AMARIN

Leading a New Paradigm in Cardiovascular Health Management

Investor Presentation

January 2018

NASDAQ: **AMRN**

Pure EPA

Vascepa®

(icosapent ethyl)

Forward-Looking Statements and Disclaimer

AMARIN

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. For example, clinical trials are inherently risky and the REDUCE-IT study may not be successful. 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.

Amarin: Growing Prescriptions and Blockbuster Opportunity

Current: net product revenues growing from U.S. sales of Vascepa; increasing 2017 guidance

- Lead product Vascepa® uniquely positioned for statin-treated patients with persistent elevated triglycerides
- Focused specialty sales effort in select geographies of U.S.
- Estimated unaudited 2017 results[1] and 2018 projection
  - 2017 net product revenue $177M - $180M, incl. Q4'17 $51M - $54M
    - Represents increase of $48M - $51M versus 2016
  - 2018 net product revenue forecasted to increase ~$50M to ~$230M with guidance to be updated after outcomes study results are known in Q3'18

Upcoming: REDUCE-IT outcomes study nearing completion

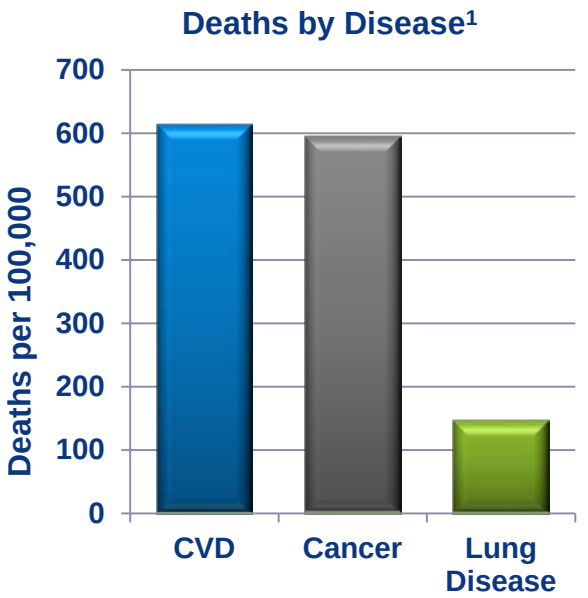
- Evaluating effect of Vascepa in lowering cardiovascular events as an add-on to statin therapy; larger need than current TG lowering label
- Studying at-risk patients with persistent elevated triglycerides
- Cardiovascular events driven study
  - Final patient study visits starting March 2018
  - Top-line results expected before the end of Q3 2018
  - 90% powered per study design to detect a 15% relative risk reduction between Vascepa plus statin arm vs. placebo plus statin arm

[1] Result for 2017, subject to audit, for U.S. GAAP purposes estimated to have exceeded upper end of prior guidance of $175M

Large Need for CV Risk Reduction Beyond Lowering LDL-C

Cardiovascular Disease: #1 cause of death in the United States

- >600,000 people die of CV disease in the United States every year
  - Represents ~1 in every 4 deaths[1]
- Heart attacks, stroke and other CV disease are expensive to treat[2]
  - Estimated annual total cost of $555 billion
  - Costs expected to double to $1.1 trillion within twenty years



Lowering LDL-C reduces CHD risk but not sufficiently alone

- Statins lower CV risk ~25% to 40%
- Remaining residual CV risk of ~60% to 75%

Raising HDL-C is failed solution demonstrated in multiple outcomes studies

Promising remaining targets for lowering CV risk beyond well-controlled LDL-C

- Lowering high triglycerides (fats in the blood) or other atherogenic biomarkers
- Lowering inflammation or other factors contributing to atherosclerosis

Sources:

1) Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm, January, 20, 2017

2) AHA: Cardiovascular Disease: A Costly Burden for America — Projections through 2035 http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491543.pdf

Elevated TGs Correlated with Increased CV Risk

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

Triglyceride (TG) levels measured on most lipid panels

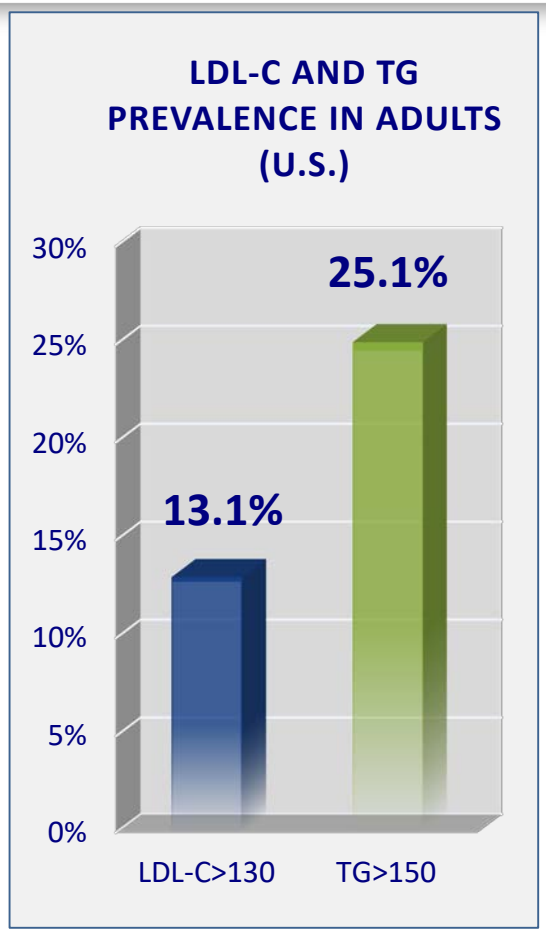
- Other measurements of lipids and atherogenic particles to consider in conjunction with TG levels include: LDL-C (addressed by statins and other therapies) and Non-HDL-C; Apo B; Ox-LDL; APO C-III; RLP-C and LDL-P
  - HDL-C might also be considered but not independently
  - Not all such measures are readily available without added tests

Correlation between TG level and CV risk broadly established

- Extensive genetic, epidemiological and clinical data suggest that elevated TG levels are associated with increased CV risk

Prospective CV outcomes study on persistent elevated TGs

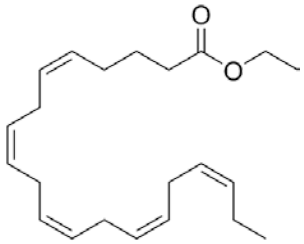
- First study is REDUCE-IT by Amarin which evaluates broad effects of Vascepa, including TG lowering, on CV risk reduction after statin therapy
- Earlier generation TG lowering therapies have significant limitations (e.g. they raise LDL-C or have tolerability issues)



Source: NHANES 2009-2012

Vascepa is Unique and Pragmatic Prescription Therapy

Single active ingredient eicosapentaenoic acid (EPA)



- Unique omega-3 molecule[1] derived from nature
  - New chemical entity designation by FDA for Vascepa as pure EPA
- Small molecule capable of entering and improving function of endothelial cells
- Doesn't inhibit clearance of LDL-C like docosahexaenoic acid (DHA)
- Excludes saturated fats, omega-6s and other ingredients in fish oil
- Expertly manufactured and encapsulated to mitigate oxidation risk of omega-3s

Effectiveness demonstrated in two placebo-controlled Phase 3 studies

- Significantly lowers TGs and other atherogenic biomarkers in patients with elevated TGs; does not increase LDL-C (bad cholesterol)
- Significantly lowers markers of inflammation
  - Separate data supports EPA having positive effects on each of the other processes beyond inflammation associated with atherosclerosis
- FDA approved for treating patients with very high TGs (≥500 mg/dL)

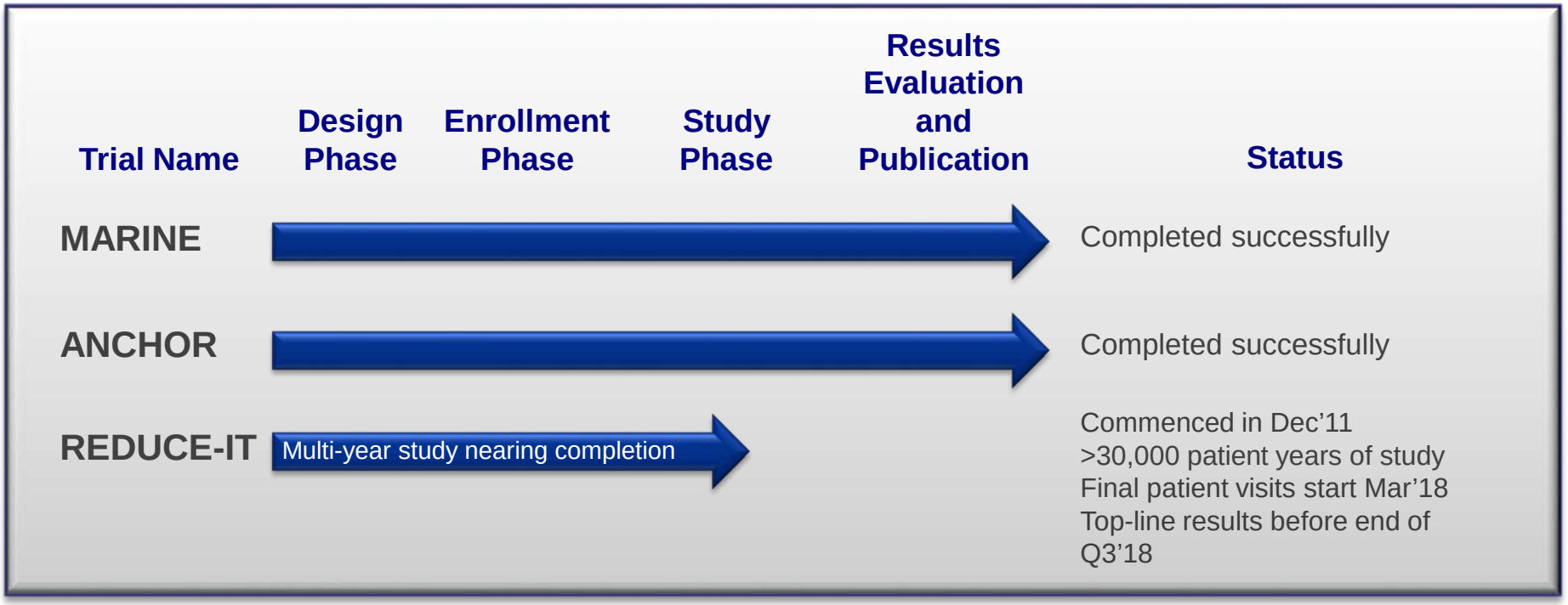
Orally administered with safety and tolerability comparable to placebo

- No known drug-drug interactions[1]

Affordably priced (similar to statins) and broadly available in U.S.

[1]See Vascepa® {package insert}. Bedminster, NJ: Amarin Pharma Inc.; 2017

Vascepa Clinical Trials: Track Record of Success

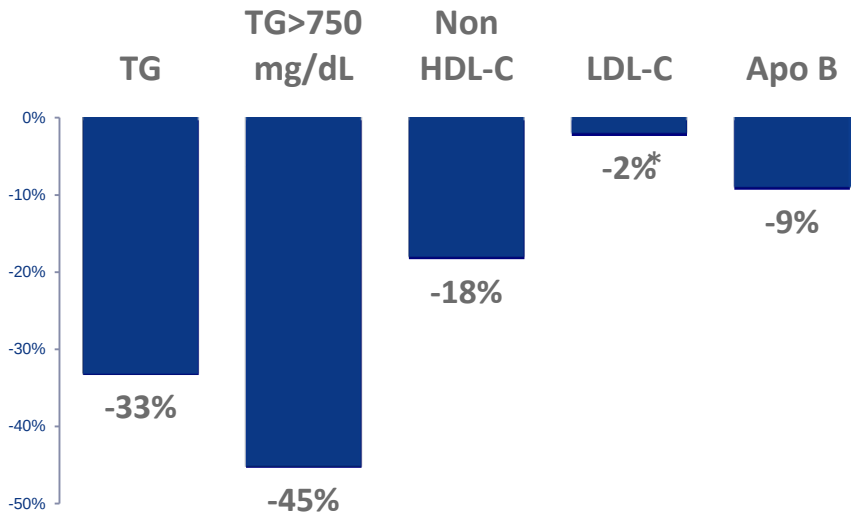


- MARINE: Demonstrated efficacy as an adjunct to diet to reduce triglyceride (TG) levels in patients with severe (≥500 mg/dL) hypertriglyceridemia, leading to FDA approval
- ANCHOR: Demonstrated efficacy in patients who, despite statin therapy, have persistent high TG levels (200-499 mg/dL), indication 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 persistent elevated triglycerides
- Other: Multiple potential other indications could be advanced further post REDUCE-IT

Vascepa Phase 3 Results Show Broad Lipid Level Improvement
(4g/day dose)

MARINE Trial:

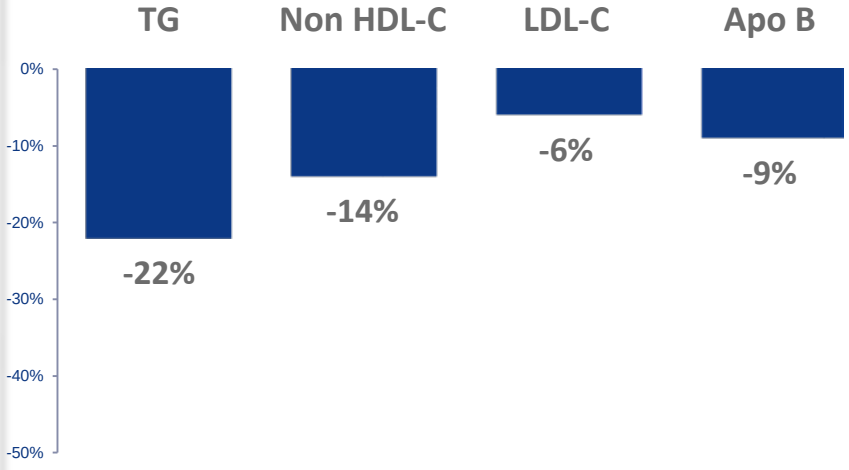
Phase 3 median placebo-adjusted 12 week results for Vascepa 4g/day dose in patients with very high TGs (≥500 mg/dL)



Ref: American Journal of Cardiology 2011; 108:682–690.

ANCHOR Trial:

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



Ref: American Journal of Cardiology 2012;110:984-992

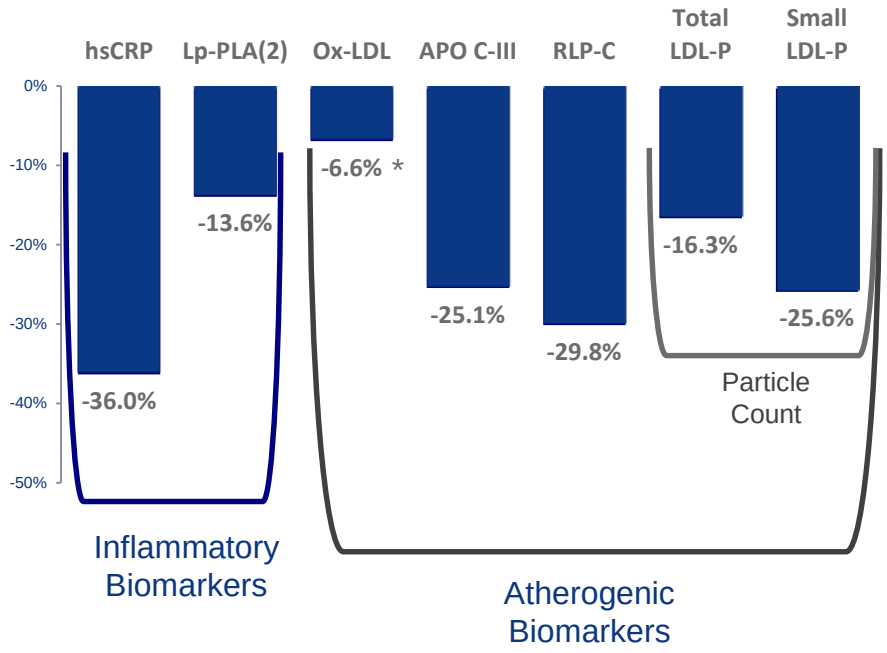
- Primary TG-lowering endpoint achieved
- Favorable effect on other clinically relevant endpoints
- Favorable safety and tolerability profile
  - Use with caution in patients with known hypersensitivity to fish and/or shellfish
  - Only reported adverse reaction across the clinical profile for Vascepa 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*

Vascepa Additional Key Published Findings (4g/day dose)

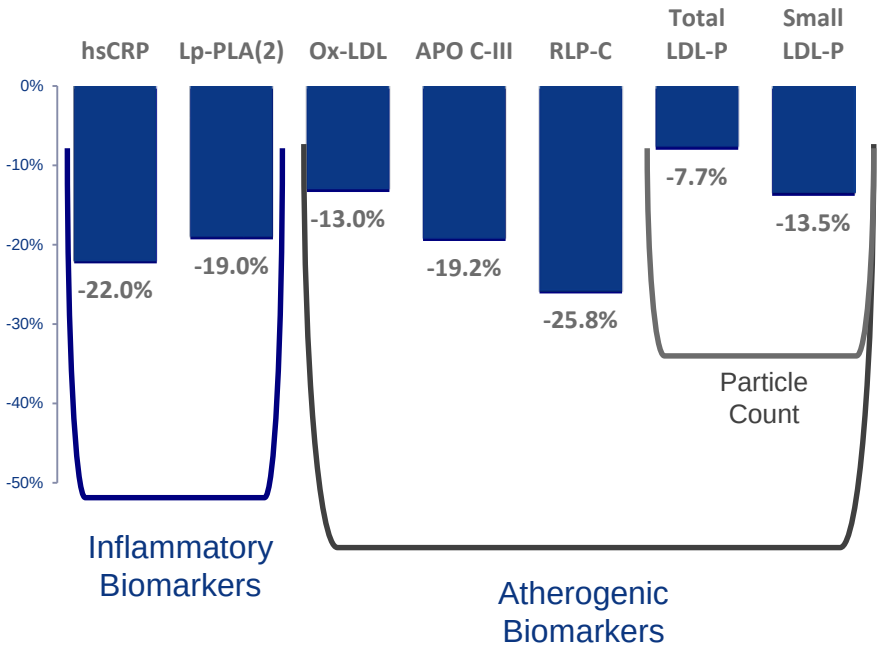
MARINE Trial:

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 persistent high TGs (200 to 499 mg/dL)



Sources:
Bays HE et al. Journal of Clinical Lipidology 2012; 6(6):565-572
Bays HE et al. American Journal of Cardiovascular Drugs 2013; 13(1):37-46
Ballantyne CM et al. Journal of Clinical Lipidology 2014; 8(3):313-314
Ballantyne CM et al. Journal of Clinical Lipidology 2015; 9(3):377-383
Ballantyne CM et al. Atherosclerosis 2016; 253:81-87

** All statistically significant results, except Ox-LDL reduction in MARINE trial*

Both the Amount and Type of Omega-3 Fatty Acid are Important for TG Lowering

Science of lipid management and clinical effects of omega-3 fatty acids are complex

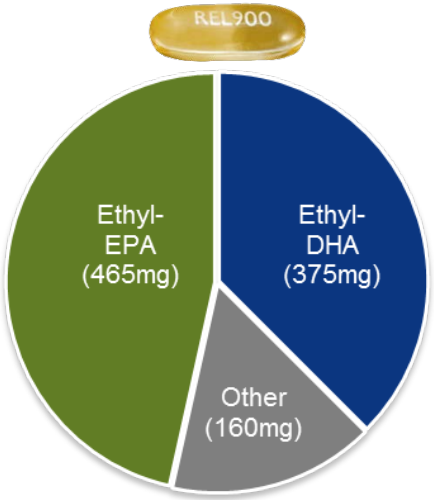
Both the amount and type of omega-3 fatty acid are important for TG lowering[1]

- Fish oil typically contains approximately 18% EPA
- Available prescription omega-3 therapies range from ~47% to nearly 100% EPA
- As evidenced in Phase 3 studies of Vascepa, low doses of omega-3s (<4 grams/day) have limited effects on lipid and other biomarkers in patients with serious medical conditions

Vascepa® (icosapent ethyl)[1]

Capsules also contain trace amounts of inactive ingredients incl. tocopherol, an anti-oxidation agent

1st Generation Rx Omega-3 Therapy[2]



- DHA has been correlated with increases in LDL-C[3,4]
- Capsules also contain tocopherol[2]

1. Vascepa® {package insert}. Bedminster, NJ: Amarin Pharma Inc.; 2017; 2. Lovaza® {package insert}. Research Triangle Park, NC: GlaxoSmithKline
3. Jacobson TA et al. *J Clin Lipidol*. 2012;6(1):5-18; 4. Wei MY, Jacobson TA. *Curr Atheroscler Rep*. 2011;13(6):474-483
No head to head studies conducted

Treatment Guidelines for CV Disease Rely on Outcomes Data

Positive outcomes study results for LDL-C lowering therapy supports vast Rx use

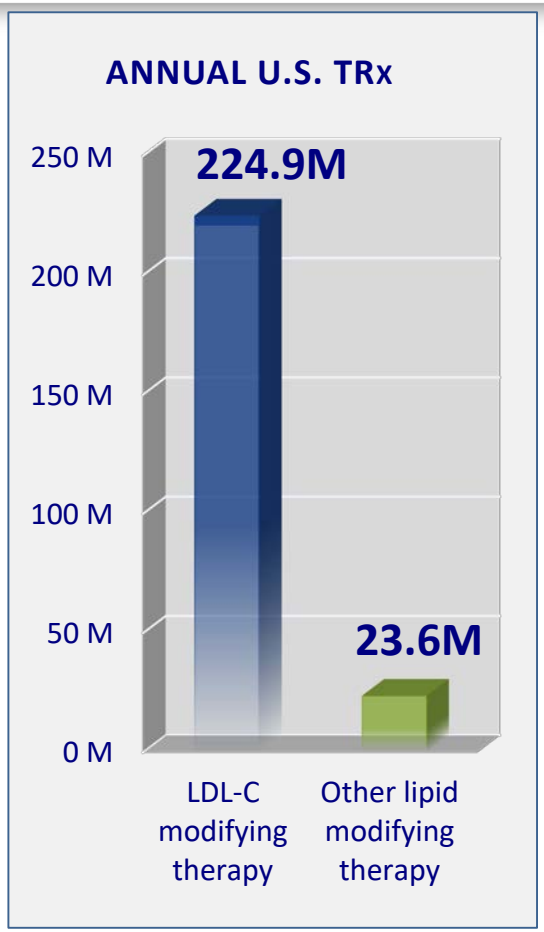
- ~38M patients in U.S. are on statin therapy
- Before going generic, statins sold over $34B/year
  - Lipitor alone sold over $12B/year globally before going generic
- ~650K physicians in the U.S. prescribe statins annually

No positive, labeled outcomes data exists for therapy that improves lipid measures on top of well-controlled LDL-C

- Fenofibrate and niacin failed in CV outcomes studies after statin therapy
- Recent study, CANTOS, positive results for lowering inflammation

<4% of patients with elevated TGs treated with Rx therapy

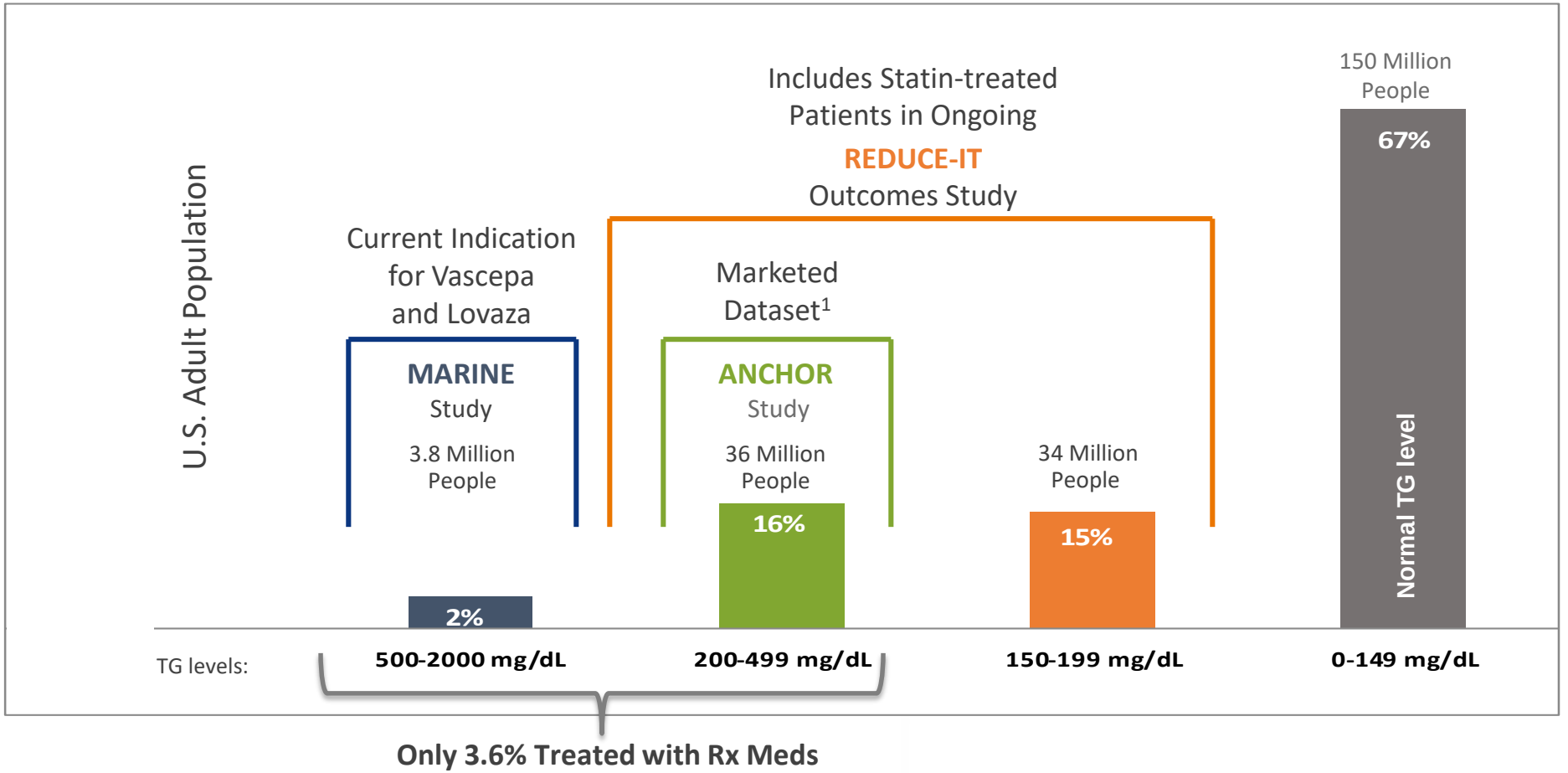
- Physicians want outcomes data to support broad Rx use after statins
- Current use of TG lowering therapy is limited
- Earlier generation TG lowering therapies are fenofibrates (~2M patients on therapy); Lovaza (~600K patients on therapy) and niacin (~240K patients on therapy); none have successful outcomes data



Source: Symphony Health, PHAST Monthly, accessed 12/21/17

Large Underpenetrated Market Opportunities

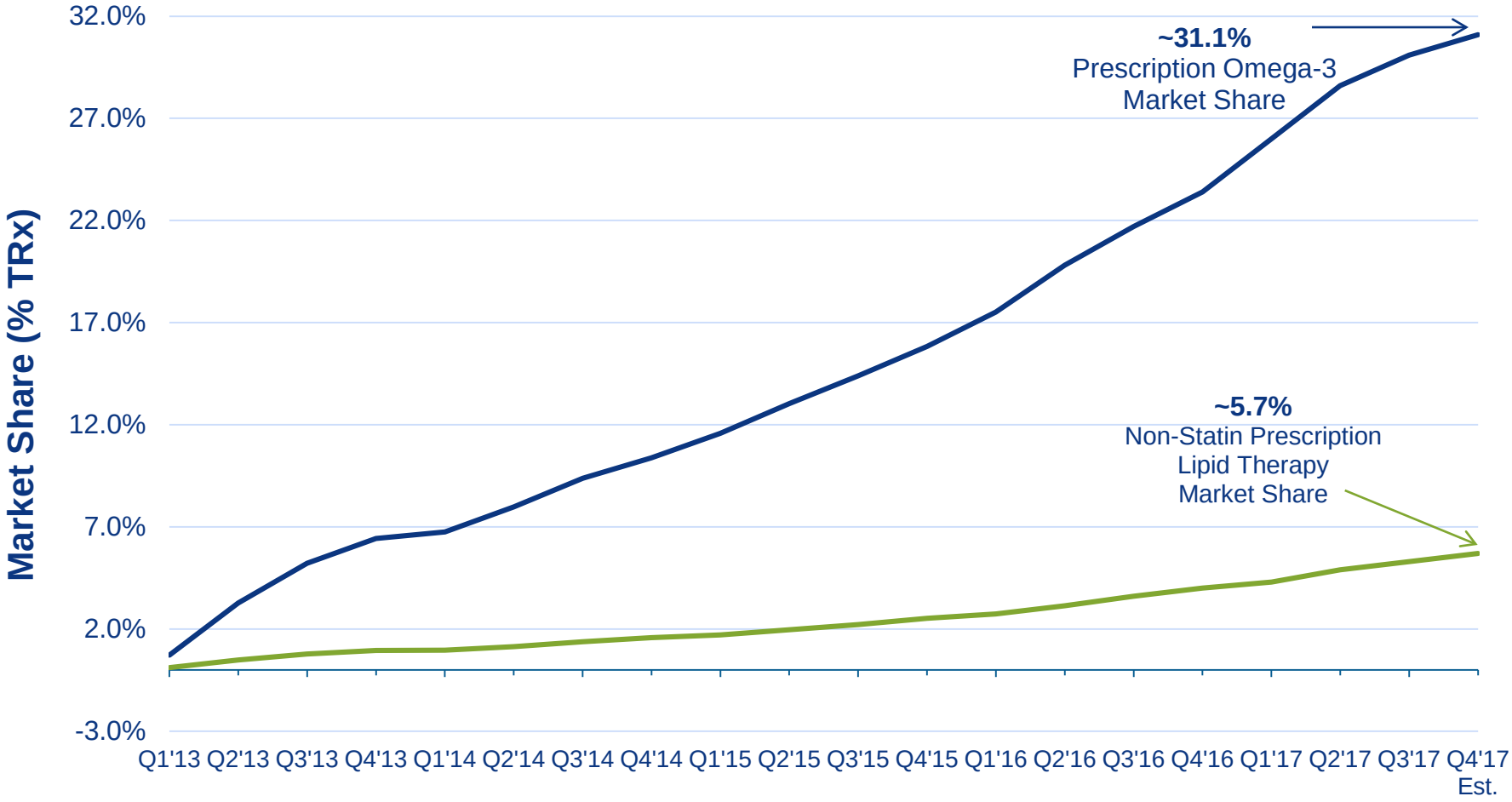
U.S. Adult Population Stratified Based on TG Levels



>100M People in Top 7 Global Markets for Initially-Targeted Indications

1) For use in patients with persistent high (200-499 mg/dL) TGs after statin therapy, as studied in ANCHOR
Sources: Journal of Clinical Lipidology 2015; 9:377-383, Datamonitor and Archives of Internal Medicine, 2009;169(6):572-578

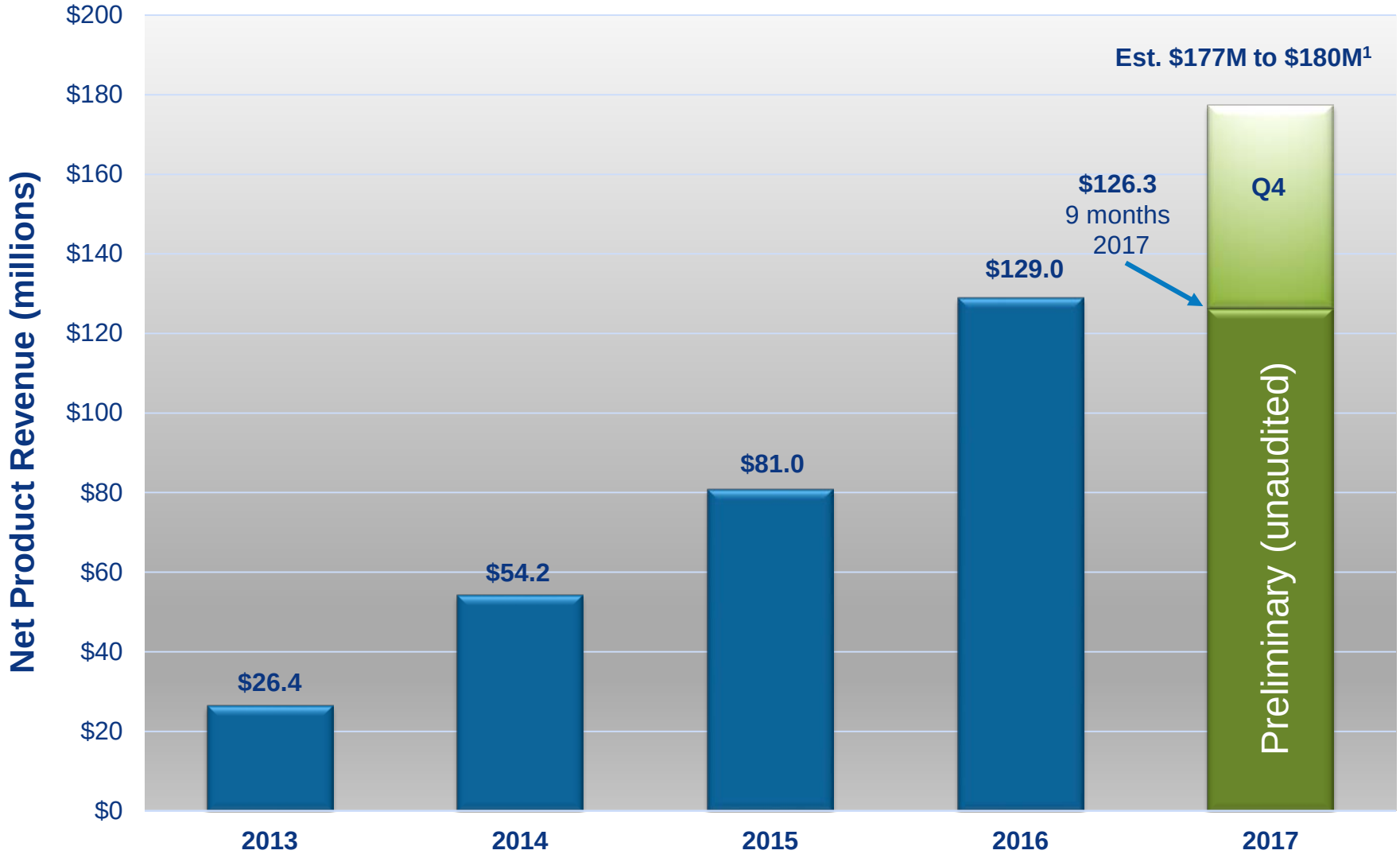
Vascepa Share of Market Is Growing



- Considerable growth opportunity remains
- Market share is higher in called upon targets than overall market share illustrated above

Source: Symphony Health Solutions, PHAST

Net Product Revenue History and Guidance ($Millions)



[1]*2017 unaudited GAAP-based estimate likely to exceed prior guidance of $165M to $175M*

Vascepa Commercialization Vision in the U.S.

	2017 and Prior	2018 Before REDUCE -IT Results	Post REDUCE -IT (assumes trial success followed by label expansion)
# of AMRN sales reps	~135	~150	~400 to 500
# of top target physicians	~20K	~20K	>40K
Consumer promotion	Minimal	Slightly expanded (potential trial DTC programs)	Yes (level tbd post trial results)
Co -promotion partner	Yes	Yes	Unlikely post-2018
Positioning	Improve biomarkers	Improve biomarkers	CV risk reduction
TRx growth focus	Market share	Market share	Expand market and market share
Net pricing to managed care payers and patients	Similar to generic Lovaza [1]	Similar to generic Lovaza [1]	Tbd (unlikely to increase significantly)
Revenue growth	5 yrs. from $0 to ~$177M - $180M	Continue growth via productivity gains	Accelerated growth (aiming for billions)

[1] >140M lives covered by payers for Vascepa on tier 2 unrestricted at end of 2017

REDUCE-IT Cardiovascular Outcomes Study: Results Expected Before End of Q3'18

AMARIN

First ever prospective, blinded study of therapy which lowers TG levels (and other markers associated with CV risk) in statin-treated patients with elevated TG levels and other CV risk factors

Designed under Special Protocol Assessment (SPA) agreement

reduce-it

Primary endpoint: time to first occurrence of composite MACE

- Blinded evaluation of CV risk reduction vs. placebo
- MACE (major adverse cardiovascular events): CV death; non-fatal MI; non-fatal stroke; coronary revascularization; and hospitalization for unstable angina (caused by myocardial ischemia, determined by invasive or non-invasive testing)
- All events adjudicated by independent, blinded, Clinical Endpoint Committee
- >30 pre-specified secondary and tertiary endpoints

Designed for 90% power to detect 15% relative risk reduction

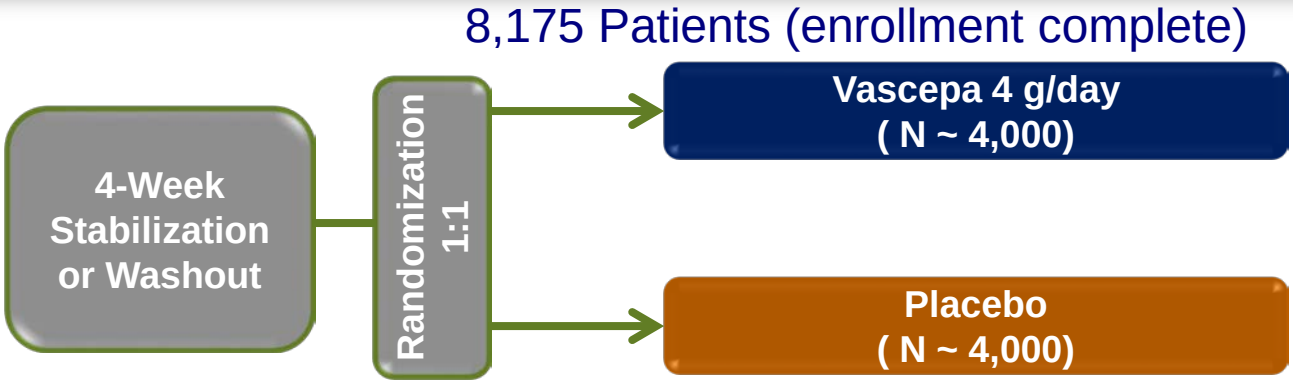
- Assumes 1,612 primary endpoint events across a 4 to 5 year median patient follow-up period
- As with other long-term outcomes trials, actual study power may be higher or lower

>30,000 patient years of study since outcomes trial started in Dec 2011

Nearing completion: study results expected before end of Q3 2018

- In Q1'18, expect onset of target final primary CV event and commencement of final patient site visits

REDUCE-IT Enrolled Patients All Have Multiple CV Risk Factors Despite Statin Therapy



Patient criteria for enrollment of high-risk population included

- Men or women age ≥45 years with established CV disease or age ≥50 years with diabetes mellitus and 1 additional CV risk factor
- Fasting triglycerides ≥150 mg/dL and <500 mg/dL
- LDL-C >40 mg/dL and ≤100 mg/dL with stable statin (+/-ezetimibe) ≥4 weeks prior to qualifying measurements

All patients remain on statin therapy (both arms of the study)

Statistical method: compare Vascepa-arm to placebo-arm of study

- Kaplan-Meier analysis based on stratified log-rank test
  - Hazard ratio and its 95% confidence intervals will be estimated using a stratified Cox proportional hazards model
  - Success requires p<0.0436 for primary endpoint
    - p-value subject to potential adjustment to reflect actual number of events (above number based on assumption that the study is completed with exactly 1,612 primary MACE, actual result may differ)

Data Supporting Potential for Vascepa Outcomes Benefit Goes Well Beyond TG Lowering and Prior Phase 3 Trial Successes

AMARIN

TG Lowering Data Examples

Lower TG levels correlated with lower CHD risk when LDL-C is well controlled

- PROVE-IT (Lipitor/Pravachol): Analysis of all patients well controlled for LDL (<70 mg/dL) in which patients with TG <200 mg/dL were associated with 40% lower risk of recurrent CHD events vs. TG> 200 mg/dL

Subset of patients in clinical outcomes studies evaluating therapies that lower TG levels showed benefit in subset populations with baseline elevated TG, despite failed trials

- ACCORD (fenofibrate): Subgroup TG≥204 mg/dL and HDL-C ≤34 mg/dL; MACE relative risk reduction 31%
- AIM-HIGH (Niacin ER); Subgroup TG≥200 mg/dL and HDL-C <32 mg/dL; MACE relative risk reduction 36%

Multiple recent large genetic studies suggest TG and LDL-C levels are similar predictors of CHD

- As summarized in recent reviews (e.g. Noordestgaard[3])

Benefits Beyond TG Lowering Examples

Mechanistic effects of EPA have shown broad favorable effects on atherosclerotic processes[1]

- Endothelial function
- Oxidative stress
- Foam cell formation
- Inflammation/cytokines
- Plaque formation/progression
- Platelet aggregation
- Thrombus formation
- Plaque rupture

Supporting data examples:

- Inflammation: CANTOS study established inflammation as independent marker of CV risk; EPA lowered hsCRP in ANCHOR and MARINE
- Plaque: CHERRY study showed EPA added to high dose statin doubled incidence of plaque regression vs. high dose statin therapy alone

Protective effect of EPA shown post PCI

- Nosaka et al. showed early EPA + statin post PCI resulted in 11% reduction in CV events vs. statin alone; CV death reduced 3.4%[2]

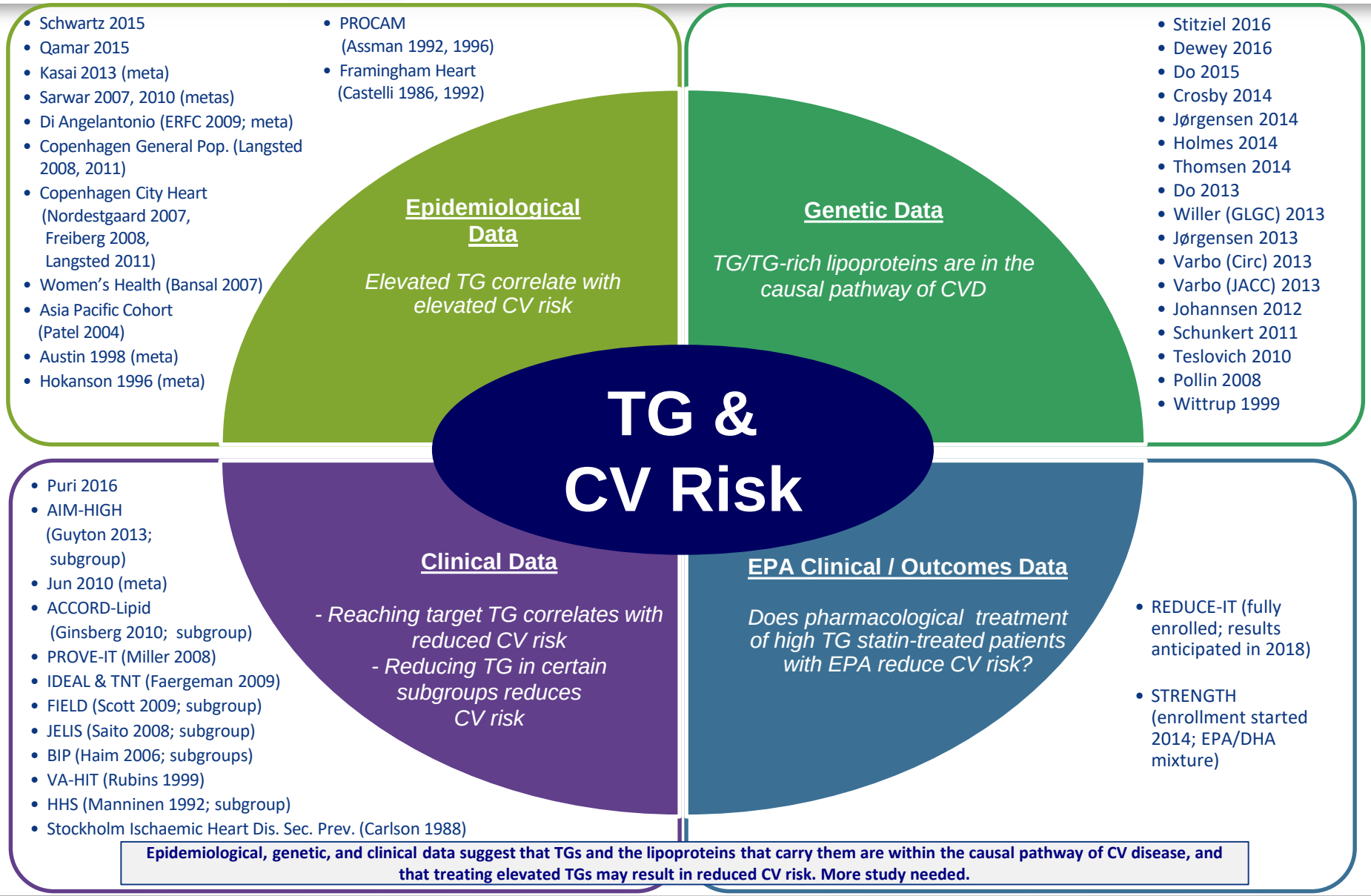
Hybrid Example of Broad Favorable Effects of EPA from JELIS (large Japanese outcomes study)

- Overall population without high TG levels: **19%** reduction in CV events (p =0.011); little change in TG levels
- Subgroup TG >150 mg/dL and HDL-C <40 mg/dL: **53%** reduction in CV events (p=0.043)

[1]Borow KM et al. Atherosclerosis. 2015;242(1). [2]*Absolute risk reduction at 1 year (9.2% vs 20.2%); absolute reduction in CV related deaths was 3.4%. Nosaka K et al. Int'l Journal Cardiology. 228 (2017); 173-179.*
[3]Nordestgaard, BG. AHA. *Triglyceride-Rich Lipoproteins and Atherosclerotic Cardiovascular Disease: New Insights From Epidemiology, Genetics, and Biology.* 2016

>40 Papers Support Correlation Between TGs and CV Risk

AMARIN



- Schwartz 2015
- Qamar 2015
- Kasai 2013 (meta)
- Sarwar 2007, 2010 (metas)
- Di Angelantonio (ERFC 2009; meta)
- Copenhagen General Pop. (Langsted 2008, 2011)
- Copenhagen City Heart (Nordestgaard 2007, Freiberg 2008, Langsted 2011)
- Women's Health (Bansal 2007)
- Asia Pacific Cohort (Patel 2004)
- Austin 1998 (meta)
- Hokanson 1996 (meta)
- PROCAM (Assman 1992, 1996)
- Framingham Heart (Castelli 1986, 1992)

- Stitziel 2016
- Dewey 2016
- Do 2015
- Crosby 2014
- Jørgensen 2014
- Holmes 2014
- Thomsen 2014
- Do 2013
- Willer (GLGC) 2013
- Jørgensen 2013
- Varbo (Circ) 2013
- Varbo (JACC) 2013
- Johannsen 2012
- Schunkert 2011
- Teslovich 2010
- Pollin 2008
- Wittrup 1999

- Puri 2016
- AIM-HIGH (Guyton 2013; subgroup)
- Jun 2010 (meta)
- ACCORD-Lipid (Ginsberg 2010; subgroup)
- PROVE-IT (Miller 2008)
- IDEAL & TNT (Faergeman 2009)
- FIELD (Scott 2009; subgroup)
- JELIS (Saito 2008; subgroup)
- BIP (Haim 2006; subgroups)
- VA-HIT (Rubins 1999)
- HHS (Manninen 1992; subgroup)
- Stockholm Ischaemic Heart Dis. Sec. Prev. (Carlson 1988)

- REDUCE-IT (fully enrolled; results anticipated in 2018)
- STRENGTH (enrollment started 2014; EPA/DHA mixture)

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.

Recent Real-World Evidence (RWE) Studies

Recent RWE studies support correlation that high triglycerides, despite controlled LDL ("bad") cholesterol, result in significantly greater risk for major adverse cardiovascular events (MACE)*

Data from the nationwide Optum database showed[1]:

- 35% increased risk for myocardial infarction (heart attacks)
- 51% increased risk for coronary revascularization

Data from the Kaiser database showed[2]:

- 30% increased risk for myocardial infarction (heart attacks)
- 30% increased risk for coronary revascularization

Both studies analyzed adults already taking statins and with controlled LDL

- One cohort had people with normal triglycerides (<150 mg/dL)
- One cohort had people with high triglycerides (200-499 mg/dL)

Optum study also showed

- 15% higher average total health care cost of patients with high TG levels
- 17% higher rate of occurrence of an inpatient stay over time of patients with high TG levels

* Nonfatal MI, nonfatal stroke, coronary revascularization, unstable angina, and all-cause mortality (Kaiser) or CV-related mortality (Optum)

[1] Toth PP et al, American Heart Association (AHA) 2017 Scientific Sessions
[2] Nichols GA et. al., American Heart Association (AHA) 2017 Scientific Sessions

Genetic Data: TG Levels Predict Heart Disease (CHD)

- Data across multiple genetic studies is consistent
  - Both TG and LDL-C genetic data point to a causal association with CVD
- Data suggest mutations that lower TGs over lifetime correlate with reduced CV risk

Predictor	CHD Risk Effect Size	Perspective	P-value
TG	**0.40**	***Genes regulating TG and LDL-C levels are comparably strong predictors of CHD***	<<<0.0001
LDL-C	**0.39**		<<<0.0001
HDL-C	0.04	HDL-C is weak predictor	0.32

Modified from: Do R et al. Nat Genet. 2013;45(11):1345-1352 (N=86,995)

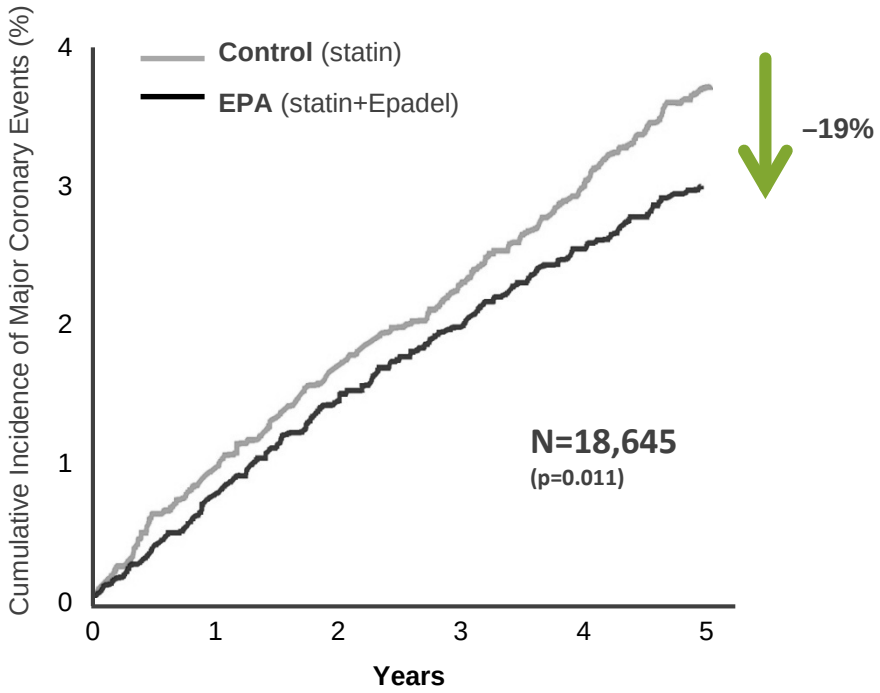
Japan: Ethyl-EPA Reduced Coronary Events 19% to 53% on Top of Statin Therapy in Outcomes Study (JELIS)

AMARIN

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

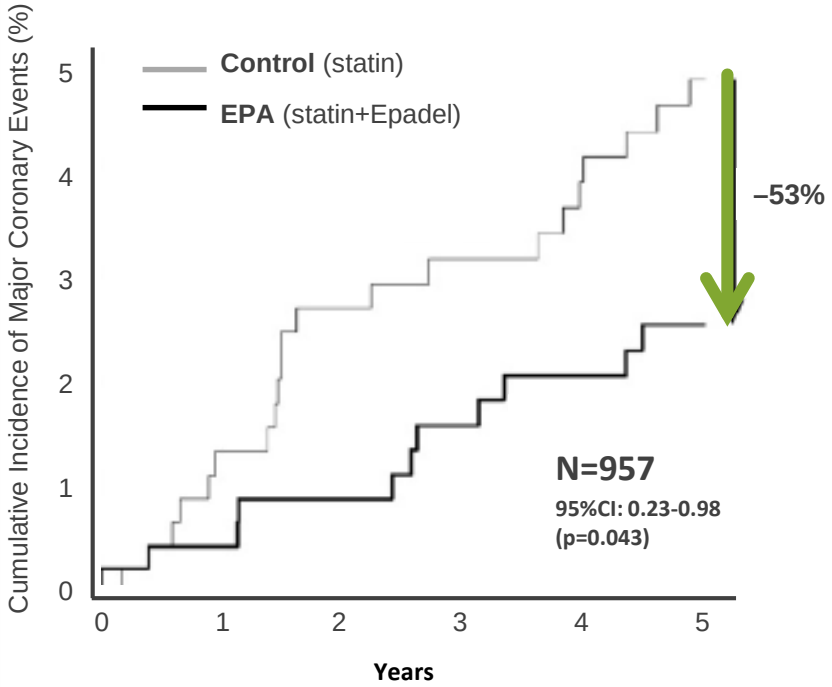
No pre-specified minimum TG level



Source: Yokoyama M. et al, *Lancet 2007; 369:1090-1098*

SUBGROUP

TG≥150 mg/dL and HDL<40 mg/dL



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

Source: Saito et al, *Atherosclerosis* 2008; 200: 135-140

REDUCE-IT and JELIS Study Design Differences

"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. Also, advances in medicine better separate patients with unstable angina, a more subjective endpoint, from patients with myocardial 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 $\geq$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-blinded study
- JELIS: Japan only, mostly women; open label, randomized with blinded endpoint analysis

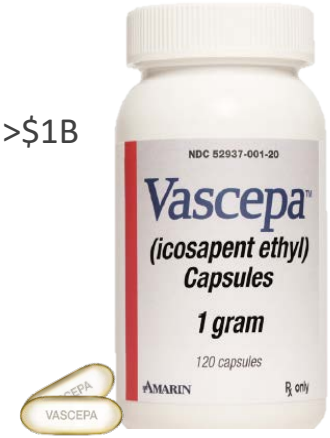
Amarin Preparing for REDUCE-IT Success

Strengthening team and relationships

- Added Mark Salyer as Chief Commercial Officer (new position) in late-'17
  - Mark twice previously led commercial growth to >$1B, most recently as head of respiratory division of Teva
- Building relationships with KOLs and industry groups
  - 25 scientific publication/posters supported in 2017, including real world evidence data from Kaiser and Optum
  - Medical affairs team led by Dr. Craig Granowitz, previous global head of medical affairs for Merck

Supply capacity expanding

- Multiple proven suppliers for Vascepa
  - Current capacity to support >$500M in revenue; capacity to expand in 2019 to support >$1B
  - Gross margin increased to mid-70%'s in 2017



Sustainable business

- Vascepa patents listed in the FDA's Orange Book expire in 2030
- NCE protection

International expansion

- Commercial partners pursuing regulatory approvals for Vascepa in Canada, China and Middle East

Capitalization Summary (Millions)

As of December 31, 2017 (unaudited)

AMARIN

Cash[1]	$73.6	
Debt Obligations[2]		
EXCHANGEABLE SENIOR NOTES[3]	$30.0	First put date Jan. 2022
ROYALTY-BEARING INSTRUMENT	$109.1	10% of revenues until fully paid; no maturity date
Common Stock and Equivalent Shares		
COMMON/PREFERRED SHARES[4]	303.9	Preferred shares mirror common but non-voting
OPTIONS AND RESTRICTED STOCK	36.0	
TOTAL IF ALL EXERCISED	339.9	
Tax Jurisdiction (primary)	Ireland	Loss carryforwards of >$570

[1] Net quarterly cash burn history in 2017 of $15.9, $10.6, $6.4 and $5.5 million, in Q1, Q2, Q3 and Q4, respectively, excluding net proceeds of transactions relating to exchangeable senior notes announced in Q1'17

[2] 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

[3] $30 million of 3.5% exchangeable senior notes due 2047; exchange price $3.89/sh., adjusted under certain circumstances

[4] Includes 32.8 million common share equivalents issuable upon conversion of preferred shares

Financial Guidance and Upcoming Milestones

2018 net product revenue estimates

- Growth, prior to REDUCE-IT results, to continue at rate of ~$50M for year
- Projecting quarterly growth of ~30% over 2017; ~$230M net product revenue for full year
  - Continued seasonality with Q1'18 projected at $45M to $48M rebounding to at least $55M in Q2'18
- Update guidance after REDUCE-IT results

2018 spending and cash flow estimates

- R&D quarterly spending remains $10M to $15M until REDUCE-IT results completed and published
- No major expansion of sales force until after REDUCE-IT results; assuming REDUCE-IT results are positive, expand U.S. sales force to 400 to 500 sales and increase promotion
- Increased spending on medical education and awareness, inventory build and publications, including potential test marketing of promotional initiatives in preparation for further promotion after REDUCE-IT results
  - In period before REDUCE-IT results, operate cash flow neutral excluding interest, royalty, R&D (most of which is REDUCE-IT related) and other preparations for REDUCE-IT results (medical education and supply build)
- Continued quarterly variability; update guidance after REDUCE-IT results

Key REDUCE-IT milestones

- Final patient study visits starting March 2018
- Report top-line results before the end of Q3 2018 with publication promptly thereafter

Investment Highlights

Large Global Sales Potential

- Multiple underserved patient populations with elevated TG levels
- Multi-billion dollar potential assuming outcomes study success
- Significant growth opportunity based on current indication
- Product revenues growing; projecting ~$230M in 2018

Differentiated Product

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

Positive Execution

- Sustained strong TRx growth
- Broad managed care coverage
- Phase 3 trials successfully completed with all primary endpoints achieved
- Outcomes study fully enrolled and nearing completion in 2018

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
- Recently added CCO with history of creating substantial growth
- Specialty sales team with history of increasing productivity

Leading a New Paradigm in Cardiovascular Health Management

AMARIN

Leading a New Paradigm in Cardiovascular Health Management

Investor Presentation

January 2018

NASDAQ: **AMRN**

Pure EPA

Vascepa®

(icosapent ethyl)