Next Generation Lipid Modification in Cardiovascular Disease

Investor Presentation

Nasdaq: AMRN
Forward-Looking Statement

This presentation contains forward-looking statements, including those relating to the Company’s product development, clinical and regulatory timelines, market opportunity, cash flow and other statements that are predictive in nature, that depend upon or refer to future events or conditions. Forward-looking statements include words such as “expects,” “anticipates,” “intends,” “plans,” “believes,” “estimates” and similar expressions. These statements involve known and unknown risks, uncertainties and other factors which may cause actual results to be materially different from any future results expressed or implied by the forward-looking statements. See discussion of Risk Factors in the Company’s Annual Report on Form 10-K and its most recent Quarterly Report on Form 10-Q as filed with the SEC. Prospective investors are cautioned not to place undue reliance on such forward-looking statements, which speak only as of the date of this presentation. Amarin’s product candidates are in various stages of development and are not available for sale or use outside of approved clinical trials.
Lead product AMR101 represents next generation lipid lowering drug for cardiovascular indications
Clearly differentiated product for existing and new markets
Blockbuster worldwide sales potential
  • AMR101 positioned to be first-in-class and best-in-class for two multi-billion dollar indications
  • Multiple potential follow-on indications
Unpartnered drug candidate
Well-defined regulatory path
  • SPA agreements with FDA for each of MARINE and ANCHOR Phase 3 trials
  • NDA expected to be filed in Q3 2011 for MARINE indication
Experienced management team capable of execution and maximizing shareholder value
  • Direct experience in the successful launch and commercialization of lipid lowering agents

Unique Opportunity: Significant Differentiation & Risk Mitigation
Emerging Clinical Focus on Lowering Triglycerides (TGs)

**Key Treatments**
- **Statins, Niacin, Fibrates**
- **Fibrates**
  - Prescription Omega-3
- **Amarin’s AMR101**

**Lipid Parameters**
- LDL
- HDL
- TGs
- LDL-C & Total Cholesterol

**Emerging Treatment**
- EMERGING THERAPY
  - Triglycerides

**Traditional Physician Focus**
- LDL-C & Total Cholesterol

**New Generation (AMR101) with No LDL Increase**
- Triglycerides

Elevated TGs, elevated LDL-C and low HDL-C are each independent cardiovascular risk factors. Current treatments for lowering TGs (fibrates and prescription Omega-3) elevate LDL-C ~50% in patients with very high triglyceride levels. Clinical data (e.g. JELIS study) suggests that lowering triglycerides lowers cardiovascular events.
New Generation of Lipid Management Therapy Needed

Existing triglyceride management therapies have significant limitations, including up to 50% increase in LDL-C.

Clinicians are increasingly looking to other biomarkers to assess lipid management, in particular:

- Apo-B (apolipoprotein B)
- Non-HDL-C (total cholesterol minus HDL)
- VLDL-C
- Lp-PLA₂ (lipoprotein phospholipase A₂)
- hs-CRP (high sensitivity C-reactive protein)

Triglyceride management is emerging along-side LDL-C management as a treatment target for cardiovascular risk.
AMR101 is Uniquely Designed and Positioned

>96% pure EPA (icosapent ethyl)

Robust TG-lowering efficacy without the LDL-C elevation correlated with other omega-3s and fenofibrates

Works with statin therapy to reduce markers of cardiovascular risk over and above statins alone with no adverse burden

Positively modifies important lipid and inflammation biomarkers, including Triglycerides (TGs), Apo-B, non-HDL-C, Total-Cholesterol, VLDL-C, Lp-PLA$_2$, and hs-CRP

Positive Phase III data positions AMR101 as a best-in-class product opportunity to effectively treat multiple patient populations while overcoming concerns with existing therapy
AMR101 Market Opportunities
Large Underpenetrated Market Opportunities:
100M people in top 7 markets* for initially targeted indications

*Source: Datamonitor
**Source: Archives of Internal Medicine, 2009;169(6):572-578
AMR101 Targets Multiple Clinical Needs

**First indication:** Reducing hypertriglyceridemia (MARINE trial)

- Population: Patients with very high triglycerides (>500 mg/dL)
- Prescription Omega-3 competition: Label similar to GSK’s Lovaza with no LDL-C increase; ~$1bn revenues

**Second indication:** Reducing hypertriglyceridemia in patients with mixed dyslipidemia (ANCHOR trial)

- Population: Patients with high triglycerides (>200 mg/dL to <500 mg/dL)
- Prescription Omega-3 competition: None approved in U.S.

**Potential Follow-on indications:** Prevention of cardiovascular events; combination with statins; diabetic patients; inflammation

- Population: Patients with cardiovascular risk factors
- Omega-3 competition: None approved in U.S.
AMR101 Clinical Program and Results
# Phase 3 Program: Concurrently Run Pivotal Trials

<table>
<thead>
<tr>
<th></th>
<th><strong>MARINE TRIAL</strong></th>
<th><strong>ANCHOR TRIAL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size:</strong></td>
<td>229 patients</td>
<td>702 patients</td>
</tr>
<tr>
<td><strong>Population:</strong></td>
<td>Patients with <em>very high</em> triglycerides (≥500 mg/dL)</td>
<td>Patients with mixed dyslipidemia (<em>high</em> triglycerides ≥200 mg/dL and &lt;500 mg/dL) on statin therapy</td>
</tr>
<tr>
<td><strong>Duration:</strong></td>
<td>12 week treatment period (6-8 week run-in period)</td>
<td>Same</td>
</tr>
<tr>
<td><strong>Dose:</strong></td>
<td>2 g and 4 g of AMR101 per day</td>
<td>Same</td>
</tr>
<tr>
<td>% of patients on background statin therapy:</td>
<td>25% - LDL-C baseline = 86 mg/dL</td>
<td>100% - LDL-C baseline = 83 mg/dL (simvastatin (Zocor), atorvastatin (Lipitor), rosuvastatin (Crestor))</td>
</tr>
<tr>
<td><strong>Control:</strong></td>
<td>Placebo-controlled, double-blind</td>
<td>Same</td>
</tr>
<tr>
<td><strong>Primary endpoint:</strong></td>
<td>Reduction in triglyceride levels</td>
<td>Same plus secondary endpoint of LDL-C non-inferiority to placebo</td>
</tr>
<tr>
<td><strong>Follow-on:</strong></td>
<td>Patients are offered a 40 week open-label extension period (Results not required for NDA)</td>
<td>Phase 3b follow-on outcome study is to be commenced (Results not required for NDA)</td>
</tr>
<tr>
<td><strong>NDA:</strong></td>
<td>Special Protocol Assessment Agreement (SPA)</td>
<td>Same (separate from MARINE trial SPA)</td>
</tr>
<tr>
<td><strong>Principal Investigator:</strong></td>
<td>H. Bays, M.D. (Louisville, KY)</td>
<td>Professor C. Ballantyne, M.D. (Houston, TX)</td>
</tr>
<tr>
<td><strong>Status:</strong></td>
<td>Complete (except optional follow-on period)</td>
<td>Complete (except outcomes study)</td>
</tr>
<tr>
<td><strong>Endpoints met:</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
MARINE Study Results – Primary Endpoint Met

AMR101 compared to placebo

<table>
<thead>
<tr>
<th></th>
<th>4 grams (TG baseline: 680 mg/dL)</th>
<th>2 grams (TG baseline: 657 mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change</td>
<td>P-value</td>
<td>Change</td>
</tr>
<tr>
<td>TG</td>
<td>↓33% p=0.0001</td>
<td>↓20% p=0.0051</td>
</tr>
<tr>
<td>TG&gt;750mg/dL</td>
<td>↓45% p=0.0001</td>
<td>↓33% p=0.0016</td>
</tr>
<tr>
<td>Non-HDL-C</td>
<td>↓18% p=0.001</td>
<td>↓8% p=0.05</td>
</tr>
<tr>
<td>LDL-C</td>
<td>↓2.3% NS</td>
<td>↑5.2% NS</td>
</tr>
</tbody>
</table>

Note: Placebo baseline TG: 703 mg/dL

Greater median reductions in TGs seen in patients on statins

First and only study to show no elevation of LDL-C in this treated population (compared to fibrates and prescription omega-3 acid ethyl esters). Typical LDL-C elevations are ~50%.

Other significant reductions a 4g dose include: Apo B (-8.5%, p=0.0019); Lp-PLA2 (-13.6%, p=0.0003); VLDL-C (-28.6%, p=0.0002); hsCRP (-0.7mg/L, p=0.0012)
ANCHOR Study Results – Primary Endpoint Met

AMR101 compared to placebo

<table>
<thead>
<tr>
<th></th>
<th>4 grams (TG baseline: 265 mg/dL)</th>
<th>2 grams (TG baseline: 254 mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Change</td>
<td>P-value</td>
</tr>
<tr>
<td>TG</td>
<td>↓21.5%</td>
<td>p=0.0001</td>
</tr>
<tr>
<td>Non-HDL-C</td>
<td>↓13.6%</td>
<td>p=0.0001</td>
</tr>
<tr>
<td>LDL-C</td>
<td>↓6.2%</td>
<td>p=0.0067</td>
</tr>
<tr>
<td>LDL-C upper confidence</td>
<td>(1.7%)*</td>
<td></td>
</tr>
</tbody>
</table>

*95% upper confidence boundary needed to be <+6.0% to demonstrate non-inferiority over statin alone

Note: Placebo baseline TG: 259 mg/dL

- The reduction in LDL-C in the 4 gram cohort demonstrated superiority over statin alone, which was better than the non-inferiority goal
- Effective in diabetic (73%) and non-diabetic subgroups

TG and LDL-C reductions even greater with higher statin potency

The ANCHOR trial demonstrated statistically significant decreases in all predefined secondary endpoints at both doses studied. These endpoints were non-HDL-C, Apo B, Lp-PLA2, and VLDL-C.
AMR101 Safety Comparable to Placebo in Both Trials

Well tolerated
Safety more favorable than other triglyceride lowering therapies
No treatment related SAEs
Lack of LDL-C elevation eliminates need to increase statin dose due to TG therapy
At either dose, AMR101 produced no significant changes in fasting plasma glucose levels

MARINE study treatment-emergent adverse events occurring in >3% of patients (Safety Population)

<table>
<thead>
<tr>
<th></th>
<th>AMR101 4 g/day (n=77)</th>
<th>AMR101 2 g/day (n=76)</th>
<th>Placebo (n=76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjects with any TEAE</td>
<td>27 (35.1)</td>
<td>26 (34.2)</td>
<td>28 (36.6)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>1 (1.3)</td>
<td>4 (5.3)</td>
<td>5 (6.6)</td>
</tr>
<tr>
<td>Nausea</td>
<td>1 (1.3)</td>
<td>5 (6.6)</td>
<td>4 (5.3)</td>
</tr>
<tr>
<td>Eruccation</td>
<td>0</td>
<td>1 (1.3)</td>
<td>3 (3.9)</td>
</tr>
</tbody>
</table>
AMR101 Competitive Positioning
# AMR101 vs. Existing Prescription Omega-3s

<table>
<thead>
<tr>
<th>AMR101 competitive positioning</th>
<th>Key elements of differentiation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Broader Indication for Use</strong></td>
<td>▪ Lovaza is not approved for treatment of the high triglyceride population (only approved for TG&gt;500 mg/dL)</td>
</tr>
<tr>
<td><strong>LDL-C Advantage</strong></td>
<td>▪ AMR101 provides TG lowering without increasing LDL-C</td>
</tr>
<tr>
<td><strong>Dose Flexibility</strong></td>
<td>▪ AMR101 demonstrated effective at 4 grams/day and 2 grams/day dosing (Lovaza only available at 4 grams/day)</td>
</tr>
</tbody>
</table>
| **Additional AMR101 Differentiation** | ▪ Reduces other CV risk factors including Apo B, non-HDL-C, Lp-PLA2, and hs-CRP  
▪ Demonstrated to work with statins to manage both LDL-C and TG’s with no adverse burden  
▪ Placebo-like safety profile should enhance patient compliance and medication adherence rates  
▪ No fishy taste, smell or burping |

**AMR 101 is highly differentiated from existing treatment alternatives**
Clear Differentiation between AMR101 and Lovaza

**Lovaza**
- A highly purified mixture of fatty acids
  - Ethyl EPA (465 mg)
  - Ethyl DHA (375 mg)
- Additional omega 6, 7 & 9 (100 mg)
- Other omega-3 acid ethyl esters (60 mg)
- Taste / Eructation: Fishy taste/smell/burp
- Non-HDL-C effect: Reduced
- LDL effect: Elevates LDL-C
- Status: Phase III complete (primary endpoints achieved in pivotal MARINE and ANCHOR trials)

**AMR101**
- Icosapent ethyl single active ingredient
  - Ethyl-EPA (>960 mg)
- Taste / Eructation: None
- LDL effect: No elevation in MARINE; Reduction in ANCHOR
  - Reduced more significantly (2X in ANCHOR)
- Non-HDL-C effect: Reduced
- TG Indications:
  - 200-500 mg/dL
  - >500 mg/dL
- Other omega-3 acid ethyl esters (60 mg)
- Daily Dose (capsules):
  - ~$1B in sales
  - (only prescription Omega-3 approved in U.S.-marketed as Omacor outside U.S.)

~$1B in sales (only prescription Omega-3 approved in U.S.-marketed as Omacor outside U.S.)
## AMR101 vs. Fenofibrates

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<th>AMR101 competitive positioning</th>
<th>Key elements of differentiation</th>
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<tbody>
<tr>
<td><strong>LDL-C advantage</strong></td>
<td>▪ Provides TG lowering without increasing LDL-C</td>
</tr>
<tr>
<td><strong>Additional data</strong></td>
<td>▪ Reduces other CV risk factors including Apo B, non-HDL-C, Lp-PLA2, and hsCRP</td>
</tr>
<tr>
<td><strong>Add-on to statin therapy</strong></td>
<td>▪ Incremental effectiveness appears to increase as statin potency increases while fenofibrate effectiveness appears to decrease under similar conditions</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td>▪ Profile is similar to placebo while fenofibrates can cause liver enzyme elevation and myopathies, especially when combined with statins</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>▪ Icosapent ethyl (EPA96) reduced cardiovascular events (JELIS); fenofibrate outcomes studies negative (ACCORD, FIELD)</td>
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</table>

AMR 101’s efficacy allows physicians to achieve desired objectives while offering significant safety advantages.
Cardiovascular Outcomes
AMR101 Outcomes Study: REDUCE-IT

Purpose: Evaluate AMR101 effectiveness in reducing cardiovascular events

Design: SPA agreement reached in Aug’11 with FDA
- ~8,000 patients on optimized statin therapy
- Population “at risk” for cardiovascular events, including elevated TGs
- International site selection

Timing: ~6 year duration; activity to begin in 2011
- Target 50% enrollment in 2012

Cost: ~$100-125M via CRO; less than $25M through 2012

Opportunity: Getting trial substantially underway is final step before requesting indication studied in the ANCHOR trial
- Potential doubling of AMR101 market opportunity beyond ANCHOR

REDUCE-IT:
Reduction of Cardiovascular Events with EPA – Intervention Trial
**JELIS study: Ethyl-EPA reduces Coronary Events**

*18,645 Japanese men and women randomized to statin alone or statin + Ethyl-EPA (Epadel) and followed for 5 years*

**Total Cohort**
(No pre-specified minimum TG level)
Cumulative Incidence of Major Coronary Events (%)

![Graph showing cumulative incidence of major coronary events](image1)

- Control (statin)
- EPA (statin+Epadel)

-19% (p=0.011)

**Sub Group**
(TG>150 mg/dL and HDL < 40 mg/dL)
Cumulative Incidence of Major Coronary Events (%)

![Graph showing cumulative incidence of major coronary events](image2)

- Control Group
- EPA Group

N=957
95%CI: 0.23-0.98 (p=0.043)

-53%

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

Yokoyama M. *The Lancet* 2007
The Company and Financials
Experienced Management Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Experience (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joseph Zakrzewski</td>
<td>Chief Executive Officer &amp; Chairman</td>
<td>&gt;20</td>
</tr>
<tr>
<td></td>
<td>• Former COO of Reliant Pharmaceuticals (which launched Lovaza and was sold to GSK for $1.6B) and former VP Corporate Business Development Eli Lilly</td>
<td></td>
</tr>
<tr>
<td>John Thero</td>
<td>President</td>
<td>&gt;25</td>
</tr>
<tr>
<td></td>
<td>• Former senior roles for multiple emerging growth companies, including ViaCell and Abiomed; previously Amarin’s Chief Financial Officer</td>
<td></td>
</tr>
<tr>
<td>Paul Huff</td>
<td>Chief Commercial Officer</td>
<td>&gt;25</td>
</tr>
<tr>
<td></td>
<td>• Former VP Marketing for Reliant Pharmaceuticals, Kos Pharmaceuticals</td>
<td></td>
</tr>
<tr>
<td>Stuart Sedlack</td>
<td>SVP Business Development</td>
<td>&gt;20</td>
</tr>
<tr>
<td></td>
<td>• Senior licensing and BD roles at Elan and Novartis</td>
<td></td>
</tr>
<tr>
<td>Paresh Soni, M.D., Ph.D.</td>
<td>SVP and Head of Development</td>
<td>&gt;20</td>
</tr>
<tr>
<td></td>
<td>• Former senior roles in clinical development and academic research at Pfizer</td>
<td></td>
</tr>
<tr>
<td>Declan Doogan, M.D.</td>
<td>Chief Medical Officer</td>
<td>&gt;30</td>
</tr>
<tr>
<td></td>
<td>• Former SVP and Head of Worldwide Development at Pfizer</td>
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AMR101: Intellectual Property Position

Potential: 2030

• Numerous filed applications with USPTO and internationally
  • Indications
    • Multiple applications based on MARINE and ANCHOR results
  • Drug Product Formulation – highly stable e-EPA, capsule formulations and method of use
  • Composition – AMR101 “fingerprint” of total fatty acids and method of use
  • Applications based upon novel positive safety finding as compared to other omega-3 formulations

Base: 2021

• Highly Purified Ethyl EPA
• AMR101 composition
• Data Exclusivity
• Know-How and Trade Secrets
Capitalization Summary (June 30, 2011)

Cash $131.4M
Debt None

Common stock and equivalent shares:
  Common shares 133.2M
  Options 10.0M average exercise price of $3.52
  Warrants 23.7M average exercise price of $1.48
  Total if all exercised 166.9M

Tax Jurisdiction (primary) Ireland 12.5% tax rate
  (est. global blended rate 15%)
### Milestone Summary: History of Positive Achievement

<table>
<thead>
<tr>
<th></th>
<th>Guidance Expressed At Start of 2010</th>
<th>Most Recent Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Begin patient enrolment:</strong></td>
<td>MARINE ANCHOR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Early 2010 Early 2010</td>
<td>Done on schedule Done on schedule</td>
</tr>
<tr>
<td><strong>Complete patient enrolment:</strong></td>
<td>MARINE ANCHOR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2011 2011</td>
<td>Done mid-2010 Done late-2010</td>
</tr>
<tr>
<td><strong>Top-line results:</strong></td>
<td>MARINE ANCHOR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2012 2012</td>
<td>Done late-2010 Done Q2-2011</td>
</tr>
<tr>
<td><strong>NDA submission</strong></td>
<td></td>
<td>Q3-2011</td>
</tr>
</tbody>
</table>

**Other milestones:**
Presentation of MARINE results at National Lipid Association (NLA) Annual Scientific Sessions (May) which included presentation of 3 Amarin-sponsored posters, Oral presentation at European Society of Cardiology (Aug.), *American Journal of Cardiology* (Sept.), MARINE and ANCHOR podium presentations at American Heart Association (AHA) Scientific Sessions (Nov.)
Phase 3 Trials Successful for Two Indications

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Clearly differentiated product for existing and new markets
Blockbuster worldwide sales potential
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Unpartnered drug candidate
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