >150 mg/dL and low HDL-C

Higher treatment dose in REDUCE-IT

- REDUCE-IT 4 grams/day of ethyl-EPA (Vascepa); JELIS 1.8 grams/day of ethyl-EPA
- In 12-week Phase 3 ANCHOR study, 4 grams/day of Vascepa increased EPA in the plasma to approximately the same level as achieved with 1.8 grams/day of ethyl-EPA in JELIS
  - Difference likely due to high fish diet in Japan
  - EPA levels in REDUCE-IT control likely lower than JELIS due to dietary differences outside Japan
- Statin therapy targeted to US guidelines in REDUCE-IT, lower statin dose given in JELIS

REDUCE-IT is a global study

- REDUCE-IT: enrollment in 11 countries including strong participation in the United States; randomized double-blind study
- JELIS: Japan only, mostly women; open label, randomized with blinded endpoint analysis
Data suggest EPA provides cardio-protective benefit via various mechanisms

- Lowers TGs without increasing LDL-C
- Mechanistic studies suggest benefit at each stage of atherosclerosis
  - CHERRY Study: EPA added to high dose statin therapy resulted in nearly twice the prevalence of plaque regression than high dose statin therapy alone
- JELIS: Large Japanese outcomes study suggests that benefits from EPA likely extend beyond TG reduction (study not designed to assess TG-lowering benefit)
  - 19% to 53% risk reduction on top of low-dose statins
  - Greater benefit in patient subpopulation with high TG and low HDL-C

EPA may have beneficial effects on multiple atherosclerosis processes¹

- endothelial function
- oxidative stress
- foam cell formation
- inflammation/cytokines
- plaque formation/progression
- platelet aggregation
- thrombus formation
- plaque rupture

REDUCE-IT: Events Based Outcomes Assessment of CV Risk Reduction vs. Placebo

Blinded Study with Interim Analysis by Independent Data Monitoring Committee (DMC) Designed Under Special Protocol Assessment (SPA)

~ 4 Year Median Treatment and Follow-up

Inclusion Criteria:
- Men and non-pregnant or sterile women ages 45 and older
- Hypertriglyceridemia: TG ≥ 150 to <500 mg/dL
  - Mean and median baseline TGs >200 mg/dL and ~1/2 of patients expected to also have low HDL-C
- On stable statin therapy for at least four weeks prior to randomization
  - LDL-C ≤ 100 mg/dL
- Established cardiovascular disease (CVD) or at high risk for CVD (diabetes + risk factors)
Primary endpoint:
- Composite MACE endpoint, time to first occurrence of:
  - CV death
  - non-fatal MI
  - non-fatal stroke
  - coronary revascularization
  - hospitalization for unstable angina (determined to be caused by myocardial ischemia by invasive or non-invasive testing)
- All events adjudicated by independent, blinded, Clinical Events Committee

Secondary/other endpoints and analyses:
- Time to event analyses of components of the primary endpoint
- Subgroup analyses such as: gender, age, geography, CV risk category, presence/absence of diabetes at baseline, etc.
Approximately 8,000 patients to be studied for median ≈ 4 years

Projected to provide 90% power to detect 15% relative risk reduction
  - >95% power to detect >20% relative risk reduction

Powering based on placebo event rates in other CV outcomes trials for statin-treated populations with CVD, or at-risk for CVD
>20,000 patient years of study since patient enrollment started in Dec 2011

Enrollment target of 8,000 patients achieved

Event rate timing is tracking to trial design

Interim analysis by independent data monitoring committee planned for Sept/Oct 2016 based on ~60% of primary CV events

- Process commenced to prepare for interim look
- Much higher threshold to stop study for efficacy at interim look
  - Base case is trial runs to completion
- Safety has been reviewed periodically throughout study by DMC, each time with recommendation that the study be continued as planned
No previous outcomes trial was designed specifically to assess TG lowering in patients with persistent high TG levels despite statin therapy.

REDUCE-IT will be the first CV outcomes trial to test pure EPA VASCEPA 4 g/day in a high-risk population.

Elevated TG levels correlate with CV risk.

EPA pleiotropic effects beyond improving lipid levels.

### Capitalization Summary (Millions) As of March 31, 2016

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Cash</strong></td>
<td>$81.4M</td>
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<tr>
<td><strong>Debt Obligations</strong></td>
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<tr>
<td>ROYALTY-LIKE DEBT</td>
<td>$134.6M</td>
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<tr>
<td>EXCHANGEABLE SENIOR NOTES</td>
<td>$165.1M</td>
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<tr>
<td><strong>Common Stock and Equivalent Shares (Millions, Except per Share Amounts)</strong></td>
<td></td>
</tr>
<tr>
<td>COMMON/PREFERRED SHARES</td>
<td>217.9</td>
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<tr>
<td>OPTIONS AND RESTRICTED STOCK</td>
<td>31.5</td>
</tr>
<tr>
<td>TOTAL IF ALL EXERCISED</td>
<td>248.8</td>
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<tr>
<td><strong>Tax Jurisdiction (primary)</strong></td>
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<tr>
<td></td>
<td>Ireland</td>
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</tbody>
</table>

1. Represents face value of debt balance remaining to be paid in cash; a lower carrying value is reported for accounting purposes in accordance with U.S. GAAP.
2. The total remaining cash payments due on this debt are a fixed amount and include the contractual interest, which is paid quarterly at 10% of Vascepa revenues subject to quarterly maximum amounts.
3. Total principal of $165.1 million has put provisions for $15.1 million in Jan 2017 and $150 million in Jan 2019. Notes accrue 3.5% interest, paid semi-annually.
4. Includes 32.8 million common share equivalents issuable upon conversion of preferred shares.
Financial Guidance and Upcoming Milestones

Product revenues
- $105 to $120 million for 2016

Spending and cash flow
- SG&A expenses and R&D expenses in 2016 to be relatively flat with 2015 levels, excluding royalties to Kowa which should increase assuming revenue growth
- Cash flow tracking to be positive entering 2017 from commercial operations, excluding REDUCE-IT and other R&D costs not essential to supporting current commercial business

Upcoming milestones
- REDUCE-IT interim look by DMC in Sept/Oct 2016
- Potential new partners for Vascepa internationally and progress towards qualifying Vascepa for sale via existing international partners
**Investment Highlights**

**Large Global Sales Potential**
- Multi-billion dollar potential
- 2015 revenues grew 51% over 2014; growth continuing in 2016
- Multiple underserved patient populations with elevated TG levels

**Differentiated Product**
- TG reduction -- no increase, or a decrease, in LDL-C
- Reductions in Apo B, non-HDL-C, VLDL-C and total cholesterol
- Safety comparable to placebo

**Positive Execution**
- Growing sales productivity; growing managed care coverage
- Phase 3 trials completed—all primary endpoints achieved
- Licensing partnership for Vascepa in China commenced in 2015
- Outcomes study enrolled; initiated closure of patient screening

**Commercialization Strategy**
- Grow revenues through specialty sales focus
- Prepare for expanded opportunity upon REDUCE-IT success
- Cost-effectively advance other opportunities

**Experienced Management**
- Team with history of product development and commercial successes
- Direct sales team of 130 sales representatives, excluding sales managers
- Amarin team supplemented by Kowa sales representatives

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