UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2020

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission File No. 0-21392

Amarin Corporation plc

(Exact name of registrant as specified in its charter)

England and Wales	**Not applicable**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

77 Sir John Rogerson's Quay, Block C,
Grand Canal Docklands, Dublin 2, Ireland
(Address of principal executive offices)

+353 (0) 1 6699 020
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol	Name of each exchange on which registered
American Depositary Shares (ADS(s)), each ADS representing the right to receive one (1) Ordinary Share of Amarin Corporation plc	AMRN	NASDAQ Stock Market LLC

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES ☑ NO ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. YES ☐ NO ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. YES ☑ NO ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). YES ☑ NO ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☑ Accelerated filer	☐
Non-accelerated filer	☐ Smaller reporting company	☐
Emerging growth company	☐	

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☑

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES ☐ NO ☑

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2020 was approximately $2,644.9 million, based upon the closing price on the NASDAQ Capital Market reported for such date.

393,635,467 shares were outstanding as of February 19, 2021, including 393,436,525 shares held as American Depositary Shares (ADSs), each representing one Ordinary Share, 50 pence par value per share, and 198,942 Ordinary Shares.

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required to be disclosed in Part III of this report is incorporated by reference from the registrant's definitive proxy statement to be filed not later than 120 days after the end of the fiscal year covered by this report.

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PART I

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS AND INDUSTRY DATA

This Annual Report on Form 10-K contains forward-looking statements. All statements other than statements of historical fact contained in this Annual Report on Form 10-K are forward-looking statements, including statements regarding the progress and timing of our clinical programs, regulatory filings and commercialization activities, and the potential clinical benefits, safety and market potential of our product candidates, as well as more general statements regarding our expectations for future financial and operational performance, regulatory environment, and market trends. In some cases, you can identify forward-looking statements by terminology such as "may," "would," "should," "could," "expects," "aims," "plans," "anticipates," "believes," "estimates," "predicts," "projects," "potential," or "continue"; the negative of these terms; or other comparable terminology. These statements include but are not limited to statements regarding the commercial success of and benefits and market opportunity for VASCEPA (brand name VAZKEPA in Europe but predominately referenced in this document by its brand name in the United States and other countries where it is approved, VASCEPA or icosapent ethyl) and factors that can affect such success; plans to obtain regulatory approvals and favorable market access and pricing in several jurisdictions, to expand promotion of VASCEPA and statements regarding cost and pricing of VASCEPA and other treatments; interpretation of court decisions; plans with respect to litigation; expectation on determinations and policy positions of the United States Food and Drug Administration, or FDA; the safety and efficacy of our product and product candidates; expectation regarding the potential for VASCEPA to be partnered, developed and commercialized outside of the United States; expectation on the scope and strength of our intellectual property protection and the likelihood of securing additional patent protection; estimates of the potential markets for our product candidates; estimates of the capacity of manufacturing and other facilities to support our products; our operating and growth strategies; our industry; our projected cash needs, liquidity and capital resources; and our expected future revenues, operations and expenditures.

Forward-looking statements are only current predictions and are subject to known and unknown risks, uncertainties, and other factors that may cause our or our industry's actual results, levels of activity, performance, or achievements to be materially different from those anticipated by such statements. These factors include, among other things, those listed under "Risk Factors" in Item 1A of Part I of this Annual Report on Form 10-K and elsewhere in this Annual Report on Form 10-K. These and other factors could cause results to differ materially from those expressed in these forward-looking statements.

Although we believe that the expectations reflected in the forward-looking statements contained in this Annual Report on Form 10-K are reasonable, we cannot guarantee future results, performance, or achievements. Except as required by law, we are under no duty to update or revise any of such forward-looking statements, whether as a result of new information, future events or otherwise, after the date of this Annual Report on Form 10-K.

Unless otherwise indicated, information contained in this Annual Report on Form 10-K concerning our product candidates, the number of patients that may benefit from these product candidates and the potential commercial opportunity for our product candidates, is based on information from independent industry analysts and third-party sources (including industry publications, surveys, and forecasts), our internal research, and management estimates. Management estimates are derived from publicly available information released by independent industry analysts and third-party sources, as well as data from our internal research, and based on assumptions made by us based on such data and our knowledge of such industry, which we believe to be reasonable. None of the sources cited in this Annual Report on Form 10-K has consented to the inclusion of any data from its reports, nor have we sought their consent. Our internal research has not been verified by any independent source, and we have not independently verified any third-party information. While we believe that such information included in this Annual Report on Form 10-K is generally reliable, such information is inherently imprecise. In addition, projections, assumptions, and estimates of our future performance are necessarily subject to a high degree of uncertainty and risk due to a variety of factors, including those described in "Risk Factors" in Item 1A of Part I of this Annual Report on Form 10-K and elsewhere in this Annual Report on Form 10-K. These and other factors could cause results to differ materially from those expressed in the estimates made by the independent parties and by us.

Item 1. *Business*

References in this report to "Amarin," the "Company," "we," "our" and "us" refer to Amarin Corporation plc and its subsidiaries, on a consolidated basis, unless otherwise indicated.

This Annual Report on Form 10-K includes the registered and unregistered trademarks and service marks of other parties.

Amarin Corporation plc is a public limited company incorporated under the laws of England and Wales. Amarin Corporation plc was originally incorporated in England as a private limited company on March 1, 1989 under the Companies Act 1985, and re-registered in England as a public limited company on March 19, 1993.

Our principal offices are located at 77 Sir John Rogerson's Quay, Block C, Grand Canal Docklands, Dublin 2 Ireland. Our registered office is located at One New Change, London EC4M 9AF, England. Our primary office for our European market access team is located at Spaces Grafenauweg 8, Zug CH-6300, Switzerland. Our primary office in the United States is located at 440 Route 22, Bridgewater, NJ 08807, USA. Our telephone number at that location is (908) 719-1315.

For purposes of this Annual Report on Form 10-K, our ordinary shares may also be referred to as "common shares" or "common stock."

Overview

We are a pharmaceutical company with expertise in omega-3 fatty acids and lipid science focused on the commercialization and development of therapeutics to improve cardiovascular, or CV, health and reduce CV risk.

Our lead product, VASCEPA® (icosapent ethyl) was first approved by the United States Food and Drug Administration, or FDA, in July 2012 for use as an adjunct to diet to reduce triglyceride, or TG, levels in adult patients with severe (TG ≥500 mg/dL) hypertriglyceridemia. We launched VASCEPA in the United States, or U.S., in January 2013. On December 13, 2019, the FDA approved a new indication and label expansion for VASCEPA based on the landmark results of our cardiovascular outcomes trial of VASCEPA, REDUCE-IT®, or Reduction of Cardiovascular Events with EPA – Intervention Trial. VASCEPA is the first and only drug approved by the FDA as an adjunct to maximally tolerated statin therapy for reducing persistent cardiovascular risk in select high risk patients.

In August 2020, we announced our plans to launch icosapent ethyl under the brand name VAZKEPA®, hereinafter along with the U.S. brand name VASCEPA, collectively referred to as VASCEPA, in major markets in Europe through our own new European sales and marketing teams. On January 28, 2021, the Committee for Medicinal Products for Human Use, or CHMP, of the European Medicines Agency, or EMA, adopted a positive opinion, recommending that a marketing authorization be granted to our drug, icosapent ethyl, in the European Union, or EU, for the reduction of risk of cardiovascular events in patients at high cardiovascular risk. The CHMP recommendation is now expected to be reviewed by the European Community, or EC, with a decision expected to take place within 67 days of the CHMP opinion. In Europe, ten years of market protection is anticipated as part of an EC approval of the pending application, in addition to pending patent protection that could extend into 2039. In Europe, launch of VAZKEPA in individual countries is gated by timing of achieving product reimbursement on a country-by-country basis. Similar to our approach in launching VASCEPA in the United States, in Europe we have been building a core team of experienced professionals and a highly capable sales team and plan to leverage third-party relationships for various support activities. We commenced 2021 with approximately 50 professionals involved with pre-approval and pre-launch planning and other commercial preparation activities.

In November 2020, we announced statistically significant topline results from the Phase 3 clinical trial of VASCEPA conducted by our partner in China. On February 9, 2021, we announced that the regulatory review processes for approval of VASCEPA in Mainland China and Hong Kong have commenced. The Chinese National Medical Products Administration, or NMPA, has accepted for review the new drug application for VASCEPA, submitted by our partner in China, based on the results from the Phase 3 clinical trial and the results from our prior studies of VASCEPA. We expect to receive a decision from the NMPA in Mainland China near the end of 2021. The Hong Kong Department of Health is evaluating VASCEPA based on current approvals in the United States and Canada. The review process in Hong Kong is expected to conclude near the end of 2021.

In addition to the United States, VASCEPA is currently available by prescription in Canada, Lebanon and the United Arab Emirates. In Canada, VASCEPA has the benefit of eight years of data protection afforded through Health Canada (until the end of 2027), in addition to separate patent protection with expiration dates that could extend into 2039. In China and the Middle East, we are pursuing such regulatory approvals and subsequent commercialization of VASCEPA with commercial partners.

Since our inception, we have devoted substantial resources to our research and development efforts, most significantly our VASCEPA cardiovascular outcomes trial, REDUCE-IT. We announced topline results from REDUCE-IT on September 24, 2018. On November 10, 2018, we presented REDUCE-IT primary results at the 2018 Scientific Sessions of the American Heart Association, or AHA, and the results were concurrently published in *The New England Journal of Medicine*. REDUCE-IT met its primary endpoint demonstrating a 25% relative risk reduction, or RRR, to a high degree of statistical significance ($p<0.001$), in first occurrence of major adverse cardiovascular events, or MACE, in the intent-to-treat patient population with use of VASCEPA 4 grams/day as compared to placebo. REDUCE-IT also showed a 26% RRR in its key secondary composite endpoint of cardiovascular death, heart attacks and stroke ($p<0.001$). On March 18, 2019, we publicly presented the total cardiovascular events results, and the method of calculating such events, of the REDUCE-IT study at the American College of Cardiology's 68th Annual Scientific Session and such results and methods were concurrently published in the *Journal of the American College of Cardiology*. VASCEPA reduced total events (first and subsequent events) by 30% compared to placebo, reflecting that for every 1,000 patients treated for five years with VASCEPA versus placebo in this trial, approximately 159 MACE could be prevented with VASCEPA.

Based on REDUCE-IT results, 13 clinical treatment guidelines or position statements from medical societies have been updated recommending the use of icosapent ethyl in at-risk patients, including those listed below:

- In March 2019, the American Diabetes Association, or ADA, issued important updates to the Standard of Medical Care in Diabetes for 2019, including a recommendation for the use of icosapent ethyl in treating at-risk patients based on the results of the REDUCE-IT cardiovascular outcomes study.
- In August 2019, the AHA recognized the results of REDUCE-IT and recommended directing medical care away from unproven fish oil dietary supplements and to prescription drug therapy in patients with elevated TG levels.
- In September 2019, the National Lipid Association issued a position statement recognizing the cardiovascular risk-lowering effects of icosapent ethyl based on the REDUCE-IT results.
- In September 2019, the European Society of Cardiology and the European Atherosclerosis Society updated their Clinical Practice Guidelines for the Management of Dyslipidemias to incorporate findings from the REDUCE-IT study and in August 2020 the European Society of Cardiology expanded their guidelines to also cover patients with acute coronary syndrome.
- In February 2020, the American Association of Clinical Endocrinologists and the American College of Endocrinology released a consensus statement on the comprehensive management of type 2 diabetes. The statement included new guidance for managing patients with established or high risk for cardiovascular disease who have triglyceride levels between 135 – 499 mg/dL with icosapent ethyl which has proven benefits to prevent the next adverse cardiovascular event.
- In December 2020, the Guidelines for Primary Prevention of Cardiovascular Disease in China was published in the *Chinese Journal of Cardiovascular Diseases*, listing icosapent ethyl 2 grams twice a day, as studied in REDUCE-IT, as a treatment consideration to further lower atherosclerotic cardiovascular risk in at-risk patients.

In October 2019, the Institute for Clinical and Economic Review, or ICER, released its final evidence report regarding clinical effectiveness and economic impacts on VASCEPA. ICER's report indicated that VASCEPA was cost effective across all of the non-profit organization's analyses, including its quality-adjusted life year metrics of <$50,000. The conclusion from the report is that VASCEPA easily meets "commonly cited thresholds for cost-effectiveness and therefore represents a high long-term value for money" based on the organization's value assessment framework. In addition, an independent academic, patient-level, cost-effectiveness analysis of icosapent ethyl led by Dr. William S. Weintraub, M.D., director of Outcomes Research with MedStar Cardiovascular Research Network, indicated that VASCEPA was projected to not only be cost-effective but also to reduce long-term health care costs in a majority of the scenarios analyzed. Based on our analysis of branded cardiovascular drugs in the United States which have positive cardiovascular outcomes studies, we believe the wholesale acquisition cost of VASCEPA is the lowest. In addition, while none of these other cardiovascular drugs compete directly with VASCEPA and no head-to-head studies have been done between VASCEPA and these other drugs and the length and construct of the respective outcomes studies of these drugs vary, our analysis of published clinical results from the cardiovascular outcomes studies of these drugs indicates that the number needed to treat, or NNT, for VASCEPA is as low or lower than for these other branded cardiovascular drugs. NNT is a measure of how many patients need to be treated before one patient benefits from the therapy. For VASCEPA, in this analysis, the NNT was based on the 25% relative risk reduction demonstrated for the primary endpoint of the study, the NNT for which is 21, as opposed to one fewer MACE on average per six patients treated over the five-year study period based on total events. The original pricing for VASCEPA was established prior to results of the REDUCE-IT cardiovascular outcomes study during a timeframe when VASCEPA was only approved for the original indication as an adjunct to diet to reduce TG levels in adult patients with severe (TG ≥500 mg/dL) hypertriglyceridemia. We believe that this relatively low price for VASCEPA in the United States will help lead to many at-risk patients being treated with VASCEPA.

The FDA granted Priority Review designation to our March 2019, supplemental new drug application, or sNDA, seeking an expanded indication for VASCEPA in the United States based on the positive results of the REDUCE-IT study. The FDA grants Priority Review designation to applications for drugs that, if approved, have the potential to offer significant improvements in the effectiveness and safety of the treatment of serious conditions when compared to standard applications. In November 2019, the FDA held an Endocrinologic and Metabolic Drugs Advisory Committee, or EMDAC, meeting to review the REDUCE-IT sNDA. The EMDAC voted unanimously (16-0) to recommend approval of an indication and label expansion for VASCEPA to reduce cardiovascular events in high-risk patients based on the REDUCE-IT results. On December 13, 2019, the FDA approved a new indication and related label expansion based on REDUCE-IT. VASCEPA is the first and only drug approved by the FDA as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated TG levels (≥150 mg/dL) and either established cardiovascular disease or diabetes mellitus and two or more additional risk factors for cardiovascular disease.

On March 30, 2020, the United States District Court for the District of Nevada, or the Nevada Court, ruled in favor of two generics companies in our patent litigation related to abbreviated new drug applications, or ANDAs, that sought FDA approval for sale of generic versions of VASCEPA. On May 22, 2020 and August 10, 2020, the two generics companies, Hikma Pharmaceutical USA Inc., or Hikma, and Dr. Reddy's Laboratories, Inc., or Dr. Reddy's, respectively, received FDA approval to market its generic versions of VASCEPA for the original indication of VASCEPA as an adjunct to diet to reduce TG levels in adult patients with severe (≥500 mg/dL) hypertriglyceridemia. On September 3, 2020, the U.S. Court of Appeals for the Federal Circuit, or the Federal Circuit, upheld the March ruling by the Nevada Court in favor of the two generics companies. On October 2, 2020, we filed a combined petition for panel rehearing or rehearing en banc. On November 4, 2020, our rehearing and en banc petitions were denied. On February 11, 2021, we filed a petition for a writ of certiorari with the United States Supreme Court to ask the Court to hear our appeal in this litigation.

In November 2020, Hikma launched their generic version of VASCEPA on a limited scale. On November 30, 2020 we filed a patent infringement lawsuit against Hikma for making, selling, offering to sell and importing generic icosapent ethyl capsules in and into the United States in a manner that we allege has induced the infringement of patents covering the use of VASCEPA to reduce specified cardiovascular risk. On January 25, 2021 we expanded the scope of this patent infringement lawsuit to include a health care insurance provider, Health Net, LLC.

Although, to date, no generics other than Hikma have been launched, in addition to ANDAs approved for Hikma and Dr. Reddy's, on September 11, 2020, Teva Pharmaceuticals USA, Inc's., or Teva's, ANDA was approved by the FDA. Apotex, Inc., or Apotex, has applied for ANDA approval which application, based on public records, has not yet been approved.

We intend to vigorously pursue these ongoing litigation matters, but cannot predict the outcomes or the impact on our business. Geographies outside the United States in which VASCEPA is sold and under regulatory review are not subject to the U.S. patent litigation and judgment. No similar litigation involving potential generic versions of VASCEPA is pending outside the United States.

We are responsible for supplying VASCEPA to all markets in which the product is sold including in the United States, Canada, Lebanon and the United Arab Emirates. Outside the United States the drug is promoted and sold through collaboration with third-party companies that compensate us for such supply. Subject to approvals in Europe and China, we will be responsible for supplying product to those markets as well. We are not responsible for providing any generic company with drug product.

Impact of COVID-19

As the COVID-19 pandemic continues to spread and impact global populations and economies, we continue to evaluate its effect on patients, distributors, customers and our employees, as well as on our operations and the operations of our business partners and communities. Given the importance of supporting patients, we are diligently working with our suppliers, customers, distributors and other partners to provide patients with access to VASCEPA, while taking into account regulatory, institutional, and government guidance, policies and protocols. Given the uncertainties regarding the scope and impact of COVID-19 on our sales, supply, research and development efforts and operations, and on the operations of our customers, suppliers, distributors, other partners and patients, particularly as COVID-19 protocols and resources have restricted or discouraged patient access to hospitals, clinics, physicians' offices and other administration sites and caused a reprioritization of health care services, the impact of COVID-19 could impact our current performance and continues to represent a risk to our future performance.

Our ability to directly promote VASCEPA to healthcare professionals has been limited due to social distancing practices associated with COVID-19 and by patients electing to forego visiting their doctors for non-urgent medical examinations and/or choose to not get blood tests, which test results provide information useful to the treatment of cardiovascular risk. Such impact has had a significant impact on slowing VASCEPA prescription and revenue growth. While COVID-19 continues to impact our promotion of VASCEPA, we have seen signs of improvement. We resumed, on a limited basis field-based, face-to-face interactions with healthcare providers beginning in June 2020. During the late part of the summer, substantially all of our field force personnel were able to resume face-to-face customer interactions, in a manner consistent with guidelines from local, state and government health officials in the United States. In the fourth quarter of 2020, the impact of COVID-19 worsened in much of the United States with some physicians again limiting access to face-to-face interactions with our field force personnel. Such access remains variable and challenging due to COVID-19. In July 2020 we launched our first television-based promotion of VASCEPA emphasizing that it is the first and only FDA approved drug for its indication. As the impact of COVID-19 on much of the United States worsened in the fourth quarter of 2020, we suspended television-based promotion of VASCEPA judging that the cost was not sufficiently justified. We anticipate that at-risk patients will increasingly resume visiting their doctors for non-urgent medical care after they are vaccinated for COVID-19. As COVID-19 protocols ease and ordinary course activities resume, we will seek to adjust our promotional initiatives accordingly, including pursuing increased face-to-face interactions with health care professionals and expanding various forms of direct-to- consumer promotion.

Thus far, COVID-19 has not materially impacted our ability to secure and deliver supply of VASCEPA. And, thus far, COVID-19 is not known to have significantly impacted ongoing clinical trials of VASCEPA.

The ultimate impacts of COVID-19 on our business are unknown; however, we are actively monitoring the situation and may take precautionary and preemptive or reactive actions that we determine are in the best interests of our business. We cannot predict the effects that such actions may have on our business or on our financial results, in particular with respect to demand for or access to VASCEPA.

We believe that the overall morale of Amarin employees is positive despite the challenges associated with COVID-19. While we have experienced modest employee turnover, the turnover level is generally consistent with the pre-COVID-19 era. As a result of COVID-19 and its limitations on our promotion of VASCEPA in the United States, we have intentionally slowed the hiring of replacements for certain of our open positions which resulted from ordinary turnover. As we witness our sales representatives increasingly able to resume direct interactions with healthcare professionals, we continually evaluate our needs and it is our intention to fill a significant number of these positions, provided such replacement is appropriate to meet our business needs.

Clinical Trials

The REDUCE-IT Study (basis for expanded FDA approved indication and label expansion in December 2019)

The REDUCE-IT study was designed to evaluate the efficacy of VASCEPA in reducing major cardiovascular events in an at-risk patient population also receiving statin therapy. REDUCE-IT was a multinational, prospective, randomized, double-blind, placebo-controlled, parallel-group study to evaluate the effectiveness of VASCEPA, as an add-on to statin therapy, in reducing first major cardiovascular events in an at-risk patient population compared to statin therapy alone. The control arm of the study was comprised of patients on optimized statin therapy plus placebo. The active arm of the study was comprised of patients on optimized statin therapy plus VASCEPA. All subjects enrolled in the study had elevated triglyceride levels and either established coronary heart disease or risk factors for coronary heart disease.

In August 2011, we reached agreement with the FDA on a SPA for the design of the REDUCE-IT cardiovascular outcomes study. A SPA is an evaluation by the FDA of a protocol with the goal of reaching an agreement that the Phase 3 trial protocol design, clinical endpoints, and statistical analyses are acceptable to support regulatory approval. The FDA agreed that, based on the information we submitted to the agency, the design and planned analysis of the REDUCE-IT study adequately addressed the objectives necessary to support a regulatory submission. A SPA is generally binding upon the FDA unless a substantial scientific issue essential to determining safety or efficacy of the drug is identified after the testing begins.

It is believed that the effects of EPA are not due to a single mode of action, such as triglyceride lowering, but rather to multiple mechanisms working together. Studies in the scientific literature explore potentially beneficial effects of EPA on multiple atherosclerosis processes, including endothelial function, oxidative stress, foam cell formation, inflammation/cytokines, plaque formation/progression, platelet aggregation, thrombus formation, and plaque rupture. With respect to triglyceride levels, our scientific rationale for the REDUCE-IT study was supported by (i) epidemiological data that suggests elevated triglyceride levels correlate with increased cardiovascular disease risk, (ii) genetic data that suggest triglyceride and/or triglyceride-rich lipoproteins (as well as LDL-C, known as bad cholesterol) are independently in the causal pathway for cardiovascular disease and (iii) clinical data that suggest substantial triglyceride reduction in patients with elevated baseline triglyceride levels correlates with reduced cardiovascular risk. The REDUCE-IT study was designed to determine the clinical benefit, if any, of stable EPA therapy in statin-treated patients with elevated triglyceride levels.

In September 2011, we engaged a clinical research organization, or CRO, and began initial trial and clinical site preparation for REDUCE-IT. In December 2011, we announced that the first patient was dosed in the study. In 2016, we completed patient enrollment and randomization of 8,179 individual patients into the REDUCE-IT study. Our personnel remained blinded to the efficacy and safety data from the REDUCE-IT study until after the study was completed and the database was locked in 2018.

On November 10, 2018, we announced primary results from our REDUCE-IT study as late-breaking clinical results at the 2018 Scientific Sessions of the AHA and the results were concurrently published in *The New England Journal of Medicine*. REDUCE-IT met its primary endpoint demonstrating a 25% RRR to a high degree of statistical significance ($p<0.001$), in first occurrence of MACE in the intent-to-treat patient population with use of VASCEPA 4 grams/day as compared to placebo. Patients qualified to enroll in REDUCE-IT had LDL-C between 41-100 mg/dL (median baseline LDL-C75 mg/dL) controlled by statin therapy and various cardiovascular risk factors including persistent elevated TG between 135-499 mg/dL (median baseline 216 mg/dL) and either established cardiovascular disease (secondary prevention cohort) or age 50 or more with diabetes mellitus and at least one other CV risk factor (primary prevention cohort). Approximately 59% of the patients had diabetes at baseline, approximately 71% of the patients had established cardiovascular disease at time of enrollment and approximately 29% were primary prevention subjects at high risk for cardiovascular disease. REDUCE-IT also showed a 26% RRR in its key secondary composite endpoint of cardiovascular death, heart attacks and stroke ($p<0.001$). We expended more than $300.0 million to fund completion of the REDUCE-IT study.

VASCEPA in the REDUCE-IT study demonstrated an NNT of 21 for the first occurrence of MACE in the 5-point primary composite endpoint. NNT is a statistical concept intended to provide a measurement of the impact of a medicine or therapy by estimating the number of patients that need to be treated in order to have an impact on one person.

An additional seven secondary endpoints were achieved below the key secondary endpoint, in order of sequential statistical testing within the prespecified hierarchy:

- Cardiovascular death or nonfatal heart attack: 25% RRR ($p<0.001$)
- Fatal or nonfatal heart attack: 31% RRR ($p<0.001$)
- Urgent or emergent revascularization: 35% RRR ($p<0.001$)
- Cardiovascular death: 20% RRR ($p=0.03$)
- Hospitalization for unstable angina: 32% RRR ($p=0.002$)
- Fatal or nonfatal stroke: 28% RRR ($p=0.01$)
- Total mortality, nonfatal heart attack or nonfatal stroke: 23% RRR ($p<0.001$)

The next prespecified secondary endpoint in the hierarchy was the only such endpoint that did not achieve statistical significance although it trended positively:

- Total mortality, which includes mortality from non-cardiovascular and cardiovascular events: 13% RRR ($p=0.09$)

Positive REDUCE-IT results were consistent across various patient subgroups, including female/male, diabetic/non-diabetic and secondary/primary prevention.

Overall adverse event rates in REDUCE-IT were similar across treatment groups and VASCEPA was well tolerated. VASCEPA was associated with an increase (3% vs 2%) in the reported rate of atrial fibrillation or atrial flutter requiring hospitalization in a double-blind, placebo-controlled trial. The incidence of atrial fibrillation was greater in patients with a previous history of atrial fibrillation or atrial flutter. It is not known whether patients with allergies to fish and/or shellfish are at an increased risk of an allergic reaction to VASCEPA. VASCEPA was associated with an increase (12% vs 10%) in the reported rate of bleeding in a double-blind, placebo-controlled trial. The reported incidence of bleeding was greater in patients receiving concomitant antithrombotic medications, such as aspirin, clopidogrel or warfarin.

Common adverse reactions in the cardiovascular outcomes trial (incidence ≥3% and ≥1% more frequent than placebo) were: musculoskeletal pain (4% vs 3%), peripheral edema (7% vs 5%), constipation (5% vs 4%), gout (4% vs 3%), and atrial fibrillation (5% vs 4%). Common adverse reactions in the hypertriglyceridemia trials (incidence >1% more frequent than placebo) were: arthralgia (2% vs 1%) and oropharyngeal pain (1% vs 0.3%). Patients receiving VASCEPA and concomitant anticoagulants and/or anti-platelet agents for bleeding are to be monitored. In the REDUCE-IT trial, cardiovascular benefits appeared not to be influenced significantly by TG levels at baseline (above or below 150 mg/dL baseline range) or as achieved at one year, potentially suggesting mechanisms at work with use of VASCEPA that are independent of baseline TG levels or therapy-driven reduction in TG levels. Determining the mechanisms responsible for the benefit shown in REDUCE-IT was not the focus of REDUCE-IT. As summarized from the primary results of REDUCE-IT in *The New England Journal of Medicine,* potential VASCEPA mechanisms of action at work in REDUCE-IT may include TG reduction, anti-thrombotic effects, antiplatelet or anticoagulant effects, membrane-stabilizing effects, effects on stabilization and/or regression of coronary plaque and inflammation reduction, each as supported by earlier stage mechanistic studies.

The FDA granted Priority Review designation to our March 2019 sNDA seeking an expanded indication for VASCEPA in the United States based on the positive results of the REDUCE-IT study. The FDA grants Priority Review designation to applications for drugs that, if approved, have the potential to offer significant improvements in the effectiveness and safety of the treatment of serious conditions when compared to standard applications. In November 2019, the FDA held an EMDAC meeting to review the REDUCE-IT sNDA. The EMDAC voted unanimously (16-0) to recommend approval of an indication and label expansion for VASCEPA to reduce cardiovascular events in high-risk patients based on the REDUCE-IT results. On December 13, 2019, the FDA approved a new indication and label expansion for VASCEPA capsules. VASCEPA is the first and only drug approved by the FDA as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated TG levels (≥150 mg/dL) and either established cardiovascular disease or diabetes mellitus and two or more additional risk factors for cardiovascular disease.

The MARINE Trial (first FDA-approved label for VASCEPA approved in July 2012)

The MARINE trial, the then largest study ever conducted with the omega-3 fatty acid ethyl EPA in treating patients with very high triglycerides (≥500 mg/dL), was a Phase 3, multi-center, placebo-controlled, randomized, double-blind, 12-week study. Patients were randomized into three treatment arms for treatment with VASCEPA 4 gram/day, 2 gram/day or placebo. Patient enrollment in this trial began in December 2009, and enrollment and randomization was completed in August 2010 at 229 patients. The primary endpoint in the trial was the percentage change in triglyceride level from baseline compared to placebo after 12 weeks of treatment. The MARINE study primary endpoint was required to meet a stringent level of statistical significance of 1% ($p < 0.01$) in our SPA agreement with the FDA.

In November 2010, we reported topline data for the MARINE trial. In the trial, VASCEPA met its primary endpoint at doses of 4 grams and 2 grams per day with median placebo-adjusted reductions in triglyceride levels of 33% ($p < 0.0001$) compared to placebo for 4 grams and 20% ($p = 0.0051$) compared to placebo for 2 grams. The median baseline triglyceride levels were 703 mg/dL, 680 mg/dL and 657 mg/dL for the patient groups treated with placebo, 4 grams of VASCEPA and 2 grams of VASCEPA, respectively.

In a pre-specified secondary analysis in the subgroup of patients with baseline triglyceride > 750 mg/dL, representing 39% of all patients, the effect of VASCEPA in reducing triglyceride levels compared to placebo was 45% for 4 grams and 33% for 2 grams, both statistically significant ($p = 0.0001$ for 4 grams and $p= 0.0016$ for 2 grams, respectively). The median baseline triglyceride levels in this subgroup were 1052 mg/dL, 902 mg/dL and 948 mg/dL for placebo, 4-gram and 2-gram groups, respectively. Twenty-five percent of patients in this trial were also on background statin therapy. These patients had greater median reduction in triglyceride levels, which was also statistically significant.

Importantly, the significant reduction in triglycerides was not associated with a statistically significant increase in median LDL-C compared to placebo at either dose (-2.3% for the 4-gram group and +5.2% for the 2-gram group [both p=NS]). In addition, there was a statistically significant decrease in median non-HDL-C (total cholesterol less so-called “good cholesterol”) compared to placebo with both of the VASCEPA-treated groups (-18% for the 4-gram group [$p < 0.001$] and -8% for the 2-gram group [$p < 0.05$]).

The MARINE trial results also included statistically significant reductions compared to placebo in several important lipid and inflammatory biomarkers, including apo B (apolipoprotein B) (8.5%), Lp-PLA2 (lipoprotein-phospholipase A2) (13.6%), VLDL-C (very low-density lipoprotein cholesterol) (28.6%), Total Cholesterol (16.3%), and hsCRP (high-sensitivity C-reactive protein) (36.0%) at the 4-gram dose. For these achieved endpoints, p-values were <0.01 for most and <0.05 for all. Apo B (apolipoprotein B) is believed to be a sensitive biomarker of cardiovascular risk and may be a better predictor of cardiovascular risk than LDL-C. Lp-PLA2 is an enzyme found in blood and atherosclerotic plaque; high levels have been implicated in the development and progression of atherosclerosis. In a post-hoc analysis of MARINE study data, VASCEPA 4 g/day and 2 g/day statistically significantly reduced ApoC-III levels by 25.1% ($p < 0.0001$) and 14.3% ($p=0.0154$) versus placebo, respectively. In the MARINE trial, patients treated with 4 grams per day of VASCEPA experienced a significant reduction in median placebo-adjusted lipoprotein particle concentrations of total LDL and small LDL. When looking at lipoprotein particle concentrations and sizes as measured with nuclear magnetic resonance spectroscopy, VASCEPA 4 grams per day, compared with placebo, significantly reduced median total LDL particle count by 16.3% ($p=0.0006$), which is an important factor in atherogenesis. LDL particle count and apo B are important risk markers for the prediction of cardiovascular events. Small LDL particle count, which is a common risk factor for cardiovascular events in patients with diabetes, was reduced by 25.6% ($p<0.0001$) compared with placebo. VASCEPA 2 grams per day, compared with placebo, significantly reduced median small LDL particle count by 12.8% ($p <0.05$) and reduced median total LDL particle count by 1.1% (NS). LDL particle size did not change significantly for the 2 or 4 gram per day doses.

VASCEPA was well tolerated in the MARINE trial, with a safety profile comparable to placebo and there were no treatment-related serious adverse events observed. No patient discontinued treatment of VASCEPA during this study due to VASCEPA-related adverse events. No significant changes in fasting blood glucose, hemoglobin A1C, vital signs, electrocardiograms, or liver or kidney function were observed with either VASCEPA dose.

Patients enrolled in the MARINE trial were given the option to be treated with VASCEPA for a period of up to 40 weeks after their last dose in the double-blind portion of the trial. Once participants completed the randomized, double blind, placebo-controlled 12-week MARINE registration trial, patients in all three randomized groups (4 grams, 2 grams and placebo) were offered the opportunity to participate in the open label extension, or OLE, phase. Patients in the OLE phase received 4 grams per day of VASCEPA for a period of up to an additional 40 weeks. As is typical of such extension phases, the OLE phase was not a controlled trial, as differentiated from the randomized, double blind, placebo-controlled 12-week MARINE registration trial. In the OLE phase, participants were not randomized at entry, VASCEPA administration was open label (and thus not blinded), and no placebo group was maintained. Also, once patients entered in the OLE phase, investigators were free to add or modify other lipid-altering nutritional, lifestyle and drug treatment regimens. Given the lack of randomization, the open-label design, the addition of various other lipid-altering drugs and changes to doses of existing lipid-altering drugs, as well as the lack of placebo control, neither we nor our independent advisors were able to draw efficacy conclusions from the data. However, we have concluded that the MARINE OLE phase revealed no new safety signals after an additional 40 weeks of exposure to VASCEPA, whether used alone or in combination with other lipid-altering regimens.

The ANCHOR Trial

The ANCHOR trial was a multi-center, placebo-controlled, randomized, double-blind, 12-week pivotal study in patients with high triglycerides (≥200 and <500 mg/dL) who were also receiving optimized statin therapy. Patients were randomized into three arms for treatment with VASCEPA 4 gram/day, 2 gram/day or placebo. Patient enrollment in this trial began in January 2010, and enrollment and randomization was completed in February 2011 at 702 patients. The primary endpoint in the trial was the percentage change in triglyceride level from baseline compared to placebo after 12 weeks of treatment.

In April 2011, we reported topline results from the ANCHOR trial. The ANCHOR trial met its primary endpoint at doses of 4 grams and 2 grams per day with median placebo-adjusted reductions in triglyceride levels of 21.5% ($p<0.0001$ value) for 4 grams and 10.1% ($p=0.0005$) for 2 grams. The median baseline triglyceride levels were 259 mg/dL, 265 mg/dL and 254 mg/dL for the patient groups treated with placebo, 4 grams and 2 grams of VASCEPA per day, respectively. The analysis of subgroups by baseline triglyceride tertiles showed that higher baseline triglycerides resulted in greater triglyceride reductions.

One of the trial's secondary endpoints was to demonstrate a lack of elevation in LDL-C, the primary target of cholesterol lowering therapy. The trial's non-inferiority criterion for LDL-C was met at both VASCEPA doses. The upper confidence boundaries for both doses were below the pre-specified +6% LDL-C threshold limit. At the 4-gram dose the upper confidence boundary was below zero (-1.7%) and at the 2-gram dose the upper confidence boundary was close to zero (0.5%). For the 4 grams per day group, LDL-C decreased significantly by 6.2% from baseline versus placebo, demonstrating superiority over placebo ($p=0.0067$). For the 2-gram group, LDL-C decreased by 3.6% from baseline versus placebo ($p=0.0867$), which is not a statistically significant decrease.

Other secondary efficacy endpoints included the median placebo-adjusted percent change in non-high-density lipoprotein cholesterol, or non-HDL-C, apolipoprotein B, or apo B, and lipoprotein-associated phospholipase A2 (Lp-PLA2). The 4-gram dose was associated with statistically significant reductions in non-HDL-C (13.6%, $p<0.0001$), apo B (9.3%, $p<0.0001$), Lp-PLA2 (19%, $p<0.0001$) and high-sensitivity C-reactive protein, or hsCRP, (22%, $p<0.001$), at week 12 compared to placebo. One published analysis showed that the VASCEPA 4-gram daily dose in the ANCHOR study also significantly decreased levels of the inflammatory marker oxidized low-density lipoprotein relative to placebo by 13% ($p < 0.0001$). In a separate, post-hoc analysis of study data, VASCEPA 4 g/day statistically significantly reduced ApoC-III levels by 25.1% in MARINE ($p < 0.0001$) and by 19.2% in ANCHOR ($p < 0.0001$) versus placebo.

VASCEPA was well tolerated in the ANCHOR trial with a safety profile comparable to placebo and there were no treatment-related serious adverse events observed. No significant changes in fasting blood glucose, hemoglobin A1C, vital signs, electrocardiograms, or liver or kidney function were observed with either VASCEPA dose. The safety results from the ANCHOR trial are included in the first FDA-approved label for VASCEPA.

In April 2015, we received a Complete Response Letter, or CRL, from the FDA in response to our sNDA that sought approval of VASCEPA for use in patients with mixed dyslipidemia, based on the successful ANCHOR study. The CRL followed an October 2013 rescission by the FDA of a SPA agreement and three failed attempts by us to appeal that rescission at FDA. The FDA has acknowledged the success of the ANCHOR study, which met all primary and secondary endpoints. However, FDA determined that there were insufficient data to conclude that drug-induced changes in serum triglycerides could be recognized by the FDA as a valid surrogate for reducing cardiovascular risk in the ANCHOR population for the purpose of regulatory approval of a drug targeted at a triglyceride-lowering indication in this population. The FDA has acknowledged that the standard of proof required by the FDA for approval of a new drug indication is higher than that generally used to inform patient treatment guidelines and that used by physicians in clinical practice. The FDA did not determine that the drug-induced effects of VASCEPA, which go beyond triglyceride-lowering, would not actually reduce cardiovascular risk in this population. The FDA acknowledged at the time that the design of the REDUCE-

IT study was such that results of that cardiovascular outcomes study should address their lack of confidence in serum triglycerides as a surrogate marker for reducing cardiovascular risk.

In May 2015, we and a group of independent physicians filed a lawsuit in federal court to permit us to promote to healthcare professionals the use of VASCEPA in patients with mixed dyslipidemia so long as the promotion is truthful and non-misleading. This use reflected recognized medical practice but was not covered by the then-current, FDA-approved labeling for the drug. Historically, FDA has considered promotion of drug uses not covered by FDA-approved labeling to be illegal off-label promotion, even if such promotion is truthful and non-misleading. In August 2015, we were granted preliminary relief in the form of a declaratory judgment in this lawsuit. The court declaration permits us to promote to healthcare professionals the FDA-reviewed and agreed effects of VASCEPA demonstrated in the ANCHOR clinical trial and presentation of the current state of scientific research related to the potential (and now demonstrated effect) of VASCEPA to reduce the risk of cardiovascular disease including through use of peer-reviewed scientific publications of available data. In August 2015, we began to communicate promotional information beyond the MARINE indication to healthcare professionals in the United States as permitted by this court declaration and in March 2016, the parties obtained court approval of negotiated settlement terms under which the FDA and the U.S. government agreed to be bound by the court's conclusions from the August 2015 declaration that we may engage in truthful and non-misleading speech promoting the off-label use of VASCEPA and that certain statements and disclosures that we proposed to make to healthcare professionals were truthful and non-misleading. The FDA-approved labeling for VASCEPA did not change as a result of this litigation and settlement, and neither government nor other third-party coverage or reimbursement to pay for the off-label use of VASCEPA promoted under the court declaration was required. Pursuant to FDA approval in December 2019 of the label for VASCEPA to reduce persistent cardiovascular risk beyond maximally tolderated statin therapy, our promotion of ANCHOR clinical trial results was de-prioritized as such results became less important.

Observed Efficacy of Ethyl-EPA

In Japan, ethyl-EPA is marketed under the product name of Epadel by Mochida Pharmaceutical Co., Ltd., or Mochida, and is indicated for hyperlipidemia and peripheral vascular disease. In an outcomes study called the Japan EPA Lipid Intervention Study, or JELIS study, which consisted of more than 18,000 patients followed over multiple years, Epadel, when used in conjunction with statins, was shown to reduce cardiovascular events by 19% compared to the use of statins alone. In this study, cardiovascular events decreased by approximately 53% compared to statins alone in the subset of primary prevention patients with triglyceride levels of ≥150 mg/dL (median of 272 mg/dL at entry) and HDL-C <40 mg/dL. Epadel has been approved and available by prescription in Japan for over a decade. In 2013, the Japan Ministry of Health approved Epadel for over-the-counter sales. JELIS provided supportive but not conclusive data that EPA drug therapy may reduce major coronary events. JELIS results cannot be generalized to populations outside of Japan due to limitations in the study's design. Due to the limitation of JELIS, further study was needed through the REDUCE-IT study to determine the clinical benefit, if any, of EPA therapy in statin-treated patients with elevated triglyceride levels in a patient population beyond that studied in JELIS.

In June 2018, we entered into a multi-faceted collaboration with Mochida related to the development and commercialization of drug products and indications based on the active pharmaceutical ingredient in VASCEPA, the omega-3 acid, EPA. Among other terms in the agreement, we obtained an exclusive license to certain Mochida intellectual property to advance our interests in the United States and certain other territories. In addition, the parties will collaborate to research and develop new products and indications based on EPA for our commercialization in the United States and certain other territories. The potential new product and indication opportunities contemplated under this agreement are currently in early stages of development. Upon closing of the collaboration agreement, we made a non-refundable, non-creditable upfront payment of approximately $2.7 million. In addition, the agreement provides for milestone payments from us upon the achievement of certain product development milestones and royalties on net sales of future products arising from the collaboration, if any. We exercised certain rights under the agreement, resulting in payments of $1.0 million in each of January 2020 and December 2020, respectively, to Mochida.

Observed Clinical Safety of VASCEPA in MARINE, ANCHOR and Early Development

In the MARINE and ANCHOR trials, patients dosed with VASCEPA demonstrated a safety profile similar to placebo. There were no treatment-related serious adverse events in the MARINE study or in the ANCHOR study. In the MARINE and ANCHOR trials, the most commonly reported adverse reaction (incidence >2% and greater than placebo) in VASCEPA treated patients was arthralgia (joint pain) (2.3% for VASCEPA vs. 1.0% for placebo). There was no reported adverse reaction > 3% and greater than placebo.

Prior to commencing the REDUCE-IT, MARINE and ANCHOR trials, we conducted a pre-clinical program for VASCEPA, including toxicology and pharmacology studies. In addition, we previously investigated VASCEPA in central nervous system disorders in several double-blind, placebo-controlled studies, including Phase 3 trials in Huntington's disease. Over 1,000 patients were dosed with VASCEPA in these studies, with over 100 receiving continuous treatment for a year or more. In all studies performed to date, VASCEPA has shown a favorable safety and tolerability profile.

In addition to the REDUCE-IT, MARINE and ANCHOR trials, we completed a 28-day pharmacokinetic study in healthy volunteers, a 26-week study to evaluate the toxicity of VASCEPA in transgenic mice and multiple pharmacokinetic drug-drug interaction studies in healthy subjects in which we evaluated the effect of VASCEPA on certain common prescription drugs. All findings from these studies were consistent with our expectations and confirmed the overall safety profile of VASCEPA.

Since VASCEPA was made commercially available in 2013, more than ten million estimated normalized total prescriptions of VASCEPA have been reported by Symphony Health.

Clinical Study in China

In addition to the studies of VASCEPA we conducted, our partner in China, Eddingpharm (Asia) Macao Commercial Offshore Limited, or Edding, completed a Phase 3 study of VASCEPA in China, the study design of which was similar to, but larger than, our MARINE study. In November 2020, we announced statistically significant positive topline results from this study. The study, which investigated VASCEPA as a treatment for patients with very high triglycerides (≥500 mg/dL), met its primary efficacy endpoint as defined in the clinical trial protocol and demonstrated a safety profile similar to placebo. Importantly, the VASCEPA 4 gram per day dose in this study appeared to be well-tolerated with a safety profile similar to placebo. There were no treatment-related serious adverse events in this study. On February 9, 2021, we announced that the regulatory review processes for approval of VASCEPA in Mainland China and Hong Kong have commenced. The NMPA has accepted for review the new drug application for VASCEPA, submitted by Edding, based on the results of this clinical study and the results from our prior studies of VASCEPA. We expect to receive a decision from the NMPA in Mainland China near the end of 2021. The Hong Kong Department of Health is evaluating VASCEPA based on current approvals in the United States and Canada. The review process in Hong Kong is expected to conclude near the end of 2021.

COVID-19

Based on our current understanding of the biological effects of a COVID-19 infection, including that patients at high risk of cardiovascular disease are at higher risk of mortality and severe effects from a COVID-19 infection, and based on data related to the mechanism of action and effects of VASCEPA in lowering cardiovascular risk in certain high-risk patients, we believe that VASCEPA could play a beneficial clinical role in helping patients infected by the virus. We are currently providing study drug product and limited financial support to investigators in multiple pilot studies designed to better understand the potential of VASCEPA and this potentially beneficial role. The clinical effects of VASCEPA are multi-factorial. Multiple mechanisms of action associated with VASCEPA from clinical and mechanistic studies support the rationale to study its effects in patients with the COVID-19 infection. Additional postulated mechanisms that might play a role in the use of VASCEPA in the patients infected with COVID-19 include potential antiviral/antimicrobial effects, fibrosis and cardiac damage mitigation in animal models and anti-inflammatory effects (acute) in pulmonary/lung tissue.

On December 12, 2020, we announced at the National Lipid Association Scientific Sessions 2020 the positive clinical results from the first study of VASCEPA in COVID-19 infected outpatients, CardioLink-9. A total of 100 COVID-19 positive and symptomatic patients were enrolled in the randomized, open-label trial. The primary biomarker endpoint of the study was within-group changes in high-sensitivity C-reaction protein, or hsCRP, a measure of inflammation and within-group changes in D-dimer were also examined. VASCEPA administration resulted in a 25% reduction in hsCRP (p=0.011) as well as a reduction in D-dimer (p=0.048). In addition to these biomarker changes, assessment was made of COVID-19 symptom changes from baseline to 14 days in the influenza patient-reported outcome, or FLU-PRO, score. VASCEPA administration resulted in a significant 52% reduction of the total FLU-PRO prevalence score as compared to a 24% reduction in the usual care group, with reductions across individual score domains. More study is needed to demonstrate the effects of VASCEPA on COVID-19 infected outpatients.

We are supporting two additional ongoing pilot studies, PREPARE-IT and MITIGATE, by providing study drug product and limited financial support to investigators with results anticipated during 2021. The PREPARE-IT clinical trial is investigating the effects of VASCEPA on reducing COVID-19 infections and subsequent clinical events associated with COVID-19 in 1,500 healthcare providers, or relatives of COVID-19 index cases who have been in contact, and at high risk of contacting COVID-19. The MITIGATE clinical trial is investigating the effects of VASCEPA on laboratory-confirmed viral upper respitory infection rates, clinical impact and outcomes, especially with COVID-19, in 1,500 adults with established atherosclerotic cardiovascular disease who are at increased risk for severe illness from COVID-19. Our personnel remain blinded to the efficacy and safety data from these until after the study is completed. Upon completion of these studies and once the results are known, we will evaluate the next steps.

EVAPORATE

The final results of the Effect of VASCEPA on Improving Coronary Atherosclerosis in People with High Triglycerides Taking Statin Therapy trial, or EVAPORATE, were presented at the European Society of Cardiology on August 29, 2020. A total of 80 patients were enrolled in the randomized, double-blind, placebo-controlled EVAPORATE trial. Patients had to have coronary atherosclerosis as documented by multidetector computed tomography, or MDCT, with 1 or more angiographic stenoses with ≥20%

narrowing, be on statin therapy, and have persistently elevated triglyceride levels (mean TG at baseline was 259.1 mg/dL [+/- 78.1]). Patients underwent an interim scan at nine months and a final scan at 18 months. The prespecified primary endpoint was a comparison of change in low attenuation plaque, or LAP, volume at 18 months between icosapent ethyl and placebo. EVAPORATE was not powered for long-term outcomes. The final results showed a significant reduction in the primary endpoint; icosapent ethyl reduced LAP plaque volume by 17% from baseline to the 18-month scan, whereas there was a progression of LAP plaque volume in the placebo group. There were significant differences between icosapent ethyl and placebo at study end for secondary endpoints of other types of plaque volume changes, including and sequentially total, total non-calcified, fibrofatty, and fibrous plaque volumes. All regressed in the icosapent ethyl group and progressed in the placebo group ($p<0.01$ for all). The only secondary endpoint which did not achieve a significant difference between groups in multivariable modeling was dense calcium ($p=0.053$). More study is needed to demonstrate the effects of VASCEPA on coronary plaque to determine the relationship of such effects, if any, on cardiovascular risk reduction.

During the Transcatheter Cardiovascular Therapeutics, or TCT, Connect 2020 Best of Abstracts session by Benjamin E. Peterson, M.D., Brigham and Women's Hospital Heart & Vascular Center and Harvard Medical School, which was held virtually from October 14 – October 18, 2020, we presented new REDUCE-IT PCI, or Percutaneous Coronary Intervention, analysis. The REDUCE-IT PCI analysis looked at 3,408 (41.7%) of patients enrolled in REDUCE-IT who had undergone a prior PCI. These patients were randomized a median of 2.9 years after PCI. Baseline characteristics were similar among patients randomized to VASCEPA versus placebo. Post hoc exploratory analyses of the subgroup of 3,408 patients with a prior PCI showed that, for the primary composite endpoint of 5-point MACE, time to first event was significantly reduced with VASCEPA versus placebo by 34% ($p<0.0001$) and total (first and subsequent) events were also reduced by 39% ($p<0.0001$). For the key secondary composite endpoint of 3-point MACE, time to first event was reduced by 34% ($p<0.0001$) in the subgroup of patients with a prior PCI. Administration of VASCEPA resulted in robust absolute risk reductions of 8.5% and 5.4% and NNT of 12 and 19, respectively, for both primary and key secondary (hard MACE) composite endpoints in post hoc exploratory subgroup analyses.

CABG

The exploratory analysis findings of REDUCE-IT CABG were presented at the AHA's Virtual Scientific Sessions 2020 from November 13 – November 17, 2020. The REDUCE-IT CABG analysis examined 1,837 (22.5%) of the patients enrolled in REDUCE-IT, representing all patients who had undergone a prior coronary artery bypass grafting, or CABG, procedure, a common form of surgical intervention to help treat coronary heart disease. Baseline characteristics were similar among patients randomized to VASCEPA versus placebo. Post hoc exploratory analyses of this subgroup showed that, for the composite endpoint of 5-point MACE, which was the prespecified primary endpoint for the full REDUCE-IT study cohort, time to first event was significantly reduced with VASCEPA versus placebo by 24% ($p=0.004$) and total (first and subsequent) events were also reduced by 36% ($p=0.0002$). For the REDUCE-IT study's key secondary composite endpoint of 3-point MACE, time to first event was reduced by 31% ($p=0.001$) in the subgroup of patients with a prior CABG. Administration of VASCEPA resulted in robust absolute risk reductions of 6.2% and 6.0% and NNT of 16 and 17, respectively, for both primary and key secondary (hard MACE) composite endpoints in these subgroup analyses.

Our Commercialization Plans

United States

We commenced the commercial launch of VASCEPA in the United States in January 2013 based on the original indication for VASCEPA. In October 2016, in addition to the original 1-gram capsule size for VASCEPA, we introduced a smaller 0.5-gram capsule size. The FDA-approved dosing for VASCEPA is 4 grams per day, and, as expected, the majority of new and existing patients taking VASCEPA continue to be prescribed the 1-gram size VASCEPA capsule. VASCEPA is sold principally to a limited number of major wholesalers, as well as selected regional wholesalers and specialty pharmacy providers, or collectively, our distributors or our customers, that in turn resell VASCEPA to retail pharmacies for subsequent resale to patients and healthcare providers.

Prior to the REDUCE-IT results topline announcement in September 2018, our U.S. direct sales force consisted of approximately 170 sales professionals, including sales representatives and their managers. Based on the positive REDUCE-IT results, in early 2019, we increased the size of our U.S. direct sales force to approximately 440 sales professionals, including approximately 400 sales representatives. As a result of the U.S. FDA's approved indication and label expansion, we expanded our U.S. direct sales force further to approximately 900 sales professionals, including approximately 800 sales representatives in early 2020. As a result of the COVID-19 pandemic and the related social distancing, in March 2020, we suspended face-to-face interactions between our sales representatives and healthcare professionals. We resumed on a limited basis field-based, face-to-face interactions with healthcare providers beginning in June 2020. During the late part of the summer, substantially all of our field force personnel were able to resume face-to-face customer interactions in a manner consistent with guidelines from local, state and government health officials in the United States. In the fourth quarter of 2020, the impact of COVID-19 worsened in much of the United States, with some physicians again limiting access to face-to-face interactions with our field force personnel. Accordingly, in the United States, we have intentionally slowed the hiring of replacements for certain of our open positions which resulted from ordinary turnover. As we witness

our sales representatives increasingly able to resume direct interactions with healthcare professionals, we continually evaluate our needs and it is our intention to fill a significant number of these positions, provided such replacement is appropriate to meet our business needs. As of December 31, 2020, our U.S. direct sales force was slightly more than 800 sales professionals, including slightly more than 700 sales representatives.

Since commercial launch of VASCEPA in January 2013, we had promoted VASCEPA based on the MARINE clinical trial data as reflected in the first FDA-approved label for VASCEPA. In August 2015, we and our co-promotion partner began communicating promotional information beyond MARINE clinical trial data to targeted healthcare professionals. Such qualified communications were made pursuant to the August 7, 2015 federal district court declaration and related March 2016 settlement allowing truthful and non-misleading promotion of the FDA-reviewed and agreed effects of VASCEPA demonstrated in the ANCHOR clinical trial. This promotion also included information related to the then current state of scientific research about the potential of VASCEPA to reduce the risk of cardiovascular disease, including REDUCE-IT data and previously other peer-reviewed scientific publications of available data. The ANCHOR clinical trial of VASCEPA demonstrated the favorable effects of VASCEPA on TGs and related lipid, lipoprotein and inflammation parameters in patients on statin therapy and persistent high TGs.

After results of REDUCE-IT were available in September 2018 and demonstrated that VASCEPA is effective in lowering the rate of major adverse cardiovascular events in statin-treated patients with CV risk factors, we expanded the size of our U.S. direct sales force and continued to expand promotion of VASCEPA. After publication of the primary results of the REDUCE-IT study in *The New England Journal of Medicine* and scientific presentation of REDUCE-IT results at the 2018 Scientific Sessions of the AHA on November 10, 2018, we updated and expanded our communication of REDUCE-IT results to include the publication and the peer-reviewed information presented in an effort to further ensure that our communications remained truthful and non-misleading. Starting December 13, 2019, we began promoting based on the new indication and label expansion.

We employ various medical affairs and marketing personnel to support our commercialization of VASCEPA. We expanded certain medical education and market awareness initiatives, including, pilot testing of new promotional initiatives following the reporting of positive REDUCE-IT results in 2018 and we further expanded such initiatives based on the approved indication and label expansion of VASCEPA. Our field sales efforts are further complemented by investments in digital and non-personal channels as well as peer-to-peer (e.g., promotional medical education programs and product theaters) initiatives to further increase VASCEPA brand awareness and clarify VASCEPA's unique clinical profile. In January 2020, we launched an educational campaign, *True To Your Heart,* to help people learn more about cardiovascular disease and how to better protect against persistent cardiovascular risk. In July 2020 we launched our first television-based promotion of VASCEPA emphasizing that it is the first and only FDA approved drug for its indication. As the impact of COVID-19 on much of the United States worsened in the fourth quarter of 2020, we suspended television-based promotion of VASCEPA judging that the cost was not sufficiently justified. We anticipate that at-risk patients will increasingly resume visiting their doctors for non-urgent medical care after they are vaccinated for COVID-19. As COVID-19 protocols ease and ordinary course activities resume, we will seek to adjust our promotional initivatives accordingly, including pursuing increased face-to-face interactions with healthcare professionals and expanding various forms of direct-to-consumer promotion.

Based on monthly compilations of data provided by a third party, Symphony Health, the estimated number of normalized total VASCEPA prescriptions for the three months ended December 31, 2020 was approximately 1,159,000 compared to 1,174,000, 1,090,000, 1,061,000, and 991,000 in the three months ended September 30, 2020, June 30, 2020, March 31, 2020, and December 31, 2019, respectively. According to data from another third party, IQVIA, the estimated number of normalized total VASCEPA prescriptions for the three months ended December 31, 2020 was approximately 1,076,000 compared to 1,081,000, 1,007,000, 962,000, and 909,000 in the three months ended September 30, 2020, June 30, 2020, March 31, 2020, and December 31, 2019, respectively. Normalized total prescriptions represent the estimated total number of VASCEPA prescriptions dispensed to patients, calculated on a normalized basis (i.e., one month's supply, or total capsules dispensed multiplied by the number of grams per capsule divided by 120 grams). Inventory levels at wholesalers tend to fluctuate based on seasonal factors, prescription trends and other factors.

Companies such as Symphony Health and IQVIA collect and report estimates of weekly, monthly, quarterly and annual prescription information. There is a limited amount of information available to such companies to determine the actual number of total prescriptions for prescription products like VASCEPA during such periods. Each vendor's estimates utilize a proprietary projection methodology and are based on a combination of data received from pharmacies and other distributors, and historical data when actual data is unavailable. Their calculations of changes in prescription levels between periods can be significantly affected by lags in data reporting from various sources or by changes in pharmacies and other distributors providing data. Such methods can from time to time result in significant inaccuracies in information when ultimately compared with actual results. These inaccuracies have historically been most prevalent and pronounced during periods of time of inflections upward or downward in rates of use. Further, data for a single and limited period may not be representative of a trend or otherwise predictive of future results. Data reported by Symphony Health and IQVIA is rarely identical. As such, the resulting conclusions from such sources should be viewed with caution. We are not responsible for the accuracy of these companies' information and we do not receive prescription data directly from retail pharmacies.

We sell VASCEPA principally to a limited number of major wholesalers, as well as selected regional wholesalers and specialty pharmacy providers in the United States, that in turn resell VASCEPA to retail pharmacies for subsequent resale to patients and healthcare providers. We recognize revenue from product sales when the distributor obtains control of our product, which occurs at a point in time, typically upon delivery to the distributor. Timing of shipments to wholesalers, as used for revenue recognition purposes, and timing of prescriptions as estimated by these third parties may differ from period to period. Although we believe these data are prepared on a period-to-period basis in a manner that is generally consistent and that such results can be generally indicative of current prescription trends, these data are based on estimates and should not be relied upon as definitive. While we expect to be able to grow VASCEPA revenues over time, no guidance should be inferred from the operating metrics described above. We also anticipate that such sales growth will be inconsistent from period to period. We believe that investors should view the above-referenced operating metrics with caution, as data for this limited period may not be representative of a trend consistent with the results presented or otherwise predictive of future results. Seasonal fluctuations in pharmaceutical sales, for example, may affect future prescription trends of VASCEPA, as could changes in prescriber sentiment, quarterly changes in distributor purchases, and other factors. We believe investors should consider our results over several quarters, or longer, before making an assessment about potential future performance.

The commercialization of pharmaceutical products is a complex undertaking, and our ability to effectively and profitably commercialize VASCEPA will depend in part on our ability to generate market demand for VASCEPA through education, marketing and sales activities, our ability to achieve market acceptance of VASCEPA, our ability to generate product revenue and our ability to receive adequate levels of reimbursement from third-party payers. In addition, Hikma launched their generic version of VASCEPA in the United States in November 2020, and we could face even more competition from generic companies in the United States in the near term in light of the patent litigation rulings. Sales of generic versions of VASCEPA could have a material and adverse impact on our revenues and results of operations. See "*Risk Factors—Risks Related to the Commercialization and Development of VASCEPA*."

In addition to promotion of VASCEPA in the United States, based on REDUCE-IT we have increased focus on expansion of our development efforts for VASCEPA to major markets outside the United States. We currently have plans for expansion into the European Union and strategic collaborations to develop and commercialize VASCEPA in select territories outside of the United States.

Europe

In December 2019, we announced that the EMA validated the marketing authorization application seeking approval for VASCEPA. The validation confirmed the submission was sufficiently complete for the EMA to begin its review. In August 2020, we announced our plans to launch VAZKEPA in major markets in Europe through our own new European sales and marketing team. Such an approach allows us to retain substantially all of the economic potential of VAZKEPA in Europe and helps ensure that VAZKEPA would get the highest level of priority and focus. On January 28, 2021, the CHMP of the EMA adopted a positive opinion, recommending that a marketing authorization be granted to icosapent ethyl in the EU for the reduction of risk of cardiovascular events in patients at high cardiovascular risk, under the brand name VAZKEPA. The CHMP recommendation is now expected to be reviewed by the EC with a decision expected to take place within 67 days of the CHMP opinion. As we did in Canada, we are seeking an indication throughout Europe for VAZKEPA targeting cardiovascular risk reduction based on the results of REDUCE-IT, which is based on outcomes study results, and not approval of the original indication in the United States for treatment of severe hypertriglyceridemia.

Similar to our approach in launching VASCEPA in the United States, in Europe we have been building a core team of experienced professionals and a highly capable sales team and plan to leverage third-party relationships for various support activities. We commenced 2021 with approximately 50 professionals involved with pre-approval and pre-launch planning and other commercial preparation activities. In Europe, patients at high risk for cardiovascular disease tend, in comparison to the United States, to be treated more often by specialists, such as cardiologists rather than by physicians who are general practitioners. Pursuant to regulatory approval of VAZKEPA in Europe, this greater concentration of at-risk patients being treated by specialists in Europe should allow for more efficient promotion in Europe than in the United States. We have been active in preparing for reimbursement negotiations which we intend to commence on a country-by-country basis in Europe following anticipated approval of VAZKEPA by the EC. In most European countries, securing product reimbursement is a requisite to launching. In all countries securing adequate reimbursement is a requisite for commercial success of any therapeutic. The time required to secure reimbursement tends to vary from country to country and cannot be reliably predicted at this time. While we believe that we have strong arguments regarding the cost effectiveness of VAZKEPA, the success of such reimbursement negotiations could have a significant impact on our ability to realize the commercial opportunity of VAZKEPA in Europe.

China

In February 2015, we entered into a Development, Commercialization and Supply Agreement, or the DCS Agreement, with Eddingpharm (Asia) Macao Commercial Offshore Limited, or Edding, related to the development and commercialization of VASCEPA in the China Territory. Under the DCS Agreement, Edding will be solely responsible for development and

commercialization activities in the China Territory and associated expenses. Additionally, Edding is required to conduct clinical trials in the China Territory to secure regulatory approval in certain territories. Edding, with our support, commenced a pivotal clinical trial aimed to support the regulatory approval of the first indication of VASCEPA in a patient population with severe hypertriglyceridemia in Mainland China. Additional clinical development efforts are necessary in certain segments of this market. In November 2020, we announced statistically significant positive topline results from the Phase 3 clinical trial of VASCEPA conducted by Edding. The study, which investigated VASCEPA as a treatment for patients with very high triglycerides (≥500 mg/dL), met its primary efficacy endpoint as defined in the clinical trial protocol and demonstrated a safety profile similar to placebo. Importantly, the VASCEPA 4 gram per day dose in this study appeared to be well-tolerated with a safety profile similar to placebo. There were no treatment-related serious adverse events in this study. On February 9, 2021, we announced that the regulatory review processes for approval of VASCEPA in Mainland China and Hong Kong have commenced. The NMPA has accepted for review the new drug application for VASCEPA, submitted by Edding, based on the results from the Phase 3 clinical trial and the results from our prior studies of VASCEPA. We expect to receive a decision from the NMPA in Mainland China near the end of 2021. The Hong Kong Department of Health is evaluating VASCEPA based on current approvals in the United States and Canada. The review process in Hong Kong is expected to conclude near the end of 2021. If Edding is not able to effectively develop and commercialize VASCEPA in the China Territory, we may not be able to generate revenue from the DCS Agreement resulting from the sale of VASCEPA in the China Territory.

Middle East and North Africa (MENA)

In March 2016, we entered into an agreement with Biologix FZCo, or Biologix, to register and commercialize VASCEPA in several Middle Eastern and North African countries. Under the terms of the distribution agreement, we granted to Biologix a non-exclusive license to use our trademarks in connection with the importation, distribution, promotion, marketing and sale of VASCEPA in the Middle East and North Africa territory. Biologix obtained approval of VASCEPA in Lebanon in March 2018, in United Arab Emirates in July 2018, in Qatar in January 2020 and in Bahrain in December 2020. VASCEPA was launched in Lebanon and the United Arab Emirates in June 2018 and February 2019, respectively. VASCEPA is under registration in additional countries in the MENA region. Commercialization across the Middle East and North Africa is subject to similar risks as in the China Territory.

Canada

In September 2017, we entered into an agreement with HLS Therapeutics Inc., or HLS, to register, commercialize and distribute VASCEPA in Canada. Under the agreement, HLS is responsible for regulatory and commercialization activities and associated costs. We are responsible for providing assistance towards local filings, supplying finished product under negotiated supply terms, and maintaining intellectual property. In December 2019, following priority review designation, HLS received confirmation from Health Canada that the Canadian regulatory authority granted approval for VASCEPA to reduce the risk of cardiovascular events (cardiovascular death, non-fatal myocardial infarction, non-fatal stroke, coronary revascularization or hospitalization for unstable angina) in statin-treated patients with elevated triglycerides, who are at high risk of cardiovascular events due to: established cardiovascular disease, or diabetes, and at least one other cardiovascular risk factor. In January 2020, HLS obtained an extended regulatory exclusivity designation and commercial launch began in February 2020. An important step in growing the potential use of therapeutics in Canada, as is true in other countries, is gaining reimbursement coverage by the applicable payers. In July 2020, the Canadian Agency for Drugs and Technologies in Health recommended that VASCEPA be reimbursed by participating public drug plans for statin-treated patients with established cardiovascular diseases and elevated triglycerides. HLS also received notification by the Patented Medicine Prices Review Board that, further to its review, VASCEPA's price did not trigger the investigation criteria for excessive pricing. If HLS is not able to effectively commercialize VASCEPA in Canada, we may not be able to generate revenue from the agreement as a result of the sale of VASCEPA in Canada.

We plan to continue to assess other potential partnership opportunities for licensing VASCEPA to partners outside of the United States.

Potential Benefits and Market Opportunity for VASCEPA

VASCEPA, encapsulated in 1-gram capsules, is 1-gram of icosapent ethyl, or ethyl-EPA, and contains no DHA. Icosapent ethyl is the only active ingredient. We believe that icosapent ethyl, in the stable form as it is presented in VASCEPA, is more effective than if combined with other omega-3 molecules. In particular, based on clinical evidence, we believe that the removal of DHA mitigates against the LDL-C raising effect observed in omega-3 compositions that include DHA. Based on the results of the REDUCE-IT trial, VASCEPA was the first omega-3 based product, or any type of product, to demonstrate a statistically significant reduction in cardiovascular risk beyond cholesterol lowering therapy in high-risk patients approved for treatment. Prior to REDUCE-IT, based on the MARINE trial, VASCEPA was the first omega-3 based product to demonstrate statistically significant triglyceride reduction without a statistically significant increase in LDL-C in this very high triglyceride population.

We believe that the results of the REDUCE-IT, ANCHOR and MARINE clinical trials of VASCEPA and VASCEPA's EPA only/DHA-free composition position VASCEPA to achieve a global "best-in-class" prescription therapy in studied patient

populations. Potential mechanisms of action at work in the reduction of cardiovascular events seen in REDUCE-IT as discussed in *The New England Journal of Medicine* publication of REDUCE-IT primary results include TG reduction, anti-thrombotic effects, antiplatelet or anticoagulant effects, membrane-stabilizing effects, effects on stabilization and/or regression of coronary plaque and inflammation reduction. Mechanisms responsible for the benefit shown in REDUCE-IT were not studied in REDUCE-IT as that was not the purpose of an outcomes study. While the mechanisms of action of VASCEPA have been broadly studied and continue to be studied, similar to other drugs with multifactorial mechanisms of action, such as aspirin, statins and metformin, we may never fully determine to what extent, if any, each of these effects or others may be responsible for the CV risk reduction benefit demonstrated in REDUCE-IT.

Manufacturing and Supply for VASCEPA

We manage the manufacturing and supply of VASCEPA and have done so since we began clinical development of VASCEPA prior to the drug's marketing approval by the FDA in 2012. We rely on contract manufacturers in each step of our commercial and clinical product supply chain. These steps include API, manufacturing, encapsulation of the API, product packaging and supply-related logistics. Our approach to product supply procurement is designed to mitigate risk of supply interruption and maintain an environment of cost competition through diversification of contract manufacturers at each stage of the supply chain and lack of reliance on any single supplier.

The FDA has approved several international large-scale API manufacturers, global encapsulation leaders and two U.S.-based packagers for use in the manufacturing of VASCEPA. All of our manufacturing facilities were approved by the FDA following successful preapproval inspections and they remain active manufacturers of VASCEPA under FDA authority.

The API material that constitutes ethyl-EPA is a chemical modification of a naturally occurring substance that is derived from specific fish sourced from qualified producers. The fishing from which the raw material for VASCEPA is derived is regulated by local government agencies under policies designed to ensure sustainability of the marine life supply. A limited number of other manufacturers have the ability, scale, know-how, sufficient supply chain capability and suitable, industrial-scale facilities to produce ethyl-EPA to the required level of purity. We have worked with our suppliers to build required scale, quality and cost-efficiency needed to meet our current market requirements. We are working with our suppliers on capacity expansion plans anticipating approval of VASCEPA in Europe, China and potentially other countries in addition to the increased demand for VASCEPA in the United States that we plan to create from our promotional initiatives. Among the conditions for FDA approval of a pharmaceutical product is the requirement that the manufacturer's quality control and manufacturing procedures are validated and conform to pharmaceutical current Good Manufacturing Practice, or cGMP, which, under applicable regulations, must be followed at all times. The FDA typically inspects manufacturing facilities before regulatory approval of a product candidate, such as VASCEPA, and on a periodic basis after the initial approval. Consistent with cGMP regulations, pharmaceutical manufacturers must expend resources and time to ensure compliance with product specifications as well as production, record keeping, quality control, reporting, and other regulatory requirements.

Similar to the FDA, regulators in other countries in which we, or our partners, sell or seek to sell VASCEPA, regulate manufacturer's quality control and manufacturing procedures. For Europe, while various of our suppliers have been inspected and, subject to regulatory approval of VAZKEPA in Europe we do not anticipate supply availability limiting our launch in Europe, COVID-19 has limited the ability of suppliers to be inspected and not all of our suppliers have completed all of the requirements of the European regulatory authorities.

Production of VASCEPA, from sourcing of starting materials through stocking of finished goods inventory requires significant coordination between companies and considerable lead-times. We are often making purchasing decisions for supply more than a year in advance of anticipated product sales. Planning for capacity expansion also requires significant lead-times as, for example, creation of new manufacturing facilities for API can require multiple years to construct, equip and qualify.

Some of our agreements with our API suppliers are exclusive and include minimum purchase commitments. During 2020, we fully met the aggregate minimum purchase requirements in our supply agreements. Under the supply agreements, we can purchase more than the minimum requirements. Certain of these agreements contemplate phased capacity expansion aimed at creating sufficient volumes to meet anticipated demand for VASCEPA. Certain of these agreements contain provisions for reduced payments (fractional API cost) for unmet annual volume requirements.

Competition

General

The biotechnology and pharmaceutical industries are highly competitive. There are many pharmaceutical companies, biotechnology companies, public and private universities and research organizations actively engaged in the research and development of products that may be similar to our product. It is probable that the number of companies seeking to develop products and therapies similar to our product will increase. Many of these and other existing or potential competitors have substantially greater financial, technical and human resources than we do and may be better equipped to develop, manufacture and market products. These companies may develop and introduce products and processes competitive with, more efficient than or superior to ours. In addition, other technologies or products may be developed that have an entirely different approach or means of accomplishing the intended purposes of our products, which might render our technology and products noncompetitive or obsolete.

United States

Our competitors include large, well-established pharmaceutical and generic companies, specialty and generic pharmaceutical sales and marketing companies, and specialized cardiovascular treatment companies. With a generic version of VASCEPA launched in the U.S. by Hikma in November 2020 and further generic versions anticipated, it may not be viable for us to invest in market education to grow the market and our ability to maintain current promotional efforts and attract favorable commercial terms in several aspects of our business will likely be adversely affected as we face increased generic competition, or if we launch our own generic version of VASCEPA.

GlaxoSmithKline plc currently sells Lovaza®, a prescription-only omega-3 fatty acid indicated for patients with severe hypertriglyceridemia, which was approved by FDA in 2004 and has been on the market in the United States since 2005. Multiple generic versions of Lovaza are available in the United States. Other large companies with competitive products include AbbVie, Inc., which currently sells Tricor® and Trilipix® for the treatment of severe hypertriglyceridemia and Niaspan®, which is primarily used to raise high-density lipoprotein cholesterol, or HDL-C, but is also used to lower triglycerides. Multiple generic versions of Tricor, Trilipix and Niaspan are also available in the United States. We compete with these drugs, and in particular, multiple low-cost generic versions of these drugs, in our FDA-approved indicated uses, even though such products do not have FDA approval to reduce CV risk on top of statin therapy.

In addition, in May 2014, Epanova® (omega-3-carboxylic acids) capsules, a free fatty acid form of omega-3 (comprised of 55% EPA and 20% DHA), was approved by the FDA for patients with severe hypertriglyceridemia. Epanova was developed by Omthera Pharmaceuticals, Inc., and is now owned by AstraZeneca Pharmaceuticals LP, or AstraZeneca. Also, in April 2014, Omtryg, another omega-3-acid fatty acid composition developed by Trygg Pharma AS, received FDA approval for severe hypertriglyceridemia. Neither Epanova nor Omtryg have been commercially launched, but could launch at any time. AstraZeneca has greater resources than we do, including financial, product development, marketing, personnel and other resources.

AstraZeneca had been conducting a long-term outcomes study to assess Statin Residual Risk Reduction With EpaNova in HiGh Cardiovascular Risk PatienTs With Hypertriglyceridemia, or STRENGTH. The study was a randomized, double-blind, placebo-controlled (corn oil), parallel group design that is believed to have enrolled approximately 13,000 patients with hypertriglyceridemia and low HDL and high risk for cardiovascular disease randomized 1:1 to either corn oil plus statin or Epanova plus statin, once daily. On January 13, 2020, following the recommendation of an independent Data Monitoring Committee, AstraZeneca decided to close the STRENGTH trial due to its low likelihood of demonstrating benefit to patients with mixed dyslipidemia who are at increased risk of cardiovascular disease. Full data from the STRENGTH trial was presented at the AHA's Scientific Sessions in November 2020 confirming that Epanova failed to meet the primary endpoint of CV risk reduction. In addition, in March 2017, Kowa Research Institute (a subsidiary of the Japanese company Kowa Co., Ltd) initiated a Phase 3 cardiovascular outcomes trial titled PROMINENT examining the effect of pemafibrate (experimental name K-877) in reducing cardiovascular events in Type II diabetic patients with hypertriglyceridemia. Kowa Research Institute has publicly estimated study completion in May 2022, and if successful, U.S. regulatory approval is estimated in mid-2023.

During 2018, two outcomes studies were completed of omega-3 mixtures which both failed to achieve their primary endpoints of cardiovascular risk reduction and two meta-analyses were published showing that omega-3 mixtures are not effective in lowering cardiovascular risk. Results of these failed outcomes studies and analysis, while not done with VASCEPA, may negatively affect sales of VASCEPA. For example, results of VITamin D and OmegA-3 TriaL, or VITAL, as announced immediately before the presentation of REDUCE-IT results at the 2018 Scientific Sessions of the AHA on November 10, 2018, failed to achieve its primary endpoint of lowering cardiovascular events. VITAL was an NIH funded randomized double-blind, placebo-controlled, 2x2 factorial trial of 2000 IU per day of vitamin D3 and 1 gram per day of omega-3 fatty acid mixture supplementation (Lovaza) for the primary prevention of cancer and cardiovascular disease in a nationwide USA cohort of 25,874 adults not selected for elevated cardiovascular or cancer risk.

Likewise, in 2018, results from A Study of Cardiovascular Events iN Diabetes (ASCEND) trial were released and showed negligible results for omega-3 fatty acid mixtures 1 gram daily. ASCEND was a British Heart Foundation funded 2x2 factorial design,

randomized study to assess whether aspirin 100 mg daily versus placebo and separately, omega-3 fatty acid mixtures 1 gram daily versus placebo, reduce the risk of cardiovascular events in a nationwide United Kingdom, or UK, cohort of over 15,000 individuals with diabetes who do not have atherosclerotic cardiovascular disease. In 2020, an additional Nordic trial known as OMEMI failed to demonstrate a reduction in cardiovascular events with an omega-3 fatty acide mixture. OMEMI, an investigator-initiated, multi-center, randomized clinical trial, was designed to evaluate the effects of daily treatment with omega-3 fatty acids compared with placebo among elderly patients (age 70-82) with recent myocardial infarction. Patients received 1.8 g omega-3 fatty acids (930 mg EPA and 660 mg DH) or placebo (corn oil) daily added to standard of care. Results presented in November 2020 at the AHA's Scientific Sessions showed no significant differences in cardiovascular events between the treatment groups for the composite primary endpoint (non-fatal MI, unscheduled revascularization, stroke, hospitalization for heart failure or all-cause mortality), nor for the individual component of this endpoint after 2 years.

In a meta-analysis, presented in 2018 by the Cochrane Foundation and separately as published in JAMA, additional omega-3 studies were evaluated. Similar to the VITAL and ASCEND studies, most of the studies in these omega-3 meta-analyses were of omega-3 mixtures, including DHA, and most were studies of relatively low doses of omega-3 as is associated with dietary supplementation and/or they studied relatively low risk patient populations. The exception was the JELIS study, conducted in Japan, of highly pure EPA which showed a positive outcome benefit but had significant limitations in its application to a wider population. The negative results from such omega-3 mixture studies could create misleading impressions about the use of omega-3s generally, including VASCEPA, despite REDUCE-IT positive results and the highly-pure and stable EPA active ingredient in VASCEPA and its higher dose regimen.

We are also aware of other pharmaceutical companies that are developing products that, if successfully developed, approved and marketed, would compete with VASCEPA. It is not fully clear at this time what the impact of COVID-19 will be on each of these programs.

We believe Micelle BioPharma Inc., or Micelle, is also developing potential treatments for hypertriglyceridemia based on omega-3 fatty acids. To our knowledge, Micelle, after acquiring SC401 from Sancilio & Company, or Sancilio, is pursuing a regulatory pathway under section 505(b)(2) of the FDCA for its product and submitted an Investigational New Drug Application, or IND, in July 2015. Micelle (Sancilio) completed two pharmacokinetic studies and Phase 2 bioavailability studies (FASTR I&II), with one comparing SC401 to Lovaza. We expect the company or a potential partner to initiate a pivotal clinical Phase 3 study as the next step in development.

Matinas BioPharma, Inc., or Matinas, is developing an omega-3-based therapeutic (MAT9001) for the treatment of severe hypertriglyceridemia and mixed dyslipidemia. In the fourth quarter of 2014 Matinas filed an IND with the FDA to conduct a human study in the treatment of severe hypertriglyceridemia and, in June 2015, the company announced topline results for its head-to-head comparative short duration pharmacokinetic and pharmacodynamic study of MAT9001 versus VASCEPA in patients under conditions inconsistent with the FDA-approved label for VASCEPA and presented results based on biomarker modification without outcomes data. In September 2017, Matinas announced that it will be seeking a partner company to develop and commercialize MAT9001. In March 2019, Matinas announced that net proceeds from a public offering of common stock would be used for development activities for MAT9001. In March 2020, Matinas announced that it completed the clinical dosing for a comparative clinical bridging bioavailability study and the in-life portion of a 90-day comparative toxicology study in the first quarter of 2020. Both studies were conducted to support a planned 505(b)(2) registration pathway. In March, Matinas also initiated an additional Phase 2 head-to-head pharmacokinetic and pharmacodynamic study, ENHANCE-IT, against VASCEPA in patients with elevated triglycerides (150-499 mg/dL), while the study was paused in the first quarter of 2020 due to the COVID-19 pandemic, enrollment resumed in June and was completed in August 2020. In the first quarter of 2021, Matinas announced topline results from the ENHANCE-IT study, stating that LYPDISO, or MAT9001, did not meet statistical significance over VASCEPA on the primary endpoint of percent change from baseline to end of treatment in triglycerides in the pharmacodynamic (PD) population. Matinas has announced that despite ENHANCE-IT not achieving its primary endpoint that it intends to continue to seek ways to advance its clinical development of MAT9001.

In June 2018, Gemphire Therapeutics (renamed NeuroBo Pharmaceuticals, Inc. following completion of a merger on December 31, 2019) announced positive topline results from a Phase 2b trial, or INDIGO-1, of its drug candidate, gemcabene, in patients with severe hypertriglyceridemia. Gemcabene is an oral, once-daily pill for a number of hypercholesterolemic populations and severe hypertriglyceridemia. In August 2018, the FDA requested that Gemphire conduct an additional long-term toxicity study before commencing any further clinical testing, thereby effectively placing gemcabene on clinical hold. In March 2020 NeuroBo announced the completion of the requested studies, and in May 2020 the company announced that it received written communication from the FDA that the clinical development program for Gemcabene remains on partial clinical hold. In June 2019, Gemphire announced top-line clinical results from a Phase 2 trial in Familial Partial Lipodystrophy (FPL)/NASH in which Gemcabene safely met the primary endpoint in a sub-set of patients. Phase 3 studies for homozygous familial hypercholesterolemia, or HoFH, heterozygous familial hypercholesterolemia, or HeFH, and non-familial hypercholesterolemia in ASCVD patients are planned.

Afimmune Ltd. has an oral, small molecule drug candidate, epeleuton (DS-102), in development for a number of conditions of the liver, lung, and metabolic system, including hypertriglyceridemia and cardiovascular risk reduction, Phase 2 clinical trials are currently ongoing for non-alcoholic fatty liver disease, or NAFLD, chronic obstructive pulmonary disease, or COPD, and planned for hypertriglyceridemia and Type 2 diabetes (TRIAGE), in the United States. In November 2019, Afimmune Ltd. announced positive results from an exploratory Phase 2 study of epeleuton in patients with NAFLD in which the molecule decreased triglycerides, improved glycemic control, and decreased markers of inflammation. In August 2020, Afimmune reported Ph2a study results of epeleuton in patients with NAFLD. Although epeleuton failed to meet the primary endpoint to demonstrate effects on liver enzyme elevation, it demonstrated significant reduction of triglycerides, HbA1c and potential for CV risk reduction. In September 2020, Afimmune announced the start of TRIglyceride And Glucose control with Epeleuton in Metabolic Syndrome Patients, or TRIAGE, a Phase IIb study of epeleuton in patients with high triglycerides and type 2 diabetes to assess the safety and efficacy of orally administered epeleuton capsules vs placebo in the treatment of hypertriglyceridemia and type 2 diabetes. Results are expected in the fourth quarter of 2021.

Based on prior communications from the FDA, including communications in connection with its review of the ANCHOR indication for VASCEPA, it is our understanding that the FDA is not prepared to approve any therapy for treatment of cardiovascular risk based on biomarker modification without cardiovascular outcomes study data, with the potential exception of therapies which lower LDL-cholesterol, depending on the circumstances. In particular, it is our understanding that the FDA is not prepared to approve any therapy based primarily on data demonstrating lowering of triglyceride levels. In our view, this position from the FDA did not change based on the REDUCE-IT study particularly in light of significant independence of the positive benefit demonstrated in the REDUCE-IT study from triglyceride levels and benefit from the REDUCE-IT study supporting that the positive effects of VASCEPA are unique to VASCEPA and extend beyond triglyceride reduction. If the FDA were to change this position, it could potentially have a negative impact on us by making it easier for other products to achieve a cardiovascular risk reduction indication without the need in advance to conduct a long and expensive cardiovascular outcomes study.

VASCEPA also faces competition from dietary supplement manufacturers marketing omega-3 products as nutritional supplements. Such products are classified as food, not as prescription drugs or as over-the-counter drugs, by the FDA in the United States. Most regulatory regimes outside the United States are similar in this regard. Some of the promoters of such products have greater resources than us and are not restricted to the same standards as are prescription drugs with respect to promotional claims or manufacturing quality, consistency and subsequent product stability. We have taken successful legal action against supplement manufacturers attempting to use the REDUCE-IT results to promote their products. Still, we cannot be sure physicians and pharmacists will view the FDA-approved, prescription-only status, and EPA-only purity and stability of VASCEPA or FDA's stringent regulatory oversight, as significant advantages versus omega-3 dietary supplements regardless of clinical study results and other scientific data.

Europe and Rest of World

On January 28, 2021, the CHMP of the EMA adopted a positive opinion recommending that a marketing authorization be granted for icosapent ethyl, under the brand name VAZKEPA, for cardiovascular risk reduction. Approval for marketing and sale by the EC is expected in April 2021. The cardiovascular risk reduction indication we are seeking in Europe is based on the outcome study results of REDUCE-IT, as opposed to the original indication for treatment of severe hypertriglyceridemia which we were granted in the United States. Following anticipated approval by the EC of VAZKEPA, there is currently no other drug that is approved for cardiovascular risk reduction in at-risk patients in Europe. In addition, there is currently no other direct competition for Canada and the Middle East. However, consistent with the U.S., our competitors include large, well-established pharmaceutical companies, specialty and generic pharmaceutical companies, marketing companies, and specialized cardiovascular treatment companies.

Recent CV outcomes trials and meta-analyses with low and high dose omega-3 fatty acid mixtures containing DHA have not shown substantial benefit in patients receiving contemporary medical therapy, including statins. Due to failed low dose omega-3 CV outcomes trials, the European regulatory authorities have concluded that omega-3 fatty acid medicines (specifically Lovaza®/Omacor®) at a dose of 1-gram per day are not effective in preventing further events for patients who have had a heart attack. The STRENGTH trial of an omega-3 mixture studied at 4-grams per day also failed to demonstrate cardiovascular benefit.

In addition, VASCEPA also faces competition from dietary supplement manufacturers marketing omega-3 productions as nutritional supplements. In Europe, such products are classified as food, not as prescription drugs or as over-the-counter drugs.

Lipid Disorders and Cardiovascular Disease

United States

Heart attacks, strokes and other cardiovascular events represent the leading cause of death and disability among men and women in western societies. According to the *Heart Disease and Stroke Statistics—2020 Update* from the American Heart Association, CVD is the underlying cause of death in approximately 1 out of every 3 deaths – one death approximately every 37 seconds. Approximately

121 million adults in the United States live with one or more types of cardiovascular disease with an estimated 1 million new or recurrent coronary events and 795,000 new or recurrent strokes occur each year. Combining the rates of cardiovascular death, stroke and heart attack, one major adverse cardiovascular event occurs in the United States every 13 seconds. An estimated 29 million adults ≥20 years of age have high total serum cholesterol levels (≥240 mg/dL), and an estimated 71 million adults ≥20 years of age have borderline high or high low-density lipoprotein ("bad") cholesterol, or LDL-C, levels (≥130 mg/dL). According to the 2020 Heart and Stroke Statistics from the AHA, 45.1% of the United States population is projected to have some form of CVD by 2035 and total costs of CVD are expected to reach $1.1 trillion in 2035, with direct medical costs projected to reach $748.7 billion and indirect costs estimated to reach $368.0 billion.

In addition to cholesterol, lipoproteins such as LDL also carry fats in the form of triglycerides. Hypertriglyceridemia refers to a condition in which patients have high levels of triglycerides in the bloodstream and has been reported to be both an independent risk factor for, and potential cause of, cardiovascular disease. Triglyceride levels provide important information as a marker associated with the risk for heart disease and stroke.

Guidelines for the management of very high triglyceride levels (≥500 mg/dL) suggest that reducing triglyceride levels is the primary treatment goal in these patients to reduce the risk of acute pancreatitis. Treating LDL-C remains an important secondary goal. Other important parameters to consider in patients with very high triglycerides include levels of apolipoprotein B, or apo B, non-HDL-C, and very low-density lipoprotein cholesterol, or VLDL-C. The effect of VASCEPA on the risk for pancreatitis in patients with hypertriglyceridemia has not been determined.

VASCEPA is the first and only drug approved by the FDA as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated TG levels (≥150 mg/dL) and either established cardiovascular disease or diabetes mellitus and two or more additional risk factors for cardiovascular disease.

It is estimated that more than 50 million adults in the United States have elevated triglyceride levels ≥150 mg/dL. Additionally, approximately 2 to 3 million adults in the United States have very high triglyceride levels (≥500 mg/dL), the condition for which VASCEPA received its annual drug approval from FDA in 2012 based on the MARINE clinical trial. There are approximately 5 to 15 million people in the United States that meet the specific REDUCE-IT inclusion criteria. Additionally, the FDA-approved label for VASCEPA mentions maximally tolerated statin therapy in the indication statement. This may mean that patients on prior statin therapy who are thought to be intolerant to statins, approximately 10% - 20% of patients with prior statin use, may be eligible for VASCEPA. Since 1976, mean triglyceride levels have increased, along with the growing epidemic of obesity, insulin resistance, and type 2 diabetes mellitus. In contrast, mean LDL-C levels have decreased. Multiple primary and secondary prevention trials have shown a significant RRR of 25% to 35% in the risk of cardiovascular events with statin therapy, leaving significant persistent residual CV risk despite the achievement of target LDL-C levels.

Mixed dyslipidemia refers to a condition in which patients have a combination of two or more lipid abnormalities including elevated triglycerides, low HDL-C, and/or elevated LDL-C. Both hypertriglyceridemia and mixed dyslipidemia are components of a range of lipid disorders collectively referred to as dyslipidemia. Dyslipidemia has been linked to atherosclerosis, commonly referred to as hardening of the arteries.

Europe

In the European Union, there are approximately 49 million people reportedly living with cardiovascular disease, including approximately 38 million diagnosed with ischemic heart disease, stroke or peripheral heart disease. The proportion of patients dying from cardiovascular disease is reportedly higher in Europe than in the United States and there are more patients on statin therapy in Europe in aggregate compared to the United States. Caring for cardiovascular disease in Europe is expensive with annual spending estimated to currently exceed 200 billion Euro annually.

Limitations of Current Therapies

Hypertriglyceridema, or HTG, is a prevalent lipid disorder in approximately 25% of the U.S. adult population. Both epidemiological and genetic data have shown associations between HTG and coronary heart disease. Many of those patients are taking statin therapy directed at lowering the risk of CVD by lowering their LDL-C levels, primarily. Recently, real world administrative database analyses have reported an increased CVD risk as well as direct healthcare costs associated with HTG despite statin therapy and controlled LDL-C compared to those with TG<150 mg/dL.

In CV outcomes trials, therapies that reduce TG levels and had other favorable effects on classically studied lipid and lipoprotein parameters, such as extended-release niacin and fibrates, did not met their primary CV endpoints to reduce risk when taken with contemporary medical therapy, including statins. Specifically, cardiovascular outcomes trials, ACCORD Lipid, AIM-HIGH, and

HPS2-THRIVE, while not designed to test the effect of lowering TG levels in patients with high TG levels after statin therapy, each failed to demonstrate incremental cardiovascular benefit of adding a second lipid-altering drug (fenofibrate or formulations of niacin), despite raising HDL-C and reducing TG levels, among statin-treated patients with well-controlled LDL-C. As a result, in 2015, the FDA updated both the Trilipix® (a fenofibrate) and extended-release niacin product labeling and removed combination use with statin therapy in mixed dyslipidemia patients as an indication due to a failed outcomes trial. No head-to head, randomized, well-controlled studies have been conducted to compare the clinical effects of VASCEPA with other FDA-approved TG-lowering therapies.

Recent CV outcomes trials and meta-analyses with low and high dose omega-3 fatty acid mixtures containing DHA have not shown substantial benefit in patients receiving contemporary medical therapy, including statins. Due to failed low dose omega-3 CV outcomes trials, the European regulatory authorities have concluded that omega-3 fatty acid medicines (specifically Lovaza®/Omacor®) at a dose of 1-gram per day are not effective in preventing further events for patients who have had a heart attack. The STRENGTH trial of an omega-3 mixture studied at 4-grams per day also failed to demonstrate cardiovascular benefit.

Regulatory Matters

Government Regulation and Regulatory Matters

Any product development activities related to VASCEPA or products that we may develop or acquire in the future will be subject to extensive regulation by various government authorities, including the FDA and comparable regulatory authorities in other countries, which regulate the design, research, clinical and nonclinical development, testing, manufacturing, storage, distribution, import, export, labeling, advertising and marketing of pharmaceutical products. Generally, before a new drug can be sold, considerable data demonstrating its quality, safety and efficacy must be obtained, organized into a format specific to each regulatory authority, submitted for review and approved by the regulatory authority. The data are generated in two distinct development stages: preclinical and clinical. Drugs must be approved by the FDA through the NDA process before they are first marketed in the United States. For new chemical entities, the preclinical development stage generally involves synthesizing the active component, developing the formulation, determining the manufacturing process and controls, as well as carrying out non-human toxicology, pharmacology and drug metabolism studies which support subsequent clinical testing.

The clinical stage of development can generally be divided into Phase 1, Phase 2 and Phase 3 clinical trials. In Phase 1, generally, a small number of healthy volunteers are initially exposed to a single dose and then multiple doses of the product candidate. The primary purpose of these studies is to assess the metabolism, pharmacologic action, side effect tolerability and safety of the drug. Phase 2 trials typically involve studies in disease-affected patients to determine the dose required to produce the desired benefits. At the same time, safety and further pharmacokinetic and pharmacodynamic information is collected. Phase 3 trials generally involve large numbers of patients at multiple sites, in multiple countries and are designed to provide the pivotal data necessary to demonstrate the effectiveness of the product for its intended use and its safety in use, provide an adequate basis for physician labeling and may include comparisons with placebo and/or other comparator treatments. The duration of treatment is often extended to mimic the actual use of a product during marketing.

United States Drug Development

In the United States, the process of obtaining regulatory approvals and the subsequent compliance with appropriate federal, state, local, and foreign statutes and regulations require the expenditure of substantial time and financial resources. Failure to comply with the applicable United States requirements at any time during the product development process, approval process or after approval, may subject an applicant to administrative or judicial sanctions. These sanctions could include the FDA's refusal to approve pending applications, withdrawal of an approval, a clinical hold, warning or untitled letters, product recalls, product seizures, total or partial suspension of production or distribution injunctions, fines, refusals of government contracts, restitution, disgorgement, or civil or criminal penalties. Any agency or judicial enforcement action could have a material adverse effect on us.

Prior to the start of human clinical studies for a new drug in the United States, preclinical laboratory and animal tests are often performed under the FDA's Good Laboratory Practices regulations, or GLP, and an IND is filed with the FDA. Similar filings are required in other countries; however, data requirements and other information needed for a complete submission may differ in other countries. The amount of data that must be supplied in the IND depends on the phase of the study. Phase 1 studies typically require less data than larger Phase 3 studies. A clinical plan must be submitted to the FDA prior to commencement of a clinical trial. If the FDA has concerns about the clinical plan or the safety of the proposed studies, it may suspend or terminate the study at any time. Studies must be conducted in accordance with Good Clinical Practice, or GCP, including the requirement that subjects provide their informed consent, and regular reporting of study progress and any adverse experiences is required. Studies are also subject to review by independent institutional review boards, or IRBs, responsible for overseeing studies at particular sites and protecting human research study subjects. An independent IRB may also suspend or terminate a study once initiated.

United States FDA Review Process

The results of nonclinical studies and clinical trials, together with other information, including manufacturing information and information on the composition of the drug and proposed labeling, are submitted to the United States FDA in an NDA requesting approval to market the drug for one or more specified indications. Each NDA is typically accompanied by a user fee and there is also an annual prescription drug product program fee for human drugs. The FDA reviews an NDA to determine, among other things, whether a drug is safe and effective for its intended use and whether the product is being manufactured in accordance with cGMP requirements to assure and preserve the product's identity, strength, quality and purity. The FDA will conduct a pre-approval inspection of the manufacturing facilities for the new drug and may audit data from clinical trials to ensure compliance with GCP requirements. Additionally, the FDA may refer applications for novel drug products or drug products which present difficult questions of safety or efficacy to an advisory committee, typically a panel that includes clinicians and other experts, for review, evaluation and a recommendation as to whether the application should be approved and under what conditions. The FDA is not bound by the recommendations of an advisory committee, but it considers such recommendations carefully when making decisions.

After the FDA evaluates an NDA, it will issue an approval letter or a complete response letter. An approval letter authorizes commercial marketing of the drug with specific prescribing information for specific indications. A complete response letter indicates that the review cycle of the application is complete and the application will not be approved in its present form, and usually describes all the specific deficiencies in the NDA identified by the FDA. The complete response letter may require additional clinical data and/or additional clinical trial(s), and/or other information. If a complete response letter is issued, the applicant may either resubmit the NDA, addressing all of the deficiencies identified in the letter, withdraw the application, or request a hearing. Even if such data and information is submitted, the FDA may ultimately decide that the NDA does not satisfy the criteria for approval.

Following the approval process of any drug product, the FDA may require post-marketing testing and surveillance to monitor the effects of approved products or it may place conditions on approvals including potential requirements or risk management plans that could restrict the commercial promotion, distribution, prescription or dispensing of products. Product approvals may be withdrawn for non-compliance with regulatory requirements or if problems occur following initial marketing.

Off-label Promotion in the United States

The Federal Food, Drug, and Cosmetic Act, or FDCA, has been interpreted by the FDA and the U.S. government to make it illegal for pharmaceutical companies to promote their FDA-approved products for uses that have not been approved by the FDA. Companies that market drugs for off-label uses or indications have been subject to related costly litigation, criminal penalties and civil liability under the FDCA and the False Claims Act. However, recent case law has called into question the extent to which government in the United States, including FDA, can, and is willing to seek to, prevent truthful and non-misleading speech related to off-label uses of FDA-approved products such as VASCEPA.

In May 2015, we and a group of independent physicians filed a lawsuit against the FDA seeking a federal court declaration that would permit us and our agents to promote to healthcare professionals the use of VASCEPA in the ANCHOR population and promote on the potential of VASCEPA to reduce the risk of cardiovascular disease so long as the promotion is truthful and non-misleading. This use of VASCEPA at issue reflected recognized medical practice but was not approved by the FDA and is thus not covered by the then current FDA-approved labeling for the drug. Promotion of an off-label use has generally been considered by the FDA to be illegal under the FDCA. The lawsuit, captioned *Amarin Pharma, Inc., et al. v. Food & Drug Administration, et al.*, 119 F. Supp. 3d 196 (S.D.N.Y. 2015), was filed in the United States District Court for the Southern District of New York. In the lawsuit, we contended principally that FDA regulations limiting off-label promotion of truthful and non-misleading information are unconstitutional under the freedom of speech clause of the First Amendment to the U.S. Constitution as applied in the case of our proposed promotion of VASCEPA. The physicians in the suit regularly treated patients at risk of cardiovascular disease and, as the complaint contended, have First Amendment rights to receive truthful and non-misleading information from us. The suit was based on the principle that better informed physicians make better treatment decisions for their patients. The FDA opposed this lawsuit but did not dispute the veracity of the subject ANCHOR clinical trial data (the safety data from which data was already and currently is in FDA-approved labeling of VASCEPA) or the peer-reviewed research related to VASCEPA and the potential for cardiovascular risk reduction.

In August 2015, we were granted preliminary relief in this lawsuit through the court's declaratory judgment that confirmed we may engage in truthful and non-misleading speech promoting the off-label use of VASCEPA to healthcare professionals, i.e., to treat patients with persistently high triglycerides, and that such speech may not form the basis of a misbranding action under the FDCA.

In March 2016, we settled this litigation under terms by which the FDA and the U.S. government agreed to be bound by the conclusions from the federal court order that we may engage in truthful and non-misleading speech promoting the off-label use of VASCEPA and that certain statements and disclosures that we proposed to make to healthcare professionals were truthful and non-misleading. As part of the settlement, given, as expressed in the court's opinion, that the dynamic nature of science and medicine is that knowledge is ever-advancing and that a statement that is fair and balanced one day may become incomplete or otherwise

misleading in the future as new studies are done and new data is acquired, we agreed that we bear the responsibility to ensure that our communications regarding off-label use of VASCEPA remain truthful and non-misleading, consistent with the federal court ruling.

If our promotional activities or other operations are found to be in violation of any law or governmental regulation through existing or new interpretations, we may be subject to prolonged litigation, penalties, including civil and criminal penalties, damages, fines and the curtailment or restructuring of our operations. Also, if governmental parties or our competitors view our claims as misleading or false, we could also be subject to liability based on fair competition-based statutes, such as the Lanham Act. Any of such negative circumstances could adversely affect our ability to operate our business and our results of operations.

Foreign Regulation of New Drug Compounds

In addition to regulations in the United States, we may be subject to a variety of regulations in other jurisdictions governing, among other things, clinical trials and any commercial sales and distribution of our products.

Whether or not we obtain FDA approval for a product, we must obtain the requisite approvals from regulatory authorities in all or most foreign countries prior to the commencement of clinical trials or marketing of the product in those countries. Certain countries outside of the United States have a similar process that requires the submission of a clinical trial application, or CTA, much like the IND prior to the commencement of human clinical trials. In Europe, for example, a CTA must be submitted to each country's national health authority and an independent ethics committee, much like the FDA and IRB, respectively. Once the CTA is approved in accordance with a country's requirements, clinical trial development may proceed. Similarly, clinical trials conducted in countries such as Australia, Canada, and New Zealand, require review and approval of clinical trial proposals by an ethics committee, which provides a combined ethical and scientific review process. Most countries in which clinical studies are conducted require the approval of the clinical trial proposals by both the regulatory body and ethics committee.

The requirements and process governing the conduct of clinical trials, product licensing, pricing and reimbursement vary from country to country. In all cases, the clinical trials must be conducted in accordance with GCP, which have their origin in the World Medical Association's Declaration of Helsinki, the applicable regulatory requirements, and guidelines developed by the International Conference on Harmonization, or ICH, for GCP practices in clinical trials.

Post-Marketing Requirements in the United States

Following approval of a new product, a pharmaceutical company generally must engage in numerous specific monitoring and recordkeeping activities, such as routine safety surveillance, and must continue to submit periodic and other reports to the applicable regulatory agencies, including any cases of adverse events and appropriate quality control records. Such reports submitted to the FDA may result in changes to the label and/or other post-marketing requirements or actions, including product withdrawal. These are viable risks once a product is on the market. Additionally, modifications or enhancements to the products or labeling or changes of site of manufacture are often subject to the approval of the FDA and other regulators, which may or may not be received or may result in a lengthy review process.

Prescription drug advertising is subject to federal, state and foreign regulations. In the United States, the FDA regulates prescription drug promotion, including direct-to-consumer advertising. Prescription drug promotional materials must be submitted to the FDA in conjunction with their first use. Any distribution of prescription drug products and pharmaceutical samples must comply with the U.S. Prescription Drug Marketing Act, or the PDMA, a part of the FDCA.

In the United States, once a product is approved, its manufacture is subject to comprehensive and continuing regulation by the FDA. The FDA regulations require that products be manufactured in specific approved facilities and in accordance with pharmaceutical cGMPs, and NDA holders must list their products and register their manufacturing establishments with the FDA. These regulations also impose certain organizational, procedural and documentation requirements with respect to manufacturing and quality assurance activities. NDA holders using contract manufacturers, laboratories or packagers are responsible for the selection and monitoring of qualified firms, and, in certain circumstances, qualified suppliers to these firms. These firms and, where applicable, their suppliers are subject to inspections by the FDA at any time, and the discovery of violative conditions, including failure to conform to cGMPs, could result in enforcement actions that interrupt the operation of any such facilities or the ability to distribute products manufactured, processed or tested by them.

Fraud and Abuse Laws and Data Regulation

In addition to FDA restrictions on marketing of pharmaceutical products, several other types of state and federal laws restrict certain marketing practices in the biopharmaceutical industry. These laws include Anti-Kickback Statutes and false claims statutes.

The federal Anti-Kickback Statute prohibits, among other things, any person or entity knowingly and willfully offering, paying, soliciting, or receiving remuneration, directly or indirectly, in cash or in kind, to induce or in return for a referral or the purchasing,

leasing, ordering, or arranging for or recommending the purchase, lease, or order of any healthcare facility, item or service reimbursable under Medicare, Medicaid, or other federal healthcare programs. This statute has been interpreted to apply to arrangements between pharmaceutical manufacturers on one hand and prescribers, purchasers, and formulary managers on the other. Liability may be established without a person or entity having actual knowledge of the federal anti-kickback statute or specific intent to violate it. In addition, the government may assert that a claim including items or services resulting from a violation of the federal Anti-Kickback Statute constitutes a false or fraudulent claim for purposes of the federal civil False Claims Act. Although there are a number of statutory exemptions and regulatory safe harbors protecting certain activities from prosecution, the exemptions and safe harbors are drawn narrowly, and practices that involve remuneration intended to induce prescribing, purchases, or recommendations may be subject to scrutiny if they do not qualify for an exemption or safe harbor. Our practices may not in all cases meet all of the criteria for safe harbor protection from anti-kickback liability. Moreover, there are no safe harbors for many common practices, such as educational and research grants or patient or product support programs. On November 20, 2020, the United States Department of Health and Human Services, or HHS, Office of Inspector General, or OIG, finalized further modifications to the federal Anti-Kickback Statute. Under the final rules, OIG added safe harbor protections under the Anti-Kickback Statute for certain coordinated care and value-based arrangements among clinicians, providers, and others. These rules, with exceptions, became effective January 19, 2021. We continue to evaluate what effect, if any, these rules will have on our business.

The federal civil and criminal false claim laws, including the civil monetary penalty laws and the civil False Claims Act prohibits, among other things, any person or entity from knowingly presenting, or causing to be presented, a false or fraudulent claim for payment of government funds, or knowingly making or using, or causing to be made or used, a false record or statement material to an obligation to pay money to the government or knowingly concealing, or knowingly and improperly avoiding, decreasing, or concealing an obligation to pay money or transmit properly to the federal government. Manufacturers can be held liable under the False Claims Act even when they do not submit claims directly to government payors if they are deemed to "cause" the submission of false or fraudulent claims. The False Claims Act also permits a private individual acting as a "whistleblower" to bring actions on behalf of the federal government alleging violations of the statute and to share in any monetary recovery. Recently, several pharmaceutical and other healthcare companies have been investigated or faced enforcement actions under the federal civil False Claims Act for a variety of alleged improper marketing activities, including allegations that they caused false claims to be submitted because of the company's marketing of the product for unapproved, and thus allegedly non-reimbursable, uses. Federal enforcement agencies also have showed increased interest in pharmaceutical companies' product and patient assistance programs, including reimbursement and co-pay support services, and a number of investigations into these programs have resulted in significant civil and criminal settlements. Pharmaceutical and other healthcare companies also are subject to other federal false claims laws, including, among others, federal criminal healthcare fraud and false statement statutes that extend to non-government health benefit programs.

The Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, or HITECH, including the Final Omnibus Rule published in January 2013, collectively referred to herein as HIPAA, among other things, imposes criminal and civil liability for knowingly and willfully executing a scheme to defraud any healthcare benefit program, including private third-party payor and knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. In addition, HITECH imposes certain requirements relating to the privacy, security and transmission of individually identifiable health information. It requires certain covered healthcare providers, health plans, and healthcare clearinghouses as well as their respective business associates that perform services for them that involve the use, or disclosure of, individually identifiable health information, relating to the privacy, security and transmission of individually identifiable health information. HITECH also created new tiers of civil monetary penalties, amended HIPAA to make civil and criminal penalties directly applicable to business associates, and gave state attorneys general new authority to file civil actions for damages or injunctions in federal courts to enforce the federal HIPAA laws and seek attorneys' fees and costs associated with pursuing federal civil actions.

The federal Physician Payment Sunshine Act, implemented as the Open Payments Program, requires manufacturers of drugs, devices, biologics, and medical supplies for which payment is available under Medicare, Medicaid or the Children's Health Insurance Program (with certain exceptions) to report annually to the Centers for Medicare and Medicaid Services, or CMS, information related to direct or indirect payments and other transfers of value to physicians (defined to include doctors, dentists, optometrists, podiatrists and chiropractors) and teaching hospitals, as well as ownership and investment interests held in the company by physicians and their immediate family members. Beginning on January 1, 2022, applicable manufacturers also will be required to report information regarding payments and transfers of value provided to physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, and certified nurse-midwives.

Many foreign countries and the majority of states also have statutes or regulations similar to the federal Anti-Kickback Statute and False Claims Act, which may apply to sales or marketing arrangements and claims involving healthcare items or services reimbursed by non-governmental third-party payors, including private insurers. Other states or localities may have laws that require pharmaceutical companies to comply with the pharmaceutical industry's voluntary compliance guidelines and the relevant compliance guidance promulgated by the federal government or otherwise restrict payments that may be made to healthcare providers; restrict the

ability of manufacturers to offer co-pay support to patients for certain prescription drugs; require drug manufacturers to report information related to clinical trials, or information related to payments and other transfers of value to physicians and other healthcare providers or marketing expenditures; relate to insurance fraud in the case of claims involving private insurers; and/or require identification or licensing of sales representatives.

Some state laws require pharmaceutical companies to comply with the pharmaceutical industry's voluntary compliance guidelines and the relevant compliance guidance promulgated by the federal government in addition to requiring manufacturers to report information related to payments to physicians and other healthcare providers, marketing expenditures, and drug pricing information. Certain state and local laws require the registration of pharmaceutical sales representatives. State and foreign laws, including for example the California Consumer Privacy Act, or CCPA, and the European Union General Data Protection Regulation, or GDPR, also govern the privacy and security of health information in some circumstances, many of which differ from each other in significant ways and often are not preempted by HIPAA, thus complicating compliance efforts.

The CCPA creates new individual privacy rights for California consumers (as defined in the law) and places increased privacy and security obligations on entities handling personal data of consumers or households. The CCPA will require covered companies to provide certain disclosures to consumers about its data collection, use and sharing practices, and to provide affected California residents with ways to opt-out of certain sales or transfers of personal information. The CCPA went into effect on January 1, 2020, and the California Attorney General has commenced enforcement against violators as of July 1, 2020. While there is currently an exception for protected health information that is subject to HIPAA and clinical trial regulations, as currently written, the CCPA may impact our business activities.

In the event we decide to conduct clinical trials or continue to enroll subjects in our ongoing or future clinical trials, we may be subject to additional privacy restrictions. The collection, use, storage, disclosure, transfer, or other processing of personal data regarding individuals in the European Economic Area, or EEA, including personal health data, is subject to the GDPR, which became effective on May 25, 2018. The GDPR is wide-ranging in scope and imposes numerous requirements on companies that process personal data, including requirements relating to processing health and other sensitive data, obtaining consent of the individuals to whom the personal data relates, providing information to individuals regarding data processing activities, implementing safeguards to protect the security and confidentiality of personal data, providing notification of data breaches, and taking certain measures when engaging third-party processors. The GDPR also imposes strict rules on the transfer of personal data to countries outside the EU, including the United States, and permits data protection authorities to impose large penalties for violations of the GDPR, including potential fines of up to €20 million or 4% of annual global revenues, whichever is greater. The GDPR also confers a private right of action on data subjects and consumer associations to lodge complaints with supervisory authorities, seek judicial remedies, and obtain compensation for damages resulting from violations of the GDPR. In addition, the GDPR includes restrictions on cross-border data transfers. Compliance with the GDPR will be a rigorous and time-intensive process that may increase our cost of doing business or require us to change our business practices, and despite those efforts, there is a risk that we may be subject to fines and penalties, litigation, and reputational harm in connection with our European activities. Further, the United Kingdom's exit of the EU, often referred to as Brexit, has created uncertainty with regard to data protection regulation in the United Kingdom. Pursuant to Article 50 of the Lisbon Treaty, the United Kingdom ceased being a Member State of the EU on January 31, 2020. A trade deal was entered into between the UK and the EU on December 24, 2020. In addition, the UK is negotiating deals in a number of other areas where cooperation with the EU is required, and there is uncertainty as to which EU regulations and directives will be replicated into UK domestic law, or replaced, going forward. In particular, it is unclear how data transfers to and from the United Kingdom will be regulated following the completion of the withdrawal.

Because of the breadth of these laws and the narrowness of the exceptions or safe harbors, it is possible that some of our business activities could be subject to challenge under one or more of such laws. Such a challenge could have a material adverse effect on our business, financial condition and results of operations. These laws may impact, among other things, our proposed sales, marketing and education programs. In addition, we may be subject to patient privacy regulation by both the federal government and the states in which we conduct our business.

If our promotional activities or other operations are found to be in violation of any of the laws described above or any other governmental regulations or guidance that apply to us through existing or new interpretations, we may be subject to prolonged litigation, penalties, including administrative, civil and criminal penalties, damages, fines, disgorgement, the exclusion from participation in federal and state healthcare programs, individual imprisonment, reputational harm and the curtailment or restructuring of our operations, as well as additional reporting obligations and oversight if we become subject to a corporate integrity agreement or other agreement to resolve allegations of non-compliance with these laws. Also, if governmental parties or our competitors view our claims as misleading or false, we could also be subject to liability based on fair competition-based statutes, such as the Lanham Act. Any of such negative circumstances could adversely affect our ability to operate our business and our results of operations.

United States Healthcare Reform and Legislation

In the United States and foreign jurisdictions, there have been a number of legislative and regulatory changes to the healthcare system that could affect our future results of operations. In particular, there have been and continue to be a number of initiatives at the United States federal and state levels that seek to reduce healthcare costs. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or the MMA, imposed new requirements for the distribution and pricing of prescription drugs for Medicare beneficiaries. Under Part D, Medicare beneficiaries may enroll in prescription drug plans offered by private entities which will provide coverage of outpatient prescription drugs. Part D plans include both stand-alone prescription drug benefit plans and prescription drug coverage as a supplement to Medicare Advantage plans. Unlike Medicare Part A and B, Part D coverage is not standardized. Part D prescription drug plan sponsors are not required to pay for all covered Part D drugs, and each drug plan can develop its own drug formulary that identifies which drugs it will cover and at what tier or level. However, Part D prescription drug formularies must include drugs within each therapeutic category and class of covered Part D drugs, though not necessarily all the drugs in each category or class. Any formulary used by a Part D prescription drug plan must be developed and reviewed by a pharmacy and therapeutic committee. Government payment for some of the costs of prescription drugs may increase demand for our products for which we receive marketing approval. However, any negotiated prices for our products covered by a Part D prescription drug plan will likely be lower than the prices we might otherwise obtain. Moreover, while the MMA applies only to drug benefits for Medicare beneficiaries, private payers often follow Medicare coverage policy and payment limitations in setting their own payment rates. Any reduction in payment that results from the MMA may result in a similar reduction in payments from non-governmental payers. In addition, there has been renewed interest in amending the Social Security Act to allow Medicare to negotiate prices for prescription drugs covered under Medicare Part B. If this were to be enacted by Congress and signed by the President, the prices we obtain for our products covered under Part B could be lower than the prices we might otherwise obtain, and it could exert a similar lowering pressure on payments from non-governmental payers.

The Agency for Healthcare Research and Quality, or AHRQ, established by the MMA and provided additional funding by the American Recovery and Reinvestment Act of 2009, conducts comparative effectiveness research on different treatments for the same illness. Although the results of the comparative effectiveness studies are not intended to mandate coverage policies for public or private payers, it is possible that comparative effectiveness research demonstrating benefits in a competitor's product could adversely affect the sales of our product candidates. If third-party payers do not consider our products to be cost-effective compared to other available therapies, they may not cover our products as a benefit under their plans or, if they do, the level of payment may not be sufficient to allow us to sell our products on a profitable basis.

In March 2010, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, or collectively the ACA, was enacted, which has substantially changed the way healthcare is financed by both governmental and private insurers and has significantly impacted the pharmaceutical industry. Among the provisions of the ACA of greatest importance to the pharmaceutical and biotechnology industry are the following:

- an annual, nondeductible fee on any entity that manufactures or imports certain branded prescription drugs and biologic products, apportioned among these entities according to their market share in certain government healthcare programs, that began in 2011;
- expanded eligibility criteria for Medicaid programs by, among other things, allowing states to offer Medicaid coverage to certain individuals with income at or below 133% of the federal poverty level, thereby potentially increasing a manufacturer's Medicaid rebate liability;
- expanded manufacturers' rebate liability under the Medicaid Drug Rebate Program by increasing the minimum rebate for both branded and generic drugs and revising the definition of "average manufacturer price," or AMP, for calculating and reporting Medicaid drug rebates on outpatient prescription drug prices;
- addressed a new methodology by which rebates owed by manufacturers under the Medicaid Drug Rebate Program are calculated for drugs that are inhaled, infused, instilled, implanted or injected;
- expanded the types of entities eligible for the 340B drug discount program;
- established the Medicare Part D coverage gap discount program by requiring manufacturers to provide a 50% point-of-sale-discount, which was increased to 70% by the Bipartisan Budget Act of 2018 (as of January 1, 2019), off the negotiated price of applicable brand drugs to eligible beneficiaries during their coverage gap period as a condition for the manufacturers' outpatient drugs to be covered under Medicare Part D;
- increases the minimum Medicaid rebates owed by manufacturers under the Medicaid Drug Rebate Program and extends the rebate program to individuals enrolled in Medicaid managed care organization;
- establishes annual fees and taxes on manufacturers of certain branded prescription drugs;
- a licensure framework for follow-on biologic products;

- a new Patient-Centered Outcomes Research Institute to oversee, identify priorities in, and conduct comparative clinical effectiveness research, along with funding for such research; and
- establishment of a Center for Medicare and Medicaid Innovation at the Centers for Medicare & Medicaid Services to test innovative payment and service delivery models to lower Medicare and Medicaid spending, potentially including prescription drug spending that began on January 1, 2011.

Certain provisions of the ACA have yet to be implemented and others have been subject to judicial challenges, as well as efforts to repeal or replace them or to alter their interpretation or implementation. For example, since January 2017, President Trump has signed two Executive Orders and other directives designed to delay the implementation of certain provisions of the ACA. On January 20, 2017, President Trump signed an Executive Order directing federal agencies with authorities and responsibilities under the ACA to waive, defer, grant exemptions from, or delay the implementation of any provision of the ACA that would impose a fiscal burden on states or a cost, fee, tax, penalty or regulatory burden on individuals, healthcare providers, health insurers, or manufacturers of pharmaceuticals or medical devices. On October 13, 2017, President Trump signed an Executive Order terminating the cost-sharing subsidies that reimburse insurers under the ACA. The Trump administration concluded that cost-sharing reduction, or CSR, payments to insurance companies required under the ACA have not received necessary appropriations from Congress and announced that it will discontinue these payments immediately until those appropriations are made. Several state Attorneys General filed suit to stop the administration from terminating the subsidies, but their request for a restraining order was denied by a federal judge in California on October 25, 2017. On August 14, 2020, the U.S. Court of Appeals for the Federal Circuit ruled in two separate cases that the federal government is liable for the full amount of unpaid CSRs for the years preceding and including 2017. For CSR claims made by health insurance companies for years 2018 and later, further litigation will be required to determine the amounts due, if any. Further, on June 14, 2018, the U.S. Court of Appeals for the Federal Circuit ruled that the federal government was not required to pay more than $12.0 billion in ACA risk corridor payments to third-party payors who argued the payments were owed to them. On April 27, 2020, the United States Supreme Court reversed the U.S. Court of Appeals for the Federal Circuit's decision and remanded the case to the U.S. Court of Federal Claims, concluding the government has an obligation to pay these risk corridor payments under the relevant formula. To date, at least $6.0 billion has been paid out to health plans and insurers, and follow-up class action and other litigation is pending. The viability of the ACA marketplace, providers, and potentially our business, are not yet known. In December 2018, CMS published a final rule permitting further collections and payments to and from certain ACA qualified health plans and health insurance issuers under the ACA risk adjustment program in response to the outcome of federal district court litigation regarding the method CMS uses to determine this risk adjustment. Since then, the ACA risk adjustment program payment parameters have been updated annually. CMS also published a final rule to give states greater flexibility, starting in 2020, in setting benchmarks for insurers in the individual and small group marketplaces, which may have the effect of relaxing the essential health benefits required under the ACA for plans sold through such marketplaces.

Concurrently, Congress has considered legislation that would repeal or repeal and replace all or part of the ACA. While Congress has not passed comprehensive repeal legislation, it has enacted laws that modify certain provisions of the ACA such as the Tax Cuts and Jobs Act enacted on December 22, 2017, or the Tax Act, which included a provision that decreased the tax-based shared responsibility payment for individuals who fail to maintain minimum essential coverage under section 5000A of the Internal Revenue Code of 1986, commonly referred to as the "individual mandate," to $0, effective January 1, 2019. On December 14, 2018, a federal district court in Texas ruled the individual mandate is a critical and inseverable feature of the ACA, and therefore, because it was repealed as part of the Tax Act, the remaining provisions of the ACA are invalid as well. On December 18, 2019, the Fifth Circuit U.S. Court of Appeals held that the individual mandate is unconstitutional, and remanded the case to the lower court to reconsider its earlier invalidation of the full ACA. On March 2, 2020, the United States Supreme Court granted the petitions for writs of certiorari to review this case, and held oral arguments on November 10, 2020. The Supreme Court's decision in this case is forthcoming. It is unclear how this decision and other efforts to repeal and replace the ACA will impact the ACA and our business. Pending review, the ACA remains in effect, but it is unclear at this time what effect the latest ruling will have on the status of the ACA. Litigation and legislation over the ACA are likely to continue, with unpredictable and uncertain results. We continue to evaluate the effect that the ACA and its possible repeal and replacement could have on our business.

Further, other legislative changes have been proposed and adopted in the United States since the ACA was enacted. The Bipartisan Budget Act of 2018 among other things, amended the Medicare statute, effective January 1, 2019, to close the coverage gap in most Medicare drug plans, commonly referred to as the "donut hole." On December 20, 2019, President Trump signed into law the Further Consolidated Appropriations Act (H.R. 1865), which repeals the "Cadillac" tax on certain high-cost employer-sponsored insurance plans, the health insurance provider tax based on market share, and the medical device excise tax on non-exempt medical devices. It is impossible to determine whether similar taxes could be instated in the future. In January 2013, President Obama signed into law the American Taxpayer Relief Act of 2012, which, among other things, further reduced Medicare payments to several providers, including hospitals, imaging centers and cancer treatment centers, and increased the statute of limitations period for the government to recover overpayments to providers from three to five years.

It is unclear how the ACA and its implementation, as well as efforts to repeal, replace, or invalidate, the ACA or its implementing regulations, or portions thereof, and other legislative changes adopted since, will affect our business. It is possible that the ACA will continue to exert pressure on pharmaceutical pricing, especially under the Medicare and Medicaid programs, and may also increase our regulatory burdens and operating costs. Additional legislative changes, regulatory changes, and judicial challenges related to the ACA remain possible. We will continue to evaluate the effect that the ACA as well as its possible repeal, replacement, or invalidation, in whole or in part, has on our business.

Pharmaceutical Pricing and Reimbursement

In the United States and markets in other countries, patients who are prescribed treatments for their conditions and providers performing the prescribed services generally rely on third-party payors to reimburse all or part of the associated healthcare costs. Our ability to successfully commercialize our product therefore depends significantly on the availability of adequate financial coverage and reimbursement from third-party payors, including, in the United States, governmental payors such as Medicare and Medicaid, as well as managed care organizations, private health insurers and other organizations. Third-party payors decide which drugs they will pay for and establish reimbursement and copayment levels. Third-party payors are increasingly challenging the prices charged for medicines and examining their cost effectiveness, in addition to their safety and efficacy. We may need to conduct expensive pharmacoeconomic studies in order to demonstrate the cost effectiveness of our products. Even with studies, our products may be considered less safe, less effective or less cost effective than other products, and third-party payors may not provide coverage and reimbursement for our product candidates, in whole or in part. Reimbursement of newly approved products and coverage may be more limited than the purposes for which the medicine is approved by the FDA or comparable foreign regulatory authorities. Product candidates may not be considered medically necessary or cost effective. In the United States, the principal decisions about reimbursement for new medicines are typically made by CMS, an agency within the HHS. CMS decides whether and to what extent a new medicine will be covered and reimbursed under Medicare and private payors tend to follow CMS to a substantial degree.

Outside the United States, ensuring coverage and adequate payment for a product also involves challenges. Pricing of prescription pharmaceuticals is subject to government control in many countries. Pricing negotiations with government authorities can extend well beyond the receipt of regulatory approval for a product and may require a clinical trial that compares the cost-effectiveness of a product to other available therapies. The conduct of such a clinical trial could be expensive and result in delays in commercialization.

In some foreign countries, the proposed pricing for a drug must be approved before it may be lawfully marketed. The requirements governing drug pricing vary widely from country to country. For example, the European Union provides options for its Member States to restrict the range of medicinal products for which their national health insurance systems provide reimbursement and to control the prices of medicinal products for human use. To obtain reimbursement or pricing approval, some of these countries may require the completion of clinical trials that compare the cost effectiveness of a particular product candidate to currently available therapies. A Member State may approve a specific price for the medicinal product or it may instead adopt a system of direct or indirect controls on the profitability of the company placing the medicinal product on the market. There can be no assurance that any country that has price controls or reimbursement limitations for pharmaceutical products will allow favorable reimbursement and pricing arrangements for any of our product candidates. Historically, products launched in the European Union do not follow price structures of the U.S. and generally prices, particularly when for the same drug and the same indication as in the U.S., tend to be significantly lower.

A decision by a third-party payor not to cover a product could reduce physician utilization once the product is approved and have a material adverse effect on sales, results of operations and financial condition. Additionally, a third-party payor's decision to provide coverage for a product does not imply that an adequate reimbursement rate will be approved. Further, one payor's determination to provide coverage for a product does not assure that other payors will also provide coverage and reimbursement for the product, and the level of coverage and reimbursement can differ significantly from payor to payor. In the United States, no uniform policy of coverage and reimbursement for drug products exists among third-party payors. Coverage and reimbursement for drug products can differ significantly from payor to payor. The process for determining whether a third-party payor will provide coverage for a product may be separate from the process for setting the price or reimbursement rate that the payor will pay for the product once coverage is approved.

The containment of healthcare costs has become a priority of federal, state and foreign governments, and the prices of products have been a focus in this effort. Governments have shown significant interest in implementing cost-containment programs, including price controls, restrictions on reimbursement and requirements for substitution of generic products. Adoption of price controls and cost-containment measures, and adoption of more restrictive policies in jurisdictions with existing controls and measures, could further limit a company's revenue generated from the sale of any approved products. Coverage policies and third-party payor reimbursement rates may change at any time. Even if favorable coverage and reimbursement status is attained for one or more products for which a company or its collaborators receive regulatory approval, less favorable coverage policies and reimbursement rates may be implemented in the future.

Political, economic and regulatory influences are subjecting the healthcare industry in the United States to fundamental changes. There have been, and we expect there will continue to be, legislative and regulatory proposals to change the healthcare system in ways that could impact our ability to sell our products profitably. We anticipate that the United States Congress, state legislatures and the private sector will continue to consider and may adopt healthcare policies intended to curb rising healthcare costs. These cost containment measures include: controls on government funded reimbursement for drugs; new or increased requirements to pay prescription drug rebates to government healthcare programs; controls on healthcare providers; challenges to the pricing of drugs or limits or prohibitions on reimbursement for specific products through other means; requirements to try less expensive products or generics before a more expensive branded product; changes in drug importation laws; expansion of use of managed care systems in which healthcare providers contract to provide comprehensive healthcare for a fixed cost per person; and public funding for cost effectiveness research, which may be used by government and private third-party payors to make coverage and payment decisions. Further, federal budgetary concerns could result in the implementation of significant federal spending cuts, including cuts in Medicare and other health related spending in the near term. For example, on August 2, 2011, the Budget Control Act of 2011, among other things, created the Joint Select Committee on Deficit Reduction to recommend to Congress proposals for spending reductions. The Joint Select Committee did not achieve a targeted deficit reduction, which triggered the legislation's automatic reductions. In concert with subsequent legislation, this has resulted in aggregate reductions to Medicare payments to providers of, on average, 2% per fiscal year through 2030 unless Congress takes additional action. Pursuant to the Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act, as well as subsequent legislation, these reductions have been suspended from May 1, 2020 through March 31, 2021 due to the COVID-19 pandemic. Proposed legislation, if passed, would extend this suspension until the end of the pandemic. These cuts reduce reimbursement payments related to our products, which could potentially negatively impact our revenue.

Payors also are increasingly considering new metrics as the basis for reimbursement rates, such as average sales price, average manufacturer price and actual acquisition cost. CMS surveys and publishes retail community pharmacy acquisition cost information in the form of National Average Drug Acquisition Cost files to provide state Medicaid agencies with a basis of comparison for their own reimbursement and pricing methodologies and rates. It is difficult to project the impact of these evolving reimbursement mechanics on the willingness of payors to cover our products. We participate in the Medicaid Drug Rebate program, the 340B drug pricing program, and the U.S. Department of Veterans Affairs, or VA, Federal Supply Schedule, or FSS, pricing program. Under the Medicaid Drug Rebate program, we are required to pay a rebate to each state Medicaid program for our covered outpatient drugs that are dispensed to Medicaid beneficiaries and paid for by a state Medicaid program as a condition of having federal funds being made available to the states for our drugs under Medicaid and Part B of the Medicare program.

Federal law requires that any company that participates in the Medicaid Drug Rebate program also participate in the 340B drug pricing program in order for federal funds to be available for the manufacturer's drugs under Medicaid and Medicare Part B. The 340B program requires participating manufacturers to agree to charge statutorily defined covered entities no more than the 340B "ceiling price" for the manufacturer's covered outpatient drugs. These 340B covered entities include a variety of community health clinics and other entities that receive health services grants from the Public Health Service, as well as hospitals that serve a disproportionate share of low-income patients. The 340B ceiling price is calculated using a statutory formula, which is based on the average manufacturer price and Medicaid rebate amount for the covered outpatient drug as calculated under the Medicaid Drug Rebate program. There have been several changes to the 340B drug pricing program, which imposes ceilings on prices that drug manufacturers can charge for medications sold to certain health care facilities. On December 27, 2018, the District Court for the District of Columbia invalidated a reimbursement formula change under the 340B drug pricing program, and CMS subsequently altered the FY's 2019 and 2018 reimbursement formula on specified covered outpatient drugs, or SCODs. The court ruled this change was not an "adjustment" which was within the Secretary's discretion to make but was instead a fundamental change in the reimbursement calculation. However, most recently, on July 31, 2020, the U.S. Court of Appeals for the District of Columbia Circuit overturned the district court's decision and found that the changes were within the Secretary's authority. On September 14, 2020, the plaintiffs-appellees filed a Petition for Rehearing En Banc, i.e., before the full court, but was denied on October 16, 2020. It is unclear how these developments could affect covered hospitals who might purchase our future products and affect the rates we may charge such facilities for our approved products in the future, if any.

In order to be eligible to have our products paid for with federal funds under the Medicaid and Medicare Part B programs and purchased by certain federal agencies and grantees, we participate in the VA/FSS pricing program. Under this program, we are obligated to make our products available for procurement on an FSS contract and charge a price to four federal agencies - the VA, U.S. Department of Defense, Public Health Service and U.S. Coast Guard - that is no higher than the statutory Federal Ceiling Price, or FCP. The FCP is based on the non-federal average manufacturer price, or Non-FAMP, which we calculate and report to the VA on a quarterly and annual basis. We also participate in the Tricare Retail Pharmacy program, under which we pay quarterly rebates on utilization of innovator products that are dispensed through the Tricare Retail Pharmacy network to Tricare beneficiaries. The rebates are calculated as the difference between the annual Non-FAMP and FCP.

The Medicaid Drug Rebate program, 340B program, and VA/FSS pricing program, and the risks relating to price reporting and other obligations under these programs, are further discussed under the heading "*If we fail to comply with our reporting and payment obligations under the Medicaid Drug Rebate program or other governmental pricing programs, we could be subject to additional*

reimbursement requirements, penalties, sanctions and fines, which could have a material adverse effect on our business, financial condition, results of operations and growth prospects" in Part I, Item 1A of this Annual Report on Form 10-K.

Recently, there have been several U.S. Congressional inquiries and proposed and adopted federal and state legislation designed to, among other things, bring more transparency to drug pricing, reduce the cost of prescription drugs under Medicare, review the relationship between pricing and manufacturer patient programs, and reform government program reimbursement methodologies for drugs. The Trump administration's budget proposal for fiscal year 2021 included a $135.0 billion allowance to support legislative proposals seeking to reduce drug prices, increase competition, lower out-of-pocket drug costs for patients, and increase patient access to lower-cost generic and biosimilar drugs. On March 10, 2020, the Trump administration sent "principles" for drug pricing to Congress, calling for legislation that would, among other things, cap Medicare Part D beneficiary out-of-pocket pharmacy expenses, provide an option to cap Medicare Part D beneficiary monthly out-of-pocket expenses, and place limits on pharmaceutical price increases. Additionally, the Trump administration released a "Blueprint" to lower drug prices and reduce out of pocket costs of drugs that contains additional proposals to increase drug manufacturer competition, increase the negotiating power of certain federal healthcare programs, incentivize manufacturers to lower the list price of their products, and reduce the out of pocket costs of drug products paid by consumers. HHS has already started the process of soliciting feedback on some of these measures and, at the same time, is immediately implementing others under its existing authority. For example, in May 2019, CMS issued a final rule to allow Medicare Advantage Plans the option of using step therapy for Part B drugs beginning January 1, 2020. Further, the Trump administration previously released a plan to lower drug prices and reduce out of pocket costs of drugs that contained proposals to increase drug manufacturer competition, increase the negotiating power of certain federal healthcare programs, incentivize manufacturers to lower the list price of their products, and reduce the out-of-pocket costs of drug products paid by consumers. On July 24, 2020 and September 11, 2020, President Trump announced several executive orders related to prescription drug pricing that seek to implement several of the administration's proposals. The FDA also released a final rule on September 24, 2020, which went into effect on November 30, 2020, providing guidance for states to build and submit importation plans for drugs from Canada. Further, on November 20, 2020, HHS finalized a regulation removing safe harbor protection for price reductions from pharmaceutical manufacturers to plan sponsors under Part D, either directly or through pharmacy benefit managers, unless the price reduction is required by law. The rule also creates a new safe harbor for price reductions reflected at the point-of-sale, as well as a safe harbor for certain fixed fee arrangements between pharmacy benefit managers and manufacturers. It is unclear whether the Biden administration will challenge, reverse, revoke or otherwise modify these executive, legislative and administrative actions.

Individual states in the United States have also increasingly passed legislation and implemented regulations designed to control pharmaceutical product pricing, including price or patient reimbursement constraints, discounts, restrictions on certain product access and marketing cost disclosure and transparency measures, and, in some cases, designed to encourage importation from other countries and bulk purchasing.

FDA Marketing Exclusivity and Generic Competition

The FDCA, as amended by the Drug Price Competition and Patent Term Restoration Act of 1984, as amended, or the Hatch-Waxman Amendments, provides for market exclusivity provisions that can help protect the exclusivity of new drugs by delaying the acceptance and final approval of certain competitive drug applications. NCE marketing exclusivity precludes approval during the five-year exclusivity period of certain 505(b)(2) applications and abbreviated new drug applications, or ANDAs, submitted by another company for another version of the drug. The timelines and conditions under the ANDA process that permit the start of patent litigation and allow the FDA to approve generic versions of brand name drugs like VASCEPA differ based on whether a drug receives three-year, or five-year, NCE marketing exclusivity.

NCE marketing exclusivity precludes approval during the five-year exclusivity period of certain 505(b)(2) applications and ANDAs submitted by another company for another version of the drug. However, an application may be submitted after four years if it contains a certification of patent invalidity or non-infringement. In such case, the pioneer drug company is afforded the benefit of a 30-month stay against the launch of such a competitive product that extends from the end of the five-year exclusivity period. A pioneer company could also be afforded extensions to the stay under applicable regulations, including a six-month pediatric exclusivity extension or a judicial extension if applicable requirements are met. In May 2016, after litigation, FDA determined that VASCEPA was entitled to NCE marketing exclusivity. The related 30-month stay expired on January 26, 2020, seven-and-a-half years after FDA approval of VASCEPA.

A three-year period of exclusivity under the Hatch-Waxman Amendments is generally granted for a drug product that contains an active moiety that has been previously approved. For example, three-year exclusivity may be granted when the application contains reports of new clinical investigations (other than bioavailability studies) conducted by the sponsor that were essential to approval of the application. Accordingly, we expect to receive three-year exclusivity in connection with any future regulatory approvals of VASCEPA. For example, we received such three-year regulatory exclusivity in connection with the recent approval based on the REDUCE-IT outcomes study results. Such three-year exclusivity protection precludes the FDA from approving a marketing application for an ANDA, a product candidate that the FDA views as having the same conditions of approval as VASCEPA (for

example, the same indication and/or other conditions of use), or a 505(b)(2) NDA submitted to the FDA with VASCEPA as the reference product, for a period of three years from the date of FDA approval. The FDA may accept and commence review of such applications during the three-year exclusivity period. Such three-year exclusivity grant does not prevent a company from challenging the validity of patents at any time, subject to any prior four-year period pending from a grant of five-year exclusivity. This three-year form of exclusivity may also not prevent the FDA from approving an NDA that relies only on its own data to support the change or innovation.

Regulatory exclusivity is in addition to exclusivity afforded by issued patents related to VASCEPA.

Other Regulatory Matters

Manufacturing, sales, promotion, importation, and other activities related to approved products are also subject to regulation by numerous regulatory authorities, including, in the United States, the FDA, the Centers for Medicare & Medicaid Services, other divisions of the Department of Health and Human Services, the Drug Enforcement Administration, the Consumer Product Safety Commission, the Federal Trade Commission, the Occupational Safety & Health Administration, the Environmental Protection Agency, and state and local governments. Sales, marketing and scientific/educational programs must comply with the Food, Drug, and Cosmetic Act, the Anti-Kickback Statute, and the False Claims Act and similar state laws. Pricing and rebate programs must comply with the Medicaid rebate requirements of the U.S. Omnibus Budget Reconciliation Act of 1990. If products are made available to authorized users of the Federal Supply Schedule of the General Services Administration, additional laws and requirements apply. Products must meet applicable child-resistant packaging requirements under the U.S. Poison Prevention Packaging Act. The distribution of pharmaceutical products is subject to additional requirements and regulations, including extensive record-keeping, licensing, storage and security requirements intended to prevent the unauthorized sale of pharmaceutical products.

The failure to comply with regulatory requirements subjects firms to possible legal or regulatory action. Depending on the circumstances, failure to meet applicable regulatory requirements can result in criminal prosecution, fines or other penalties, injunctions, recall or seizure of products, total or partial suspension of production, denial or withdrawal of product approvals, or refusal to allow a firm to enter into supply contracts, including government contracts. In addition, even if a firm complies with FDA and other requirements, new information regarding the safety or effectiveness of a product could lead the FDA to modify or withdraw a product approval. Prohibitions or restrictions on sales or withdrawal of future products marketed by us could materially affect our business in an adverse way.

Changes in regulations or statutes or the interpretation of existing regulations could impact our business in the future by requiring, for example: (i) changes to our manufacturing arrangements; (ii) additions or modifications to product labeling; (iii) the recall or discontinuation of our products; or (iv) additional record-keeping requirements. If any such changes were to be imposed, they could adversely affect the operation of our business.

Patents, Proprietary Technology, Trade Secrets

Our success depends in part on our ability to obtain and maintain intellectual property protection for our drug candidates, technology and know-how, and to operate without infringing the proprietary rights of others. Our ability to successfully implement our business plan and to protect our products with our intellectual property will depend in large part on our ability to:

- obtain, defend and maintain patent protection and market exclusivity for our current and future products;
- preserve any trade secrets relating to our current and future products;
- acquire patented or patentable products and technologies; and
- operate without infringing the proprietary rights of third parties.

We have prosecuted, and are currently prosecuting, multiple patent applications to protect the intellectual property developed during the VASCEPA development program. As of the date of this report, we had 110 patent applications in the United States that have been either issued or allowed and more than 30 additional patent applications are pending in the United States. Such 110 allowed and issued applications include the following:

- one issued U.S. patent directed to a pharmaceutical composition of VASCEPA in a capsule that expires in 2030;
- one issued U.S. patent covering a composition containing highly pure EPA that expires in 2021;
- 53 U.S. patents covering or related to the use of VASCEPA in either the MARINE or ANCHOR populations that have terms that expire in 2030 or later;
- 23 U.S. patents covering or related to the use of VASCEPA in the REDUCE-IT population with terms expiring in 2033 or later;

- two additional US patents directed to a pharmaceutical composition comprised of free fatty acids with a term that expires in 2030;
- four additional patents related to the use of a pharmaceutical composition comprised of free fatty acids to treat the ANCHOR patient population with a term that expires in 2030 or later;
- two additional patents related to the use of a pharmaceutical composition comprised of free fatty acids to treat the MARINE patient population with a term that expires in 2030;
- three additional patents related to the use of a pharmaceutical composition comprised of free fatty acids to treat the REDUCE-IT population expiring 2033;
- four additional patents related to a pharmaceutical composition comprised of free fatty acids and uses thereof to treat both the MARINE and ANCHOR patient populations with a term that expires in 2030;
- one additional patent related to the use of a pharmaceutical composition comprised of re-esterified EPA triglyceride to treat the REDUCE-IT population expiring 2033;
- four additional patents related to a formulation of EPA/DHA and uses thereof with a term that expires in 2030;
- two additional patents related to the use of VASCEPA to treat obesity with a term that expires in 2034;
- one additional patent related to the use of VASCEPA to treat prostate cancer with a term that expires in 2037;
- four additional patents covering a pharmaceutical composition comprised of EPA and a hydroxyl compound with a term that expires in 2034; and
- five additional patents covering a new combination therapy comprised of EPA and another drug.

A Notice of Allowance is issued after the USPTO makes a determination that a patent can be granted from an application. A Notice of Allowance does not afford patent protection until the underlying patent is issued by the USPTO. No assurance can be given that applications with issued notices of allowance will be issued as patents or that any of our pending patent applications will issue as patents. No assurance can be given that, if and when issued, our patents will prevent competitors from competing with VASCEPA. For example, we may choose to not assert all issued patents in patent litigation and patents or claims within patents may be determined to be invalid.

We are the owner of the above-listed patents. We are also the exclusive licensee of certain patents owned by others covering products in development. To secure our debt under our outstanding royalty-like instrument, we had granted the holders of such instrument a security interest in our VASCEPA-related patents.

On March 30, 2020, the Nevada Court, ruled in favor of two generic companies in our patent litigation related to ANDAs that sought FDA approval for sale of generic versions of VASCEPA. On May 22, 2020 and August 10, 2020, the two generic companies, Hikma and Dr. Reddy's, respectively, received FDA approval to market its generic versions of VASCEPA for the original indication of VASCEPA as an adjunct to diet to reduce TG levels in adult patients with severe (≥500 mg/dL) hypertriglyceridemia. On September 3, 2020, the Federal Circuit upheld the March ruling by the Nevada Court in favor of the two generics companies. On October 2, 2020, we filed a combined petition for panel rehearing or rehearing en banc. On November 4, 2020, our rehearing and en banc petitions were denied. On February 11, 2021, we filed a petition for a writ of certiorari with the United States Supreme Court to ask the Court to hear our appeal in this litigation.

In November 2020, Hikma launched its generic version of VASCEPA on a limited scale. On November 30, 2020 we filed a patent infringement lawsuit against Hikma for making, selling, offering to sell and importing generic icosapent ethyl capsules in and into the United States in a manner that we allege has induced the infringement of patents covering the use of VASCEPA to reduce specified cardiovascular risk. On January 25, 2021, we expanded the scope of this patent infringement lawsuit to include a health care insurance provider, Health Net, LLC.

Although, to date, no generics other than Hikma have been launched, in addition to the ANDAs approved for Hikma and Dr. Reddy's, on September 11, 2020, Teva's ANDA was approved by the FDA. Apotex has applied for ANDA approval such application, based on public records, has not yet been approved. We intend to vigorously pursue these ongoing litigation matters, but cannot predict the outcomes or the impact on our business.

We are also pursuing patent applications related to VASCEPA in multiple jurisdictions outside the United States. Geographies outside the United States in which VASCEPA is sold and under regulatory review are not subject to the U.S. patent litigation and judgment. No litigation involving potential generic versions of VASCEPA is pending outside the United States. VASCEPA is also currently available by prescription in Canada, Lebanon and the United Arab Emirates. In Canada, VASCEPA has the benefit of eight years of data protection afforded through Health Canada (until the end of 2027), in addition to separate patent protection with

expiration dates that could extend into 2039. We are pursuing additional regulatory approvals for VASCEPA in Europe, China and the Middle East. In China and the Middle East, we are pursuing such regulatory approvals and subsequent commercialization of VASCEPA with commercial partners. Ten years of market protection is anticipated to be granted in the EU as part of EC approval of the pending application. Furthermore, patent protection in Europe includes:

- One allowed patent related to the use of a pharmaceutical composition comprised of 4g of 96% EPA ethyl ester to treat the REDUCE-IT population expiring 2033.

In addition, pending patent applications in Europe have the potential to extend exclusivity into 2039.

We may be dependent in some cases upon third-party licensors to pursue filing, prosecution and maintenance of patent rights or applications owned or controlled by those parties, including, for example, under our collaboration with Mochida. It is possible that third parties will obtain patents or other proprietary rights that might be necessary or useful to us. In cases where third parties are first to invent a particular product or technology, or first to file after various provisions of the America Invents Act of 2011 went into effect on March 16, 2013, it is possible that those parties will obtain patents that will be sufficiently broad so as to prevent us from utilizing such technology or commercializing our current and future products.

Although we intend to make reasonable efforts to protect our current and future intellectual property rights and to ensure that any proprietary technology we acquire or develop does not infringe on the rights of other parties, we may not be able to ascertain the existence of all potentially conflicting claims. Therefore, there is a risk that third parties may make claims of infringement against our current or future products or technologies. In addition, third parties may be able to obtain patents that prevent the sale of our current or future products or require us to obtain a license and pay significant fees or royalties in order to continue selling such products.

We may in the future discover the existence of products that infringe patents that we own or that have been licensed to us. If we were to initiate legal proceedings against a third party to stop such an infringement, such proceedings could be costly and time consuming, regardless of the outcome. No assurances can be given that we would prevail, and it is possible that, during such a proceeding, our patent rights could be held to be invalid, unenforceable or both. Although we intend to protect our trade secrets and proprietary know-how through confidentiality agreements with our manufacturers, employees and consultants, we may not be able to prevent parties subject to such confidentiality agreements from breaching these agreements or third parties from independently developing or learning of our trade secrets.

We anticipate that competitors may from time to time oppose our efforts to obtain patent protection for new technologies or to submit patented technologies for regulatory approvals. Competitors may seek to oppose our patent applications to delay the approval process or to challenge our granted patents, for example, by requesting a reexamination of our patent at the USPTO, or by filing an opposition in a foreign patent office, even if the opposition or challenge has little or no merit. For example, one of our patents was revoked in an opposition proceeding in Europe due to a determination of improper claim amendments under a provision of law not applicable in the United States. Such proceedings are generally highly technical, expensive, and time consuming, and there can be no assurance that such a challenge would not result in the narrowing or complete revocation of any patent of ours that was so challenged.

Human Capital Management

As of December 31, 2020, we had approximately 1,000 full-time employees located in five countries. Attracting, developing and retaining key scientific, technical, research, marketing, sales and other personnel is critical to our ability to implement and execute our business plan and is key to the success of the business. Our ability to recruit and retain such talent depends on a number of factors, including compensation and benefits, talent development, career opportunities and work environment.

Diversity and Inclusion

We believe that a diverse workforce makes us better and is critical to our success. In our hiring of prospective candidates, we give priority to attitude, intelligence, competency for the position and assessment of what they can contribute to our company. We promote employees based on merit with emphasis on accompliments over effort. In our hiring, promotion, compensation, retention and other employment practices, we regularly evaluate whether women and minority popuations are being treated equally. We seek ways to continually improve in this area. While we acknowledge and support the benefits of diversity, individual hiring and promotion decisions are made irrespective of personal characteristics such as race, disability, gender, sexual orientation, religion, or age.

	2020 Workforce Diversity Representation	
	Gender	**Race**
Executive	24%	14%
Management	42%	32%
Sales Professionals and Other Associates	62%	37%

In the above table, executive is defined as positions of vice president and above. Management is defined as positions of director, manager or equivalent roles.

Employee Development & Engagement

We believe in a direct management-employee engagement model by which managers and employees maintain a regular dialogue about working conditions, compensation, compliance, safety and advancement opportunities. We communicate frequently and transparently with our employees through a variety of communication methods, including written communications and town hall meetings. We believe these engagement efforts keep our employees informed about our strategy, purpose and priorities, which is consistent with our core values of integrity, operational excellence, collaboration and commitment to quality and we believe this engagement motivates our employees to do their best work.

Compensation and Benefits

We are committed to rewarding, supporting, and developing our employees who make it possible to deliver on our strategy. To that end, we offer a comprehensive rewards program aimed at the varying health and financial needs of our employees. Our program includes market-competitive salaries and wages, bonuses and broad-based stock grants, healthcare benefits, retirement plans with employer matching provisions, paid time off and family leave and a strong commitment to corporate wellness. We utilize independent consultants to help us ensure that our compensation and benefits are competitive with market practices and compliant with laws and regulations in the various geographies in which we operate.

COVID-19

Very high in our priorities during the COVID-19 pandemic is the health and safety of our employees, their families, and the community. We attempt to balance this very high priority with the high importance of the work we are doing to reduce the incidence of at-risk patients having strokes, heart attacks and other major adverse cardiovascular events, the prevalence of which are high, while also evaluating whether our lead drug, VASCEPA, can be used to lower the rate of COVID-19 infections or help mitigate the symptoms of COVID-19. On March 15, 2020, we suspended field based, face-to-face interactions with healthcare providers and moved to remote work for our office-based employees. We were one of the first pharmaceutical companies to announce such an action, which was taken to promote safety. Beginning in June 2020, on a limited basis, we resumed field based, face-to-face interactions in a manner consistent with government guidelines for our field force. During the late part of the summer, substantially all of our field force personnel were able to resume face-to-face customer interactions in a manner consistent with guidelines from local, state and government health officials in the United States. In the fourth quarter of 2020, the impact of COVID-19 worsened in much of the United States, with some physicians again limiting access to face-to-face interactions with our field force personnel. We continue to limit the number of employees in our office at one time. The vast majority of our employees are paid based on fixed salaries and their compensation has not been reduced as a result of COVID-19. For hourly employees, we have been flexible in ensuring that, when necessary, they are able to work remotely to avoid significant reduction, if any, in their hours and level of compensation. We

have not had any mass layoffs of employees. While we have experienced modest employee turnover, the turnover level is generally consistent with the pre-COVID-19 levels. When employees have departed, as a result of COVID-19 we have sometimes elected to move slower in replacing such position than might occur in a more robust non-COVID-19 impacted environment. We believe that the overall morale of our employees is positive despite the challenges associated with COVID-19.

Organizational Structure

At February 19, 2021, we had the following subsidiaries:

Subsidiary Name	Country of Incorporation or Registration	Proportion of Ownership Interest and Voting Power Held
Amarin Pharmaceuticals Ireland Limited	Ireland	100%
Amarin Pharma, Inc.	United States	100%
Ester Neurosciences Limited	Israel	100%
Amarin Switzerland GmbH	Switzerland	100%
Amarin Germany GmbH	Germany	100%
Amarin France SAS	France	100%
Amarin UK Limited	United Kingdom	100%
Amarin Italy S.r.l.	Italy	100%

As of the date of this Annual Report on Form 10-K, our principal operating activities were being conducted by Amarin Corporation plc, together with Amarin Pharmaceuticals Ireland Limited and Amarin Pharma, Inc., with little to no operating activity being conducted by the European subsidiaries or Ester Neurosciences Limited. Corsicanto II DAC was liquidated in April 2020 and Amarin Neuroscience Limited was liquidated in January 2021.

Available Information

Our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to reports filed pursuant to Sections 13(a) and 15(d) of the Securities Exchange Act of 1934, as amended, are made available free of charge on or through our website at www.amarincorp.com as soon as reasonably practicable after such reports are filed with, or furnished to, the Securities and Exchange Commission, or SEC. The SEC also maintains a website, *www.sec.gov*, that contains reports and other information regarding issuers that file electronically with the SEC. We are not, however, including the information contained on our website, or information that may be accessed through links on our website, as part of, or incorporating such information by reference into, this Annual Report on Form 10-K.

Financial Information

The financial information required under this Item 1 is incorporated herein by reference to Item 8 of this Annual Report on Form 10-K.

Item 1A. *Risk Factors*

This Annual Report on Form 10-K contains forward-looking information based on our current expectations. Because our actual results may differ materially from any forward-looking statements that we make or that are made on our behalf, this section includes a discussion of important factors that could affect our actual future results, including, but not limited to, our ability to successfully commercialize VASCEPA, our capital resources, the progress and timing of our clinical programs, the safety and efficacy of our product candidates, risks associated with regulatory filings, the potential clinical benefits and market potential of our product candidates, commercial market estimates, future development efforts, patent protection, effects of healthcare reform, reliance on third parties, effects of tax reform, and other risks set forth below.

Summary Risk Factors

Our business is subject to numerous risks and uncertainties that you should be aware of in evaluating our business. These risks include, but are not limited to, the following:

- We are substantially dependent upon VASCEPA® (icosapent ethyl), its commercialization in the United States and its development and commercialization in Europe and other major markets. In the United States, VASCEPA competes with a

generic version of VASCEPA and we could experience increased generic competition in the near term and in Europe VAZKEPA is not currently approved for sale by applicable regulatory authorities.

- As a result of the decision in favor of the two generic drug companies in connection with our ANDA patent trial, which ruling was upheld on appeal by a Federal Circuit panel, a generic version of VASCEPA has launched in the United States, and we could face further generic competition in the near term and our revenues and results of operations could be materially and adversely affected.
- Factors outside of our control make it more difficult for VASCEPA to achieve a level of market acceptance by physicians, patients, healthcare payors and others in the medical community necessary to meet expectations for commercial success.
- The scale and scope of the coronavirus, or COVID-19, pandemic is uncertain and poses a significant threat to public health and infrastructure throughout the world, which could have a negative impact on our business.
- Our current and planned commercialization efforts may not be successful in increasing sales of VASCEPA in the United States and developing sales internationally.
- Our promotion of VASCEPA is subject to regulatory scrutiny and associated risk.
- We may not be able to compete effectively against our competitors' pharmaceutical products.
- VASCEPA is a prescription-only omega-3 fatty acid product. Omega-3 fatty acids are also marketed by other companies as non-prescription dietary supplements. As a result, VASCEPA is subject to non-prescription competition and consumer substitution.
- The commercial value to us of sales of VASCEPA outside the United States may be smaller than we anticipate, including adequacy of product reimbursement which can vary from country to country resulting in potential patient access restrictions.
- Our supply of product for the commercial market and clinical trials is dependent upon relationships with third-party manufacturers and suppliers.
- Our dependence on third parties in the distribution channel from our manufacturers to patients subject us to risks that limit our profitability and could limit our ability to supply VASCEPA to large market segments.
- Our commercialization of VASCEPA outside the United States is substantially dependent on third parties and other circumstances outside our control.
- We are dependent on patents, proprietary rights and confidentiality to protect the commercial potential of VASCEPA.
- Our issued patents may not prevent competitors from competing with VASCEPA, even if we seek to enforce our patent rights.
- There can be no assurance that any of our pending patent applications relating to VASCEPA or its use will issue as patents.

The summary risk factors described above should be read together with the text of the full risk factors below and in the other information set forth in this Annual Report on Form 10-K, including our consolidated financial statements and the related notes, as well as in other documents that we file with the SEC. If any such risks and uncertainties actually occur, our business, prospects, financial condition and results of operations could be materially and adversely affected. The risks summarized above or described in full below are not the only risks that we face. Additional risks and uncertainties not currently known to us, or that we currently deem to be immaterial may also materially adversely affect our business, prospects, financial condition and results of operations.

Risks Related to the Commercialization and Development of VASCEPA

We are substantially dependent upon VASCEPA, its commercialization in the United States and its development and commercialization in Europe and other major markets. In the United States, VASCEPA competes with a generic version of VASCEPA and we could experience increased generic competition in the near term and in Europe VASCEPA is not currently approved for sale by applicable regulatory authorities.

The success of our company depends on our ability to successfully commercialize our only product, VASCEPA® (icosapent ethyl) capsules, in major markets globally. Much of our near-term financial results and value as a company had depended and currently depends on our ability to execute our development and commercial strategy for VASCEPA in the United States. A generic version of VASCEPA launched in the United States in November 2020, and VASCEPA could face even more competition from generic companies in the United States in the near term in light of the patent litigation rulings against us in this territory. Sales of generic versions of VASCEPA could have a material and adverse impact on our revenues and results of operations.

We continue our development efforts to support regulatory approvals and launch of VASCEPA in major markets outside the United States. Our expansion and development of VASCEPA outside the United States is generally not subject to the adverse patent ruling in the United States. Development outside the United States is primarily based on the second indication approval for VASCEPA in the United States, use of the drug in the reduction of cardiovascular risk in select high-risk patients, which we believe has significantly more value potential. We are currently developing VASCEPA on our own in Europe for the use of the drug in the reduction of cardiovascular risk in select high-risk patients and are exploring possible strategic collaborations in smaller markets within Europe and in other major markets. We currently have multiple partners for the development and commercialization of VASCEPA in select geographies and intend to consider potential additional partners to commercialize VASCEPA in other parts of the world. For example, we have strategic collaborations for the development and commercialization of VASCEPA in Canada, the Middle East and Greater China. However, we cannot make any guarantees as to the success of these efforts, and if commercialization plans for VASCEPA do not meet expectations in major markets such as the United States and Europe, our business and prospects could be materially and adversely affected.

The development and commercial time cycle for VASCEPA or other products that we may develop from our research and development efforts could result in delays in our ability to achieve commercial success. For example, it took over a decade of preceding product development before we announced, in January 2021, a positive recommendation from a regulatory panel advising the European Medicines Agency toward anticipated approval by the European Commission in April 2021 for icosapent ethyl, under the brand name VAZKEPA® (brand name VASCEPA in the United States and hereafter collectively referred to as VASCEPA) as a treatment to reduce the risk of cardiovascular events in select high-risk patients.

Likewise, if we seek to diversify our development programs or product offerings through licensing or acquisitions, such transactions are also time-consuming, may be dilutive to existing shareholdings, and can be disruptive to operations, and may not be available on favorable terms, or at all. These dynamics can restrict our ability to respond rapidly to adverse business conditions for VASCEPA. If development of, or demand for, VASCEPA does not meet expectations, we may not have the ability to effectively shift our resources to the development of alternative products, or do so in a timely manner, without suffering material adverse effects on our business. As a result, the lack of alternative markets and products we develop could constrain our ability to generate revenues and achieve profitability.

As a result of the decision in favor of the two generic drug companies in connection with our ANDA patent trial, which ruling was upheld on appeal by a Federal Circuit panel, a generic version of VASCEPA has launched in the United States, and we could face further generic competition in the near term and our revenues and results of operations could be materially and adversely affected.

We received paragraph IV certification notices from certain companies contending to varying degrees that certain of our patents are invalid, unenforceable and/or will not be infringed by the manufacture, use, sale or offer for sale of a generic form of VASCEPA as described in those companies' ANDAs. Following receipt of the paragraph IV certifications, beginning in late 2017 we were involved in litigation against these companies, including Dr. Reddy's Laboratories, Inc., or Dr. Reddy's or DRL, and Hikma Pharmaceuticals USA Inc., or Hikma, (formerly known as West-Ward) and certain of their affiliates, or the Defendants, in the U.S. District Court for the District of Nevada, or the Nevada Court. In these lawsuits, we sought, among other remedies, an order enjoining each Defendant from marketing generic versions of VASCEPA before the last to expire of the asserted patents in 2030.

On March 30, 2020, following conclusion of a trial in late January 2020, the Nevada Court issued its ruling in favor of the Defendants. On May 22, 2020 and August 10, 2020, Hikma and Dr. Reddy's, respectively, received its FDA approval to market its generic versions of VASCEPA. On September 3, 2020, the U.S. Court of Appeals for the Federal Circuit, or the Federal Circuit, upheld the March ruling by the Nevada Court in favor of the two generic companies. On October 2, 2020, we filed a combined petition for panel rehearing or rehearing en banc. On November 4, 2020, our rehearing and en banc petitions were denied. The mandate of the court was issued on November 12, 2020. On February 11, 2021, we filed a petition for a writ of certiorari with the United States Supreme Court to ask the Court to hear our appeal in this litigation.

In November 2020, Hikma launched its generic version of VASCEPA on a limited scale. On November 30, 2020 we filed a patent infringement lawsuit against Hikma affiliate for making, selling, offering to sell and importing generic icosapent ethyl capsules in and into the United States in a manner that we allege has induced the infringement of patents covering the use of VASCEPA to reduce specified cardiovascular risk. On January 25, 2021 we expanded the scope of this patent infringement lawsuit to include a health care insurance provider, Health Net, LLC.

Although, to date, no generics other than Hikma have been launched, in addition to ANDAs approved for Hikma and Dr. Reddy's, on September 11, 2020, Teva Pharmaceuticals USA, Inc's., or Teva's, ANDA was approved by the FDA. Apotex Inc., or Apotex, has applied for ANDA approval such application, based on public records, has not yet been approved. We intend to vigorously pursue these ongoing litigation matters, but cannot predict the outcomes or the impact on our business.

The court rulings detailed above could also permit each of Teva and Apotex to launch a generic version of VASCEPA under certain circumstances pursuant to a settlement agreement with us. For example, Teva and Apotex settlement agreements permit such companies to launch their generic version of VASCEPA under royalty-free license from us given that our petition for en banc Federal Circuit review was not granted, after issuance of the Federal Circuit mandate on November 12, 2020. While Teva received FDA approval of its ANDA, any launch by Apotex would be subject to FDA approval of the Apotex ANDA and each generic launch is subject to procurement of adequate supply.

Once a generic version of VASCEPA is available in the market, whether based on a generic product with a MARINE indication label or REDUCE-IT indication label it is typically used in many U.S. states to fill a prescription for any use of the drug, subject, in certain circumstances, to state reimbursement law, the potential for patent infringement under certain case law and subject to certain Teva and Apotex settlement agreement terms. We currently face generic competition from Hikma's generic version of VASCEPA in the United States, and could face increased competition from additional generic entrants in the near term, which could have a material and adverse impact on our revenues and our results of operations. There can be no assurance that we will be successful in preventing use of generic versions of VASCEPA in indications for which they have not been approved by FDA, even if such use are determined to infringe certain of our patent claims.

Further, although we are pursuing available remedies, including a petition for a writ of certiorari to ask the United States Supreme Court to hear our appeal, we may not be successful in any such efforts, which will be costly and time-consuming to pursue. Such efforts will also require considerable attention of management and could, even if ultimately successful, negatively impact our results of operations.

Additionally, while we believe that VASCEPA is difficult to manufacture and that building capacity to manufacture VASCEPA is time-consuming and expensive. These factors limit the amount of VASCEPA supply available to generic companies, as experienced by Hikma. We do not have direct visibility into the supply levels of any of the generic company and we rely on our own experience together with information from third parties, which information may not be reliable. The generic companies could potentially find or develop sources of qualified VASCEPA supply that are not known to us and that are more efficient or inexpensive than our sources. Furthermore, generic companies could potentially convince our suppliers to prioritize supply to the generic companies ahead of any applicable contractual commitments to supply us. While we anticipate that our suppliers will honor their commitments to us, if generic competitors are successful in gaining an advantage in the supply chain promotional and educational efforts, and potentially manufacture and supply, with respect to VASCEPA will suffer and consequentially VASCEPA prescriptions will likely decrease. In addition, we may need to litigate with such suppliers to protect our rights, which can be costly and distracting to management. Such circumstances could have a material and adverse impact on our revenues and results of operations directly in the United States and potentially outside of the United States as well if supply costs and availability are affected or promotion and education programs reduced.

Factors outside of our control make it more difficult for VASCEPA to achieve a level of market acceptance by physicians, patients, healthcare payors and others in the medical community necessary to meet expectations for commercial success.

In January 2013, we launched VASCEPA based on the U.S. Food and Drug Administration, or FDA, approval of our MARINE indication, for use as an adjunct to diet to reduce triglyceride levels in adult patients with severe (TG ≥500 mg/dL) hypertriglyceridemia. Guidelines for the management of very high triglyceride levels suggest that the primary goal of reducing triglyceride levels in this patient population is reduction in the risk of acute pancreatitis. A secondary goal for this patient population is to reduce cardiovascular risk. The effect of VASCEPA on the risk for pancreatitis in patients with severe hypertriglyceridemia has not been determined and our FDA-approved labeling and promotional efforts state these facts.

In September 2018, we announced topline results from the REDUCE-IT®, or Reduction of Cardiovascular Events with EPA—Intervention Trial cardiovascular outcomes study of VASCEPA. In November 2018, we announced the primary results of our REDUCE-IT cardiovascular outcomes study confirming 25% relative risk reduction for the topline primary endpoint result with multiple robust demonstrations of efficacy, including 20% reduction in cardiovascular death. REDUCE-IT was a multinational, prospective, randomized, double-blind, placebo-controlled study, enrollment for which started in November 2011. REDUCE-IT investigated the effects of VASCEPA on CV risk in statin-treated adults with well-controlled LDL-C 41-100 mg/dL (median baseline LDL-C: 75 mg/dL) and other CV risk factors, including persistent elevated TG 150-499 mg/dL (median baseline TG: 216 mg/dL). REDUCE-IT topline results showed the trial met its primary endpoint demonstrating an approximately 25% relative risk reduction, to a high degree of statistical significance ($p<0.001$), in MACE in the intent-to-treat patient population with use of VASCEPA 4 grams/day as compared to placebo. MACE events were defined as a composite of cardiovascular death, nonfatal myocardial infarction (MI), nonfatal stroke, coronary revascularization, or unstable angina requiring hospitalization. This result was supported by robust demonstrations of efficacy across multiple secondary endpoints. VASCEPA was well tolerated in REDUCE-IT with a safety profile generally consistent with clinical experience associated with omega-3 fatty acids and current FDA-approved labeling.

In December 2019, the FDA approved a new indication and label expansion for VASCEPA as an adjunct to statin therapy to reduce the risk of MACE events in adult patients with elevated TG levels (≥150 mg/dL) and established cardiovascular disease or diabetes mellitus and two or more additional risk factors for cardiovascular disease.

Despite FDA approval for this new indication and expanded label for VASCEPA, we may not meet expectations for market acceptance by physicians, patients, healthcare payors and others in the medical community for this new approved use, even if we are successful in our appeal effort. If VASCEPA does not achieve an adequate level of acceptance, we may not generate product revenues sufficient to become profitable on an ongoing basis. The degree of market acceptance of VASCEPA for its approved indications and uses or otherwise will depend on a number of factors, including:

- the impact of and outcome of pending patent litigation appeal efforts;
- the commercialization and pricing of any current or potential generic version of VASCEPA;
- the perceived efficacy and safety of VASCEPA by prescribing healthcare professionals and patients, as compared to no treatment and as compared to alternative treatments in various at-risk patient populations;
- peer review of different elements of REDUCE-IT results over time;
- continued review and analysis of the results of REDUCE-IT by regulatory authorities internationally;
- our ability to offer VASCEPA for sale at competitive prices;
- convenience and ease of administration compared to alternative treatments;
- the willingness of the target patient population to try new therapies and of physicians to prescribe these therapies;
- the scope, effectiveness and strength of product education, marketing and distribution support, including our sales and marketing team;
- publicity concerning VASCEPA or competing products;
- our ability to continually promote VASCEPA in the United States consistent with and outside of FDA-approved labeling and the related perception thereof;
- sufficient third-party coverage or reimbursement for VASCEPA and its prescribe uses, on-label and off-label;
- natural disasters, including pandemics such as the recent outbreak of COVID-19 and political unrest that could inhibit our ability to promote VASCEPA regionally and can negatively affect product demand by creating obstacles for patients to seek treatment and fill prescriptions;
- new policies or laws affecting VASCEPA sales, such as state and federal efforts to affect drug pricing and provide or remove healthcare coverage that includes reimbursement for prescription drugs; and
- the actual and perceived efficacy of the product and the prevalence and severity of any side effects and warnings in VASCEPA's approved labeling internationally.

For example, two major factors that affect market use of prescription drugs are their perceived cost-effectiveness and the breadth of their use among different patient populations, both on label and off-label. In October 2019, the Institute for Clinical and Economic Review, or ICER, released its final evidence report regarding clinical effectiveness and economic impacts on VASCEPA. The conclusion from the report is that VASCEPA easily met even the most stringent "commonly cited thresholds for cost-effectiveness and therefore represent(s) a high long-term value for money," based on the organization's value assessment framework. As part of the public meeting held by ICER analyzing REDUCE-IT data, the ICER review committee discussed whether, based on REDUCE-IT, VASCEPA should be considered for use in patients as an add-on to statin therapy generally, and not just in patients with persistent elevated triglyceride levels after statin therapy, which ICER defined as triglyceride levels of at least 135 mg/dL. Use as an add-on to statin therapy generally represents a larger patient population than studied in REDUCE-IT and larger than covered by FDA-approved labeling. By contrast, FDA-approved labeling for VASCEPA reflects limitations such as use in patients with persistent elevated triglyceride levels defined as triglyceride levels of at least 150 mg/dL after statin therapy and specific criteria designed to ensure the patient populations approved for use had sufficiently high degrees of CV risk. While the clinical judgment of prescribing physicians is the most important factor that determines the breadth of a drug's use in the United States and often results in prescriptions in patient populations that go beyond FDA labeling, FDA-approved labeling that is more closely tied to the patient population studied in a clinical trial could limit use generally and by making reimbursement more difficult.

The scale and scope of the COVID-19 pandemic is uncertain and poses a significant threat to public health and infrastructure throughout the world, which could have a negative impact on our business.

The global spread of the coronavirus has created significant volatility, uncertainty and disruption in healthcare, social and economic infrastructures. The extent to which the coronavirus pandemic impacts our business, operations and financial results will depend on numerous evolving factors that we may not be able to accurately predict or plan around, including:

- the duration, volatility and scope of the pandemic;
- governmental, business and individuals' actions that have been and continue to be taken in response to the pandemic;
- the impact of the pandemic on economic and political activity and actions taken in response;
- the effect on patients, healthcare providers and business partners, including patients' ability to access supplies of VASCEPA and the willingness of patients to visit doctors for non-urgent medical examination or to visit labs for blood tests to assess biomarkers such as lipid levels;
- our ability to commercialize VASCEPA, including as a result of travel restrictions, social distancing and other containment measures;
- the enrollment or monitoring of patients in clinical trials, particularly at clinical trial sites located in highly impacted jurisdictions;
- the ability to access, secure and otherwise obtain and deliver sufficient and timely commercial or clinical supplies of VASCEPA to meet demand if the production capabilities of suppliers is disrupted;
- disruptions in regulatory oversight and actions if regulators and industry professionals are expending significant and unexpected resources addressing COVID-19;
- the availability of coverage and reimbursement from government and health administration authorities, private health insurers and other third-party payors if the system becomes overly strained; and
- any further or prolonged closures of our and our partners' offices, operations and facilities impeding our ability to work together as a company and with our business and healthcare partners.

To comply with travel restrictions, social distancing, quarantines and other containment measures implemented in various geographies, in March 2020, we suspended field based face-to-face interactions. We resumed on a limited basis field-based, face-to-face interactions with healthcare providers beginning in June 2020. During the late part of the summer, substantially all of our field force personnel had the ability to resume face-to-face customer interactions, in a manner consistent with state and local guidance. In the fourth quarter of 2020, the impact of COVID-19 worsened in much of the United State, with some healthcare professionals again limiting access to face-to-face interactions. Additionally, the number of patient visits to doctors' offices and patients undergoing blood testing remains down considerably from pre-COVID-19 levels. These circumstances vary geographically and vary over time, with continued risk of resurgences in COVID-19 cases, and reinstitution of protocols, in various geographies. We hope to be able to maintain our substantial resumption of our business efforts, however, given the dynamics related to COVID-19, there can be no assurance that this will be the case. While we have supplemented these face-to-face interactions with virtual outreach, these efforts may not be as successful as traditional, in-person interactions. Specifically, access to healthcare professionals through the internet or other channels, may not be as productive as in-person interactions.

Although we have a geographically diversified supply chain for VASCEPA and believe we have sufficient inventory on hand at pharmacies throughout the United States and other markets where it is approved for sale, and at various stages of manufacturing with our suppliers, the global spread of the outbreak and containment measures has been unprecedented and could have a negative impact on the availability of VASCEPA at various points in our supply chain, including limiting the ability of new suppliers to be inspected, which would have a material and adverse effect on our business.

The disruptions associated with the coronavirus pandemic could also delay the timing of a determination on our ability to seek legal remedies as travel, operational resources and personnel are disrupted, with respect to our efforts and capabilities, as well as those of our advisors and the courts. The disruptions associated with the coronavirus pandemic could delay the potential timing of subsequent steps for our application to get VAZKEPA approved to be marketed in Europe. COVID-19 could also delay our plans to hire additional employees for the planned commercialization of VAZKEPA in Europe.

As with any cardiovascular outcomes trial, over time further data assessment related to REDUCE-IT by international regulatory authorities or otherwise could yield additional useful information to inform greater understanding of study outcome. If the additional data or related interpretations do not meet expectations, the perception of REDUCE-IT results and VASCEPA revenue potential may suffer and our stock price may decline.

In December 2019, the FDA approved a new indication and label expansion for VASCEPA as an adjunct to statin therapy to reduce the risk of MACE events in adult patients with elevated TG levels (≥150 mg/dL) and established cardiovascular disease or diabetes mellitus and two or more additional risk factors for cardiovascular disease. Even though FDA has approved VASCEPA for this expanded label and new indication based on the REDUCE-IT results, additional data assessment by international regulatory authorities or otherwise could yield additional useful information to inform greater understanding of study outcome. Generally, trial data assessment sufficient to convey a complete picture of trial outcome can take years to complete and publish. When new data are assessed and released or presented it could exceed, match or may not meet investor expectations.

In addition, the same set of data can sometimes be interpreted to reach different conclusions. This was the case when Health Canada approved an indication based on REDUCE-IT data that was different in certain respects than that approved by FDA in the United States. It is possible the scope of subsequent regulatory approvals, if any, could likewise differ based on the same data, such as with our pending European Union, or EU, application. In January 2021, we announced a positive recommendation from a regulatory panel advising the European Medicines Agency toward anticipated approval by the European Commission in April 2021 for icosapent ethyl, under VAZKEPA, as a treatment to reduce the risk of cardiovascular events in select high-risk patients in the EU. Conflicting interpretations of data, or new data, could impact public and medical community perception of the totality of the efficacy and safety data from REDUCE-IT.

Regulatory authorities and medical guideline committees outside of the United States may consider the following additional factors, which could lead to evaluations of the totality of the efficacy and safety data from REDUCE-IT that differ from those of the FDA:

- the magnitude of the treatment benefit and related risks on the primary composite endpoint, its components, secondary endpoints and the primary and secondary risk prevention cohorts;
- consideration of which components of the composite or secondary endpoints have the most clinical significance;
- the consistency of the primary and secondary outcomes;
- the consistency of findings across cohorts and important subgroups;
- safety considerations and risk/benefit considerations (such as related to adverse events such as bleeding and atrial fibrillation generally and in different sub-populations);
- consideration of REDUCE-IT results in the context of other clinical studies;
- consideration of the cumulative effect of VASCEPA in studied patients; and
- study conduct and data quality, integrity and consistency, including aspects such as analyses regarding the placebo used in REDUCE-IT and other studies of VASCEPA and its impact, if any, on the reliability of clinical data.

If regulatory authorities and medical guideline committees outside of the United States draw conclusions that differ from those of the FDA, the FDA could reevaluate its conclusions as to the safety and efficacy of VASCEPA. Likewise, if additional data or analyses released from time to time do not meet expectations, the perception of REDUCE-IT results and the perceived and actual value of VASCEPA may suffer. In these instances our revenue and business could suffer and our stock price could significantly decline.

Ongoing clinical trials or new clinical data involving VASCEPA and similar moderate-to-high doses of eicosapentaenoic acid or icosapent ethyl could influence public perception of VASCEPA's clinical profile and the commercial and regulatory prospects of VASCEPA.

Ongoing trials of moderate-to-high doses of VASCEPA and icosapent ethyl or a similar, eicosapentaenoic acid, product could provide further information on the effects of VASCEPA and its commercial and regulatory prospects.

For example, the Randomized Trial for Evaluation in Secondary Prevention Efficacy of Combination Therapy–Statin and EPA (RESPECT-EPA; UMIN Clinical Trials Registry number, UMIN000012069) is a study examining Japanese patients with chronic coronary artery disease receiving LDL-C lowering treatment by statin therapy. Patients will be randomized to either a control group (standard treatment) or EPA group (standard treatment plus 1.8 grams/day of eicosapentaenoic acid), to examine the effects of a different formulation of icosapent ethyl than VASCEPA on the incidence of cardiovascular events. The relationship between the ratio of EPA to arachidonic acid and incidence of events will also be examined. Results from this study are expected in the second half of 2021, but could be announced sooner or, due to delay related to COVID-19 or otherwise, later.

In November 2020, we announced statistically significant topline results from a Phase 3 clinical trial of VASCEPA, conducted by our partner in China, Edding, which investigated VASCEPA as a treatment for patients with very high triglycerides (≥500 mg/dL). Even though such results are similar to the results of the MARINE study, additional clinical development efforts may be necessary in this market to demonstrate the effectiveness of VASCEPA in reducing major adverse cardiovascular events in Chinese patients with persistent cardiovascular risk.

We have also funded investigational studies on the use of VASCEPA in the setting of COVID-19 infection. On December 12, 2020, we announced at the National Lipid Association Scientific Sessions 2020 positive clinical results from the CardioLink-9 Trial, the first results of a study of VASCEPA in COVID-19 infected outpatients. Results from the other investigational studies are expected over the next year.

If the outcomes of one or more of these studies do not meet expectations, the perception of existing clinical results of VASCEPA, such as MARINE or REDUCE-IT, or the perceived clinical profile and commercial value of VASCEPA and its regulatory status may suffer. If this occurs our revenue and business could suffer and our stock price could significantly decline.

Our current and planned commercialization efforts may not be successful in increasing sales of VASCEPA in the United States and developing sales internationally.

It is estimated that over 25 million adults in the United States have elevated triglyceride levels ≥200 mg/dL and that more than 50 million adults in the United States have elevated triglyceride levels ≥150 mg/dL. Approximately two to three million adults in the United States have very high (≥500mg/dL) triglyceride levels, the MARINE patient population. There are approximately five to 15 million people in the United States who meet the specific REDUCE-IT inclusion criteria. Since 1976, mean triglyceride levels have increased in concert with the growing epidemic of obesity, insulin resistance, and type 2 diabetes mellitus. In contrast, mean LDL-C levels have decreased. Prior to the REDUCE-IT results topline announcement in September 2018, our U.S. direct sales force consisted of approximately 170 sales professionals, including sales representatives and their managers. Based on the positive REDUCE-IT results, in early 2019, we increased the size of our U.S. direct sales force to approximately 440 sales professionals, including approximately 400 sales representatives. As a result of the additional indication and label expansion approved by the U.S. FDA in December 2019, for cardiovascular risk reduction, we completed the further expansion of our direct sales force to approximately 900 sales professionals, including approximately 800 sales representatives in early 2020. As a result of the COVID-19 pandemic and the related social distancing, in March 2020, we suspended face-to-face interactions between our sales representatives and healthcare professionals. We resumed on a limited basis field-based, face-to-face interactions with healthcare providers beginning in June 2020. During the late part of the summer, substantially all of our field force personnel were able to resume face-to-face customer interactions in a manner consistent with guidelines from local, state and government health officials in the United States. In the fourth quarter of 2020, the impact of COVID-19 worsened in much of the United States, with some physicians again limiting access to face-to-face interactions with our field force personnel. Accordingly, we have intentionally slowed the hiring of replacements for our open positions which resulted from ordinary turnover. As we witness our sales representatives increasingly able to resume direct interactions with healthcare professionals, we continually evaluate our needs and it is our intention to fill a significant number of these positions, provided such replacement is appropriate to meet our business needs. As of December 31, 2020, our U.S. direct sales force was slightly more than 800 sales professionals, including slightly more than 700 sales representatives. Thus, despite this significant expansion of our sales team, it is not large enough to call upon all physicians and we may not have sufficient sales personnel and resources to maximize the sales potential of VASCEPA.

In addition to the sales force expansion in the United States, we plan to work internally and with partners to support regulatory efforts toward approvals and commercialization outside the United States based primarily on REDUCE-IT results. For example, assuming regulatory approval, we plan to launch VAZKEPA on our own in the most commercially significant markets in Europe. The commercial launch of a new pharmaceutical product is a complex undertaking for a company to manage, and we have no prior experience as a company operating a commercial-stage pharmaceutical business in Europe.

Factors related to building and managing a sales and marketing organization in Europe and different territories world-wide that could inhibit our efforts to successfully commercialize VASCEPA include the following:

- the impact the expiration of regulatory exclusivities and entry into the market of additional generic versions of VASCEPA, as covered above or with respect to the impact such an event may have on the factors below;
- our inability to secure market access and adequate reimbursement in one or more countries;
- our inability to attract and retain adequate numbers of effective sales and marketing personnel;
- our inability to adequately train our sales and marketing personnel and our inability to adequately monitor compliance with these requirements;
- the inability of our new sales personnel, to obtain access to or persuade adequate numbers of physicians to prescribe VASCEPA;
- the lack of complementary products to be offered by sales personnel, which may put us at a competitive disadvantage relative to companies with more extensive product lines;
- an inability by us or our partners to obtain regulatory and marketing approval or establish marketing channels in foreign jurisdictions; and
- unforeseen costs and expenses associated with operating a new independent sales and marketing organization.

If we are not successful in maintaining a sales force that is rightsized for our efforts to market and sell VASCEPA, our anticipated revenues or our expenses could be materially and negatively affected, and we may not obtain profitability, may need to cut back on research and development activities or implement other cost-containment measures, or we may need to raise additional funding that could result in substantial dilution or impose considerable restrictions on our business.

Although substantially all of our sales force personnel have the ability to resume face-to-face customer interactions, in a manner consistent with state and local guidance, given the dynamics related to COVID-19, there can be no assurance that we will be able to substantially resume or sustain our business efforts. While we have supplemented these face-to-face interactions with virtual outreach, these efforts may not be as successful as traditional, in-person interactions. Specifically, access to healthcare professionals through the internet or other channels, may not be as productive as in-person interactions. In July 2020 we launched our first ever direct-to- consumer promotional campaign regarding VASCEPA demonstrating results in lowering cardiovascular risk in patients with persistent cardiovascular risk in high risk patients. In September 2020, we launched a new, nationwide television advertisement in connection with our expanded promotional campaign which was further complemented by additional digital, point-of-care and other forms of healthcare professional and patient educational outreach. There can be no assurance that such promotion will have the intended positive increase in patients asking their healthcare providers regarding VASCEPA or that prescription rates for VASCEPA will increase in the near future or at all from such promotion. Data on increased product usage from similar promotion of other products suggests that the impact of television-based promotion can be positive and sustained but is rarely immediate in its effect. After assessing the scope, timing and pricing of generic competition, we may also decide to contract our VASCEPA promotional efforts.

Our promotion of VASCEPA is subject to regulatory scrutiny and associated risk generally.

The Federal Food, Drug, and Cosmetic Act, or FDCA, has been interpreted by the FDA and the U.S. government to make it illegal for pharmaceutical companies to promote their FDA-approved products for uses that have not been approved by the FDA. Companies that market drugs for off-label uses or indications have been subject to related costly litigation, criminal penalties and civil liability under the FDCA and the False Claims Act. However, case law over the last several years has called into question the extent to which government in the United States, including the FDA, can, and is willing to seek to, prevent truthful and non-misleading speech related to off-label uses of FDA-approved products such as VASCEPA.

In May 2015, we and a group of independent physicians filed a lawsuit against the FDA seeking a federal court declaration that would permit us and our agents to promote to healthcare professionals the use of VASCEPA in the ANCHOR population and promote on the potential of VASCEPA to reduce the risk of cardiovascular disease so long as the promotion is truthful and non-misleading. This use of VASCEPA at issue reflected recognized medical practice at the time but was not approved by the FDA and was thus not covered by then FDA-approved labeling for the drug. Promotion of an off-label use has generally been considered by the FDA to be illegal under the FDCA. The lawsuit, captioned *Amarin Pharma, Inc., et al. v. Food & Drug Administration, et al.*, 119 F. Supp. 3d 196 (S.D.N.Y. 2015), was filed in the United States District Court for the Southern District of New York. In the lawsuit, we contended principally that FDA regulations limiting off-label promotion of truthful and non-misleading information are unconstitutional under the freedom of speech clause of the First Amendment to the U.S. Constitution as applied in the case of our proposed promotion of VASCEPA. The physicians in the suit regularly treated patients at risk of cardiovascular disease and, as the complaint contended, have First Amendment rights to receive truthful and non-misleading information from Amarin. The suit was based on the principle that better informed physicians make better treatment decisions for their patients. The FDA opposed this lawsuit but did not dispute the veracity of the subject ANCHOR clinical trial data (the safety data from which was already and currently is in FDA-approved labeling of VASCEPA) or the peer-reviewed research related to VASCEPA and the potential for cardiovascular risk reduction.

In August 2015, we were granted preliminary relief in this lawsuit through the court's declaratory judgment that confirmed we may engage in truthful and non-misleading speech promoting the off-label use of VASCEPA to healthcare professionals, i.e., to treat patients with persistently high triglycerides, and that such speech may not form the basis of a misbranding action under the FDCA. In August 2015, we began to communicate promotional information beyond the MARINE indication to healthcare professionals in the United States as permitted by this court declaration. The FDA did not appeal the court's ruling. In March 2016, we settled this litigation under terms by which the FDA and the U.S. government agreed to be bound by the conclusions from the federal court order that we may engage in truthful and non-misleading speech promoting the off-label use of VASCEPA and that certain statements and disclosures that we proposed to make to healthcare professionals were truthful and non-misleading. As part of the settlement, given, as expressed in the court's opinion, that the dynamic nature of science and medicine is that knowledge is ever-advancing and that a statement that is fair and balanced one day may become incomplete or otherwise misleading in the future as new studies are done and new data is acquired, we agreed that we bear the responsibility to ensure that our communications regarding off-label use of VASCEPA remain truthful and non-misleading, consistent with the federal court ruling.

While we believe we are now permitted under applicable law to more broadly promote VASCEPA, the FDA-approved labeling for VASCEPA did not change as a result of this litigation and settlement, and neither government nor other third-party coverage or reimbursement to pay for the off-label use of VASCEPA promoted under the court declaration was required. In addition to claims classically considered to be on-label based on our expanded label for VASCEPA based on the REDUCE-IT results, we proactively communicate information related to VASCEPA in a manner that we believe is truthful and non-misleading and thus protected under the freedom of speech clause of the First Amendment to the United States Constitution.

Promotional activities in the biotechnology and pharmaceutical industries generally are subject to considerable regulatory scrutiny and, even though we have the benefit of a final settlement in this litigation, our efforts may be subject to enhanced scrutiny to ensure that our promotion remains within the scope covered by the settlement. For example, under the settlement, we remain responsible for ensuring our speech is truthful and non-misleading, which is subject to a considerable amount of judgment. We, the FDA, the U.S. government, our competitors and other interested parties may not agree on the truthfulness and non-misleading nature of our promotional materials. Federal and state governments or agencies may also seek to find other means to prevent our promotion of unapproved truthful and non-misleading information about VASCEPA.

In June 2020, we received a civil investigative demand, or CID, from the U.S. Department of Justice, or the DOJ, informing us that the DOJ is investigating whether aspects of our promotional speaker programs and copayment waiver program during the period from January 1, 2015 to the present violated the U.S. Anti-Kickback Statute and the U.S. False Claims Act in relation to the sale and marketing of VASCEPA by us and our previous co-marketing partner, Kowa Pharmaceuticals America, Inc. The CID requires us to produce documents and answer written questions, or interrogatories, relevant to the specified time period. We are cooperating with the DOJ. We cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on our business. Such investigations can be lengthy, costly and could materially affect and disrupt our business. If the government determines that we have violated the Anti-Kickback Statute and False Claims Act, we could be subject to significant civil and criminal fines and penalties.

If our promotional activities or other operations are found to be in violation of any law or governmental regulation through existing or new interpretations, we may be subject to prolonged litigation, penalties, including civil and criminal penalties, damages, fines and the curtailment or restructuring of our operations. Also, if governmental parties or our competitors view our claims as misleading or false, we could be subject to liability based on fair competition-based statutes, such as the Lanham Act. Any allegations that our promotional activities are not truthful or misleading, even allegations without merit, could cause reputational harm and adversely affect our ability to operate our business and our results of operations.

We may not be able to compete effectively against our competitors' pharmaceutical products.

The biotechnology and pharmaceutical industries are highly competitive. There are many pharmaceutical companies, biotechnology companies, public and private universities and research organizations actively engaged in the research and development of products that may be similar to our product. It is probable that the number of companies seeking to develop products and therapies similar to our product will increase. Many of these and other existing or potential competitors have substantially greater financial, technical and human resources than we do and may be better equipped to develop, manufacture and market products. These companies may develop and introduce products and processes competitive with, more efficient than or superior to ours. In addition, other technologies or products may be developed that have an entirely different approach or means of accomplishing the intended purposes of our products, which might render our technology and products noncompetitive or obsolete.

Our competitors both in the United States and abroad include large, well-established pharmaceutical and generic companies, specialty and generic pharmaceutical sales and marketing companies, and specialized cardiovascular treatment companies. With a generic version of VASCEPA launched by Hikma in November 2020 and further generic versions anticipated, it may not be viable for us to invest in market education to grow the United States market and our ability to maintain current promotional efforts and attract favorable commercial terms in several aspects of our business will likely be adversely affected as we face increased generic competition, or if we launch our own generic version of VASCEPA.

GlaxoSmithKline plc currently sells Lovaza®, a prescription-only omega-3 fatty acid indicated for patients with severe hypertriglyceridemia, which was approved by FDA in 2004 and has been on the market in the United States since 2005. Multiple generic versions of Lovaza are available in the United States. Other large companies with competitive products include AbbVie, Inc., which currently sells Tricor® and Trilipix® for the treatment of severe hypertriglyceridemia and Niaspan®, which is primarily used to raise high-density lipoprotein cholesterol, or HDL-C, but is also used to lower triglycerides. Multiple generic versions of Tricor, Trilipix and Niaspan are also available in the United States. We compete with these drugs, and in particular, multiple low-cost generic versions of these drugs, in our FDA-approved indicated uses, even though such products do not have FDA approval to reduce CV risk on top of statin therapy.

In addition, in May 2014, Epanova® (omega-3-carboxylic acids) capsules, a free fatty acid form of omega-3 (comprised of 55% EPA and 20% DHA), was approved by the FDA for patients with severe hypertriglyceridemia. Epanova was developed by Omthera Pharmaceuticals, Inc., and is now owned by AstraZeneca Pharmaceuticals LP, or AstraZeneca. Also, in April 2014, Omtryg, another omega-3-acid fatty acid composition developed by Trygg Pharma AS, received FDA approval for severe hypertriglyceridemia. Neither Epanova nor Omtryg have been commercially launched, but could launch at any time. AstraZeneca has greater resources than we do, including financial, product development, marketing, personnel and other resources.

AstraZeneca conducted a long-term outcomes study to assess Statin Residual Risk Reduction With EpaNova in HiGh Cardiovascular Risk PatienTs With Hypertriglyceridemia (STRENGTH). The study was a randomized, double-blind, placebo-controlled (corn oil), parallel group design that is believed to have enrolled approximately 13,000 patients with hypertriglyceridemia and low HDL and high risk for cardiovascular disease randomized 1:1 to either corn oil plus statin or Epanova plus statin, once daily. On January 13, 2020 following the recommendation of an independent Data Monitoring Committee, AstraZeneca decided to close the STRENGTH trial due to its low likelihood of demonstrating benefit to patients with mixed dyslipidemia who are at increased risk of cardiovascular disease. Full data from the STRENGTH trial was presented at the American Heart Association's Scientific Sessions in November 2020, confirming that Epanova failed to meet the primary endpoint of CV risk reduction. In addition, in March 2017, Kowa Research Institute (a subsidiary of the Japanese company Kowa Co., Ltd) initiated a Phase 3 cardiovascular outcomes trial titled PROMINENT examining the effect of pemafibrate (experimental name K-877) in reducing cardiovascular events in Type II diabetic patients with hypertriglyceridemia. Kowa Research Institute has publicly estimated study completion in May 2022, and if successful, U.S. regulatory approval is estimated in mid-2023.

During 2018, two outcomes studies were completed of omega-3 mixtures which both failed to achieve their primary endpoints of cardiovascular risk reduction and two meta-analyses were published showing that omega-3 mixtures are not effective in lowering cardiovascular risk. Results of these failed outcomes studies and analysis, while not done with VASCEPA, may negatively affect sales of VASCEPA. For example, results of VITamin D and OmegA-3 TriaL (VITAL), as announced immediately before the presentation of REDUCE-IT results at the 2018 Scientific Sessions of the AHA on November 10, 2018, failed to achieve its primary endpoint of lowering cardiovascular events. VITAL was an NIH funded randomized double-blind, placebo-controlled, 2x2 factorial trial of 2000 IU per day of vitamin D3 and 1 gram per day of omega-3 fatty acid mixture supplementation (Lovaza) for the primary prevention of cancer and cardiovascular disease in a nationwide USA cohort of 25,874 adults not selected for elevated cardiovascular or cancer risk.

Likewise, in 2018, results from A Study of Cardiovascular Events iN Diabetes (ASCEND) trial were released and showed negligible results for omega-3 fatty acid mixtures 1 gram daily. ASCEND was a British Heart Foundation funded 2x2 factorial design, randomized study to assess whether aspirin 100 mg daily versus placebo and separately, omega-3 fatty acid mixtures 1 gram daily versus placebo, reduce the risk of cardiovascular events in a nationwide UK cohort of over 15,000 individuals with diabetes who do not have atherosclerotic cardiovascular disease. In 2020, an additional Nordic trial known as OMEMI failed to demonstrate a reduction in cardiovascular events with an omega-3 fatty acid mixture. OMEMI, an investigator-initiated, multi-center, randomized clinical trial, was designed to evaluate the effects of daily treatment with omega-3 fatty acids compared with placebo among elderly patients (ages 70-82) with recent myocardial infarction. Patients received 1.8 g omega-3 fatty acids (930 mg EPA and 660 mg DHA) or placebo (corn oil) daily added to standard of care. Results presented in November 2020 at the American Heart Association's Scientific Sessions showed no significant differences in cardiovascular events between the treatment groups for the composite primary endpoint (non-fatal MI, unscheduled revascularization, stroke, hospitalization for heart failure or all-casuse mortality), nor for the individual componsents of this endpoint after 2 years.

In a meta-analysis, presented in 2018 by the Cochrane Foundation and separately as published in JAMA, additional omega-3 studies were evaluated. Similar to the VITAL and ASCEND studies, most of the studies in these omega-3 meta-analyses were of omega-3 mixtures, including DHA, and most were studies of relatively low doses of omega-3 as is associated with dietary supplementation and/or they studied relatively low risk patient populations. The exception was the JELIS study, conducted in Japan, of highly pure EPA which showed a positive outcome benefit but had significant limitations in its application to a wider population. The negative results from such omega-3 mixture studies could create misleading impressions about the use of omega-3s generally, including VASCEPA, despite REDUCE-IT positive results and the highly-pure and stable EPA active ingredient in VASCEPA and its higher dose regimen.

We are also aware of other pharmaceutical companies that are developing products that, if successfully developed, approved and marketed, would compete with VASCEPA. It is not fully clear at this time what the impact of COVID-19 will be on each of these programs.

We believe Micelle BioPharma Inc., or Micelle, is also developing potential treatments for hypertriglyceridemia based on omega-3 fatty acids. To our knowledge, Micelle, after acquiring SC401 from Sancilio & Company, or Sancilio, is pursuing a regulatory pathway under section 505(b)(2) of the FDCA for its product and submitted an Investigational New Drug Application, or IND, in July 2015. Micelle (Sancilio) completed two pharmacokinetic studies and Phase 2 bioavailability studies (FASTR I&II), with

one comparing SC401 to Lovaza. We expect the company or a potential partner to initiate a pivotal clinical Phase 3 study as the next step in development.

Matinas BioPharma, Inc., or Matinas, is developing an omega-3-based therapeutic, MAT9001, for the treatment of severe hypertriglyceridemia and mixed dyslipidemia. In the fourth quarter of 2014 Matinas filed an IND with the FDA to conduct a human study in the treatment of severe hypertriglyceridemia and, in June 2015, the company announced topline results for its head-to-head comparative short duration pharmacokinetic and pharmacodynamic study of MAT9001 versus VASCEPA in patients under conditions inconsistent with the FDA-approved label for VASCEPA and presented results based on biomarker modification without outcomes data. In September 2017, Matinas announced that it will be seeking a partner company to develop and commercialize MAT9001. In March 2019, Matinas announced that net proceeds from a public offering of common stock would be used for development activities for MAT9001. In March 2020, Matinas announced that it completed the clinical dosing for a comparative clinical bridging bioavailability study and the in-life portion of a 90-day comparative toxicology study. Both studies were conducted to support a planned 505(b)(2) registration pathway. In March, Matinas also initiated an additional Phase 2 head-to-head pharmacokinetic and pharmacodynamic study (ENHANCE-IT) against VASCEPA in patients with elevated triglycerides (150-499 mg/dL), while the study was paused in the first quarter of 2020 due to the COVID-19 pandemic, enrollment resumed in June and was completed in August 2020. In the first quarter of 2021, Matinas announced topline results from the ENHANCE-IT study, stating that LYPDISO, or MAT9001, did not meet statistical significance over VASCEPA on the primary endpoint of percent change from baseline to end of treatment in triglycerides in the pharmacodynamic, or PD, population. Matinas has announced that despite ENHANCE-IT not achieving its primary endpoint that it intends to continue to seek ways to advance its clinical development of MAT9001.

The Phase 3 program requirement includes a single 12-week study, to support efficacy in SHTG, or AMPLIFY, which is expected to start in June 2021. In June 2018, NeuroBo Pharmaceuticals, Inc. (then-named Gemphire Therapeutics) announced positive topline results from a Phase 2b trial (INDIGO-1) of its drug candidate, gemcabene, in patients with severe hypertriglyceridemia. Gemcabene is an oral, once-daily pill for a number of hypercholesterolemic populations and severe hypertriglyceridemia. In August 2018, the FDA requested that Gemphire conduct an additional long-term toxicity study before commencing any further clinical testing, thereby effectively placing gemcabene on clinical hold. In March 2020 NeuroBo announced the completion of the requested studies, and in May 2020 the company announced that it received written communication from the FDA that the clinical development program for Gemcabene remains on partial clinical hold. In June 2019, Gemphire announced top-line clinical results from a Phase 2 trial in Familial Partial Lipodystrophy (FPL)/NASH in which Gemcabene safely met the primary endpoint in a sub-set of patients. Phase 3 studies for homozygous familial hypercholesterol emia (HoFH), heterozygous familial hypercholesterolemia (HeFH) and non-familial hypercholesterolemia in ASCVD patients are planned.

Afimmune Ltd. has an oral, small molecule drug candidate, epeleuton (DS-102), in development for a number of conditions of the liver, lung, and metabolic system, including hypertriglyceridemia and cardiovascular risk reduction, Phase 2 clinical trials are currently ongoing for non-alcoholic fatty liver disease, or NAFLD, chronic obstructive pulmonary disease, or COPD, and planned for hypertriglyceridemia and Type 2 diabetes (TRIAGE), in the United States. In November 2019, Afimmune Ltd. announced positive results from an exploratory Phase 2 study of epeleuton in patients with NAFLD in which the molecule decreased triglycerides, improved glycemic control, and decreased markers of inflammation. In August 2020, Afimmune reported Ph2a study results of epeleuton in patients with NAFLD. Although epeleuton failed to meet the primary endpoint to demonstrate effects on liver enzyme elevation, it demonstrated significant reduction of triglycerides, HbA1c and potential for CV risk reduction. In September 2020, Afimmune announced the start of TRIglyceride And Glucose control with Epeleuton in Metabolic Syndrome Patients, or TRIAGE, a Phase IIb study of epeleuton in patients with high triglycerides and type 2 diabetes to assess the safety and efficacy of orally administered epeleuton capsules vs placebo in the treatment of hypertriglyceridemia and type 2 diabetes. Results are expected in fourth quarter of 2021.

Based on prior communications from the FDA, including communications in connection with its review of the ANCHOR indication for VASCEPA, it is our understanding that the FDA is not prepared to approve any therapy for treatment of cardiovascular risk based on biomarker modification without cardiovascular outcomes study data, with the exception of therapies which lower LDL-cholesterol, depending on the circumstances. In particular, it is our understanding that the FDA is not prepared to approve any therapy based primarily on data demonstrating lowering of triglyceride levels. In our view, this position from the FDA did not change based on the REDUCE-IT study particularly in light of significant independence of the positive benefit demonstrated in the REDUCE-IT study from triglyceride levels and benefit from the REDUCE-IT study supporting that the positive effects of VASCEPA are unique to VASCEPA and extend beyond triglyceride reduction. If the FDA were to change this position, it could potentially have a negative impact on Amarin by making it easier for other products to achieve a cardiovascular risk reduction indication without the need in advance to conduct a long and expensive cardiovascular outcomes study.

VASCEPA also faces competition from dietary supplement manufacturers marketing omega-3 products as nutritional supplements. Such products are classified as food, not as prescription drugs or as over-the-counter drugs, by the FDA in the United States. Most regulatory regimes outside the United States are similar in this regard. Some of the promoters of such products have greater resources than us and are not restricted to the same standards as are prescription drugs with respect to promotional claims or

manufacturing quality, consistency and subsequent product stability. We have taken successful legal action against supplement manufacturers attempting to use the REDUCE-IT results to promote their products. Still, we cannot be sure physicians and pharmacists will view the FDA-approved, prescription-only status, and EPA-only purity and stability of VASCEPA or FDA's stringent regulatory oversight, as significant advantages versus omega-3 dietary supplements regardless of clinical study results and other scientific data.

On January 28, 2021, the CHMP of the EMA adopted a positive opinion recommending that a marketing authorization be granted for icosapent ethyl, under the brand name VAZKEPA, for cardiovascular risk reduction. Approval for marketing and sale by the EC is expected in April 2021. The cardiovascular risk reduction indication we are seeking in Europe is based on the outcome study results of REDUCE-IT, as opposed to the original indication for treatment of severe hypertriglyceridemia which we were granted in the U.S. Following anticipated approval by the EC of VAZKEPA, there is currently no other drug that is approved for cardiovascular risk reduction in at-risk patients in Europe. In addition, there is currently no other direct competition for Canada and the Middle East. However, consistent with the U.S., our competitors include large, well-established pharmaceutical companies, specialty and generic pharmaceutical companies, marketing companies, and specialized cardiovascular treatment companies.

Recent CV outcomes trials and meta-analyses with low and high dose omega-3 fatty acid mixtures containing DHA have not shown substantial benefit in patients receiving contemporary medical therapy, including statins. Due to failed low dose omega-3 CV outcomes trials, the European regulatory authorities have concluded that omega-3 fatty acid medicines (specifically Lovaza®/Omacor®) at a dose of 1-gram per day are not effective in preventing further events for patients who have had a heart attack. The STRENGTH trial of an omega-3 mixture studied at 4-grams per day also failed to demonstrate cardiovascular benefit.

In addition, VAZKEPA also faces competition from dietary supplement manufacturers marketing omega-3 productions as nutritional supplements. In Europe, such products are classified as food, not as prescription drugs or as over-the-counter drugs.

As generic company competitors seek to compete with copies of VASCEPA in the United States and elsewhere we could face additional challenges to our patents and additional patent litigation.

The FDCA, as amended by the Drug Price Competition and Patent Term Restoration Act of 1984, as amended, or the Hatch-Waxman Amendments, permits the FDA to approve ANDAs for generic versions of brand name drugs like VASCEPA. We refer to the process of generic drug applications as the "ANDA process." The ANDA process permits competitor companies to obtain marketing approval for a drug product with the same active ingredient, dosage form, strength, route of administration, and labeling as the approved brand name drug, but without having to conduct and submit clinical studies to establish the safety and efficacy of the proposed generic product. In place of such clinical studies, an ANDA applicant needs to submit data demonstrating that its product is bioequivalent to the brand name product, usually based on pharmacokinetic studies.

As an alternate path to FDA approval for modifications of products previously approved by the FDA, an applicant may submit a new drug application, or NDA, under Section 505(b)(2) of the FDCA (enacted as part of the Hatch-Waxman Amendments). This statutory provision permits the filing of an NDA where at least some of the information required for approval comes from studies not conducted by or for the applicant and for which the applicant has not obtained a right of reference from the owner of the data. The Hatch-Waxman Amendments permit the applicant to rely upon the FDA findings of safety and effectiveness of a drug that has obtained FDA approval based on preclinical or clinical studies conducted by others. In addition to relying on FDA prior findings of safety and effectiveness for a referenced drug product, the FDA may require companies to perform additional preclinical or clinical studies to support approval of the modification to the referenced product.

If an application for a generic version of a branded product or a Section 505(b)(2) application relies on a prior FDA finding of safety and effectiveness of a previously-approved product including an alternative strength thereof, the applicant is required to certify to the FDA concerning any patents listed for the referenced product in the FDA publication called "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the "Orange Book." Specifically, the applicant must certify in the application that:

(I) there is no patent information listed for the reference drug;

(II) the listed patent has expired for the reference drug;

(III) the listed patent for the reference drug has not expired, but will expire on a particular date and approval is sought after patent expiration; or

(IV) the listed patent for the reference drug is invalid, unenforceable, or will not be infringed by the manufacture, use or sale of the product for which the ANDA or 505(b)(2) NDA is submitted.

The Hatch-Waxman Amendments require an applicant for a drug product that relies, in whole or in part, on the FDA's prior approval of VASCEPA, to notify us of its application, a "paragraph IV" notice, if the applicant is seeking to market its product prior to the expiration of the patents that both claim VASCEPA and are listed in the Orange Book. A bona fide paragraph IV notice may not

be given under the Hatch-Waxman Amendments until after the generic company receives from the FDA an acknowledgement letter stating that its ANDA is sufficiently complete to permit a substantive review.

The paragraph IV notice is required to contain a detailed factual and legal statement explaining the basis for the applicant's opinion that the proposed product does not infringe our patents, that the relevant patents are invalid, or both. After receipt of a valid notice, the branded product manufacturer has the option of bringing a patent infringement suit in federal district court against any generic company seeking approval for its product within 45 days from the date of receipt of each notice. If such a suit is commenced within this 45-day period, the Hatch-Waxman Amendments provide for a 30-month stay on FDA's ability to give final approval to the proposed generic product, which period begins on the date the paragraph IV notice is received. Generally, during a period of time in which generic applications may be submitted for a branded product based on a product's regulatory exclusivity status, if no patents are listed in the Orange Book before the date on which a complete ANDA application for a product (excluding an amendment or supplement to the application) is submitted, an ANDA application could be approved by FDA without regard to a stay. For products entitled to five-year exclusivity status, the Hatch-Waxman Amendments provide that an ANDA application may be submitted after four years following FDA approval of the branded product if it contains a certification of patent invalidity or non-infringement to a patent listed in the Orange Book. In such a case, the 30-month stay runs from the end of the five-year exclusivity period. Statutory stays may be shortened or lengthened if either party fails to cooperate in the litigation and it may be terminated if the court decides the case in less than 30 months. If the litigation is resolved in favor of the ANDA applicant before the expiration of the 30-month period, the stay will be immediately lifted and the FDA's review of the application may be completed. Such litigation is often time-consuming and costly, and may result in generic competition if such patents are not upheld or if the generic competitor is found not to infringe such patents.

In addition to the ANDA patent litigation described above, we could face patent litigation related to the patents filed in the Orange Book related to the REDUCE-IT study. A three-year period of exclusivity under the Hatch-Waxman Amendments is generally granted for a drug product that contains an active moiety that has been previously approved, such as when the application contains reports of new clinical investigations (other than bioavailability studies) conducted by the sponsor that were essential to approval of the application. Accordingly, we received three-year exclusivity in connection with the approval of our sNDA for REDUCE-IT study results. Such three-year exclusivity protection precludes, unless otherwise agreed, the FDA from approving a marketing application for an ANDA, a product candidate that the FDA views as having the same conditions of approval as VASCEPA (for example, the same indication and/or other conditions of use), or a 505(b)(2) NDA submitted to the FDA with VASCEPA as the reference product until December 13, 2022, three years from the date of FDA approval of the REDUCE-IT sNDA. While this three-year exclusivity would generally prevent such an approval based on our REDUCE-IT indication during such time, it does not preclude tentative or final approval of an ANDA based on our MARINE indication. The FDA may accept and commence review of such REDUCE-IT-related applications during the three-year exclusivity period. Such three-year exclusivity grant does not prevent a company from challenging the validity of REDUCE-IT patents during such period. This three-year form of exclusivity may also not prevent the FDA from approving an NDA that relies only on its own data to support the change or innovation. Regulatory exclusivity is in addition to exclusivity afforded by issued patents related to VASCEPA.

We may also face challenges to the validity of our patents through a procedure known as inter partes review. Inter partes review is a trial proceeding conducted through the Patent Trial and Appeal Board, of the U.S. Patent and Trademark Office. Such a proceeding could be introduced against us within the statutory one-year window triggered by service of a complaint for infringement related to an ANDA filing or at any time by an entity not served with a complaint. Such proceedings may review the patentability of one or more claims in a patent on specified substantive grounds such as allegations that a claim is obvious on the basis of certain prior art.

We intend to vigorously enforce our intellectual property rights relating to VASCEPA, but we cannot predict the outcome of the pending lawsuits, any appeals, or any subsequently filed lawsuits or inter partes review.

Generally, if an ANDA filer meets the approval requirements for a generic version of VASCEPA to the satisfaction of the FDA under its ANDA, FDA may grant tentative approval to the ANDA during a Hatch-Waxman 30-month stay period and during the Hatch-Waxman 36-month regulatory exclusivity period. A tentative approval is issued to an ANDA applicant when its application is approvable prior to the expiration of any exclusivities applicable to the branded, reference listed drug product. A tentative approval does not allow the applicant to market the generic drug product and postpones the final ANDA approval until applicable exclusivity protections have expired.

Once a generic version of VASCEPA is available in the market, whether based on a generic product with a MARINE indication label or REDUCE-IT indication label, it is often used to fill a prescription for any intended use of the drug. If final approval of a generic ANDA is granted and an ANDA filer is able to supply the product in significant commercial quantities, generic companies could introduce generic versions of VASCEPA in the market, as Hikma did in November 2020, although on a limited scale. Although any such introduction of a generic version of VASCEPA would also be subject to any litigation settlement terms and patent

infringement claims (including any new claims and those that may then be subject to an appeal), pursuing such litigation may be prohibitively costly or could put a substantial constraint on our resources.

Any significant degree of generic market entry would limit our U.S. sales, which would have a significant adverse impact on our business and results of operations. In addition, even if a competitor's effort to introduce a generic product is ultimately unsuccessful, the perception that such development is in progress and/or news related to such progress could materially affect the reputation of VASCEPA or the perceived value of our company and our stock price. For example, our stock price suffered a significant decline following our announcement of the Nevada Court's ruling in favor of the Defendants and the Federal Circuit ruling upholding the Nevada Court's ruling.

VASCEPA is a prescription-only omega-3 fatty acid product. Omega-3 fatty acids are also marketed by other companies as non-prescription dietary supplements. As a result, VASCEPA is subject to non-prescription competition and consumer substitution.

Our only product, VASCEPA, is a prescription-only form of EPA, an omega-3 fatty acid in ethyl ester form. Mixtures of omega-3 fatty acids in triglyceride form are naturally occurring substances contained in various foods, including fatty fish. Omega-3 fatty acids are marketed by others in a number of chemical forms as non-prescription dietary supplements. We cannot be sure physicians will view the pharmaceutical grade purity and proven efficacy and safety of VASCEPA as having a superior therapeutic profile to unproven and loosely regulated omega-3 fatty acid dietary supplements. In addition, the FDA has not yet enforced to the full extent of its regulatory authority what we view as illegal claims made by certain omega-3 fatty acid product manufacturers to the extent we believe appropriate under applicable law and regulations, for example, claims that certain of such chemically altered products are dietary supplements and that certain of such products reduce triglyceride levels or could reduce cardiovascular risk.

Also, for over a decade, subject to certain limitations, the FDA has expressly permitted dietary supplement manufacturers that sell supplements containing the omega-3 fatty acids EPA and/or DHA to make the following qualified health claim directly to consumers: Supportive but not conclusive research shows that consumption of EPA and DHA omega-3 fatty acids may reduce the risk of coronary heart disease. Such companies are not, however, permitted, based on FDA enforcement activity, to make claims that suggest or imply treatment of cardiovascular disease.

These factors enable dietary supplements to compete with VASCEPA to a certain degree. Although we have taken steps to address these competitive issues, and plan to continue to do so vigorously, we may not be successful in such efforts.

For example, on October 29, 2018, Amarin filed two lawsuits in U.S. federal court, each against a different dietary supplement company for unlawfully using the results from the REDUCE-IT cardiovascular outcomes study to falsely and deceptively claim that their omega-3 dietary supplement products are effective in reducing cardiovascular risk. The defendants in the cases were Omax Health, Inc., or Omax, and The Coromega Company, Inc., or Coromega. In April 2019, based on the strength of our case and available legal remedies, Omax and Coromega settled these litigations under terms by which Omax and Coromega agreed to substantially all the demands in Amarin's complaints. Under the settlements, Coromega and Omax agreed to publicly correct their prior statements that wrongly suggested the REDUCE-IT cardiovascular outcomes trial supports the safety and efficacy of omega-3 dietary supplements. Each dietary supplement company also acknowledged that as a general matter under federal law dietary supplements may be lawfully marketed to supplement the diet, but they cannot be lawfully marketed to treat, mitigate, or prevent disease, such as cardiovascular disease.

Similarly, on August 30, 2017, Amarin filed a lawsuit with the United States International Trade Commission, or the ITC, against manufacturers, importers, and distributors of products containing synthetically produced omega-3 products in ethyl ester or re-esterified triglyceride form that contain more EPA than DHA or any other single component for use in or as dietary supplements. The lawsuit sought an investigation by the ITC regarding potentially unfair methods of competition and unfair acts involving the importation and sale of articles in the United States that injure or threaten injury to a domestic industry. In October 2017, the ITC determined to not institute our requested investigation. We appealed this determination to the U.S. Federal Circuit, but that court upheld ITC's determination. On July 30, 2019, we filed a petition with the U.S. Supreme Court seeking to appeal the Federal Circuit decision, which petition was denied on December 9, 2019, ending this litigation. We have also engaged with FDA on the topic of synthetically produced omega-3 products through the citizen's petition process and otherwise.

In addition, to the extent the net price of VASCEPA after insurance and offered discounts is significantly higher than the prices of commercially available omega-3 fatty acids marketed by other companies as dietary supplements (through that lack of coverage by insurers or otherwise), physicians and pharmacists may recommend these commercial alternatives instead of writing or filling prescriptions for VASCEPA or patients may elect on their own to take commercially available omega-3 fatty acids. Also, insurance plans may increasingly impose policies that favor supplement use over VASCEPA. While VASCEPA is priced comparatively with, or in some cases lower than, many competing treatments, particularly when taking into account insurance coverage, such pricing might not be sufficient for healthcare providers or patients to elect VASCEPA over alternative treatments that may be perceived as less expense or more convenient to access. If healthcare providers or patients favor dietary supplements over prescribing VASCEPA, we

may be constrained in how we price our product of VASCEPA's market acceptance may be less than expected, which would have a negative impact on our revenues and results of operations.

The commercial value to us of sales of VASCEPA outside the United States may be smaller than we anticipate, including adequacy of product reimbursement such as in Europe, which can vary from country to country resulting in potential patient access restrictions.

There can be no assurance as to the adequacy for commercial success of VASCEPA outside the United States. For example, even if we obtain approval to commercialize VAZKEPA in Europe or we and Edding obtain marketing approval for VASCEPA in Mainland China, Hong Kong, Macau and Taiwan, or the China Territory, applicable regulatory agencies may impose restrictions on the product's conditions for use, distribution or marketing and in some cases may impose ongoing requirements for post-market surveillance, post-approval studies or clinical trials.

Also, there is a degree of unpredictability with regard to the eventual pricing and reimbursement levels of medications in markets outside the United States. In some foreign countries, including major markets in Europe, the pricing of prescription pharmaceuticals is subject to governmental control. In these countries, pricing negotiations with individual governmental authorities can take six to 12 months or longer after the receipt of regulatory marketing approval for a product. The time required to secure reimbursement tends to vary from country to country and cannot be reliably predicted at this time. In certain European countries, securing product reimbursement is a requisite to launching. In all countries securing adequate reimbursement is a requisite for commercial success of any therapeutic. To obtain reimbursement or pricing approval in some countries, we may be required to conduct a pharmacoeconomic study that compares the cost-effectiveness of VASCEPA to other available therapies. Such pharmacoeconomic studies can be costly and the results uncertain. Our business could be harmed if reimbursement of our products is unavailable or limited in scope or amount or if pricing is set at unsatisfactory levels. If the pricing and reimbursement levels of VASCEPA are lower than we anticipate, then affordability of, and market access to, VASCEPA may be adversely affected and thus market potential in these territories would suffer.

We or our partners may even choose to not proceed with marketing VASCEPA in a market, even after a regulatory approval, due to negative commercial dynamics. Furthermore, with regard to any indications for which we may gain approval in territories outside the United States, the number of actual patients with the condition included in such approved indication may be smaller than we anticipate. Further, we could face competition from products similar or deemed equivalent to VASCEPA in various jurisdictions through regulatory pathways that are more lenient than in the United States or in jurisdictions in which we do not have exclusivity from regulations or intellectual property. If any of these market dynamics exist, the commercial potential in these territories for our product would suffer.

Our products and marketing efforts are subject to extensive post-approval government regulation.

Once a product candidate receives FDA marketing approval, numerous post-approval requirements apply. Among other things, the holder of an approved NDA is subject to periodic and other monitoring and reporting obligations enforced by the FDA and other regulatory bodies, including obligations to monitor and report adverse events and instances of the failure of a product to meet the specifications in the approved application. Application holders must also submit advertising and other promotional material to regulatory authorities and report on ongoing clinical trials.

With respect to sales and marketing activities, advertising and promotional materials must comply with FDA rules in addition to other applicable federal and local laws in the United States and in other countries. The result of our First Amendment litigation and settlement may cause the government to scrutinize our promotional efforts or otherwise monitor our business more closely. Industry-sponsored scientific and educational activities also must comply with FDA and other requirements. In the United States, the distribution of product samples to physicians must comply with the requirements of the U.S. Prescription Drug Marketing Act. Manufacturing facilities remain subject to FDA inspection and must continue to adhere to the FDA's pharmaceutical current good manufacturing practice requirements, or cGMPs. Application holders must obtain FDA approval for product and manufacturing changes, depending on the nature of the change.

We also are subject to the federal transparency requirements under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, or collectively the ACA, enacted in March 2010, which require manufacturers of certain drugs, devices, biologics, and medical supplies to report to the Centers for Medicare & Medicaid Services, or CMS, information related to payments and other transfers of value to physicians and teaching hospitals and physician ownership and investment interests. We may also be subject, directly or indirectly through our customers and partners, to various fraud and abuse laws, including, without limitation, the U.S. Anti-Kickback Statute, U.S. False Claims Act, and similar state laws, which impact, among other things, our proposed sales, marketing, and scientific/educational grant programs. We participate in the U.S. Medicaid Drug Rebate Program, the Federal Supply Schedule, or FSS, of the U.S. Department of Veterans Affairs, or the VA, and other government drug programs, and, accordingly, are subject to complex laws and regulations regarding reporting and payment obligations. We must also comply with requirements to collect and report adverse events and product complaints associated with our

products. Our activities are also subject to U.S. federal and state consumer protection and unfair competition laws, non-compliance with which could subject us to significant liability. Similar requirements exist in many of these areas in other countries.

Depending on the circumstances, failure to meet post-approval requirements can result in criminal prosecution, fines or other penalties, injunctions, recall or seizure of products, total or partial suspension of production, denial or withdrawal of pre-marketing product approvals, or refusal to allow us to enter into supply contracts, including government contracts. We may also be held responsible for the non-compliance of our partners, such as our former co-promotion partner Kowa Pharmaceuticals America, Inc. For example, in June 2020, we received a civil investigative demand, or CID, from the U.S. Department of Justice, or the DOJ, informing us that the DOJ is investigating whether aspects of our promotional speaker programs and copayment waiver programs during the period from January 1, 2015 to the present violated the U.S. Anti-Kickback Statute and the U.S. False Claims Act in relation to the sale and marketing of VASCEPA by us and our previous co-marketing partner, Kowa Pharmaceuticals America, Inc. The CID requires us to produce documents and answer written questions, or interrogatories, relevant to the specified time period. We are cooperating with the DOJ. We cannot predict when the investigation will be resolved, the outcome of the investigations or its potential impact on our business. Such investigations can be lengthy, costly and could materially affect and disrupt our business. If the government determines that we have violated the Anti-Kickback Statute and False Claims Act, we could be subject to significant civil and criminal fines and penalties. In addition, even if we comply with FDA and other requirements, new information regarding the safety or effectiveness of a product could lead the FDA to modify or withdraw a product approval. Newly discovered or developed safety or effectiveness data may require changes to a drug's approved labeling and marketing, including the addition of new warnings and contraindications, and also may require the implementation of other risk management measures. Adverse regulatory action, whether pre- or post-approval, can potentially lead to product liability claims and increase our product liability exposure. We must also compete against other products in qualifying for coverage and reimbursement under applicable third-party payment and insurance programs. In addition, all of the above factors may also apply to any regulatory approval for VASCEPA obtained in territories outside the United States. Given our inexperience with marketing and commercializing products outside the United States, in certain territories we may need to rely on third parties, such as our partners in Canada, China and the Middle East, to assist us in dealing with any such issues.

Legislative or regulatory reform of the healthcare system in the United States and foreign jurisdictions may affect our ability to profitably sell VASCEPA.

Our ability to commercialize our future products successfully, alone or with collaborators, will depend in part on the extent to which coverage and reimbursement for the products will be available from government and health administration authorities, private health insurers and other third-party payors. The continuing efforts of the U.S. and foreign governments, insurance companies, managed care organizations and other payors of healthcare services to contain or reduce healthcare costs may adversely affect our ability to set prices for our products which we believe are fair, and our ability to generate revenues and achieve and maintain profitability.

Specifically, in both the United States and some foreign jurisdictions, there have been a number of legislative and regulatory changes and proposed changes to the healthcare system in ways that could affect our ability to sell our products profitably. For example, on August 2, 2011, the Budget Control Act of 2011, among other things, created the Joint Select Committee on Deficit Reduction to recommend to Congress proposals for spending reductions. The Joint Select Committee did not achieve a targeted deficit reduction, which triggered the legislation's automatic reductions. In concert with subsequent legislation, this has resulted in aggregate reductions to Medicare payments to providers of, on average, 2% per fiscal year through 2030 unless Congress takes additional action. These cuts reduce reimbursement payments related to our products, which could potentially negatively impact our revenue. However, these Medicare sequester reductions have been suspended through March 31, 2021 due to the COVID-19 pandemic. Proposed legislation, if passed, would extend this suspension until the end of the pandemic. Also for example, the ACA has substantially changed the way healthcare is financed by both governmental and private insurers and has significantly impacted the U.S. pharmaceutical industry. Among other cost-containment measures, the ACA establishes:

- an annual, nondeductible fee on any entity that manufactures or imports certain branded prescription drugs and biologic agents;
- a new Medicare Part D coverage gap discount program, in which pharmaceutical manufacturers who wish to have their drugs covered under Part D must offer discounts to eligible beneficiaries during their coverage gap period; and
- a new formula that increases the rebates a manufacturer must pay under the Medicaid Drug Rebate Program and extends the Medicaid Drug Rebate Program to individuals enrolled in Medicaid managed care organizations.

There has been increasing legislative and enforcement interest in the United States with respect to specialty drug pricing practices. Specifically, there have been several recent U.S. Congressional inquiries and proposed federal and state legislation designed to, among other things, bring more transparency to drug pricing, reduce the cost of prescription drugs under Medicare, review the relationship between pricing and manufacturer patient programs, and reform government program reimbursement methodologies for drugs. On July 24, 2020 and September 13, 2020, President Trump announced several executive orders related to prescription drug

pricing that seek to implement several of the administration's proposals. In response, the FDA released a final rule on September 24, 2020, which went into effect on November 30, 2020, providing guidance for states to build and submit importation plans for drugs from Canada. Further, on November 20, 2020 CMS issued an Interim Final Rule implementing the Most Favored Nation, or MFN. Model under which Medicare Part B reimbursement rates will be calculated for certain drugs and biologicals based on the lowest price drug manufacturers receive in Organization for Economic Cooperation and Development countries with a similar gross domestic product per capita. The MFN Model regulations mandate participation by identified Part B providers and will apply in all U.S. states and territories for a seven-year period beginning January 1, 2021 and ending December 31, 2027. The Interim Final Rule has not been finalized and is subject to revision and challenge. On November 20, 2020, HHS finalized a regulation removing safe harbor protection for price reductions from pharmaceutical manufacturers to plan sponsors under Part D, either directly or through pharmacy benefit managers, unless the price reduction is required by law. The rule also creates a new safe harbor for price reductions reflected at the point-of-sale, as well as a safe harbor for certain fixed fee arrangements between pharmacy benefit managers and manufacturers. Although a number of these and other proposed measures may require authorization through additional legislation to become effective, and the Biden administration may reverse or otherwise change these measures, Congress has indicated that it will continue to seek new legislative measures to control drug costs. At the state level, legislatures have increasingly passed legislation and implemented regulations designed to control pharmaceutical and biological product pricing, including price or patient reimbursement constraints, discounts, restrictions on certain product access and marketing cost disclosure and transparency measures, and, in some cases, designed to encourage importation from other countries and bulk purchasing. For example, the State of California enacted legislation that requires notice for exceeding specified limits on annual drug price increases and other legislation that seeks to limit the use of co-pay cards in certain situations.

In addition, it is time-consuming and expensive for us to go through the process of seeking coverage and reimbursement from Medicare and private payors. Our products may not be considered cost effective, and government and third-party private health insurance coverage and reimbursement may not be available to patients for any of our future products or sufficient to allow us to sell our products on a competitive and profitable basis. Our results of operations could be adversely affected by ACA and by other healthcare reforms that may be enacted or adopted in the future. In addition, increasing emphasis on managed care in the United States will continue to put pressure on the pricing of pharmaceutical products. For example, proposals are being considered to expand the use of dietary supplements in addition to or in place of drugs in government and private payor plans. In addition, cost control initiatives could decrease the price that we or any potential collaborators could receive for any of our future products and could adversely affect our profitability.

These and similar regulatory dynamics, including the recent entry of a generic version of VASCEPA into the market, and the potential for additional generic version in the near term, can affect our ability to commercialize VASCEPA on commercially reasonable terms and limit the commercial value of VASCEPA.

If we fail to comply with our reporting and payment obligations under the Medicaid Drug Rebate program or other governmental pricing programs, we could be subject to additional reimbursement requirements, penalties, sanctions and fines, which could have a material adverse effect on our business, financial condition, results of operations and growth prospects.

We participate in the Medicaid Drug Rebate program, the 340B drug pricing program, and the VA's FSS pricing program. Under the Medicaid Drug Rebate program, we are required to pay a rebate to each state Medicaid program for our covered outpatient drugs that are dispensed to Medicaid beneficiaries and paid for by a state Medicaid program as a condition of having federal funds being made available to the states for our drugs under Medicaid and Medicare Part B. Those rebates are based on pricing data reported by us on a monthly and quarterly basis to CMS, the federal agency that administers the Medicaid Drug Rebate program. These data include the average manufacturer price and, in the case of innovator products, the best price for each drug which, in general, represents the lowest price available from the manufacturer to any entity in the U.S. in any pricing structure, calculated to include all sales and associated rebates, discounts and other price concessions. Our failure to comply with these price reporting and rebate payment obligations could negatively impact our financial results.

The ACA made significant changes to the Medicaid Drug Rebate program. CMS issued a final regulation, which became effective on April 1, 2016, to implement the changes to the Medicaid Drug Rebate program under the ACA. The issuance of the final regulation has increased and will continue to increase our costs and the complexity of compliance, has been and will continue to be time-consuming to implement, and could have a material adverse effect on our results of operations, particularly if CMS challenges the approach we take in our implementation of the final regulation.

Federal law requires that any company that participates in the Medicaid Drug Rebate program also participate in the Public Health Service's 340B drug pricing program in order for federal funds to be available for the manufacturer's drugs under Medicaid and Medicare Part B. The 340B program requires participating manufacturers to agree to charge statutorily defined covered entities no more than the 340B "ceiling price" for the manufacturer's covered outpatient drugs. These 340B covered entities include a variety of community health clinics and other entities that receive health services grants from the Public Health Service, as well as hospitals that serve a disproportionate share of low-income patients. The 340B ceiling price is calculated using a statutory formula based on the average manufacturer price and Medicaid rebate amount for the covered outpatient drug as calculated under the Medicaid Drug Rebate program, and in general, products subject to Medicaid price reporting and rebate liability are also subject to the 340B ceiling price calculation and discount requirement. Any additional future changes to the definition of average manufacturer price and the Medicaid rebate amount under the ACA, other legislation, or in regulation could affect our 340B ceiling price calculations and negatively impact our results of operations.

The Health Resources and Services Administration, or HRSA, which administers the 340B program, issued a final regulation regarding the calculation of the 340B ceiling price and the imposition of civil monetary penalties on manufacturers that knowingly and intentionally overcharge covered entities, which became effective on January 1, 2019. It is currently unclear how HRSA will apply its enforcement authority under the new regulation. We also are required to report our 340B ceiling prices to HRSA on a quarterly basis. Implementation of the civil monetary penalties regulation and the issuance of any other final regulations and guidance could affect our obligations under the 340B program in ways we cannot anticipate. In addition, legislation may be introduced that, if passed, would further expand the 340B program to additional covered entities or would require participating manufacturers to agree to provide 340B discounted pricing on drugs used in the inpatient setting.

Pricing and rebate calculations vary across products and programs, are complex, and are often subject to interpretation by us, governmental or regulatory agencies and the courts. In the case of our Medicaid pricing data, if we become aware that our reporting for a prior quarter was incorrect, or has changed as a result of recalculation of the pricing data, we are obligated to resubmit the corrected data for up to three years after those data originally were due. Such restatements and recalculations increase our costs for complying with the laws and regulations governing the Medicaid Drug Rebate program and could result in an overage or underage in our rebate liability for past quarters. Price recalculations also may affect the ceiling price at which we are required to offer our products under the 340B program or could require us to issue refunds to 340B covered entities.

Significant civil monetary penalties can be applied if we are found to have knowingly submitted any false pricing information to CMS, or if we fail to submit the required price data on a timely basis. Such conduct also could be grounds for CMS to terminate our Medicaid drug rebate agreement, in which case federal payments may not be available under Medicaid or Medicare Part B for our covered outpatient drugs. Significant civil monetary penalties also can be applied if we are found to have knowingly and intentionally charged 340B covered entities more than the statutorily mandated ceiling price. We cannot assure you that our submissions will not be found by CMS or HRSA to be incomplete or incorrect.

In order to be eligible to have our products paid for with federal funds under the Medicaid and Medicare Part B programs and purchased by certain federal agencies and grantees, as noted above, we participate in the VA's FSS pricing program. As part of this program, we are obligated to make our products available for procurement on an FSS contract under which we must comply with standard government terms and conditions and charge a price that is no higher than the statutory Federal Ceiling Price, or FCP, to four federal agencies (the VA, U.S. Department of Defense, or DOD, Public Health Service, and the U.S. Coast Guard). The FCP is based on the Non-Federal Average Manufacturer Price, or Non-FAMP, which we calculate and report to the VA on a quarterly and annual basis. Pursuant to applicable law, knowing provision of false information in connection with a Non-FAMP filing can subject a manufacturer to significant penalties for each item of false information. These obligations also contain extensive disclosure and certification requirements.

We also participate in the Tricare Retail Pharmacy program, under which we pay quarterly rebates on utilization of innovator products that are dispensed through the Tricare Retail Pharmacy network to Tricare beneficiaries. The rebates are calculated as the difference between the annual Non-FAMP and FCP. We are required to list our covered products on a Tricare Agreement in order for these products to be eligible for DOD formulary inclusion. If we overcharge the government in connection with our FSS contract or Tricare Agreement, whether due to a misstated FCP or otherwise, we are required to refund the difference to the government. Failure to make necessary disclosures and/or to identify contract overcharges can result in allegations against us under the False Claims Act and other laws and regulations. Unexpected refunds to the government, and responding to a government investigation or enforcement action, would be expensive and time-consuming, and could have a material adverse effect on our business, financial condition, results of operations and growth prospects.

Changes in reimbursement procedures by government and other third-party payors may limit our ability to market and sell our approved drugs. These changes could have a material adverse effect on our business and financial condition.

In the U.S. and abroad, sales of pharmaceutical drugs are dependent, in part, on the availability of reimbursement to the consumer from third-party payors, such as government and private insurance plans. Third-party payors are increasingly challenging the prices charged for medical products and services. Some third-party payor benefit packages restrict reimbursement, charge copayments to patients, or do not provide coverage for specific drugs or drug classes.

In addition, certain healthcare providers are moving toward a managed care system in which such providers contract to provide comprehensive healthcare services, including prescription drugs, for a fixed cost per person. We are unable to predict the reimbursement policies employed by third-party healthcare payors.

We expect to experience pricing and reimbursement pressures in connection with the sale of our products due to the trend toward managed healthcare, the increasing influence of health maintenance organizations and additional legislative and executive proposals. In addition, we may confront limitations in insurance coverage for our products. If we fail to successfully secure and maintain reimbursement coverage for our approved drugs or are significantly delayed in doing so, we may have difficulty achieving market acceptance of our approved drugs and investigational drug candidates for which we obtain approval, and our business may be harmed. Congress has enacted healthcare reform and may enact further reform, which could adversely affect the pharmaceutical industry as a whole, and therefore could have a material adverse effect on our business.

Ongoing healthcare legislative and regulatory reform measures may have a material adverse effect on our business and results of operations.

Certain provisions of the ACA have been subject to judicial challenges, as well as efforts to repeal or replace them or to alter their interpretation or implementation. Since January 2017, the Trump administration has signed Executive Orders designed to delay the implementation of certain provisions of the ACA or otherwise circumvent some of the requirements for health insurance mandated by the ACA. One Executive Order directs federal agencies with authorities and responsibilities under the ACA to waive, defer, grant exemptions from, or delay the implementation of any provision of the ACA that would impose a fiscal or regulatory burden on states, individuals, healthcare providers, health insurers, or manufacturers of pharmaceuticals or medical devices. The second Executive Order terminated the cost-sharing subsidies under the ACA. Nineteen state Attorneys General filed suit to stop the administration from terminating the subsidies, but on July 18, 2018, the U.S. District Court for the Northern District of California dismissed the case without prejudice. Further, on June 14, 2018, U.S. Court of Appeals for the Federal Circuit ruled that, due to Congressional appropriations riders that prohibited the HHS from paying out more in risk corridor payments than it collected, HHS was not required to pay more than $12.0 billion in ACA risk corridor payments owed to insurers under the risk corridor formula. On November 6, 2018, the Federal Circuit declined to rehear the case en banc. This decision was appealed to the U.S. Supreme Court, which on April 27, 2020, reversed the U.S. Court of Appeals for the Federal Circuit's decision and remanded the case to the U.S. Court of Federal Claims, concluding the government has an obligation to pay these risk corridor payments under the relevant formula. It is not clear what effect this result will have on our business, but we will continue to monitor any developments. Moreover, the Tax Act included a provision that eliminated the tax-based shared responsibility payment for individuals who fail to maintain minimum essential coverage under section 5000A of the Internal Revenue Code of 1986, commonly referred to as the "individual mandate," effective January 1, 2019. The Bipartisan Budget Act of 2018, or the BBA, among other things, amends the ACA to create a new Medicare Part D coverage gap discount program, in which manufacturers must agree to offer 70% (an increase from 50% effective as of January 1, 2019) point-of-sale discounts off negotiated prices of applicable brand drugs to eligible beneficiaries during their coverage gap period as a condition for the manufacturer's outpatient drugs to be covered under Medicare Part D. Under the Trump Administration, CMS issued regulations that gave states greater flexibility, starting in 2020, in the identification of the essential health benefits benchmarks for non-grandfathered individual and small group market health insurance coverage, including plans sold through the health insurance exchanges established under the ACA. On December 14, 2018, the U.S. District Court for the Northern District of Texas ruled (i) that the "individual mandate" was unconstitutional as a result of the associated tax penalty being repealed by Congress as part of the Tax Act; and (ii) the individual mandate is not severable from the rest of the ACA, as a result the entire ACA is invalid. On December 18, 2019, the U.S. Court of Appeals for the Fifth Circuit affirmed the district court's decision that the individual mandate is unconstitutional, but remanded the case to the district court to reconsider the severability question. On March 2, 2020, the U.S. Supreme Court granted the petitions for writs of certiorari to review this case and held oral arguments on November 10, 2020. It is unclear how the ultimate decision in this case, which is now pending before the U.S. Supreme Court, or other efforts to repeal, replace, or invalidate the ACA or its implementing regulations, or portions thereof, will impact our business. We will continue to evaluate the effect that the ACA and its possible repeal, replacement, or invalidation, in whole or in part, has on our business.

The Trump administration's budget proposal for fiscal year 2021 included a $135.0 billion allowance to support legislative proposals seeking to reduce drug prices, increase competition, lower out-of-pocket drug costs for patients, and increase patient access to lower-cost generic and biosimilar drugs. On March 10, 2020, the Trump administration sent "principles" for drug pricing to Congress, calling for legislation that would, among other things, cap Medicare Part D beneficiary out-of-pocket pharmacy expenses, provide an option to cap Medicare Part D beneficiary monthly out-of-pocket expenses, and place limits on pharmaceutical price increases. Further, the Trump administration also previously released a "Blueprint" to lower drug prices and reduce out of pocket costs of drugs that contains additional proposals to increase manufacturer competition, increase the negotiating power of certain federal healthcare programs, incentivize manufacturers to lower the list price of their products and reduce the out of pocket costs of drug products paid by consumers. The HHS has already started the process of soliciting feedback on some of these measures and, at the same time, is immediately implementing others under its existing authority. For example, in May 2019, CMS issued a final rule to allow Medicare Advantage Plans the option of using step therapy for Part B drugs beginning January 1, 2020. However, it is unclear whether the Biden administration will challenge, reverse, revoke or otherwise modify these executive and administrative actions after January 20, 2021. In addition, there have been several changes to the 340B drug pricing program, which imposes ceilings on prices that drug manufacturers can charge for medications sold to certain health care facilities. On December 27, 2018, the District Court for the District of Columbia invalidated a reimbursement formula change under the 340B drug pricing program, and CMS subsequently altered the FYs 2019 and 2018 reimbursement formula on specified covered outpatient drugs, or SCODs. The court ruled this change was not an "adjustment" which was within the Secretary's discretion to make but was instead a fundamental change in the reimbursement calculation. However, most recently, on July 31, 2020, the U.S. Court of Appeals for the District of Columbia Circuit overturned the district court's decision and found that the changes were within the Secretary's authority. On September 14, 2020, the plaintiffs-appellees filed a Petition for Rehearing En Banc (i.e., before the full court), but was denied on October 16, 2020. It is unclear how these developments could affect covered hospitals who might purchase our future products and affect the rates we may charge such facilities for our approved products in the future, if any. We expect that the healthcare reform measures that have been adopted and may be adopted in the future, may result in more rigorous coverage criteria, and new payment methodologies, and in additional downward pressure on coverage and payment and the price that we receive for any approved product, and could seriously harm our future revenues. Any reduction in reimbursement from Medicare or other government programs may result in a similar reduction in payments from private third-party payors.

There have been, and likely will continue to be, legislative and regulatory proposals at the foreign, federal and state levels directed at broadening the availability of healthcare and containing or lowering the cost of healthcare. The enactment and implementation of cost containment measures or other healthcare reforms may prevent us from being able to generate revenue, attain profitability, or commercialize our product. Such reforms could have an adverse effect on anticipated revenue from product candidates that we may successfully develop and for which we may obtain regulatory approval and may affect our overall financial condition and ability to develop product candidates.

Failure to comply with health and data protection laws and regulations could lead to government enforcement actions (which could include civil or criminal penalties), private litigation, and/or adverse publicity and could negatively affect our operating results and business.

We and any potential collaborators may be subject to federal, state, and foreign data protection laws and regulations (i.e., laws and regulations that address privacy and data security). In the United States, numerous federal and state laws and regulations, including federal health information privacy laws, state data breach notification laws, state health information privacy laws, and federal and state consumer protection laws (e.g., Section 5 of the Federal Trade Commission Act), that govern the collection, use, disclosure and protection of health-related and other personal information could apply to our operations or the operations of our collaborators. In addition, we may obtain health information from third parties (including research institutions from which we obtain clinical trial data) that are subject to privacy and security requirements under the federal Health Insurance Portability and Accountability Act of 1996, or HIPAA. Although we are not directly subject to HIPAA – other than with respect to providing certain employee benefits – we could potentially be subject to criminal penalties if we, our affiliates, or our agents knowingly obtain, use, or disclose individually identifiable health information maintained by a HIPAA-covered entity in a manner that is not authorized or permitted by HIPAA. In addition, state laws govern the privacy and security of health information in specified circumstances, many of which differ from each other in significant ways and may not have the same effect, thus complicating compliance efforts.

Compliance with U.S. and international data protection laws and regulations could require us to take on more onerous obligations in our contracts, restrict our ability to collect, use and disclose data, or in some cases, impact our ability to operate in certain jurisdictions. Failure to comply with these laws and regulations could result in government enforcement actions (which could include civil, criminal and administrative penalties), private litigation, and/or adverse publicity and could negatively affect our operating results and business. Moreover, clinical trial subjects, employees and other individuals about whom we or our potential collaborators obtain personal information, as well as the providers who share this information with us, may limit our ability to collect, use and disclose the information. Claims that we have violated individuals' privacy rights, failed to comply with data protection laws, or breached our contractual obligations, even if we are not found liable, could be expensive and time-consuming to defend and could result in adverse publicity that could harm our business.

European data collection is governed by restrictive regulations governing the use, processing and cross-border transfer of personal information.

The REDUCE-IT cardiovascular outcomes trial was conducted in part through clinical sites in the EU. As a result, we are subject to additional privacy restrictions. The collection and use of personal health data in the EU is governed by the provisions of the General Data Protection Regulation, or GDPR. The GDPR imposes several requirements relating to the legal basis for processing personal data which may include the consent of the individuals to whom the personal data relates, the information provided to the individuals and the security and confidentiality of the personal data. The GDPR also imposes strict rules on the transfer of personal data out of the EU to the United States. Failure to comply with the requirements of the GDPR, and the related national data protection laws of the EU Member States may result in restrictions against regulatory approval in the EU or substantial fines for breaches of the data protection rules. The GDPR may impose additional responsibility and liability in relation to personal data that we process and we may be required to put in place additional mechanisms ensuring compliance with these and/or new data protection rules. This may be onerous and adversely affect our business, financial condition, prospects and results of operations.

The FDA and other regulatory agencies strictly regulate the promotional claims that may be made about prescription products and promotional efforts such as speaker programs. If we or our partners are found to have improperly promoted uses, efficacy or safety of VASCEPA or otherwise are found to have violated the law or applicable regulations, we may become subject to significant fines and other liability. The government may seek to find means to prevent our promotion of truthful and non-misleading information beyond the current court ruling and litigation settlement or seek to find violations of other laws or regulations in connection with the promotional efforts we undertake on our own or through third parties.

The FDA and other regulatory agencies strictly regulate the promotional claims that may be made about prescription products. In particular, in general, the U.S. government's position has been that a product may not be promoted for uses that are not approved by the FDA as reflected in the product's approved labeling. The Federal government has levied large civil and criminal fines against companies for alleged improper promotion and has enjoined several companies from engaging in off-label promotion. The FDA has also requested that companies enter into consent decrees or permanent injunctions under which specified promotional conduct is changed or curtailed. Even though we received FDA marketing approval for VASCEPA for the MARINE indication and for cardiovascular risk reduction based on the REDUCE-IT study, and we believe the First Amendment court ruling and litigation settlement affords us a degree of protection for other promotional efforts, physicians may still prescribe VASCEPA to their patients for use in the treatment of conditions that are not included as part of the indication statement in our FDA-approved VASCEPA label or our settlement. If we are found to have promoted VASCEPA outside the terms of the litigation settlement or in violation of what federal or state government may determine to be acceptable, we may become subject to significant government fines and other related liability, such as under the FDCA, the False Claims Act, or other theories of liability. Government may also seek to hold us responsible for the non-compliance of our former co-promotion partner, Kowa, or our commercialization partners outside the United States or other third-parties that we retain to help us implement our business plan.

In addition, incentives exist under applicable laws that encourage competitors, employees and physicians to report violations of rules governing promotional activities for pharmaceutical products. These incentives could lead to so-called "whistleblower lawsuits" as part of which such persons seek to collect a portion of moneys allegedly overbilled to government agencies due to, for example, promotion of pharmaceutical products beyond labeled claims. These incentives could also lead to suits that we have mischaracterized a competitor's product in the marketplace and we may, as a result, be sued for alleged damages to our competitors. Such lawsuits, whether with or without merit, are typically time-consuming and costly to defend. Such suits may also result in related shareholder lawsuits, which are also costly to defend.

In June 2020, we received a civil investigative demand, or CID, from the U.S. Department of Justice, or the DOJ, informing us that the DOJ is investigating whether aspects of our promotional speaker programs and copayment waiver program during the period from January 1, 2015 to the present violated the U.S. Anti-Kickback Statute and the U.S. False Claims Act in relation to the sale and marketing of VASCEPA by us and our previous co-marketing partner, Kowa Pharmaceuticals America, Inc. The CID requires us to produce documents and answer written questions, or interrogatories, relevant to the specified time period. We are cooperating with the DOJ. We cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on our business. Such investigations can be lengthy, costly and could materially affect and disrupt our business. If the government determines that we have violated the Anti-Kickback Statute and False Claims Act, we could be subject to significant civil and criminal fines and penalties.

We may not be successful in developing and receiving regulatory approval for VASCEPA in other jurisdictions or marketing future products if we cannot meet the extensive regulatory requirements of regulatory agencies such as for quality, safety, efficacy and data privacy.

The success of our research and development efforts is dependent in part upon our ability, and the ability of our partners or potential partners, to meet regulatory requirements in the jurisdictions where we or our partners or potential partners ultimately intend to sell such products once approved. The development, manufacture and marketing of pharmaceutical products are subject to extensive regulation by governmental authorities in the United States and elsewhere. In the United States, the FDA generally requires preclinical testing and clinical trials of each drug to establish its safety and efficacy and extensive pharmaceutical development to ensure its quality before its introduction into the market. Regulatory authorities in other jurisdictions impose similar requirements. The process of obtaining regulatory approvals is lengthy and expensive and the issuance of such approvals is uncertain. The commencement and rate of completion of clinical trials and the timing of obtaining marketing approval from regulatory authorities may be delayed by many factors, including, among others:

- the lack of efficacy during clinical trials;
- the inability to manufacture sufficient quantities of qualified materials under cGMPs for use in clinical trials;
- slower than expected rates of patient recruitment;
- the inability to observe patients adequately after treatment;
- changes in regulatory requirements for clinical trials or preclinical studies;
- the emergence of unforeseen safety issues in clinical trials or preclinical studies;
- delay, suspension, or termination of a trial by the institutional review board responsible for overseeing the study at a particular study site;
- unanticipated changes to the requirements imposed by regulatory authorities on the extent, nature or timing of studies to be conducted on quality, safety and efficacy;
- compliance with laws and regulations related to patient data privacy;
- government or regulatory delays or "clinical holds" requiring suspension or termination of a trial; and
- political instability or other social or government protocols affecting our clinical trial sites.

Even if we obtain positive results from our efforts to seek regulatory approvals, from early stage preclinical studies or clinical trials, we may not achieve the same success in future efforts. Clinical trials that we or potential partners conduct may not provide sufficient safety and efficacy data to obtain the requisite regulatory approvals for product candidates. The failure of clinical trials to demonstrate safety and efficacy for our desired indications could harm the development of that product candidate as well as other product candidates, and our business and results of operations would suffer. For example, during the public advisory committee meeting held by FDA as part of its review of our ANCHOR data and sNDA in October 2013, a discussion regarding observed, nominally statistically significant changes from baseline in an adverse direction, while on background statin therapy, in certain lipid parameters, including LDL cholesterol and triglycerides, in the placebo group, raised questions about the possibility that the light liquid paraffin oil, or mineral oil, placebo used in the ANCHOR trial and then in use in the REDUCE-IT trial might not be biologically inert and might be viewed as artificially exaggerating the clinical effect of VASCEPA when measured against placebo. Ultimately, in 2012, no strong evidence for biological activity of mineral oil was identified by the FDA before its approval of VASCEPA after review of the MARINE and ANCHOR trials and consideration of other data regarding mineral oil. It was ultimately concluded that the between-group differences likely provided the most appropriate descriptions of the treatment effect of VASCEPA and that whatever factor(s) led to the within-group changes over time in the placebo group were likely randomly distributed to all treatment groups. Thus, the FDA approved VASCEPA for use in the MARINE indication in July 2012, FDA did not dispute the veracity of the ANCHOR trial data and, in connection with the March 2016 agreement we reached with the FDA allowing us to promote the results of the ANCHOR study, the FDA did not seek to require that we include any qualification related to this earlier question regarding the mineral oil placebo. For example, in connection with FDA's review of REDUCE-IT data and sNDA in 2019, the agency determined that an interaction between mineral oil and statins leading to decreased absorption of statins cannot be excluded when the two are co-administered as could have been the case in some patients in REDUCE-IT and that, in the agency's view, indirect evidence suggested the presence of a potential inhibitory effect on statin absorption by mineral oil. However, FDA's exploratory analysis indicated that the effect of LDL cholesterol values on the time to the primary endpoint was numerically small and unlikely to change the overall conclusion of treatment benefit. FDA then relied on this assessment and all data available to it to approve a new indication statement and labeling based on REDUCE-IT results. This matter illustrates that concerns such as this may arise in the future that could affect our product development, regulatory reviews or the public perception of our products and our future prospects, including REDUCE-IT results. Any approvals that are obtained may be limited in scope, may require additional post-approval studies

or may require the addition of labeling statements, including boxed warnings, focusing on product safety that could affect the commercial potential for our product candidates. Any of these or similar circumstances could adversely affect our ability to gain approval for new indications and affect revenues from the sale of our products. Even in circumstances where products are approved by a regulatory body for commercialization, the regulatory or legal requirements may change over time, or new safety or efficacy information may be identified concerning a product, which may lead to the withdrawal of a product from the market or similar use restrictions. The discovery of previously unknown problems with a clinical trial or product, or in connection with the manufacturer of products, may result in regulatory issues that prevent proposed future approvals of a product and/or restrictions on that product or manufacturer, including withdrawal of an indication or the product from the market, which would have a negative impact on our potential revenue stream.

As we continue to build our infrastructure for commercializing VASCEPA, we may encounter difficulties in managing our growth and expanding our operations successfully.

The process of establishing, maintaining and expanding a commercial infrastructure is difficult, expensive and time-consuming. Prior to the REDUCE-IT results topline announcement in September 2018, our U.S. direct sales force consisted of approximately 170 sales professionals, including sales representatives and their managers. Based on the positive REDUCE-IT results, in early 2019, we increased the size of our U.S. direct sales force to approximately 440 sales professionals, including approximately 400 sales representatives. As a result of the additional indication and label expansion approved by the U.S. FDA in December 2019, for cardiovascular risk reduction, we completed the further expansion of our U.S. direct sales force to approximately 900 sales professionals, including approximately 800 sales representatives in early 2020. As a result of the COVID-19 pandemic and the related social distancing, in March 2020, we suspended face-to-face interactions between our sales representatives and healthcare professionals. We resumed on a limited basis field-based, face-to-face interactions with healthcare providers beginning in June 2020. During the late part of the summer, substantially all of our field force personnel were able to resume face-to-face customer interactions in a manner consistent with guidelines from local, state and government health officials in the United States. In the fourth quarter of 2020, the impact of COVID-19 worsened in much of the United States, with some physicians again limiting access to face-to-face interactions with our field force personnel. Accordingly, we have intentionally slowed the hiring of replacements for our open positions which resulted from ordinary turnover. As we witness our sales representatives increasingly able to resume direct interactions with healthcare professionals, we continually evaluate our needs and it is our intention to fill a significant number of these positions, provided such replacement is appropriate to meet our business needs. As of December 31, 2020, our U.S. direct sales force was slightly more than 800 sales professionals, including slightly more than 700 sales representatives. This sales team promotes VASCEPA to a limited group of physicians and other healthcare professionals in select geographies in the United States and is not large enough to call upon all physicians.

In addition to sales force expansion in the United States, we continue to work on our own and with our international partners to support regulatory efforts outside the United States based on REDUCE-IT results. As our operations expand with the anticipated growth of our product sales, we expect that we will need to manage additional relationships with various collaborative partners, suppliers and other third parties. Future growth will impose significant added responsibilities on members of management, including the need to identify, recruit, maintain and integrate additional employees. For example, in Europe we commenced 2021 with approximately 50 professionals involved in pre-approval and pre-launch planning and other commercial preparation activities, with plans to expand to approximately 200 professionals by the end of 2021. The time required to secure reimbursement tends to vary from country to country and cannot be reliably predicted at this time. While we believe that we have strong arguments regarding the cost effectiveness of VAZKEPA, the success of such reimbursement negotiations could have a significant impact on our ability to hire and retain personnel and realize the commercial opportunity of VAZKEPA in Europe. Our future financial performance and our ability to commercialize VASCEPA and to compete effectively will depend, in part, on our ability to manage our future growth effectively, and such efforts may be disrupted by the COVID-19 protocols. To that end, we must be able to manage our development efforts effectively, and hire, train, integrate and retain additional management, administrative and sales and marketing personnel and have limited experience managing a commercial organization. We may not be able to accomplish these tasks, and our failure to accomplish any of them could prevent us from successfully growing our company.

Risks Related to Our Reliance on Third Parties

Our supply of product for the commercial market and clinical trials is dependent upon relationships with third-party manufacturers and suppliers.

We have no in-house manufacturing capacity and rely on contract manufacturers for our clinical and commercial product supply. We cannot ensure that we will successfully manufacture any product we may develop, either independently or under manufacturing arrangements, if any, with our third-party manufacturers. Moreover, if our manufacturers should cease doing business with us or experience delays, shortages of supply or excessive demands on their capacity, we may not be able to obtain adequate quantities of product in a timely manner, or at all. If we are not able to continue to operate our business relationships in a manner that

is sufficiently profitable for us and our suppliers, certain members of our supply chain could compete with us through supply to competitors, such as generic drug companies, through breach of our agreements or otherwise.

Any manufacturing problem, natural or manmade disaster affecting manufacturing facilities, government action, or the loss of a contract manufacturer could be disruptive to our operations and result in lost sales. Any reliance on suppliers may involve several risks, including a potential inability to obtain critical materials and reduced control over production costs, delivery schedules, reliability and quality. Any unanticipated disruption to future contract manufacture caused by problems at suppliers could delay shipment of products, increase our cost of goods sold and/or result in lost sales. If our suppliers were unable to supply us with adequate volumes of active pharmaceutical ingredient (drug substance) or encapsulated bulk product (drug product), it would have a material adverse effect on our ability to continue to commercialize VASCEPA.

We have contractual freedom to source the API for VASCEPA and to procure other services supporting our supply chain. We have entered into supply agreements with multiple suppliers who also rely on other third-party suppliers to manufacture the API and other elements necessary for the sale of VASCEPA. Our strategy in sourcing API and other components in our supply chain from multiple suppliers has been to expand manufacturing capacity, maintain competitive advantages, and mitigate the risk of reliance on any single supplier.

Expanding manufacturing capacity and qualifying such capacity is complex and subject to numerous regulations and other operational challenges. The resources of our suppliers vary and are limited; costs associated with projected expansion and qualification can be significant. There can be no assurance that the expansion plans of any of our suppliers will be successful. Our aggregate capacity to produce API is dependent upon the continued qualification of our API suppliers and, depending on the ability of existing suppliers to meet our supply demands, potentially the qualifications of new suppliers. Each of our API suppliers has outlined plans for potential further capacity expansion. If no additional API supplier is approved by the FDA as part of an sNDA, our API supply will be limited to the API we purchase from previously approved suppliers. If our third-party manufacturing capacity is not expanded and/or compliant with applicable regulatory requirements, we may not be able to supply sufficient quantities of VASCEPA to meet anticipated demand. We cannot guarantee that we can contract with any future manufacturer on acceptable terms or that any such alternative supplier will not require capital investment from us in order for them to meet our requirements. Alternatively, our purchase of supply may exceed actual demand for VASCEPA.

There can be no guarantee that current suppliers and future suppliers with which we have contracted to encapsulate API will be continually qualified to manufacture the product to our specifications or that current and any future suppliers will have the manufacturing capacity to meet anticipated demand for VASCEPA.

We may purchase too much or not enough supply to satisfy actual demand, which could have a material adverse effect on our financial results and financial condition.

Certain of our agreements with our suppliers include minimum purchase obligations and limited exclusivity provisions. These purchases are generally made on the basis of rolling 12-month forecasts which in part are binding on us and the balance of which are subject to adjustment by us subject to certain limitations. Certain of our agreements also include contractual minimum purchase commitments regardless of the rolling 12-month forecasts. We may not purchase sufficient quantities of VASCEPA to meet actual demand or our purchase of supply may exceed actual demand. In either case, such event could have a material adverse effect on our financial results and financial condition.

Our dependence on third parties in the distribution channel from our manufacturers to patients subject us to risks that limit our profitability and could limit our ability to supply VASCEPA to large market segments.

We sell VASCEPA principally to a limited number of major wholesalers, as well as selected regional wholesalers and specialty pharmacy providers, or collectively, our distributors or our customers, that in turn resell VASCEPA to retail pharmacies for subsequent resale to patients and healthcare providers. These parties exercise a substantial amount of bargaining power over us given their control over large segments of the market for VASCEPA. This bargaining power has led us to bear increasingly higher discounts in the sale of VASCEPA. In addition, payors have broad latitude to change individual products' formulary position or to implement other barriers that inhibit patients from receiving therapies prescribed by their healthcare professionals. These payor barriers include requirements that patients try another drug before VASCEPA, known as step edits, and the requirement that prior authorization be obtained by a healthcare provider after a prescription is written before a patient will be reimbursed by their health plan for the cost of a VASCEPA prescription. Further, pharmacy benefit managers implement plans that act as disincentives for VASCEPA use, such as increasingly higher deductibles. One practical impact of higher deductibles is that they may cause patients to delay filling prescriptions for asymptomatic, chronic care medications such as hypertriglyceridemia earlier in the year, until patients meet their deductible and the cost of VASCEPA is then borne more by their insurance carrier. Collectively, these dynamics negatively affect our profitability for the sale of VASCEPA and could increase over time further impacting our operating results. Consolidation among these industry participants could increase the pressure from these market dynamics.

The manufacture, packaging and distribution of pharmaceutical products such as VASCEPA are subject to FDA regulations and those of similar foreign regulatory bodies. If we or our third-party manufacturers fail to satisfy these requirements, our product development and commercialization efforts may be materially harmed.

The manufacture, packaging and distribution of pharmaceutical products, such as VASCEPA, are regulated by the FDA and similar foreign regulatory bodies and must be conducted in accordance with the FDA's cGMPs and comparable requirements of foreign regulatory bodies. There are a limited number of manufacturers that operate under these cGMPs as well as the International Council for Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use, or ICH, regulations and guidelines, that are both capable of manufacturing VASCEPA and willing to do so. Failure by us or our third-party manufacturers to comply with applicable regulations, requirements, or guidelines could result in sanctions being imposed on us, including fines, injunctions, civil penalties, failure of regulatory authorities to grant marketing approval of our products, delays, suspension or withdrawal of approvals, license revocation, seizures or voluntary recalls of product, operating restrictions and criminal prosecutions and penalties, any of which could significantly and adversely affect our business. If we are not able to manufacture VASCEPA to required specifications through our current and potential API suppliers, we may be delayed in successfully supplying the product to meet anticipated demand and our anticipated future revenues and financial results may be materially adversely affected.

Changes in the manufacturing process or procedure, including a change in the location where the product is manufactured or a change of a third-party manufacturer, may require prior FDA review and pre-approval of the manufacturing process and procedures in accordance with the FDA's cGMPs. Any new facility may be subject to a pre-approval inspection by the FDA and would again require us to demonstrate product comparability to the FDA. There are comparable foreign requirements under ICH guidelines. In addition, COVID-19 has limited the ability of suppliers to be inspected. This review may be costly and time consuming and could delay or prevent the launch of a product.

Furthermore, the FDA and foreign regulatory agencies require that we be able to consistently produce the API and the finished product in commercial quantities and of specified quality on a repeated basis, including demonstrated product stability, and document our ability to do so. This requirement is referred to as process validation. This includes stability testing, measurement of impurities and testing of other product specifications by validated test methods. If the FDA does not consider the result of the process validation or required testing to be satisfactory, the commercial supply of VASCEPA may be delayed, or we may not be able to supply sufficient quantities of VASCEPA to meet anticipated demand.

The FDA and similar foreign regulatory bodies may also implement new requirements, or change their interpretation and enforcement of existing requirements, for manufacture, packaging or testing of products at any time. If we or our approved suppliers are unable to comply, we may be subject to regulatory, civil actions or penalties, or we may be prevented from manufacturing or selling VASCEPA, all of which could significantly and adversely affect our business.

Our commercialization of VASCEPA outside the United States is substantially dependent on third parties and other circumstances outside our control.

We have expanded our VASCEPA commercialization activities outside of the United States through several contractual arrangements in territories including China, the Middle East, North Africa and Canada. We continue to assess other opportunities to develop VASCEPA commercialization outside of the United States through similar arrangements.

In February 2015, we entered into a Development, Commercialization and Supply Agreement, or the DCS Agreement, with Eddingpharm (Asia) Macao Commercial Offshore Limited, or Edding, related to the development and commercialization of VASCEPA in the China Territory. Under the DCS Agreement, Edding is responsible for development and commercialization activities in the China Territory and associated expenses. Additionally, Edding is required to conduct clinical trials in the China Territory to secure regulatory approval in certain territories. For example, in December 2017, Edding commenced a pivotal clinical trial aimed to demonstrate that VASCEPA lowers triglyceride levels and otherwise has beneficial effects in Chinese patients with severe hypertriglyceridemia (TG >500 mg/dL), as we previously demonstrated with VASEPA in the more diverse population studied in the MARINE study. In November 2020, we announced statistically significant positive topline results from our Phase 3 clinical trial of VASCEPA. On February 9, 2021, we announced that the regulatory review processes for approval of VASCEPA in Mainland China and Hong Kong have commenced. The Chinese National Medical Products Administration, or NMPA, has accepted for review the new drug application for VASCEPA, submitted by Edding, based on the results from the Phase 3 clinical trial and the results from our prior studies of VASCEPA. We expect to receive a decision from the NMPA in Mainland China near the end of 2021. The Hong Kong Department of Health is evaluating VASCEPA based on current approvals in the United States and Canada. The review process in Hong Kong is expected to conclude near the end of 2021. Even though such results are similar to the MARINE study, additional clinical development efforts may be necessary in this market to demonstrate the effectiveness of VASCEPA in reducing major adverse cardiovascular events in Chinese patients with persistent cardiovascular risk. Any development and regulatory efforts in the China Territory may be negatively impacted by the spread of the coronavirus and the unexpected diversion of resources by regulators and industry professionals to address the coronavirus outbreak. Any development and regulatory efforts in the China Territory may be negatively impacted by heightened political tension between China and the United States, including in connection with COVID-19

and other issues expressed between the countries regarding trade practices, tariffs and honoring intellectual property rights. If Edding is not able to effectively develop and commercialize VASCEPA in the China Territory, we may not be able to generate revenue from the DCS Agreement resulting from the sale of VASCEPA in the China Territory.

In March 2016, we entered into an agreement with Biologix FZCo, or Biologix, to register and commercialize VASCEPA in several Middle Eastern and North African countries. Under the terms of the distribution agreement, we granted to Biologix a non-exclusive license to use our trademarks in connection with the importation, distribution, promotion, marketing and sale of VASCEPA in the Middle East and North Africa territory. Biologix obtained approval of VASCEPA in Lebanon in March 2018, in United Arab Emirates in July 2018, in Qatar in January 2020 and Bahrain in December 2020. VASCEPA was launched in Lebanon and the United Arab Emirates in June 2018 and February 2019, respectively. VASCEPA is under registration in additional countries in the MENA region. Commercialization across the Middle East and North Africa is subject to similar risks as in the China Territory, and has been negatively impacted by COVID-19 and the destabilized local economy in Saudi Arabia.

In September 2017, we entered into an agreement with HLS Therapeutics Inc., or HLS, to register, commercialize and distribute VASCEPA in Canada. Under the agreement, HLS is responsible for regulatory and commercialization activities and associated costs. We are responsible for providing assistance towards local filings, supplying finished product under negotiated supply terms, maintaining intellectual property, and continuing the development and funding of REDUCE-IT related activities. In December 2019, VASCEPA was approved for use in Canada to reduce the risk of cardiovascular events in statin-treated patients with elevated triglycerides, who are at high risk of cardiovascular events due to established cardiovascular disease, or diabetes, and at least one other cardiovascular risk factor. In January 2020, HLS obtained an extended regulatory exclusivity designation. In February 2020, HLS launched VASCEPA in Canada, with strong initial uptake before the impact of COVID-19 pandemic. In July 2020, Patented Medicine Prices Review Board confirmed VASCEPA price is compliant with current guidelines, and CADTH recommended reimbursement for VASCEPA in Canada in secondary prevention population. However, if HLS is not able to effectively commercialize VASCEPA in Canada through effective pricing (initially and over time), reimbursement or otherwise we may not be able to generate revenue from the sale of VASCEPA in Canada.

Our efforts to launch VAZKEPA on our own in Europe, assuming a regulatory approval, is a complex undertaking for a company that has not launched a product in Europe and could be subject to significant risks of execution to our successful development of VAZKEPA in Europe. While various of our suppliers have been inspected and, subject to regulatory approval of VAZKEPA in Europe we do not anticipate supply availability limiting our launch in Europe, COVID-19 has limited the ability of suppliers to be inspected and not all of our suppliers have completed all of the requirements of the European regulatory authorities.

We have limited experience working with partners outside the United States to develop and market our products in non-U.S. jurisdictions. In order for our partners to market and sell VASCEPA in any country outside of the United States for any indication, it will be necessary to obtain regulatory approval from the appropriate regulatory authorities. The requirements and timing for regulatory approval, which may include conducting clinical trials, vary widely from country to country and may in some cases be different than or more rigorous than requirements in the United States. Any failure by us or our partners to obtain approval for VASCEPA in non-U.S. jurisdictions in a timely manner may limit the commercial success of VASCEPA and our ability to grow our revenues.

Our relationships with healthcare providers and physicians and third-party payors are subject to applicable anti-kickback, fraud and abuse and other healthcare laws and regulations, which could expose use to criminal sanctions, civil penalties, contractual damages, reputational harm and diminished profits and future earnings.

Healthcare providers, physicians and third-party payors in the United States and elsewhere play a primary role in the recommendation and prescription of pharmaceutical products. Arrangements with third-party payors and customers can expose pharmaceutical manufacturers to broadly applicable fraud and abuse and other healthcare laws and regulations, which may constrain the business or financial arrangements and relationships through which such companies sell, market and distribute pharmaceutical products. In particular, the promotion, sales and marketing of healthcare items and services, as well as a wide range of pricing, discounting, marketing and promotion, structuring and commission(s), certain customer incentive programs and other business arrangements, are subject to extensive laws designed to prevent fraud, kickbacks, self-dealing and other abusive practices. The applicable federal and state healthcare laws and regulations laws that may affect our ability to operate include, but are not limited to:

- the federal Anti-Kickback Statute, which prohibits, among other things, knowingly and willfully soliciting, receiving, offering or paying any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind, to induce, or in return for, either the referral of an individual, or the purchase, lease, order or recommendation of any good, facility, item or service for which payment may be made, in whole or in part, under a federal healthcare program, such as the Medicare and Medicaid programs. Liability may be established without a person or entity having actual knowledge of the federal anti-kickback statute or specific intent to violate it. In addition, the government may assert that a claim including items or services resulting from a violation of the federal anti-kickback statute constitutes a false or fraudulent claim for purposes of the federal civil False Claims Act. Although there are a number of statutory exemptions and regulatory safe harbors protecting certain activities from prosecution, the exemptions and safe harbors are

drawn narrowly, and practices that involve remuneration intended to induce prescribing, purchases, or recommendations may be subject to scrutiny if they do not qualify for an exemption or safe harbor. Our practices may not in all cases meet all of the criteria for safe harbor protection from anti-kickback liability. Violations are subject to significant civil and criminal fines and penalties for each violation, plus up to three times the renumeration involved, imprisonment, and exclusion from government healthcare workers;

- the federal civil and criminal false claims laws, including the federal Civil False Claims Act, or FCA, which prohibits, among other things, any person from knowingly presenting, or causing to be presented, a false or fraudulent claim for payment of government funds, or knowingly making or using, or causing to be made or used, a false record or statement material to an obligation to pay money to the government or knowingly concealing, or knowingly and improperly avoiding, decreasing, or concealing an obligation to pay money to the federal government. The FCA also permits a private individual acting as a "whistleblower" to bring actions on behalf of the federal government alleging violations of the statute and to share in any monetary recovery. Manufacturers can be held liable under the FCA even when they do not submit claims directly to government payors if they are deemed to "case" the submission of false or fraudulent claims. Recently, several pharmaceutical and other healthcare companies have been investigated or faced enforcement actions under the FCA for a variety of alleged improper marketing activities, including allegations that they caused false claims to be submitted because of the company's marketing of the product for unapproved, and thus allegedly non-reimbursable, uses. Federal enforcement agencies also have showed increased interest in pharmaceutical companies' product and patient assistance programs, including reimbursement and co-pay support services, and a number of investigations into these programs have resulted in significant civil and criminal settlements. A claim that includes items or services resulting from a violations of the federal Anti-Kickback Statute constitutes a false or fraudulent claim under the FCA. When an entity is determined to have violated the FCA, the government may impose civil fines and penalties for each false claim, plus treble damages, and exclude the entity from participation in Medicare, Medicaid and other federal healthcare programs. Pharmaceutical and other healthcare companies also are subject to other federal false claims laws, including, among others, federal criminal healthcare fraud and false statement statutes that extend to non-government health benefit programs;
- HIPAA, which, among other things, imposes criminal and civil liability for knowingly and willfully executing a scheme to defraud any healthcare benefit program, including private third-party payor and knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services;
- HIPAA, and its implementing regulations, which impose, among other things, requirements on certain covered healthcare providers, health plans, and healthcare clearinghouses as well as their respective business associates that perform services for them that involve the use, or disclosure of, individually identifiable health information, relating to the privacy, security and transmission of individually identifiable health information without appropriate authorization. The Health Information Technology for Economic and Clinical Health Act of 2009, or HITECH, also created new tiers of civil monetary penalties, amended HIPAA to make civil and criminal penalties directly applicable to business associates, and gave state attorneys general new authority to file civil actions for damages or injunctions in federal courts to enforce the federal HIPAA laws and seek attorneys' fees and costs associated with pursuing federal civil actions;
- the federal Physician Payment Sunshine Act, being implemented as the Open Payments Program, which requires manufacturers of drugs, devices, biologics, and medical supplies for which payment is available under Medicare, Medicaid or the Children's Health Insurance Program (with certain exceptions) to report annually to CMS information related to direct or indirect payments and other transfers of value to physicians (defined to include doctors, dentists, optometrists, podiatrists, and chiropractors) and teaching hospitals, as well as ownership and investment interests held in the company by physicians and their immediate family members. Beginning in 2022, applicable manufacturers also will be required to report information regarding payments and transfers of value provided to physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, and certified nurse-midwives;
- federal consumer protection and unfair competition laws, which broadly regulate marketplace activities and activities that potentially harm consumers; and
- analogous state and foreign laws and regulations, such as state anti-kickback and false claims laws, which may apply to sales or marketing arrangements and claims involving healthcare items or services reimbursed by non-governmental third-party payors, including private insurers; and other state or local laws that require pharmaceutical companies to comply with the pharmaceutical industry's voluntary compliance guidelines and the relevant compliance guidance promulgated by the federal government or otherwise restrict payments that may be made to healthcare providers; restrict the ability of manufacturers to offer co-pay support to patients for certain prescription drugs; require drug manufacturers to report information related to clinical trials, or information related to payments and other transfers of value to physicians and other healthcare providers or marketing expenditures; and/or require identification or licensing of sales representatives; and state and foreign laws governing the privacy and security of health information in certain circumstances, many of which differ from each other in significant ways and often are not preempted by HIPAA, thus complicating compliance efforts.

The distribution of pharmaceutical products is subject to additional requirements and regulations, including extensive record-keeping, licensing, storage and security requirements intended to prevent the unauthorized sale of pharmaceutical products.

The scope and enforcement of each of these laws is uncertain and subject to rapid change in the current environment of healthcare reform, especially in light of the lack of applicable precedent and regulations. Federal and state enforcement bodies continue to give regular and close scrutiny to interactions between healthcare companies and healthcare providers, and such scrutiny often leads to investigations, prosecutions, convictions and settlements in the healthcare industry. Ensuring business arrangements comply with applicable healthcare laws, as well as responding to possible investigations by government authorities, can be time- and resource-consuming and can divert a company's attention from the business. For example, in June 2020, we received a civil investigative demand, or CID, from the U.S. Department of Justice, or the DOJ, informing us that the DOJ is investigating whether aspects of our promotional speaker programs and copayment waiver program during the period from January 1, 2015 to the present violated the U.S. Anti-Kickback Statute and U.S. False Claims Act in relation to the sale and marketing of VASCEPA by us and our previous co-marketing partner, Kowa Pharmaceuticals, Inc. The CID requires us to produce documents and answer written questions, or interrogatories, relevant to the specified time period. We are cooperating with the DOJ. We cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on our business. Such investigations can be lengthy, costly and could materially affect and disrupt our business. If the government determines that we have violated the Anti-Kickback Statute and Fake Claims Act, we could be subject to significant civil and criminal fines and penalties. The failure to comply with any of these laws or regulatory requirements subjects entities to possible legal or regulatory action. Depending on the circumstances, failure to meet applicable regulatory requirements can result in significant civil, criminal and administrative penalties, damages, fines, disgorgement, individual imprisonment, exclusion from participation in federal and state funded healthcare programs (such as Medicare and Medicaid), contractual damages and the curtailment or restructuring of our operations, as well as additional reporting obligations and oversight if we become subject to a corporate integrity agreement or other agreement to resolve allegations of non-compliance with these laws. Any action for violation of these laws, even if successfully defended, could cause a pharmaceutical manufacturer to incur significant legal expenses and divert management's attention from the operation of the business. If any of the physicians or other healthcare providers or entities with whom we expect to do business is found not to be in compliance with applicable laws, that person or entity may be subject to criminal, civil or administrative sanctions, including exclusions from government funded healthcare programs. Prohibitions or restrictions on sales or withdrawal of future marketed products could materially affect business in an adverse way.

Although compliance programs can mitigate the risk of investigation and prosecution for violations of these laws, it is not always possible to identify and deter employee misconduct, and the precautions we take to detect and prevent inappropriate conduct may not be effective in controlling unknown or unmanaged risks or losses or in protecting us from governmental investigations or other actions or lawsuits stemming from a failure to be in compliance with such laws or regulations.

In addition, the approval and commercialization of any of our products outside the United States will also likely subject us to foreign equivalents of the healthcare laws mentioned above, among other foreign laws.

We rely on third parties to conduct our clinical trials, and those third parties may not perform satisfactorily, including failing to meet established deadlines for the completion of such clinical trials.

Our reliance on third parties for clinical development activities reduces our control over these activities. However, if we sponsor clinical trials, we are responsible for ensuring that each of our clinical trials is conducted in accordance with the general investigational plan and protocols for the trials. Moreover, the FDA requires us to comply with requirements, commonly referred to as good clinical practices, for conducting, recording, and reporting the results of clinical trials to ensure that data and reported results are credible and accurate and that the rights, integrity and confidentiality of trial participants are protected. Our reliance on third parties does not relieve us of these responsibilities and requirements. Furthermore, these third parties may also have relationships with other entities, some of which may be our competitors. If these third parties do not successfully carry out their contractual duties or meet expected deadlines, we may be delayed in obtaining regulatory approvals for our product candidates and may be delayed in our efforts to successfully commercialize our product candidates for targeted diseases.

Risks Related to Our Intellectual Property

We are dependent on patents, proprietary rights and confidentiality to protect the commercial potential of VASCEPA.

Our success depends in part on our ability to obtain and maintain intellectual property protection for our drug candidates, technology and know-how, and to operate without infringing the proprietary rights of others. While certain key patents related to our product based on the MARINE clinical study were determined to be invalid as obvious by a district court in the United States, and we are pursuing an appeal process, it remains the case that our ability to successfully implement our business plan and to protect our products with our intellectual property will depend in large part on our ability to:

- obtain, defend and maintain patent protection and market exclusivity for our current and future products;
- preserve any trade secrets relating to our current and future products;
- acquire patented or patentable products and technologies; and

- operate without infringing the proprietary rights of third parties.

We have prosecuted, and are currently prosecuting, multiple patent applications to protect the intellectual property developed during the VASCEPA development program. As of the date of this report, we had 110 patent applications in the United States that have been either issued or allowed and more than 30 additional patent applications are pending in the United States. Such 110 allowed and issued applications include the following:

- one issued U.S. patent directed to a pharmaceutical composition of VASCEPA in a capsule that expires in 2030;
- one issued U.S. patent covering a composition containing highly pure EPA that expires in 2021;
- 53 U.S. patents covering or related to the use of VASCEPA in either the MARINE or ANCHOR populations that have terms that expire in 2030 or later;
- 23 U.S. patents covering or related to the use of VASCEPA in the REDUCE-IT population with terms expiring in 2033 or later;
- two additional US patents directed to a pharmaceutical composition comprised of free fatty acids with a term that expires in 2030;
- four additional patents related to the use of a pharmaceutical composition comprised of free fatty acids to treat the ANCHOR patient population with a term that expires in 2030 or later;
- two additional patents related to the use of a pharmaceutical composition comprised of free fatty acids to treat the MARINE patient population with a term that expires in 2030;
- three additional patents related to the use of a pharmaceutical composition comprised of free fatty acids to treat the REDUCE-IT population expiring 2033;
- four additional patents related to a pharmaceutical composition comprised of free fatty acids and uses thereof to treat both the MARINE and ANCHOR patient populations with a term that expires in 2030;
- one additional patent related to the use of a pharmaceutical composition comprised of re-esterified EPA triglyceride to treat the REDUCE-IT population expiring 2033;
- four additional patents related to a formulation of EPA/DHA and uses thereof with a term that expires in 2030;
- two additional patents related to the use of VASCEPA to treat obesity with a term that expires in 2034;
- one additional patent related to the use of VASCEPA to treat prostate cancer with a term that expires in 2037;
- four additional patents covering a pharmaceutical composition comprised of EPA and a hydroxyl compound with a term that expires in 2034; and
- five additional patents covering a new combination therapy comprised of EPA and another drug.

A Notice of Allowance is issued after the USPTO makes a determination that a patent can be granted from an application. A Notice of Allowance does not afford patent protection until the underlying patent is issued by the USPTO. No assurance can be given that applications with issued notices of allowance will be issued as patents or that any of our pending patent applications will issue as patents. No assurance can be given that, if and when issued, our patents will prevent competitors from competing with VASCEPA. For example, we may choose to not assert all issued patents in patent litigation and patents or claims within patents may be determined to be invalid.

We are the owner of the above-listed patents. We are also the exclusive licensee of certain patents owned by others covering products and products in development. To secure our debt under our outstanding royalty-like instrument, we have granted the holders of such instrument a security interest in our VASCEPA-related patents.

We are also pursuing patent applications related to VASCEPA in multiple jurisdictions outside the United States. Geographies outside the United States in which VASCEPA is sold and under regulatory review are not subject to the U.S. patent litigation and judgment. No litigation involving potential generic versions of VASCEPA is pending outside the United States. VASCEPA is currently available by prescription in Canada, Lebanon and the United Arab Emirates. In Canada, VASCEPA has the benefit of data protection afforded through Health Canada (until the end of 2027), in addition to separate patent protection with expiration dates that could extend into 2039. We are pursuing additional regulatory approvals for VASCEPA in Europe, China and the Middle East. In China and the Middle East, we are pursuing such regulatory approvals and subsequent commercialization of VASCEPA with commercial partners. Ten years of market protection is anticipated in the European Union as part of a European Community, or EC, approval of the pending application. Furthermore, patent protection in Europe includes:

One allowed patent related to the use of a pharmaceutical composition comprised of 4g of 96% EPA ethyl ester to treat the REDUCE-IT population expiring 2033.

In addition, pending patent applications in Europe have the potential to extend exclusivity into 2039.

We may be dependent in some cases upon third-party licensors to pursue filing, prosecution and maintenance of patent rights or applications owned or controlled by those parties, including, for example, under our collaboration with Mochida. It is possible that third parties will obtain patents or other proprietary rights that might be necessary or useful to us. In cases where third parties are first to invent a particular product or technology, or first to file after various provisions of the America Invents Act of 2011 went into effect on March 16, 2013, it is possible that those parties will obtain patents that will be sufficiently broad so as to prevent us from utilizing such technology or commercializing our current and future products. Although we intend to make reasonable efforts to protect our current and future intellectual property rights and to ensure that any proprietary technology we acquire or develop does not infringe the rights of other parties, we may not be able to ascertain the existence of all potentially conflicting claims. Therefore, there is a risk that third parties may make claims of infringement against our current or future products or technologies. In addition, third parties may be able to obtain patents that prevent the sale of our current or future products or require us to obtain a license and pay significant fees or royalties in order to continue selling such products.

We may in the future discover the existence of products that infringe patents that we own or that have been licensed to us. If we were to initiate legal proceedings against a third party to stop such an infringement, such proceedings could be costly and time consuming, regardless of the outcome. No assurances can be given that we would prevail, and it is possible that, during such a proceeding, our patent rights could be held to be invalid, unenforceable or both. Although we intend to protect our trade secrets and proprietary know-how through confidentiality agreements with our manufacturers, employees and consultants, we may not be able to prevent parties subject to such confidentiality agreements from breaching these agreements or third parties from independently developing or learning of our trade secrets.

We anticipate that competitors may from time to time oppose our efforts to obtain patent protection for new technologies or to submit patented technologies for regulatory approvals. Competitors may seek to oppose our patent applications to delay the approval process or to challenge our granted patents, for example, by requesting a reexamination of our patent at the USPTO, or by filing an opposition in a foreign patent office, even if the opposition or challenge has little or no merit. For example, one of our patents was revoked in an opposition proceeding in Europe due to a determination of improper claim amendments under a provision of law not applicable in the United States. Such proceedings are generally highly technical, expensive, and time consuming, and there can be no assurance that such a challenge would not result in the narrowing or complete revocation of any patent of ours that was so challenged.

Our issued patents may not prevent competitors from competing with VASCEPA, even if we seek to enforce our patent rights.

We plan to vigorously defend our rights under issued patents. For example, on November 30, 2020 we filed a patent infringement lawsuit against Hikma for making, selling, offering to sell and importing generic icosapent ethyl capsules in and into the United States in a manner that we allege has induced the infringement of patents covering the use of VASCEPA to reduce specified cardiovascular risk. On January 25, 2021, we expanded the scope of this patent infringement lawsuit to include a health care insurance provider, Health Net, LLC. We intend to vigorously pursue these ongoing litigation matters, but cannot predict the outcomes or the

impact on our business. We likewise plan to engage in similar patent litigation should other competitors arise with products that infringe our intellectual property rights.

Patent litigation is a time-consuming and costly process. There can be no assurance that we will be successful in enforcing this patent or that it will not be successfully challenged and invalidated. Even if we are successful in enforcing this patent, the process could take years to reach conclusion. Other drug companies may challenge the validity, enforceability, or both of our patents and seek to design its products around our issued patent claims and gain marketing approval for generic versions of VASCEPA or branded competitive products based on new clinical studies. The pharmaceutical industry is highly competitive and many of our competitors have greater experience and resources than we have. Any such competition could undermine sales, marketing and collaboration efforts for VASCEPA, and thus reduce, perhaps materially, the revenue potential for VASCEPA.

Even if we are successful in enforcing our issued patents, we may incur substantial costs and divert management's time and attention in pursuing these proceedings, which could have a material adverse effect on us. Patent litigation is costly and time consuming, and we may not have sufficient resources to bring these actions to a successful conclusion.

There can be no assurance that any of our pending patent applications relating to VASCEPA or its use will issue as patents.

We have filed and are prosecuting numerous families of patent applications in the United States and internationally with claims designed to protect the proprietary position of VASCEPA. For certain of these patent families, we have filed multiple patent applications. Collectively the patent applications include numerous independent claims and dependent claims. Several of our patent applications contain claims that are based upon what we believe are unexpected and favorable findings from our clinical trials. If granted, many of the resulting granted patents from REDUCE-IT, for example, would expire in 2039, beyond the 2030 and 2033 expiration dates of currently issued REDUCE-IT patents. However, no assurance can be given that any of our pending patent applications will be granted or, if they grant, that they will prevent competitors from competing with VASCEPA.

Securing patent protection for a product is a complex process involving many legal and factual questions. The patent applications we have filed in the United States and internationally are at varying stages of examination, the timing of which is outside our control. The process to getting a patent granted can be lengthy and claims initially submitted are often modified in order to satisfy the requirements of the patent office. This process includes written and public communication with the patent office. The process can also include direct discussions with the patent examiner. There can be no assurance that the patent office will accept our arguments with respect to any patent application or with respect to any claim therein. We cannot predict the timing or results of any patent application. In addition, we may elect to submit, or the patent office may require, additional evidence to support certain of the claims we are pursuing. Furthermore, third parties may attempt to submit publications for consideration by the patent office during examination of our patent applications. Providing such additional evidence and publications could prolong the patent office's review of our applications and result in us incurring additional costs. We cannot be certain what commercial value any granted patent in our patent estate will provide to us.

Despite the use of confidentiality agreements and/or proprietary rights agreements, which themselves may be of limited effectiveness, it may be difficult for us to protect our trade secrets.

In addition to our patent portfolio and strategy, we will also rely upon trade secrets and know-how to help protect our competitive position. We rely on trade secrets to protect technology in cases when we believe patent protection is not appropriate or obtainable. However, trade secrets are difficult to protect. While we require certain of our academic collaborators, contractors and consultants to enter into confidentiality agreements, we may not be able to adequately protect our trade secrets or other proprietary information.

Risks Related to Our Business

If the estimates we make, or the assumptions on which we rely, in preparing our projected guidance prove inaccurate, our actual results may vary from those reflected in our projections and accruals.

In January 2021, we issued financial and business guidance, including expectations regarding inventory build, and 2021 operating expenses. All such guidance and updates are based on estimates, assumptions and the judgment of management. Because of the inherent nature of estimates, including during the uncertainty of COVID-19's impact on our business, we have suspended providing net revenue guidance and there could be significant differences between our estimates and the actual amount of product demand. If we fail to realize or if we change or update any element of our publicly disclosed financial guidance as we have done in the past or other expectations about our business change, our stock price could decline in value.

Our internal computer systems, or those of our third-party clinical research organizations or other contractors or consultants, may fail or suffer security breaches, which could result in a material disruption of our research and development programs.

Despite the implementation of security measures, our internal computer systems and those of our third-party clinical research organizations and other contractors and consultants are vulnerable to damage from computer viruses, unauthorized access, natural disasters, terrorism, war, and telecommunication and electrical failures. Any such incident could cause interruptions in our operations or a material disruption of our programs. To the extent that any disruption or security breach results in a loss of or damage to our data or applications or other data or applications relating to our technology or products candidates, or inappropriate disclosure of confidential or proprietary information, we could incur liabilities and our research and development program could be delayed.

We could be subject to risks caused by misappropriation, misuse, leakage, falsification or intentional or accidental release or loss of information maintained in the information systems and networks of our company and our vendors, including personal information of our employees and patients, and company and vendor confidential data. In addition, outside parties may attempt to penetrate our systems or those of our vendors or fraudulently induce our personnel or the personnel of our vendors to disclose sensitive information in order to gain access to our data and/or systems. We may experience threats to our data and systems, including malicious codes and viruses, phishing and other cyber-attacks. The number and complexity of these threats continue to increase over time. For example, in June 2019, a report published by security researchers claimed that a database belonging to one of our vendors containing information about individuals who use or have expressed interest in VASCEPA was accessible to unauthorized users. Although we were informed that such breach did not include social security numbers or credit card information, we cannot guarantee that a more material breach will not occur in the future. If a material breach of our information technology systems or those of our vendors occurs, the market perception of the effectiveness of our security measures could be harmed and our reputation and credibility could be damaged. We could be required to expend significant amounts of money and other resources to repair or replace information systems or networks and to repair reputational costs. In addition, we could be subject to regulatory actions and/or claims made by individuals and groups in private litigation involving privacy issues related to data collection and use practices and other data privacy laws and regulations, including claims for misuse or inappropriate disclosure of data, as well as unfair or deceptive practices. We may incur significant costs or divert significant internal resources as a result of any regulatory actions or private litigation. Any of the foregoing consequences may adversely affect our business and financial condition.

Although we develop and maintain systems and controls designed to prevent these events from occurring, and we have a process to identify and mitigate threats, the development and maintenance of these systems, controls and processes is costly and requires ongoing monitoring and updating as technologies change and efforts to overcome security measures become increasingly sophisticated. Moreover, despite our efforts, the possibility of these events occurring cannot be eliminated entirely. As we outsource more of our information systems to vendors, engage in more electronic transactions with payors and patients, and rely more on cloud-based information systems, the related security risks will increase and we will need to expend additional resources to protect our technology and information systems. In addition, there can be no assurance that our internal information technology systems or those of our third-party contractors, or our consultants' efforts to implement adequate security and control measures, will be sufficient to protect us against breakdowns, service disruption, data deterioration or loss in the event of a system malfunction, or prevent data from being stolen or corrupted in the event of a cyberattack, security breach, industrial espionage attacks or insider threat attacks which could result in financial, legal, business or reputational harm.

We are subject to potential product liability.

We are subject to the potential risk of product liability claims relating to the manufacturing and marketing of VASCEPA. Any person who is injured as a result of using VASCEPA may have a product liability claim against us without having to prove that we were at fault.

In addition, we could be subject to product liability claims by persons who took part in clinical trials involving our current or former development stage products. A successful claim brought against us could have a material adverse effect on our business. We cannot guarantee that a product liability claim will not be asserted against us in the future.

A change in our tax residence could have a negative effect on our future profitability.

We expect that our tax jurisdiction will remain in Ireland. Under current UK legislation, a company incorporated in England and Wales, or which is centrally managed and controlled in the UK, is regarded as resident in the UK for taxation purposes. Under current Irish legislation, a company is regarded as resident for tax purposes in Ireland if it is centrally managed and controlled in Ireland, or, in certain circumstances, if it is incorporated in Ireland. Up to December 31, 2019, where a company was treated as tax resident under the domestic laws of both the UK and Ireland, then the provisions of article 4(3) of the Double Tax Agreement, or DTA, between the UK and Ireland provided that such enterprise would be treated as resident only in the jurisdiction in which its place of effective

management is situated. We had at all times sought to conduct our affairs in such a way so as to be solely resident in Ireland for tax purposes by virtue of having our place of effective management situated in Ireland.

These rules regarding determination of tax residence changed effective January 1, 2020, when a modified Ireland-UK DTA came into effect pursuant to the OECD's Multilateral Instrument, or MLI. Under the modified Ireland-UK DTA, from January 1, 2020, we would be solely tax resident in Ireland and not tax resident in the UK if we continued to be centrally managed and controlled in Ireland and if it were mutually agreed between the Irish and UK tax authorities under the MLI "tie-breaker rule" that we are solely tax resident in Ireland. Having made the relevant submission under the amended provisions, we received confirmation effective January 1, 2020 of the mutual agreement of Irish and UK tax authorities that we are solely tax resident in Ireland for the purposes of the modified DTA.

However, we cannot assure you that we are or will continue to be solely resident in Ireland for tax purposes. It is possible that in the future, whether as a result of a change in law or the practice of any relevant tax authority or as a result of any change in the conduct of our affairs, we could become, or be regarded as having become resident in a jurisdiction other than Ireland. Should we cease to be an Irish tax resident, we may be subject to a charge to Irish capital gains tax on our assets and the basis on which our income is taxed may also change. Similarly, if the tax residency of our Irish or UK subsidiaries were to change from their current jurisdiction, they may be subject to a charge to local capital gains tax on their assets and the basis on which their income is taxed may also change.

Our and our subsidiaries' income tax returns are periodically examined by various tax authorities, including the Internal Revenue Service, or the IRS, and states. For example, the IRS began an examination of our 2018 US income tax return in the first quarter of 2020. Although the outcome of tax audits is always uncertain and could result in significant cash tax payments, we do not believe the outcome of any future audits will have a material adverse effect on our consolidated financial position or results of operations.

We could be adversely affected by our exposure to customer concentration risk.

A significant portion of our sales are to wholesalers in the pharmaceutical industry. Three customers individually accounted for 10% or more of our gross product sales. Customers A, B, and C accounted for 38%, 29%, and 25%, respectively, of gross product sales for the year ended December 31, 2020 and represented 31%, 18%, and 37%, respectively, of the gross accounts receivable balance as of December 31, 2020. Customers A, B, and C accounted for 36%, 29%, and 25%, respectively, of gross product sales for the year ended December 31, 2019 and represented 35%, 20%, and 37%, respectively, of the gross accounts receivable balance as of December 31, 2019. There can be no guarantee that we will be able to sustain our accounts receivable or gross sales levels from our key customers. If, for any reason, we were to lose, or experience a decrease in the amount of business with our largest customers, whether directly or through our distributor relationships, our financial condition and results of operations could be negatively affected.

Risks Related to Our Financial Position and Capital Requirements

We have a history of operating losses and anticipate that we will incur continued losses for an indefinite period of time.

We have not yet reached sustained profitability. For the fiscal years ended December 31, 2020, 2019, and 2018, we reported losses of approximately $18.0 million, $22.6 million, and $116.4 million, respectively, and we had an accumulated deficit as of December 31, 2020 of $1.4 billion. Substantially all of our operating losses resulted from costs incurred in connection with our research and development programs, from general and administrative costs associated with our operations, and costs related to the commercialization of VASCEPA. Additionally, as a result of our significant expenses relating to research and development and to commercialization, we expect to continue to incur significant operating losses for an indefinite period. Because of the numerous risks and uncertainties associated with developing and commercializing pharmaceutical products, we are unable to predict the magnitude of these future losses. Our historic losses, combined with expected future losses, have had and will continue to have an adverse effect on our cash resources, shareholders' deficit and working capital.

Although we began generating revenue from VASCEPA in January 2013, we may never be profitable for a full year.

Our ability to become profitable on a sustained basis depends upon our ability to generate revenue. We have been generating product revenue from sales of VASCEPA since January 2013, but we may not be able to generate sufficient revenue to achieve a steady state of profitability. Our ability to generate profits on sales of VASCEPA is subject to the market acceptance and commercial success of VASCEPA and our ability to manufacture commercial quantities of VASCEPA through third parties at acceptable cost levels, and may also depend upon our ability to effectively market and sell VASCEPA through our strategic collaborations.

Even though VASCEPA has been approved by the FDA for marketing in the United States for two important indications, it may not gain enough market acceptance to support profitability. We anticipate continuing to incur significant costs associated with expanding the commercialization of VASCEPA. We may not achieve profitability on a sustained basis in the near term due to high costs associated with, for example, our expanded commercialization efforts in the United States and our expected commercialization efforts in Europe. If we are unable to continue to generate robust product revenues, we will not become profitable on a sustained basis in the near term, if ever, and may be unable to continue operations without continued funding.

Our operating results are unpredictable and may fluctuate. If our operating results are below the expectations of securities analysts or investors, the trading price of our stock could decline.

Our operating results are difficult to predict and will likely fluctuate from quarter to quarter and year to year, and VASCEPA prescription figures will likely fluctuate from month to month. VASCEPA sales are difficult to predict from period to period and as a result, you should not rely on VASCEPA sales results in any period as being indicative of future performance, and sales of VASCEPA may be below the expectation of securities analysts or investors in the future. We believe that our quarterly and annual results of operations may be affected by a variety of factors, including those risks and uncertainties described in this Part II, Item 1A and the following:

- the receent launch of a generic version of VASCEPA, and the potential launch of additional generic versions;
- continued and prolonged disruption to our business from the COVID-19 pandemic;
- the continuing evolution of the medical community's and the public's perception of the REDUCE-IT study results;
- the level of demand for VASCEPA, due to changes in prescriber sentiment, quarterly changes in Distributor purchases, and other factors;
- the extent to which coverage and reimbursement for VASCEPA is available from government and health administration authorities, private health insurers, managed care programs and other third-party payers and the timing and extent to which such coverage and reimbursement changes;
- the timing, cost and level of investment in our sales and marketing efforts to support VASCEPA sales and the resulting effectiveness of those efforts;
- disruptions or delays in our or our partners' commercial or development activities, including as a result of political instability, civil unrest, terrorism, pandemics or other natural disasters, such as the recent outbreak of coronavirus;
- the timing and ability of efforts outside the United States, to develop, register and commercialize VASCEPA in Europe, China Territory, several Middle Eastern and North African countries, and Canada, for example, including obtaining necessary regulatory approvals, favorable pricing and establishing marketing channels;
- additional developments regarding our intellectual property portfolio and regulatory exclusivity protections, if any;
- outcomes of litigation and other legal proceedings; and
- our ongoing regulatory dialogue.

We may require substantial additional resources to fund our operations. If we cannot find additional capital resources, we will have difficulty in operating as a going concern and growing our business.

We currently operate with limited resources. We believe that our cash and cash equivalents balance of $187.0 million and short-term investment balance of $314.0 million as of December 31, 2020, will be sufficient to fund our projected operations for at least 12 months. We have based this estimate on assumptions that may prove to be wrong, and we could use our capital resources sooner than we expect or fail to achieve positive cash flow. Depending on the level of cash generated from operations, and depending in part on the rate of prescription growth for VASCEPA, additional capital may be required to support planned VASCEPA promotion and potential VASCEPA promotion beyond which we are currently executing and for commercialization of VAZKEPA in Europe. If additional capital is required and we are unable to obtain additional capital, we may be forced to delay, limit or eliminate certain promotional activities. We anticipate that quarterly net cash outflows in future periods will be variable as a result of the timing of certain items, including our purchases of API, VASCEPA promotional activities from approval by the FDA for the new indication and expanded label and the impact from COVID-19 on our operations and those of our customers and any current or potential generic competition.

In order to fully realize the market potential of VASCEPA, we may need to enter into a new strategic collaboration or raise additional capital.

Our future capital requirements will depend on many factors, including:

- the timing, amount and consistency of revenue generated from the commercial sale of VASCEPA;

- the costs associated with commercializing VASCEPA in the United States, including expenditures such as potential direct-to-consumer advertising and increased sales force sizing, and for commercializing VAZKEPA in Europe, including hiring experienced professionals, and for additional regulatory approvals internationally, if any, the cost and timing of securing commercial supply of VASCEPA and the timing of entering into any new strategic collaboration with others relating to the commercialization of VASCEPA, if at all, and the terms of any such collaboration;
- continued costs associated with litigation and other legal proceedings;
- the time and costs involved in obtaining additional regulatory approvals for VASCEPA based on REDUCE-IT results internationally;
- the extent to which we continue to develop internally, acquire or in-license new products, technologies or businesses; and
- the cost of filing, prosecuting, defending and enforcing any patent claims and other intellectual property rights.

If we require additional funds and adequate funds are not available to us in amounts or on terms acceptable to us or on a timely basis, or at all, our commercialization efforts for VASCEPA, and our business generally, may suffer materially.

The potential future benefit of our substantial net operating loss carryforwards could be lost and our prospects for profitability could be materially diminished if tax regulations or rates change or if we are deemed to not have active operations in Ireland.

Tax law and policies in the United States and Ireland are subject to change based on adjustments in political perspectives. In the United States and internationally, how to tax entities with international operations, like Amarin, has been subject to significant re-evaluation. We believe we developed VASCEPA in and from Ireland based on understanding of applicable requirements. In recent years, particularly since 2013 when commercial sale of VASCEPA commenced in the United States, the majority of our consolidated operations have been in the United States. Ownership of VASCEPA continues to reside with our wholly-owned Ireland-based subsidiary, Amarin Pharmaceuticals Ireland Ltd., and oversight and operations of that entity are structured to be maintained in Ireland. In order to effectively utilize our accumulated net operating loss carryforwards for tax purposes in Ireland, our operations, particularly for this subsidiary, need to be active in Ireland under applicable requirements. In addition, utilization of these accumulated net operating loss carryforwards assumes that tax treaties between Ireland and other countries, particularly the United States, do not change in a manner that limit our future ability to offset earnings with these operating loss carryforwards for tax purposes.

Similarly, a change in our Irish tax residence could materially affect our ability to obtain and maintain profitability, if otherwise achievable. Changes in tax law and tax rates, particularly in the United States and Ireland, could also impact our assessment of deferred taxes. Any change in our assessment of the realizability or the timing for realizing deferred taxes could have a negative impact our future profitability.

Risks Related to Ownership of our ADSs and Common Shares

The price of our ADSs and common shares may be volatile.

The stock market has from time to time experienced significant price and volume fluctuations that may be unrelated to the operating performance of particular companies. In addition, the market prices of the securities of many pharmaceutical and medical technology companies have been especially volatile in the past, and this trend is expected to continue in the future.

As of February 19, 2021, we had 393,635,467 common shares outstanding including 393,436,525 shares held as ADSs and 198,942 held as ordinary shares (which are not held in the form of ADSs). There is a risk that there may not be sufficient liquidity in the market to accommodate significant increases in selling activity or the sale of a large block of our securities. Our ADSs have historically had limited trading volume, which may also result in volatility. If any of our large investors seek to sell substantial amounts of our ADSs, particularly if these sales are in a rapid or disorderly manner, or other investors perceive that these sales could occur, the market price of our ADSs could decrease significantly.

The market price of our ADSs and common shares may also be affected by factors such as:

- developments or disputes concerning ongoing patent prosecution efforts and any future patent or proprietary rights;
- litigation and regulatory developments in the United States affecting our VASCEPA promotional rights, and regulatory developments in other countries;
- actual or potential medical results relating to our products or our competitors' products;
- interim failures or setbacks in product development;
- innovation by us or our competitors;
- currency exchange rate fluctuations; and

- period-to-period variations in our results of operations.

Further, the United Kingdom ceased to be a member of the European Union on January 31, 2020, commonly referred to as Brexit, and the 11-month implementation period ended on December 31, 2020 and a new trade deal between the United Kingdom and the European Union was agreed to on December 24, 2020. The effects of Brexit are uncertain and may have a negative effect on global economic conditions, financial markets and our business, which could reduce the price of our ADSs and common shares. In particular, Brexit could lead to a period of considerable uncertainty in relation to the UK financial and banking markets, as well as on the regulatory process in Europe, which could cause the broader global financial markets to experience significant volatility. Asset valuations, currency exchange rates and credit ratings may also be subject to increased market volatility due to the ongoing uncertainty, particularly in regards to whether there will be a trade deal between the UK and the EU. Lack of clarity about future UK laws and regulations as the United Kingdom determines which EU rules and regulations to replace or replicate could decrease foreign direct investment in the UK, increase costs, disrupt our business, depress economic activity and restrict our access to capital, any of which could negatively impact the price of our ADSs and common shares.

Actual or potential sales of our common shares by our employees, including members of our senior management team, pursuant to pre-arranged stock trading plans could cause our stock price to fall or prevent it from increasing for numerous reasons, and actual or potential sales by such persons could be viewed negatively by other investors.

In accordance with the guidelines specified under Rule 10b5-1 of the Securities Exchange Act of 1934 and our policies regarding stock transactions, a number of our directors and employees, including members of our senior management team, have adopted and may continue to adopt pre-arranged stock trading plans to sell a portion of our common stock. Generally, sales under such plans by members of our senior management team and directors require public filings. Actual or potential sales of our ADSs by such persons could cause the price of our ADSs to fall or prevent it from increasing for numerous reasons. For example, a substantial amount of our ADSs becoming available (or being perceived to become available) for sale in the public market could cause the market price of our ADSs to fall or prevent it from increasing. Also, actual or potential sales by such persons could be viewed negatively by other investors.

If we were to be characterized as a passive foreign investment company there could be adverse consequences to U.S. investors.

A non-U.S. corporation will be classified as a passive foreign investment company, or PFIC, for U.S. federal income tax purposes for any taxable year, if either (i) 75% or more of its gross income for such year consists of certain types of "passive" income or (ii) 50% or more of the value of its assets (determined on the basis of a quarterly average) during such year produce or are held for the production of passive income. Passive income generally includes dividends, interest, royalties, rents, annuities, net gains from the sale or exchange of property producing such income and net foreign currency gains. In addition, a non-U.S. corporation will be treated as owning its proportionate share of the assets and earning its proportionate share of the income of any other corporation in which it owns, directly or indirectly, no more than 25% (by value) of the stock.

Based on certain estimates of our gross income and gross assets, the latter determined by reference to the expected value of our ADSs and shares, we believe that we will not be classified as a PFIC for the taxable year ended December 31, 2020 and we do not expect to be treated as a PFIC in any future taxable year for the foreseeable future. However, because PFIC status is based on our income, assets and activities for the entire taxable year, which we expect may vary substantially over time, it is not possible to determine whether we will be characterized as a PFIC for any taxable year until after the close of the taxable year. Moreover, we must determine our PFIC status annually based on tests that are factual in nature, and our status in future years will depend on our income, assets and activities in each of those years. There can be no assurance that we will not be considered a PFIC for any taxable year.

We do not intend to pay cash dividends on the ordinary shares in the foreseeable future.

We have never paid dividends on ordinary shares and do not anticipate paying any cash dividends on the ordinary shares in the foreseeable future. Under English law, any payment of dividends would be subject to relevant legislation and our Articles of Association, which requires that all dividends must be approved by our Board of Directors and, in some cases, our shareholders, and may only be paid from our distributable profits available for the purpose, determined on an unconsolidated basis.

The rights of our shareholders may differ from the rights typically offered to shareholders of a U.S. corporation.

We are incorporated under English law. The rights of holders of ordinary shares and, therefore, certain of the rights of holders of ADSs, are governed by English law, including the provisions of the Companies Act 2006, and by our Articles of Association. These rights differ in certain respects from the rights of shareholders in typical U.S. corporations. The principal differences include the following:

- Under English law and our Articles of Association, each shareholder present at a meeting has only one vote unless demand is made for a vote on a poll, in which case each holder gets one vote per share owned. Under U.S. law, each shareholder typically is entitled to one vote per share at all meetings.
- Under English law, it is only on a poll that the number of shares determines the number of votes a holder may cast. You should be aware, however, that the voting rights of ADSs are also governed by the provisions of a deposit agreement with our depositary bank.
- Under English law, subject to certain exceptions and disapplications, each shareholder generally has preemptive rights to subscribe on a proportionate basis to any issuance of ordinary shares or rights to subscribe for, or to convert securities into, ordinary shares for cash. Under U.S. law, shareholders generally do not have preemptive rights unless specifically granted in the certificate of incorporation or otherwise.
- Under English law and our Articles of Association, certain matters require the approval of 75% of the shareholders who vote (in person or by proxy) on the relevant resolution (or on a poll of shareholders representing 75% of the ordinary shares voting (in person or by proxy)), including amendments to the Articles of Association. This may make it more difficult for us to complete corporate transactions deemed advisable by our board of directors. Under U.S. law, generally only majority shareholder approval is required to amend the certificate of incorporation or to approve other significant transactions.
- In the United Kingdom, takeovers may be structured as takeover offers or as schemes of arrangement. Under English law, a bidder seeking to acquire us by means of a takeover offer would need to make an offer for all of our outstanding ordinary shares/ADSs. If acceptances are not received for 90% or more of the ordinary shares/ADSs under the offer, under English law, the bidder cannot complete a "squeeze out" to obtain 100% control of us. Accordingly, acceptances of 90% of our outstanding ordinary shares/ADSs will likely be a condition in any takeover offer to acquire us, not 50% as is more common in tender offers for corporations organized under Delaware law. By contrast, a scheme of arrangement, the successful completion of which would result in a bidder obtaining 100% control of us, requires the approval of a majority of shareholders voting at the meeting and representing 75% of the ordinary shares voting for approval.
- Under English law and our Articles of Association, shareholders and other persons whom we know or have reasonable cause to believe are, or have been, interested in our shares may be required to disclose information regarding their interests in our shares upon our request, and the failure to provide the required information could result in the loss or restriction of rights attaching to the shares, including prohibitions on certain transfers of the shares, withholding of dividends and loss of voting rights. Comparable provisions generally do not exist under U.S. law.
- The quorum requirement for a shareholders' meeting is a minimum of two shareholders entitled to vote at the meeting and present in person or by proxy or, in the case of a shareholder which is a corporation, represented by a duly authorized officer (although the marketplace rules of the Nasdaq Stock Market require that shareholders holding at least one-third of our outstanding shares of voting stock are present at the meeting or by proxy). Under U.S. law, a majority of the shares eligible to vote must generally be present (in person or by proxy) at a shareholders' meeting in order to constitute a quorum. The minimum number of shares required for a quorum can be reduced pursuant to a provision in a company's certificate of incorporation or bylaws, but typically not below one-third of the shares entitled to vote at the meeting.

Shareholder protections found in provisions under the UK City Code on Takeovers and Mergers, or the Takeover Code, do not apply to us.

The Takeover Code provides a framework within which takeovers of certain companies organized in the United Kingdom are regulated and conducted. However, because our place of central management and control is currently outside of the United Kingdom, we are not subject to the Takeover Code. As a result, our shareholders are not entitled to the benefit of certain takeover offer protections provided under the Takeover Code. The following is a brief summary of some of the most important rules of the Takeover Code which, as noted, does not apply to us:

- In connection with a potential offer, if following an approach by or on behalf of a potential bidder, the company is "the subject of rumor or speculation" or there is an "untoward movement" in the company's share price, there is a requirement for the potential bidder to make a public announcement about a potential offer for the company, or for the company to make a public announcement about the potential offer.
- When a person or group of persons who are treated as "acting in concert" with each other (a) acquires interests in shares carrying 30% or more of the voting rights of a company (which percentage is treated by the Takeover Code as the level at which effective control is obtained) or (b) increases the aggregate percentage interest they have when they are already

interested in not less than 30% and not more than 50%, they must make a cash offer to all other shareholders at the highest price paid by them in the 12 months before the offer was announced.

- When interests in shares of any class representing 10% of shares of that class have been acquired for cash by an offeror (i.e., a bidder) during the offer period (i.e., broadly speaking, the period after the potential offer has been made public) and within 12 months prior to commencement of the offer period, the offer must be in cash or be accompanied by a cash alternative for all shareholders of that class at the highest price paid by the offeror in that period. Further, if an offeror acquires any interest in shares for cash during the offer period, the offer for the shares must be in cash or accompanied by a cash alternative at a price at least equal to the price paid for such shares during the offer period.
- If after an announcement is made, the offeror acquires an interest in shares in an offeree company (i.e., a target) at a price higher than the value of the offer, the offer must be increased accordingly.
- The offeree company must appoint a competent independent adviser whose advice on the financial terms of the offer must be made known to all the shareholders, together with the opinion of the board of directors of the offeree company.
- Favorable deals for selected shareholders are not permitted, except in certain circumstances where independent shareholder approval is given and the arrangements are regarded as fair and reasonable in the opinion of the financial adviser to the offeree.
- All shareholders must be given the same information.
- The directors of those parties issuing takeover circulars must include statements taking responsibility for the contents thereof.
- Profit forecasts, quantified financial benefits statements and asset valuations must be made to specified standards and must be reported on by professional advisers.
- Misleading, inaccurate or unsubstantiated statements made in documents or to the media must be publicly corrected immediately.
- Actions during the course of an offer (or even before if the board of the offeree company is aware that an offer is imminent) by the offeree company, which might frustrate the offer are generally prohibited unless shareholders approve these plans (or the bidder consents to the proposed course of action). Frustrating actions would include, for example, issuing new shares, lengthening the notice period for directors under their service contract or agreeing to sell off material parts of the target group.
- Stringent requirements are laid down for the disclosure of dealings in relevant securities during an offer, including the prompt disclosure of positions and dealing in relevant securities by the parties to an offer and any person who is interested (directly or indirectly) in 1% or more of any class of relevant securities.
- Employees of both the offeror and the offeree company and the trustees of the offeree company's pension scheme must be informed about an offer. In addition, the offeree company's employee representatives and pension scheme trustees have the right to have a separate opinion on the effects of the offer on employment and pension schemes appended to the offeree board of directors' circular or published on a website.

U.S. shareholders may not be able to enforce civil liabilities against us.

We are incorporated under the laws of England and Wales, and our subsidiaries are incorporated in various jurisdictions, including foreign jurisdictions. A number of the officers and directors of each of our subsidiaries are non-residents of the United States, and all or a substantial portion of the assets of such persons are located outside the United States. As a result, it may not be possible for investors to affect service of process within the United States upon such persons or to enforce against them judgments obtained in U.S. courts predicated upon the civil liability provisions of the federal securities laws of the United States. We have been advised by our English solicitors that there is doubt as to the enforceability in England in original actions, or in actions for enforcement of judgments of U.S. courts, of civil liabilities to the extent predicated upon the federal securities laws of the United States.

U.S. holders of the ADSs or ordinary shares may be subject to U.S. federal income taxation at ordinary income tax rates on undistributed earnings and profits.

There is a risk that we will be classified as a controlled foreign corporation, or CFC, for U.S. federal income tax purposes. If we are classified as a CFC, any ADS holder or shareholder that is a U.S. person that owns directly, indirectly or by attribution, 10% or more of the voting power of our outstanding shares may be subject to U.S. income taxation at ordinary income tax rates on all or a portion of our undistributed earnings and profits attributable to "subpart F income." Such 10% holder may also be taxable at ordinary income tax rates on any gain realized on a sale of ordinary shares or ADS, to the extent of our current and accumulated earnings and

profits attributable to such shares. The CFC rules are complex and U.S. holders of the ordinary shares or ADSs are urged to consult their own tax advisors regarding the possible application of the CFC rules to them in their particular circumstances.

General Risk Factors

Potential technological changes in our field of business create considerable uncertainty.

The pharmaceutical industry in which we operate is characterized by extensive research efforts and rapid technological progress. New developments in research are expected to continue at a rapid pace in both industry and academia. We cannot assure you that research and discoveries by others will not render some or all of our programs or product candidates uncompetitive or obsolete. Our business strategy is based in part upon new and unproven technologies to the development of therapeutics to improve cardiovascular health. We cannot assure you that unforeseen problems will not develop with these technologies or applications or that any commercially feasible products will ultimately be developed by us.

The effect on us of comprehensive U.S. tax reform legislation whether adverse or favorable, is uncertain.

On December 22, 2017, President Trump signed into law H.R. 1, "An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018", or informally, the Tax Cuts and Jobs Act. Among a number of significant changes to the U.S. federal income tax rules, the Tax Cuts and Jobs Act reduces the marginal U.S. corporate income tax rate from 35% to 21%, limits the deduction for net interest expense, shifts the United States toward a more territorial tax system, and imposes new taxes to combat erosion of the U.S. federal income tax base. The effect of the Tax Cuts and Jobs Act on our company and our affiliates, whether adverse or favorable, is uncertain, and may not become evident for some period of time. You are urged to consult your tax adviser regarding the implications of the Tax Cuts and Jobs Act for an investment in our ADSs.

The loss of key personnel could have an adverse effect on our business.

We are highly dependent upon the efforts of our senior management. The loss of the services of one or more members of senior management could have a material adverse effect on us. Given our rapidly expanding enterprise coupled with a streamlined management structure, the departure of any key person could have a significant impact and would be potentially disruptive to our business until such time as a suitable replacement is hired. Furthermore, because of the specialized nature of our business, as our business plan progresses we will be highly dependent upon our ability to attract and retain qualified scientific, technical and key management personnel. As we continue to evolve from a development stage company to a commercial stage company we may experience turnover among members of our senior management team. We may have difficulty identifying and integrating new executives to replace any such losses. As we prepare for commercialization in Europe, we need to rapidly hire employees and ensure that they are well trained and working cohesively with core values which are consistent with our existing operations and which, we believe, help improve our position for success. In the United States, employees are increasingly being recruited by other companies. While our business priorities emphasize continued promotion of VASCEPA in the United States, the current and potential threat of generic competition can create employee uncertainty which could lead to increased employee turnover. There is intense competition for qualified personnel in the areas of our activities. In this environment, we may not be able to attract and retain the personnel necessary for the development of our business, particularly if we do not achieve profitability. The failure to recruit key scientific, technical and management personnel would be detrimental to our ability to implement our business plan.

Legal, political and economic uncertainty surrounding the exit of the UK from the EU may be a source of instability in international markets, create significant currency fluctuations, adversely affect our operations in the UK and pose additional risks to our business, revenue, financial condition, and results of operations.

On June 23, 2016, the UK held a referendum in which a majority of the eligible members of the electorate voted to leave the EU, commonly referred to as Brexit. Pursuant to Article 50 of the Lisbon Treaty, the UK ceased being a Member State of the EU on January 31, 2020. A trade deal was entered into between the UK and the EU on December 24, 2020. In addition, the UK is negotiating deals in a number of other areas where cooperation with the EU is required, and there is uncertainty as to which EU regulations and directives will be replicated into UK domestic law, or replaced, going forward. Given the recent deal terms and the lack of clarity on future UK laws and regulations and their divergence from, or consistency with, the EU laws and regulations may negatively impact foreign direct investment in the UK, increase costs, depress economic activity and restrict access to capital.

The continued uncertainty concerning the UK's legal, political and economic relationship with the EU after Brexit may be a source of instability in the international markets, create significant currency fluctuations, and/or otherwise adversely affect trading agreements or similar cross-border co-operation arrangements (whether economic, tax, fiscal, legal, regulatory or otherwise) both during and (depending on the terms of any trade deal that is reached) after the implementation period.

These developments, or the perception that any of them could occur, may have a significant adverse effect on global economic conditions and the stability of global financial markets, and could significantly reduce global market liquidity and limit the ability of key market participants to operate in certain financial markets. In particular, it could also lead to a period of considerable uncertainty in relation to the UK financial and banking markets, as well as on the regulatory process in Europe. Asset valuations, currency exchange rates and credit ratings may also be subject to increased market volatility.

If the UK and the EU are unable to implement acceptable agreements or if other EU member states pursue withdrawal, barrier-free access between the UK and other EU member states or among the European Economic Area, or EEA, overall could be diminished or eliminated. The long-term effects of Brexit will depend on any agreements (or lack thereof) between the UK and the EU.

Such a withdrawal from the EU is unprecedented, and it is unclear how the UK's access to the European single market for goods, capital, services and labor within the EU, or single market, and the wider commercial, legal and regulatory environment, will impact our current and future operations (including business activities conducted by third parties and contract manufacturers on our behalf) and clinical activities in the UK. In addition to the foregoing, our UK operations support our current and future operations and clinical activities in other countries in the EU and EEA and these operations and clinical activities could be disrupted by the ongoing effects of Brexit, particularly in regards to the specific terms of any trade deal that is reached between the UK and the EU.

We may also face new regulatory costs and challenges that could have an adverse effect on our operations. Depending on the terms of any trade deal between the UK and EU, the UK could lose the benefits of global trade agreements negotiated by the EU on behalf of its members, which may result in increased trade barriers that could make our doing business in the EU and the EEA more difficult. Since the regulatory framework in the UK covering quality, safety and efficacy of pharmaceutical products, clinical trials, marketing authorization, commercial sales and distribution of pharmaceutical products is derived from EU directives and regulations, Brexit could materially impact the future regulatory regime with respect to the approval of our product candidates in the UK. For instance, in November 2017, EU member states voted to move the EMA, the EU's regulatory body for medicines, from London to Amsterdam. Operations in Amsterdam commenced in March 2019, and the move itself may cause significant disruption to the regulatory approval process in Europe. It remains to be seen how, if at all, Brexit will impact regulatory requirements for product candidates and products in the UK, particularly after the end of the implementation period. Any delay in obtaining, or an inability to obtain, any regulatory approvals, as a result of Brexit or otherwise, would prevent us from commercializing our product candidates in the UK and/or the EU and restrict our ability to generate revenue and achieve and sustain profitability. If any of these outcomes occur, we may be forced to restrict or delay efforts to seek regulatory approval in the UK and/or EU for our product candidates, which could significantly and materially harm our business. The uncertainty around the UK's future relationship with the EU continues to cause economic uncertainty which could adversely impact customer confidence resulting in customers reducing their spending budgets on our solutions, which could adversely affect our business, revenue, financial condition, results of operations and could adversely affect the market price of our ADSs.

Negative economic conditions would likely have a negative effect on our ability to obtain financing on acceptable terms.

While we may seek additional funding through public or private financings, we may not be able to obtain financing on acceptable terms, or at all. There can be no assurance that we will be able to access equity or credit markets in order to finance our current operations or expand development programs for VASCEPA, or that there will not be deterioration in financial markets and confidence in economies, particularly in light of the continued volatility attributed to COVID-19. We may also have to scale back or further restructure our operations. If we are unable to obtain additional funding on a timely basis, we may be required to curtail or terminate some or all of our research or development programs or our commercialization strategies.

Raising additional capital may cause dilution to our existing shareholders, restrict our operations or require us to relinquish rights.

We may seek additional capital through a combination of private and public equity offerings, debt financings and collaboration, strategic and licensing arrangements. To the extent that we raise additional capital through the sale of equity or convertible debt securities, your ownership interest will be diluted, and the terms may include liquidation or other preferences that adversely affect your rights as a shareholder.

Debt financing, if available, may involve agreements that include burdensome covenants limiting or restricting our ability to take specific actions such as incurring additional debt, making capital expenditures or declaring dividends. If we raise additional funds through collaboration, strategic alliance and licensing arrangements with third parties, we may have to relinquish valuable rights to our technologies, VASCEPA or product candidates beyond the rights we have already relinquished, or grant licenses on terms that are not favorable to us.

Potential business combinations or other strategic transactions may disrupt our business or divert management's attention.

On a regular basis, we explore potential business combination transactions, including an acquisition of us by a third party, exclusive licenses of VASCEPA or other strategic transactions or collaborations with third parties. The consummation and performance of any such future transactions or collaborations will involve risks, such as:

- diversion of managerial resources from day-to-day operations;
- exposure to litigation from the counterparties to any such transaction, other third parties or our shareholders;
- misjudgment with respect to the value;
- higher than expected transaction costs; or
- an inability to successfully consummate any such transaction or collaboration.

As a result of these risks, we may not be able to achieve the expected benefits of any such transaction or collaboration or deliver the value thereof to our shareholders. If we are unsuccessful in consummating any such transaction or collaboration, we may be required to reevaluate our business only after we have incurred substantial expenses and devoted significant management time and resources.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

The following table lists the location, use and ownership interest of our principal properties as of February 25, 2021:

Location	Use	Ownership	Size (sq. ft.)
Dublin, Ireland	Offices	Leased	4,983
Bridgewater, New Jersey, USA	Offices	Leased	67,747
Zug, Switzerland	Offices	Leased	967

On April 12, 2019 we entered into an Office Centre Sharing Agreement for office space in Dublin, Ireland effective May 1, 2019, which was scheduled to terminate on April 30, 2020 and was extended for one additional year through April 30, 2021 and can continue to be extended automatically for successive one year periods. On July 4, 2019, we entered into an Office Centre Sharing Agreement effective October 1, 2019 for office space in Dublin, Ireland, which was scheduled to terminate on September 30, 2020 and was extended through April 30, 2021 and can be extended automatically for successive one year periods. On August 1, 2020 we entered into an Office Centre Sharing Agreement effective September 14, 2020 for office space in Dublin, Ireland which terminates on April 30, 2021 and can be extended automatically for successive one year periods.

Effective February 5, 2019, we entered into a lease agreement for approximately 67,747 square feet of office space in Bridgewater, New Jersey. The lease commenced on August 15, 2019 for an 11-year period, with two five-year renewal options.

On November 5, 2020, we entered into two lease agreements for approximately 468 square feet and 498 square feet, respectively, of office space in Zug, Switzerland. The leases commenced on December 1, 2020 and February 2, 2021, respectively, and will terminate on January 30, 2022.

Item 3. ***Legal Proceedings***

In the ordinary course of business, we are from time to time involved in lawsuits, claims, investigations, proceedings, and threats of litigation relating to intellectual property, commercial arrangements and other matters. Refer to Note—8 Commitments and Contingencies in the accompanying Notes to Consolidated Financial Statements in this Annual Report on Form 10-K for further details on our legal proceedings.

Item 4. ***Mine Safety Disclosures***

Not applicable.

PART II

Item 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Market Information

The following table sets forth the high and low prices for our ADSs in each of the quarters over the past two fiscal years, as quoted on The NASDAQ Global Market under the symbol "AMRN."

	Common Stock Price			
	Fiscal 2020		Fiscal 2019	
	High	Low	High	Low
First Quarter	$ 21.84	$ 3.95	$ 23.25	$ 12.44
Second Quarter	$ 8.46	$ 4.00	$ 20.97	$ 16.20
Third Quarter	$ 7.90	$ 3.36	$ 23.91	$ 13.76
Fourth Quarter	$ 5.57	$ 3.96	$ 26.12	$ 13.87

Shareholders

As of January 31, 2021, there were approximately 345 holders of record of our ordinary shares. Because many ordinary shares are held by broker nominees, we are unable to estimate the total number of shareholders represented by these record holders. Our depositary, Citibank, N.A., constitutes a single record holder of our ordinary shares.

Dividends

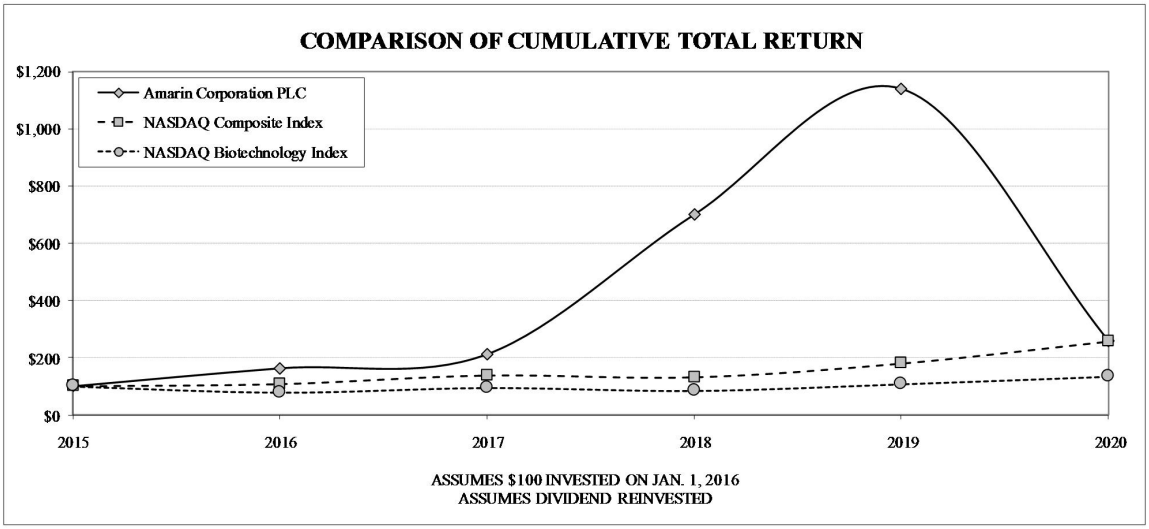
We have never paid dividends on common shares and do not anticipate paying any cash dividends on the common shares in the foreseeable future. Under English law, any payment of dividends would be subject to relevant legislation and our Articles of Association, which requires that all dividends must be approved by our Board of Directors and, in some cases, our stockholders, and may only be paid from our distributable profits available for the purpose, determined on an unconsolidated basis.

Performance Graph—5 Year

The following performance graph and related information shall not be deemed "soliciting material" or to be "filed" with the Securities and Exchange Commission, nor shall such information be incorporated by reference into any future filing under the Securities Act of 1933 or Securities Exchange Act of 1934, each as amended, except to the extent that we specifically incorporate it by reference into such filing.

The following graph compares the cumulative 5-year return provided to stockholders of Amarin's ADSs relative to the cumulative total returns of the NASDAQ Composite Index and the NASDAQ Biotechnology Index. We believe these indices are the most appropriate indices against which the total shareholder return of Amarin should be measured. The NASDAQ Biotechnology Index has been selected because it is an index of U.S. quoted biotechnology and pharmaceutical companies. An investment of $100 (with reinvestment of all dividends) is assumed to have been made in our ADSs and in each of the indices on January 1, 2016 and its relative performance is tracked through December 31, 2020.

Included in this 5-year time period is the substantial positive impact on the price of Amarin's ADSs in 2018 following presentation and publication of positive REDUCE-IT results and, in late 2019, following approval by the FDA of a new indication and label expansion for VASCEPA to reduce cardiovascular risk. Also included during this 5-year period is the substantial negative impact on the price of Amarin's ADSs in 2020 following the loss of the Company's patent litigation and subsequent appeal. During this entire 5-year time period, cumulative total return for Amarin's ADSs approximated or exceeded both the NASDAQ Composite Index and NASDAQ Biotechnology Index.



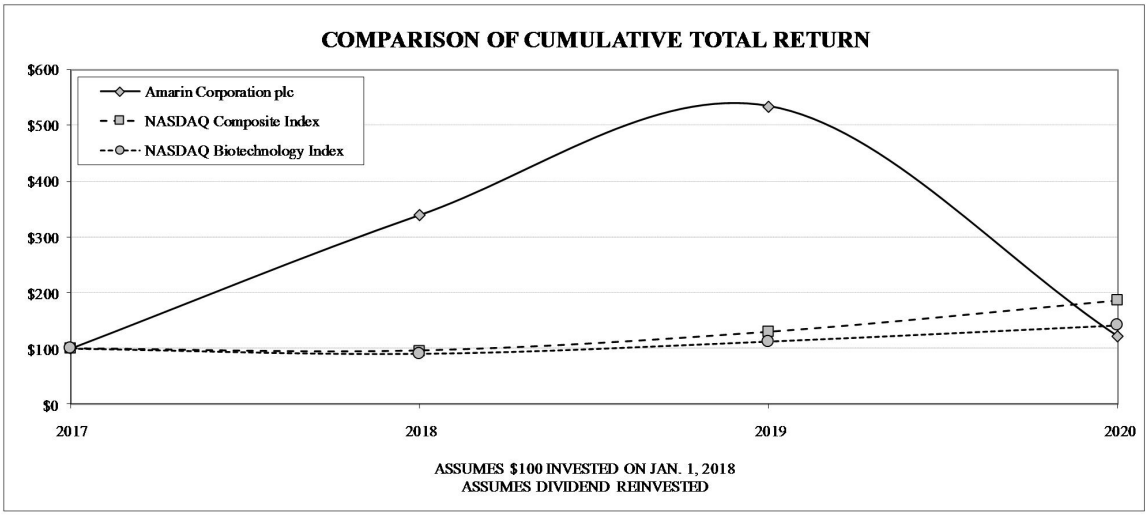
Company/Market/Peer Company	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020
Amarin Corporation PLC	$ 162.96	$ 212.17	$ 700.53	$ 1,140.21	$ 258.73
NASDAQ Composite Index	$ 107.50	$ 137.86	$ 131.50	$ 179.87	$ 257.38
NASDAQ Biotechnology Index	$ 78.32	$ 94.81	$ 84.32	$ 107.77	$ 134.42

Performance Graph—3 Year

The following performance graph and related information shall not be deemed "soliciting material" or to be "filed" with the Securities and Exchange Commission, nor shall such information be incorporated by reference into any future filing under the Securities Act of 1933 or Securities Exchange Act of 1934, each as amended, except to the extent that we specifically incorporate it by reference into such filing.

The following graph compares the cumulative 3-year return provided to stockholders of Amarin's ADSs relative to the cumulative total returns of the NASDAQ Composite Index and the NASDAQ Biotechnology Index. We believe these indices are the most appropriate indices against which the total shareholder return of Amarin should be measured. The NASDAQ Biotechnology Index has been selected because it is an index of U.S. quoted biotechnology and pharmaceutical companies. An investment of $100 (with reinvestment of all dividends) is assumed to have been made in our ADSs and in each of the indices on January 1, 2018 and its relative performance is tracked through December 31, 2020.

Included in this 3-year time period is the substantial positive impact on the price of Amarin's ADSs in 2018 following presentation and publication of positive REDUCE-IT results and, in late 2019, following approval by the FDA of a new indication and label expansion for VASCEPA to reduce cardiovascular risk. Also included during this 3-year period is the substantial negative impact on the price of Amarin's ADSs in 2020 following the loss of the Company's patent litigation and subsequent appeal.



Company/Market/Peer Company	12/31/2018	12/31/2019	12/31/2020
Amarin Corporation PLC	$ 339.40	$ 534.66	$ 121.95
NASDAQ Composite Index	$ 96.12	$ 129.97	$ 186.69
NASDAQ Biotechnology Index	$ 90.68	$ 112.81	$ 141.78

Information about Our Equity Compensation Plans

Information regarding our equity compensation plans is incorporated by reference in Item 12 of Part III of this Annual Report on Form 10-K.

Unregistered Sales of Equity Securities and Use of Proceeds

Issuer Purchases of Equity Securities

Shares purchased in the fourth quarter of 2020 are as follows:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share
October 1 – 31, 2020	14,212	$ 4.86
November 1 – 30, 2020	39,946	4.60
December 1 – 31, 2020	19,376	5.23
Total	73,534	$ 4.82

(1) Represents shares withheld to satisfy tax withholding amounts due from employees related to the exercise or vesting of equity awards.

TAXATION

The following summary contains a description of material U.S., UK and Irish federal income tax consequences of the ownership and disposition of our ordinary shares or ADSs. This summary should not be considered a comprehensive description of all the tax considerations that may be relevant to beneficial owners of ADSs.

Certain Material U.S. Tax Considerations

The following is a summary of certain U.S. federal income tax considerations with respect to the ownership and disposition of ordinary shares or ADSs by a U.S. Holder (as defined below). This summary applies to you only if you hold ordinary shares or ADSs as a capital asset. This summary is based upon the U.S. Internal Revenue Code of 1986, as amended, which is referred to herein as the Code, regulations promulgated under the Code and administrative rulings and judicial decisions as in effect on the date of this report, all of which are subject to change and to differing interpretations, possibly with retroactive effect, which could result in U.S. federal income tax considerations different from those summarized below.

This summary is general in nature and does not address the effects of any state or local taxes, the tax consequences in jurisdictions other than the United States or any U.S. federal taxes other than income tax (such as estate or gift tax). In addition, it does not address U.S. federal income tax consequences that may be relevant to you in your particular circumstances, including alternative minimum tax consequences, nor does it apply to you if you are a holder with a special status, such as:

- a person that owns, or is treated as owning under certain ownership attribution rules, 10% or more of the voting power or value of the stock of Amarin;
- a broker, dealer or trader in securities or currencies;
- a bank, mutual fund, life insurance company or other financial institution;
- a tax-exempt entity;
- a qualified retirement plan or individual retirement account;
- a person that holds ordinary shares or ADSs as part of a straddle, hedge, constructive sale or other integrated transaction for tax purposes;
- a partnership, S corporation or other pass-through entity;
- an investor in a partnership, S corporation or other pass-through entity;
- a person that is required to report income with respect to ordinary shares or ADSs no later than such income is reported on an "applicable financial statement;"
- a person who received ordinary shares or ADSs in connection with the performance of services; and
- a person whose functional currency for U.S. federal income tax purposes is not the U.S. dollar.

If an entity treated as a partnership for U.S. federal income tax purposes holds ordinary shares or ADSs, the tax treatment of a partner will generally depend upon the status of the partner and upon the activities of the partnership. A partner of a partnership that owns or disposes of ADSs should consult the partner's tax advisor regarding the specific tax consequences of the ownership and disposition of ordinary shares or ADSs.

YOU SHOULD CONSULT YOUR OWN ADVISOR REGARDING THE TAX CONSEQUENCES OF THE OWNERSHIP AND DISPOSITION OF ORDINARY SHARES AND ADSS IN LIGHT OF YOUR PARTICULAR CIRCUMSTANCES.

U.S. holders

For purposes of this discussion, a U.S. Holder is any beneficial owner of an ordinary share or ADS that is, for U.S. federal income tax purposes:

- an individual who is a citizen or resident of the United States, any state thereof or the District of Columbia;
- corporation created or organized under the laws of the United States, any state thereof or the District of Columbia;
- an estate the income of which is subject to U.S. federal income taxation regardless of its source; or,
- a trust (1) that validly elects to be treated as a U.S. person for U.S. federal income tax purposes, or (2) the administration over which a U.S. court can exercise primary supervision and all of the substantial decisions of which one or more U.S. persons have the authority to control.

Distributions

Subject to the discussion under "—Passive Foreign Investment Company," below, the gross amount of distributions, if any, payable on ordinary shares and ADSs generally would be treated as dividend income to the extent paid out of current or accumulated earnings and profits (as determined for U.S. federal income tax purposes). A U.S. Holder would be required to include the amount of such distribution in gross income as a dividend (without reduction for any income tax withheld from such distribution). Because Amarin does not maintain calculations of its earnings and profits in accordance with U.S. federal income tax principles, U.S. Holders should assume that any distribution by Amarin with respect to the ordinary shares and ADSs will constitute ordinary dividend income.

Subject to the discussion under "—Passive Foreign Investment Company," below, as long as our ordinary shares or ADSs (as applicable) are treated as publicly traded on an established securities market, or we are eligible for the benefits of the U.S.-Irish Tax Treaty, any distributions treated as dividends will generally be qualified dividend income in the hands of non-corporate U.S. Holders, provided that certain significant holding period and other requirements are met. Any dividends that are qualified dividend income will generally be taxed at preferential rates to a non-corporate U.S. Holder. Any dividends paid to a corporate holder will not be eligible for the dividends received deduction.

U.S. Holders generally may claim the amount of Irish withholding tax withheld either as a deduction from gross income or as a credit against U.S. federal income tax liability. However, the foreign tax credit is subject to numerous complex limitations that must be determined and applied on an individual basis. Generally, the credit cannot exceed the proportionate share of a U.S. Holder's U.S. federal income tax liability that such U.S. Holder's foreign source taxable income bears to such U.S. Holder's worldwide taxable income. In applying this limitation, a U.S. Holder's various items of income and deduction must be classified, under complex rules, as either foreign source or U.S. source. In addition, this limitation is calculated separately with respect to specific categories of income. The amount of a distribution with respect to the ordinary shares or ADSs that is treated as a dividend may be lower for U.S. federal income tax purposes than it is for Irish income tax purposes, potentially resulting in a reduced foreign tax credit for the U.S. Holder. Each U.S. Holder should consult its own tax advisors regarding the foreign tax credit rules.

The amount of a distribution paid to a U.S. Holder of ordinary shares or ADSs in foreign currency generally will be equal to the U.S. dollar value of such distribution based on the exchange rate applicable on the date of receipt. A U.S. Holder that does not convert foreign currency received as a distribution into U.S. dollars on the date of receipt generally will have a tax basis in such foreign currency equal to the U.S. dollar value of such foreign currency on the date of receipt. Such a U.S. Holder generally will recognize ordinary income or loss on the subsequent sale or other taxable disposition of such foreign currency (including an exchange for U.S. dollars).

Sale or other disposition of ordinary shares or ADSs

Subject to the discussion under "—Passive Foreign Investment Company," below, in general, if you sell or otherwise dispose of ordinary shares or ADSs in a taxable disposition:

- you will recognize gain or loss equal to the difference (if any) between the U.S. dollar value of the amount realized on such sale or other taxable disposition and your adjusted tax basis in such ordinary shares or ADSs;
- any gain or loss will be capital gain or loss and will be long-term capital gain or loss if your holding period for the ordinary shares or ADSs sold or otherwise disposed of is more than one year at the time of such sale or other taxable disposition; and,
- any gain or loss will generally be treated as U.S.-source income for U.S. foreign tax credit purposes, although special rules apply to U.S. Holders who have a fixed place of business outside the United States to which this gain is attributable.

Under current law, long-term capital gains of non-corporate U.S. Holders are taxed at reduced rates. The deductibility of capital losses is subject to limitations.

In certain circumstances, amounts received by a U.S. Holder upon the redemption of ordinary shares or ADSs may be treated as a dividend with respect to such ordinary shares or ADSs, rather than as a payment in exchange for such ordinary shares or ADSs that results in the recognition of capital gain or loss. In these circumstances, the redemption payment would be included in a U.S. Holder's gross income as a dividend to the extent such payment is made out of our earnings and profits (as described above). The determination of whether redemption of ordinary shares or ADSs will be treated as a dividend, rather than as a payment in exchange for such ordinary shares or ADSs, will depend, in part, on whether and to what extent the redemption reduces the U.S. Holder's ownership in us (including as a result of certain constructive ownership attribution rules). The rules applicable to redemptions are complex, and each U.S. Holder should consult its own tax adviser to determine the consequences of any redemption.

Passive foreign investment company

PFIC Rules Generally. U.S. Holders of ordinary shares and ADSs should be aware that each of Amarin and certain of its subsidiaries could constitute a PFIC for U.S. federal income tax purposes. The tests for determining PFIC status for a taxable year

depend upon the relative values of certain categories of assets and the relative amounts of certain kinds of income. The application of these factors depends upon our financial results for the year, which are beyond our ability to predict or control, and the application of the relevant rules is subject to legal and factual uncertainties. Based on certain estimates of our gross income and gross assets, the latter determined by reference to the expected value of our ADSs and shares, we believe that we will not be classified as a PFIC for the taxable year ended December 31, 2020 and we do not expect to be treated as a PFIC in any future taxable year for the foreseeable future. However, there can be no assurance that we will be classified as a PFIC for any taxable year.

In general terms, Amarin will be a PFIC for any taxable year in which either (i) 75% or more of its gross income is passive income, or the income test, or (ii) the average percentage, by fair market value, of its assets that produce or are held for the production of passive income is 50% or more, or the asset test. "Passive income" includes, for example, dividends, interest, certain rents and royalties, certain gains from the sale of stock and securities, and certain gains from commodities transactions.

If Amarin is a PFIC for any year, subject to the discussion of QEF and mark-to-market elections below, a U.S. taxpayer who disposes or is deemed to dispose of an ordinary share or ADS at a gain or who receives a distribution treated as an "excess distribution" on an ordinary share or ADS generally would be required to allocate such gain and distribution ratably to each day in the U.S. taxpayer's holding period for the ordinary share or ADS in question.

The portion of any excess distributions including gains, which are treated for all purposes as excess distributions, allocated to the current taxable year or to a year prior to the first year in which Amarin was a PFIC would be includible as ordinary income in the current taxable year. In contrast, the portion of any excess distributions allocated to the first year in the U.S. Holder's holding period in which Amarin was a PFIC and any subsequent year or years (excluding the current year) would be taxed at the highest marginal rate applicable to ordinary income for each year (regardless of the U.S. Holder's actual marginal rate for that year and without reduction by any losses or loss carryforwards) and would be subject to interest charges to reflect the value of the U.S. federal income tax deferral.

In accordance with the rules above, if Amarin is or was a PFIC at any time during the U.S. Holder's holding period, none of the gain recognized on the sale or other disposition of an ordinary share or ADS would be eligible for the preferential long-term capital gains rate. In addition, dividends generally will not be qualified dividend income if in the year of payment or the preceding year Amarin is a PFIC.

Certain elections may sometimes be used to reduce the adverse impact of the PFIC rules on U.S. Holders qualifying electing fund, or QEF, and mark-to-market elections, but these elections may accelerate the recognition of taxable income and may result in the recognition of ordinary income.

QEF Election. The rules described above for excess distributions would not apply to a U.S. Holder if the U.S. Holder makes a timely QEF election for the first taxable year of the U.S. Holder's holding period for ordinary shares or ADSs during which Amarin is a PFIC and Amarin complies with specified reporting requirements. A timely QEF election for a taxable year generally must be made on or before the due date (as may be extended) for filing the taxpayer's U.S. federal income tax return for the year. A U.S. Holder who makes a QEF election generally must report and include in income on a current basis a pro rata share of Amarin's ordinary earnings and net capital gain for any taxable year in which Amarin is a PFIC, whether or not those earnings or gains are distributed. A U.S. Holder who makes a QEF election must file a Form 8621 with its annual income tax return. For U.S. Holders who seek to make a QEF election, with respect to our ordinary shares or ADSs, Amarin will make available an information statement that will contain the necessary information required for making a QEF election and permit such U.S. Holders access to certain information in the event of an audit by the U.S. tax authorities.

If a U.S. Holder does not make a QEF election for the first taxable year of the U.S. Holder's holding period for ordinary shares or ADSs during which Amarin is a PFIC, the QEF election will not be treated as timely and the adverse tax regime described above would apply to dispositions of or excess distributions on the ordinary shares or ADSs. In such case, a U.S. Holder may make a deemed sale election whereby the U.S. Holder would be treated as if the U.S. Holder had sold the ordinary shares or ADSs in a fully taxable sale at fair market value on the first day of such taxable year in which the QEF election takes effect. Such U.S. Holder would be required to recognize any gain on the deemed sale as an excess distribution and pay any tax and interest due on the excess distribution when making the deemed sale election. The effect of such further election would be to restart the U.S. Holder's holding period in the ordinary shares or ADSs, subject to the QEF regime, and to purge the PFIC status of such ordinary shares or ADSs going forward.

Mark-to-Market Election. If Amarin is or becomes a PFIC, a U.S. Holder of ordinary shares or ADSs may elect to recognize any gain or loss on ordinary shares or ADSs on a mark-to-market basis at the end of each taxable year, so long as the ordinary shares and ADSs, respectively, are regularly traded on a qualifying exchange. The mark-to-market election under the PFIC rules is an alternative to the QEF election. A U.S. Holder who makes a mark-to-market election generally must recognize as ordinary income all appreciation inherent in the U.S. Holder's investment in ordinary shares or ADSs on a mark-to-market basis and may recognize losses inherent in such ordinary shares or ADSs only to the extent of prior mark-to-market gain recognition. The income and deductions entailed by the mark-to-market regime will increase and decrease the U.S. Holder's adjusted basis in its ordinary shares or ADSs. Upon a sale or other disposition of ordinary shares or ADSs that have been marked-to-market, any gain recognized will be treated as

ordinary income. The mark-to-market election must be made by the due date (as may be extended) for filing the U.S. Holder's federal income tax return for the first year in which the election is to take effect. If a mark-to-market election is made after the first taxable year of a U.S. Holder's holding period, any gain recognized in the year of the election will be treated like an excess distribution (as described above). Whether or not the mark-to-market election is available will depend on whether the ordinary shares or ADSs are regularly traded on a qualifying exchange and Amarin cannot provide assurance that the ordinary shares or ADSs will be considered regularly traded (which determination is based on the volume of trading of the ordinary shares or ADSs) for all years in which Amarin may be a PFIC.

Rules for Lower-Tier PFIC Subsidiaries. Special adverse rules apply to U.S. Holders of ordinary shares or ADSs for any year in which Amarin is a PFIC and has a non-U.S. subsidiary that is also a PFIC, or a lower-tier PFIC. If Amarin is or becomes a PFIC and a U.S. Holder does not make a QEF election (as described above) in respect of any lower-tier PFIC, the U.S. Holder could incur liability for the deferred tax and interest charge described above if (i) Amarin receives a distribution from, or disposes of all or part of its interest in, the lower-tier PFIC or (ii) the U.S. Holder disposes of all or part of its ordinary shares or ADSs. A QEF election that is made for ordinary shares or ADSs will not apply to a lower tier PFIC, although a separate QEF election may be made with respect to a lower-tier PFIC. For U.S. Holders who seek to make a QEF election, with respect to our ordinary shares or ADSs, Amarin will make available an information statement that will contain the necessary information required for making a QEF election with respect to any lower-tier PFIC and permit such U.S. Holders access to certain information in the event of an audit by the U.S. tax authorities. For U.S. Holders that make a mark-to-market election for Amarin, if available, no such election may be made with respect to the stock of a lower-tier PFIC that a U.S. Holder is treated as owning if such stock is not marketable. Hence, the mark-to-market election will not be effective to eliminate a U.S. Holder's liability for the deferred tax and interest charge described above with respect to deemed dispositions of lower-tier PFIC stock or distributions from a lower-tier PFIC.

Taxpayer Reporting Obligations. A U.S. Holder's ownership of ordinary shares or ADSs in a PFIC generally must be reported by filing Form 8621 with the U.S. Holder's annual U.S. federal income tax return. Every U.S. Holder who is a shareholder in a PFIC must file an annual report containing the information required by the Internal Revenue Service.

The PFIC rules are extremely complex, and U.S. Holders are urged to consult their own tax advisers regarding the potential tax consequences of Amarin being classified as a PFIC.

Medicare tax

Certain U.S. Holders that are individuals, estates or trusts are required to pay up to an additional 3.8% tax on the lesser of (i) the U.S. person's net investment income (or undistributed net investment income in the case of an estate or trust) for the relevant taxable year and (ii) the excess of the U.S. person's modified adjusted gross income (or adjusted gross income, in the case of an estate or trust) for the taxable year over a certain threshold (which in the case of individuals will be between $125,000 and $250,000, depending on the individual's circumstances). A U.S. Holder's net investment income will include dividends and capital gains on the U.S. Holder's ordinary shares and ADSs. U.S. Holders should consult their own tax advisors regarding the effect, if any, of the Medicare tax on the ownership and disposition of ordinary shares or ADSs.

Taxpayer reporting obligations

Certain U.S. Holders that hold certain foreign financial assets are required to report information relating to such assets to the IRS, subject to certain exceptions. U.S. Holders may also be required to make other tax filings with respect to their investments in our ordinary shares and ADSs, including IRS Form 926 (Return by a U.S. Transferor of Property to a Foreign Corporation). Failure to provide such information could result in significant additional taxes and penalties.

U.S. Information reporting and backup withholding

U.S. Holders of ordinary shares and ADSs may be subject to information reporting and may be subject to backup withholding on distributions on ordinary shares and ADSs or on the proceeds from a sale or other disposition of ordinary shares and ADSs paid within the United States. Payments of distributions on, or the proceeds from the sale or other disposition of ordinary shares and ADSs to or through a foreign office of a broker generally will not be subject to backup withholding, although information reporting may apply to those payments in certain circumstances. Backup withholding will generally not apply, however, to a U.S. Holder who:

- furnishes a correct taxpayer identification number and certifies that the U.S. Holder is not subject to backup withholding on IRS Form W-9, Request for Taxpayer Identification Number and Certification (or substitute form); or
- is otherwise exempt from backup withholding.

Backup withholding is not an additional tax. Any amounts withheld from a payment to a holder under the backup withholding rules may be credited against the holder's U.S. federal income tax liability, and a holder may obtain a refund of any excess amounts withheld by filing the appropriate claim for refund with the IRS in a timely manner.

Certain Material UK Tax Considerations

The following discussion is limited to an overview of the tax consequences of ownership and disposition of ordinary shares, or such shares represented by ADSs (those ordinary shares or ADSs deriving over 75% of their value otherwise than from United Kingdom land). Tax considerations applicable to other types of securities will be described in the related prospectus supplement. Each shareholder should however seek individual tax advice as specific rules may apply in certain circumstances.

Capital gains

If you are not resident in the United Kingdom, or UK, for UK tax purposes, you will not be liable for UK tax on capital gains realized or accrued on the sale or other disposition of ordinary shares or ADSs unless the ordinary shares or ADSs are held in connection with your trade carried on in the UK through a branch or agency and the ordinary shares or ADSs are or have been used, held or acquired for the purposes of such trade or such branch or agency.

An individual holder of ordinary shares or ADSs who ceases to be resident in the UK for UK tax purposes for a period of less than 5 years and who disposes of ordinary shares or ADSs during that period may also be liable on returning to the UK for UK capital gains tax despite the fact that the individual may not be resident in the UK at the time of the disposal.

Inheritance tax

If you are an individual domiciled in the United States and are not a national of the UK for the purposes of the Inheritance and Gift Tax Treaty 1978 between the United States and the UK, any ordinary shares or ADS beneficially owned by you will not generally be subject to UK inheritance tax on your death or on a gift made by you during your lifetime, provided that any applicable United States federal gift or estate tax liability is paid, except where the ordinary share or ADS is part of the business property of your UK permanent establishment. Where the ordinary shares or ADSs have been placed in trust by a settlor who, at the time of the settlement, was domiciled in the United States and not a national of the UK, the ordinary shares or ADSs will not generally be subject to UK inheritance tax.

Stamp duty and stamp duty reserve tax

Transfer of ADSs and ADRs representing ADSs

No UK stamp duty or stamp duty reserve tax will be payable on an instrument transferring an ADS or an ADR representing an ADS or on a written agreement to transfer an ADS or an ADR representing an ADS whether made in or outside the UK.

Issue and transfer of ordinary shares

The issue of ordinary shares by Amarin will not give rise to a charge to UK stamp duty or stamp duty reserve tax. Transfers of ordinary shares, as opposed to ADSs or ADRs representing ADSs, will generally attract ad valorem stamp duty at the rate of 0.5% of the amount or value of the consideration (or in some circumstances, the open market value of those ordinary shares, if higher). A charge to stamp duty reserve tax, at the rate of 0.5% of the amount or value of the consideration (or in some circumstances, the open market value of the ordinary shares, if higher), will generally arise on an agreement to transfer ordinary shares. The stamp duty reserve tax is payable on the seventh day of the month following the month in which the charge arises. Where an instrument of transfer is executed and duly stamped before the expiry of a period of six years beginning with the date of that agreement, any stamp duty reserve tax that has not been paid ceases to be payable.

Taxation of dividends

Under UK law, there is no withholding tax on dividends paid on the ordinary shares or ADSs.

Certain Material Irish Tax Considerations

The summary only applies to U.S. Holders that legally and beneficially hold their ordinary shares, or such shares represented by ADSs evidenced by ADRs as capital assets (i.e. investments) and does not address special classes of holders including, but not limited to, dealers in securities, insurance companies, pension schemes, employee share ownership trusts, collective investment undertakings, charities, tax-exempt organizations, financial institutions and close companies, each of which may be subject to special rules not discussed below.

Solely for the purposes of this summary of Irish Tax Considerations, a U.S. Holder means a holder of shares or ADSs evidenced by ADRs that (i) beneficially owns the shares or ADSs registered in their name; (ii) is resident in the United States for the purposes of the Ireland-United States Double Taxation Convention, or the Treaty; (iii) in the case of an individual holder, is not also resident or ordinarily resident in Ireland for Irish tax purposes; (iv) in the case of a corporate holder, is not a resident in Ireland for Irish tax purposes and is not ultimately controlled by persons resident in Ireland; and (v) is not engaged in any trade or business and does not

perform independent personal services through a permanent establishment or fixed base in Ireland; and (vi) is a qualified person as defined in Article 23 of the Treaty.

For Irish taxation purposes, and for the purposes of the Treaty, U.S. Holders of ADSs will be treated as the owners of the shares represented by such ADSs.

The following discussion is limited to the tax consequences of ownership and disposition of shares or ADSs. Tax considerations applicable to other types of securities will be described in the related prospectus supplement.

Taxation of dividends

We do not expect to pay dividends in the foreseeable future. Should we begin paying dividends, such dividends will generally be subject to dividend withholding tax, or DWT, in Ireland at a rate of 25%. Where DWT applies, we will be responsible for withholding such tax at source.

Dividends paid by us to U.S. Holders of shares or ADSs evidenced by ADRs will be exempt from DWT if, prior to the payment of such dividends, the recipient U.S. Holder delivers to us a declaration in the form prescribed by the Irish Revenue Commissioners. In addition, a certificate of residency in the form prescribed by the Irish Revenue Commissioners, will also be required if the US holder is an individual.

Where DWT is withheld from dividend payments to U.S. Holders of shares or ADSs evidenced by ADRs, such U.S. Holders can apply to the Irish Revenue Commissioners claiming a full refund of DWT paid by filing a declaration in the form prescribed by the Irish Revenue Commissioners. As above, a certificate of residency in the form prescribed by the Irish Revenue Commissioners, will also be required if the US holder is an individual.

The DWT rate applicable to U.S. Holders may be reduced under the terms of the Treaty, however, in the first instance, an exemption should be in place under Irish domestic legislation.

Irish source income

U.S. Holders will not be liable to Irish income tax on dividends paid by us.

Capital gains on disposals of shares or ADSs

U.S. Holders will not be subject to Irish capital gains tax, or CGT, on the disposal of shares or ADSs provided that such shares or ADSs are quoted on a stock exchange at the time of disposition such as Nasdaq. While it is our intention to continue the listing of ADSs on Nasdaq, no assurances can be given in this regard.

If, for any reason, our ADSs cease to be listed on Nasdaq, U.S. Holders will not be subject to CGT on the disposal of their shares or ADSs provided that the shares or ADSs do not, at the time of the disposal, derive the greater part of their value from land, buildings, minerals, or mineral rights or exploration rights in Ireland.

Irish Capital Acquisitions Tax (CAT)

CAT comprises principally gift and inheritance tax. A gift or inheritance of shares or ADSs will come within the charge to CAT if either:

(i) the disponer or the donee/successor in relation to the gift or inheritance is resident or ordinarily resident in Ireland (please note that special rules with regard to residence apply where an individual is not domiciled in Ireland); or

(ii) the ordinary shares or ADSs are regarded as property situated in Ireland (e.g. shares would be regarded as Irish property if the share register is maintained in Ireland. ADSs, if registered, will be regarded as Irish property if the register is maintained in Ireland, or, if in bearer form, if the instrument of ownership is located in Ireland).

On the basis that the shares or ADSs (assuming they are registered) should not be regarded as property situated in Ireland (given that the registers are not maintained in Ireland), a gift or inheritance of the shares or ADSs should only come within the charge to Irish CAT if either the disponer or donee/successor is resident or ordinarily resident in Ireland at the date of the gift or inheritance.

The rate of CAT is currently 33% and is payable if the taxable value of the gift or inheritance exceeds certain tax-free thresholds. The appropriate tax-free threshold depends on the relationship between the disponer and the donee/successor. A gift or inheritance received from a spouse is exempt from CAT.

The person who receives the gift or inheritance is generally accountable for any CAT due.

Irish stamp duty

No Irish stamp duty should arise on the issue or transfer for cash of shares or ADSs on the basis that such a transfer does not relate to stocks or marketable securities of an Irish registered company.

Item 6 ***Selected Financial Data***

Not applicable.

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

This Annual Report on Form 10-K contains forward-looking statements concerning future events and performance of the Company. When used in this report, the words "may," "would," "should," "could," "expects," "aims," "plans," "anticipates," "believes," "estimates," "predicts," "projects," "potential," or "continue" or the negative of these terms or other comparable terminology are included to identify forward-looking statements. These statements include but are not limited to statements regarding the commercial success of VASCEPA and factors that can affect such success; interpretation of court decisions; plans with respect to litigation; expectation on determinations and policy positions of the United States Food and Drug Administration, or FDA; the safety and efficacy of our product and product candidates; expectation regarding the potential for VASCEPA to be partnered, developed and commercialized outside of the United States; expectation on the scope and strength of our intellectual property protection and the likelihood of securing additional patent protection; estimates of the potential markets for our product candidates; estimates of the capacity of manufacturing and other facilities to support our products; our operating and growth strategies; our industry; our projected cash needs, liquidity and capital resources; and our expected future revenues, operations and expenditures. These forward-looking statements are based on our current expectations and assumptions and many factors could cause our actual results to differ materially from those indicated in these forward-looking statements. You should review carefully the factors identified in this report in Item 1A, "Risk Factors". We disclaim any intent to update or announce revisions to any forward-looking statements to reflect actual events or developments, except as required by law. Except as otherwise indicated herein, all dates referred to in this report represent periods or dates fixed with reference to our fiscal year ended December 31, 2020.

Overview

We are a pharmaceutical company focused on the commercialization and development of therapeutics to improve cardiovascular, or CV, health and reduce CV risk.

Our lead product, VASCEPA® (icosapent ethyl) was first approved by the United States Food and Drug Administration, or FDA, for use as an adjunct to diet to reduce triglyceride, or TG, levels in adult patients with severe (≥500 mg/dL) hypertriglyceridemia. We launched VASCEPA in the United States, or U.S., in January 2013. On December 13, 2019 the FDA approved a new indication and label expansion for VASCEPA based on the landmark results of our cardiovascular outcomes trial of VASCEPA, REDUCE-IT®, or Reduction of Cardiovascular Events with EPA – Intervention Trial. VASCEPA is the first and only drug approved by the FDA as an adjunct to maximally tolerated statin therapy for reducing persistent cardiovascular risk in select high risk patients.

In August 2020, we announced our plans to launch icosapent ethyl under the brand name VAZKEPA®, hereinafter along with the U.S. brand name VASCEPA, collectively referred to as VASCEPA, in major markets in Europe through our own new European sales and marketing teams. On January 28, 2021, the Committee for Medicinal Products for Human Use, or CHMP, of the European Medicines Agency, or EMA, adopted a positive opinion, recommending that a marketing authorization be granted to our drug, icosapent ethyl, in the European Union, or EU, for the reduction of risk of cardiovascular events in patients at high cardiovascular risk, under the brand name VAZKEPA, hereinafter along with the U.S. brand name VASCEPA, collectively referred to as VASCEPA. The CHMP recommendation is now expected to be reviewed by the European Community, or EC, with a decision expected to take place within 67 days of the CHMP opinion. In Europe, ten years of market protection is anticipated as part of an EC approval of the pending application, in addition to pending patent protection that could extend into 2039. In Europe, launch of VAZKEPA in individual countries is gated by timing of achieving product reimbursement on a country-by-country basis as is typical for new drugs. Similar to our approach in launching VASCEPA in the United States, in Europe we have been building a core team of experienced professionals and a highly capable sales team and plan to leverage third-party relationships for various support activities. We commenced 2021 with approximately 50 professionals involved with pre-approval and pre-launch planning and other commercial preparation activities.

In November 2020, we announced statistically significant topline results from the Phase 3 clinical trial of VASCEPA conducted by our partner in China. On February 9, 2021, we announced that our partner in China commenced the regulatory review processes in Mainland China and Hong Kong. The Chinese National Medical Products Administration, or NMPA, has accepted for review the new drug application for VASCEPA based on the results from the Phase 3 clinical trial and the results from our prior studies of VASCEPA. We expect to receive a decision from the NMPA in Mainland China near the end of 2021. The Hong Kong Department of

Health is evaluating VASCEPA based on current approvals in the United States and Canada. The review process in Hong Kong is expected to conclude near the end of 2021.

In addition to the United States, VASCEPA is currently available by prescription in Canada, Lebanon and the United Arab Emirates. In Canada, VASCEPA has the benefit of eight years of data protection afforded through Health Canada (until the end of 2027), in addition to separate patent protection with expiration dates that could extend into 2039. In China and the Middle East, we are pursuing such regulatory approvals and subsequent commercialization of VASCEPA with commercial partners.

Since our inception, we have devoted substantial resources to our research and development efforts, most significantly our VASCEPA cardiovascular outcomes trial, REDUCE-IT. We announced topline results from REDUCE-IT on September 24, 2018. On November 10, 2018, we publicly presented primary results at the 2018 Scientific Sessions of the American Heart Association, or AHA, and the results were concurrently published in *The New England Journal of Medicine*. REDUCE-IT met its primary endpoint demonstrating a 25% relative risk reduction, or RRR, to a high degree of statistical significance ($p<0.001$), in first occurrence of major adverse cardiovascular events, or MACE, in the intent-to-treat patient population with use of VASCEPA 4 grams/day as compared to placebo. REDUCE-IT also showed a 26% RRR in its key secondary composite endpoint of cardiovascular death, heart attacks and stroke ($p<0.001$). On March 18, 2019, we publicly presented the total cardiovascular events results, and the method of calculating such events, of the REDUCE-IT study at the American College of Cardiology's, or ACC, 68th Annual Scientific Session and such results and methods were concurrently published in the *Journal of the American College of Cardiology*. Included in such results were that VASCEPA reduced total events (first and subsequent events) by 30% compared to placebo, reflecting that for every 1,000 patients treated for five years with VASCEPA versus placebo in this trial, approximately 159 MACE would have been prevented with VASCEPA.

Based on REDUCE-IT results, 13 clinical treatment guidelines or position statements from medical societies have been updated recommending the use of icosapent ethyl in at-risk patients, including those listed below:

- In March 2019, the American Diabetes Association, or ADA, issued important updates to the *Standard of Medical Care in Diabetes* for 2019, including a recommendation for the use of icosapent ethyl in treating at-risk patients based on the results of the REDUCE-IT cardiovascular outcomes study.
- In August 2019, the AHA recognized the results of REDUCE-IT and recommended directing medical care away from unproven fish oil dietary supplements and to prescription drug therapy in patients with elevated TG levels.
- In September 2019, the National Lipid Association issued a position statement recognizing the cardiovascular risk-lowering effects of icosapent ethyl based on the REDUCE-IT results.
- In September 2019, the European Society of Cardiology and the European Atherosclerosis Society updated their Clinical Practice Guidelines for the Management of Dyslipidemias to incorporate findings from the REDUCE-IT study and in August 2020 the European Society of Cardiology expanded their guidelines to also cover patients with acute coronary syndrome.
- In February 2020, the American Association of Clinical Endocrinologists and the American College of Endocrinology released a consensus statement on the comprehensive management of type 2 diabetes. The statement included new guidance for managing patients with established or high risk for cardiovascular disease who have triglyceride levels between 135 – 499 mg/dL with icosapent ethyl which has proven benefits to prevent the next adverse cardiovascular event.
- In December 2020, the Guidelines for Primary Prevention of Cardiovascular Diseases in China was published in the *Chinese Journal of Cardiovascular Diseases* listing icosapent ethyl 2 grams twice a day, as studied in REDUCE-IT, as a treatment consideration to further lower atherosclerotic cardiovascular risk in at-risk patients.

In October 2019, the Institute for Clinical and Economic Review, or ICER, released its final evidence report regarding clinical effectiveness and economic impacts on VASCEPA. ICER's report indicated that VASCEPA was cost effective across all of the non-profit organization's analyses, including its quality-adjusted life year metrics of <$50,000. The conclusion from the report is that VASCEPA easily meets "commonly cited thresholds for cost-effectiveness and therefore represents a high long-term value for money" based on the organization's value assessment framework. In addition, an independent academic, patient-level, cost-effectiveness analysis of icosapent ethyl led by Dr. William S. Weintraub, M.D., director of Outcomes Research with MedStar Cardiovascular Research Network, indicated that VASCEPA was projected to not only be cost-effective but also to reduce long-term health care costs in a majority of the scenarios analyzed. Based on our analysis of branded cardiovascular drugs in the United States which have positive cardiovascular outcomes studies, we believe the wholesale acquisition cost of VASCEPA is the lowest. In addition, while none of these other cardiovascular drugs compete directly with VASCEPA and no head-to-head studies have been done between VASCEPA and these other drugs and the length and construct of the respective outcomes studies of these drugs vary, analysis of published clinical results from the cardiovascular outcomes studies of these drugs indicates that the number needed to treat, or NNT, for VASCEPA is as low or lower than for these other branded cardiovascular drugs. NNT is a measure of how many patients

need to be treated before one patient benefits from the therapy. For VASCEPA, in this analysis, the NNT was based on the 25% relative risk reduction demonstrated for the primary endpoint of the study, the NNT for which is 21, as opposed to one fewer MACE on average per six patients treated over the five-year study period based on total events. The original pricing for VASCEPA was established prior to results of the REDUCE-IT cardiovascular outcomes study during a timeframe when VASCEPA was only approved for the original indication as an adjunct to diet to reduce TG levels in adult patients with severe (TG ≥500 mg/dL) hypertriglyceridemia. We believe that this relatively low price for VASCEPA in the United States will help lead to many at-risk patients being treated by VASCEPA.

The FDA granted Priority Review designation to our March 2019 supplemental new drug application, or sNDA, seeking an expanded indication for VASCEPA in the United States based on the positive results of the REDUCE-IT study. The FDA grants Priority Review designation to applications for drugs that, if approved, have the potential to offer significant improvements in the effectiveness and safety of the treatment of serious conditions. In November 2019, FDA held an Endocrinologic and Metabolic Drugs Advisory Committee, or EMDAC, meeting to review the REDUCE-IT sNDA. The EMDAC voted unanimously (16-0) to recommend approval of an indication and label expansion for VASCEPA to reduce cardiovascular events in high-risk patients based on the REDUCE-IT results. On December 13, 2019 the FDA approved a new indication and label expansion for VASCEPA capsules. VASCEPA is the first and only drug approved by the FDA as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated TG levels (≥150 mg/dL) and either established cardiovascular disease or diabetes mellitus and two or more additional risk factors for cardiovascular disease.

On March 30, 2020, the United States District Court for the District of Nevada, or the Nevada Court, decided in favor of two generic companies in our patent litigation related to their abbreviated new drug applications, or ANDAs, that sought FDA approval for sale of generic versions of VASCEPA. On May 22, 2020 and August 10, 2020, the two generic companies, Hikma Pharmaceutical USA Inc., or Hikma, and Dr. Reddy's Laboratories, Inc., or Dr. Reddy's, received FDA approval to market its generic versions of VASCEPA for the original indication of VASCEPA as an adjunct to diet to reduce TG levels in adult patients with severe (≥500 mg/dL) hypertriglyceridemia. On September 3, 2020, the U.S. Court of Appeals for the Federal Circuit upheld the March ruling by the Nevada Court in favor of the two generic companies. On October 2, 2020, we filed a combined petition for panel rehearing or rehearing en banc. On November 4, 2020, our rehearing and en banc petitions were denied. On February 11, 2021, we filed a petition for a writ of certiorari with the United States Supreme Court to ask the Court to hear our appeal in this litigation. We intend to vigorously pursue this matter, but we cannot predict the outcome.

In November 2020, Hikma launched their generic version of VASCEPA on a limited scale. On November 30, 2020 we filed a patent infringement lawsuit against Hikma for making, selling, offering to sell and importing generic icosapent ethyl capsules in and into the United States in a manner that we allege has induced the infringement of patents covering the use of VASCEPA to reduce specified cardiovascular risk. On January 25, 2021 we expanded the scope of the patent infringement lawsuit to include a health care insurance provider, Health Net, LLC.

Although, to date, no generics other than Hikma have been launched, in addition to ANDAs approved for Hikma and Dr. Reddy's, on September 11, 2020, Teva Pharmaceuticals USA, Inc's., or Teva's, ANDA was approved by the FDA. Apotex, Inc., or Apotex, has applied for ANDA approval such application, based on public records, has not yet been approved.

We believe that VASCEPA is not yet known to most healthcare professionals and generics companies rarely invest in product or disease state related market education. Furthermore, VASCEPA is relatively expensive to manufacture and already sold at an affordable price as documented by third-party analysis such that saving, if any, on the price of generic VASCEPA is likely to come at the expense of reduced market education and development. Thus, we believe that the launch of a generic version of VASCEPA in the United States at this early stage in the life cycle of VASCEPA is potentially harmful to patient care and discourages new product development, including identifying and pursuing additional indications that could be treated with VASCEPA.

We intend to vigorously pursue these ongoing litigation matters, but cannot predict the outcomes or the impact on our business. Geographies outside the United States in which VASCEPA is sold and under regulatory review are not subject to this U.S. patent litigation and judgment. No similar litigation involving potential generic versions of VASCEPA is pending outside the United States.

We are responsible for supplying VASCEPA to all markets in which the branded product is sold, including Canada, Lebanon and the United Arab Emirates where the drug is promoted and sold via collaborations with third-party companies that compensate us for such supply. Subject to approvals in Europe and China, we will be responsible for supplying products to those markets as well. We are not responsible for providing any generic company with drug product.

Commercialization

United States

We commenced the commercial launch of VASCEPA in the United States in January 2013 based on the original indication for VASCEPA. In October 2016, in addition to the original 1-gram capsule size for VASCEPA, we introduced a smaller 0.5-gram capsule size. The FDA-approved dosing for VASCEPA continues to be 4 grams per day, and, as expected, the majority of new and existing patients taking VASCEPA continue to be prescribed the 1-gram size VASCEPA capsule. VASCEPA is sold principally to a limited number of major wholesalers, as well as selected regional wholesalers and specialty pharmacy providers, or collectively, our distributors or our customers, that in turn resell VASCEPA to retail pharmacies for subsequent resale to patients and healthcare providers.

Prior to the REDUCE-IT results topline announcement in September 2018, our U.S. direct sales force consisted of approximately 170 sales professionals, including sales representatives and their managers. Based on the positive REDUCE-IT results, in early 2019, we increased the size of our U.S. direct sales force to approximately 440 sales professionals, including approximately 400 sales representatives. As a result of the U.S. FDA's approved indication and label expansion in December 2019, our U.S. direct sales force was further expanded to approximately 900 sales professionals, including approximately 800 sales representatives in early 2020. As a result of the COVID-19 pandemic and the related social distancing, in March 2020, we suspended face-to-face interactions between our sales representatives and healthcare professionals. We resumed on a limited basis field-basis, face-to-face interactions with healthcare providers beginning in June 2020. During the late part of the summer, substantially all of our field force personnel were able to resume face-to-face customer interactions in a manner consistent with guidelines from local, state and government health officials in the United States. In the fourth quarter of 2020, the impact of COVID-19 worsened in much of the United States, with some physicians again limiting access to face-to-face interactions with our field force personnel. Accordingly, in the United States, we have intentionally slowed the hiring of replacements for certain of our open positions which resulted from ordinary turnover. As we witness our sales representatives increasingly able to resume direct interactions with healthcare professionals, we continually evaluate our needs and it is our intention to fill a significant number of these positions, provided such replacement is appropriate to meet our business needs. As of December 31, 2020, our U.S. direct sales force was slightly more than 800 sales professionals, including slightly more than 700 sales representatives.

Based on monthly compilations of data provided by a third party, Symphony Health, the estimated number of normalized total VASCEPA prescriptions for the three months ended December 31, 2020 was approximately 1,159,000 compared to 1,174,000, 1,090,000, 1,061,000, and 991,000 in the three months ended September 30, 2020, June 30, 2020, March 31, 2020, and December 31, 2019, respectively. According to data from another third party, IQVIA, the estimated number of normalized total VASCEPA prescriptions for the three months ended December 31, 2020 was approximately 1,076,000 compared to 1,081,000, 1,007,000, 962,000, and 909,000 in the three months ended September 30, 2020, June 30, 2020, March 31, 2020, and December 31, 2019, respectively. Normalized total prescriptions represent the estimated total number of VASCEPA prescriptions dispensed to patients, calculated on a normalized basis (i.e., one month's supply, or total capsules dispensed multiplied by the number of grams per capsule divided by 120 grams). Inventory levels at wholesalers tend to fluctuate based on seasonal factors, prescription trends and other factors.

Companies such as Symphony Health and IQVIA collect and report estimates of weekly, monthly, quarterly and annual prescription information. There is a limited amount of information available to such companies to determine the actual number of total prescriptions for prescription products like VASCEPA during such periods. Each vendor's estimates utilize a proprietary projection methodology and are based on a combination of data received from pharmacies and other distributors, and historical data when actual data is unavailable. Their calculations of changes in prescription levels between periods can be significantly affected by lags in data reporting from various sources or by changes in pharmacies and other distributors providing data. Such methods can from time to time result in significant inaccuracies in information when ultimately compared with actual results. These inaccuracies have historically been most prevalent and pronounced during periods of time of inflections upward or downward in rates of use. Further, data for a single and limited period may not be representative of a trend or otherwise predictive of future results. Data reported by Symphony Health and IQVIA is rarely identical. As such, the resulting conclusions from such sources should be viewed with caution. We are not responsible for the accuracy of these companies' information and we do not receive prescription data directly from retail pharmacies.

We recognize revenue from product sales when the distributor obtains control of our product, which occurs at a point in time, typically upon delivery to the distributor. Timing of shipments to wholesalers, as used for revenue recognition purposes, and timing of prescriptions as estimated by these third parties may differ from period to period. Although we believe these data are prepared on a period-to-period basis in a manner that is generally consistent and that such results can be generally indicative of current prescription trends, these data are based on estimates and should not be relied upon as definitive. While we expect to be able to grow VASCEPA revenues over time, no guidance should be inferred from the operating metrics described above. We also anticipate that such sales growth will be inconsistent from period to period. We believe that investors should view the above-referenced operating metrics with caution, as data for this limited period may not be representative of a trend consistent with the results presented or otherwise predictive of future results. Seasonal fluctuations in pharmaceutical sales, for example, may affect future prescription trends of VASCEPA, as

could changes in prescriber sentiment, quarterly changes in distributor purchases, and other factors. We believe investors should consider our results over several quarters, or longer, before making an assessment about potential future performance.

We employ various medical affairs and marketing personnel to support our commercialization of VASCEPA. We expanded certain medical education and market awareness initiatives, including, pilot testing of new promotional initiatives following the reporting of positive REDUCE-IT results in 2018 and we further expanded such initiatives based on the newly approved indication and label expansion of VASCEPA. Our field sales efforts are further complemented by investments in digital and non-personal channels as well as peer-to-peer (e.g., promotional medical education programs and product theaters) initiatives to further increase VASCEPA brand awareness and clarify VASCEPA's unique clinical profile. In January 2020, we launched an educational campaign, *True To Your Heart,* to help people learn more about cardiovascular disease and how to better protect against persistent cardiovascular risk. In July 2020 we launched our first television-based promotion of VASCEPA emphasizing that it is the first and only FDA approved drug for its indication. As the impact of COVID-19 on much of the United States worsened in the fourth quarter of 2020, we suspended television-based promotion of VASCEPA judging that the cost was not sufficiently justified. We anticipate that at-risk patients will increasingly resume visiting their doctors for non-urgent medical care after they are vaccinated for COVID-19. As COVID-19 protocols ease and ordinary course activities resume, we will seek to adjust our promotional initiatives accordingly, including pursuing increased face-to-face interactions with healthcare professionals and expanding various forms of direct-to- consumer promotion.

On March 30, 2020, the Nevada Court ruled in favor of two generic companies in our patent litigation related to its ANDAs that seek FDA approval for sale of generic versions of VASCEPA. On May 22, 2020 and August 10, 2020, the two generic companies, Hikma and Dr. Reddy's received FDA approval to market its generic versions of VASCEPA. On September 3, 2020, the Federal Circuit upheld the March ruling by the Nevada Court in favor of the two generic companies. On October 2, 2020, we filed a combined petition for panel rehearing or rehearing en banc. On November 4, 2020, our rehearing and en banc petitions were denied. On February 11, 2021, we filed a petition for a writ of certiorari with the United States Supreme Court to ask the Court to hear our appeal in this litigation.

In November 2020, Hikma launched their generic version of VASCEPA on a limited scale. On November 30, 2020 we filed a patent infringement lawsuit against Hikma for making, selling, offering to sell and importing generic icosapent ethyl capsules in and into the United States in a manner that we allege has induce the infringement of patents covering the use of VASCEPA to reduce specified cardiovascular risk. On January 25, 2021 we expanded the scope of this patent infringement lawsuit to include a health care insurance provider, Health Net, LLC.

Although, to date, no generics other than Hikma have been launched, in addition to ANDAs approved for Hikma and Dr. Reddy's, on September 11, 2020, Teva's ANDA was approved by the FDA. Apotex has applied for ANDA approval which application, based on public records, has not yet been approved.

We believe that VASCEPA is not yet known to most healthcare professionals and generics companies rarely invest in product or disease state related market education. Furthermore, VASCEPA is relatively expensive to manufacture and already sold at an affordable price as documented by third-party analysis such that saving, if any, on the price of generic VASCEPA is likely to come at the expense of reduced market education and development. Thus, we believe that the launch of a generic version of VASCEPA in the United States at this early stage in the life cycle of VASCEPA is potentially harmful to patient care and discourages new product development, including identifying and pursuing additional indications that could be treated with VASCEPA.

Geographies outside the United States in which VASCEPA is sold and under regulatory review are not subject to this U.S. patent litigation and judgment. No similar litigation involving potential generic versions of VASCEPA is pending outside the United States. VASCEPA is currently available by prescription in Canada, Lebanon and the United Arab Emirates. In Canada, VASCEPA has the benefit of eight years of data protection afforded through Health Canada (until the end of 2027), in addition to separate patent protection with expiration dates that could extend into 2039. In China and the Middle East, we are pursuing such regulatory approvals and subsequent commenrcialization of VASCEPA with commercial partners. In Europe, ten years of market protection is anticipated due to regulatory exclusivity in the European Union as part of EC approval, in addition to pending patent protection that could extend into 2039.

In addition to promotion of VASCEPA in the United States, based on REDUCE-IT, we have increased focus on expansion of our development efforts for VASCEPA to major markets outside the United States. We currently have plans for expansion into the European Union and strategic collaborations to develop and commercialize VASCEPA in select territories outside the United States.

Europe

In December 2019, we announced that the EMA validated the marketing authorization application seeking approval for VASCEPA. The validation confirmed the submission was sufficiently complete for the EMA to begin its review. In August 2020, we announced our plans to launch VAZKEPA in major markets in Europe through our own European sales and marketing team. Such an

approach allows us to retain substantially all of the economic potential of VAZKEPA in Europe and helps ensure that VAZKEPA would get the highest level of priority and focus. On January 28, 2021, the CHMP of the EMA adopted a positive opinion, recommending that a marketing authorization be granted to icosapent ethyl in the EU for the reduction of risk of cardiovascular events in patients at high cardiovascular risk, under the brand name VAZKEPA. The CHMP recommendation is now expected to be reviewed by the EC with a decision expected to take place within 67 days of the CHMP opinion. As we did in Canada, we are seeking an indication throughout Europe for VAZKEPA targeting cardiovascular risk reduction based on the results of REDUCE-IT, which is based on outcomes study results, and not approval of the original indication in the United States for treatment of severe hypertriglyceridemia.

Similar to our approach in launching VASCEPA in the United States, in Europe we intend to build a core team of experienced professionals and a highly capable sales team and plan to leverage third-party relationships for various support activities. We commenced 2021 with approximately 50 professionals involved with pre-approval and pre-launch planning and other commercial preparation activities. In Europe, patients at high risk for cardiovascular disease tend, in comparison to the United States, to be treated more often by specialists, such as cardiologists rather than by physicians who are general practitioners. Pursuant to regulatory approval of VAZKEPA in Europe, this greater concentration of at-risk patients being treated by specialists in Europe should allow for more efficient promotion in Europe than in the United States. We have been active in preparing for reimbursement negotiations which we intend to commence on a country-by-country basis in Europe following anticipated approval of VAZKEPA. In most European countries, securing product reimbursement is a requisite to launching. In all countries securing adequate reimbursement is a requisite for commercial success of any therapeutic. The time required to secure reimbursement tends to vary from country to country and cannot be reliably predicted at this time. While we believe that we have strong arguments regarding the cost effectiveness of VAZKEPA, the success of such reimbursement negotiations could have a significant impact on our ability to realize the commercial opportunity of VAZKEPA in Europe.

China

In February 2015, we announced an exclusive agreement with Eddingpharm (Asia) Macao Commercial Offshore Limited, or Edding, to develop and commercialize VASCEPA capsules in what we refer to as the China Territory, consisting of the territories of Mainland China, Hong Kong, Macau and Taiwan, for uses that are currently commercialized and under development by us in the United States. Edding, with our support, conducted a clinical trial of VASCEPA in China, which evaluated the effect of VASCEPA on patients with very high triglyceride levels (>500 mg/dL). In November 2020, we announced statistically significant topline positive results from this Phase 3 clinical trial of VASCEPA conducted by Edding. The study, which investigated VASCEPA as a treatment for patients with very high triglycerides (≥500 mg/dL), met its primary efficacy endpoint as defined in the clinical trial protocol and demonstrated a safety profile similar to placebo. Importantly, the VASCEPA 4 gram per day dose in this study appeared to be well-tolerated with a safety profile similar to placebo. There were no treatment-related serious adverse events in this study. On February 9, 2021, we announced that the regulatory review processes in Mainland China and Hong Kong have commenced. The NMPA has accepted for review the new drug application for VASCEPA, submitted by Edding, based on the results from the Phase 3 clinical trial and the results from our prior studies of VASCEPA. We expect to receive a decision from the NMPA in Mainland China near the end of 2021. The Hong Kong Department of Health is evaluating VASCEPA based on current approvals in the United States and Canada. The review process in Hong Kong is expected to conclude near the end of 2021.

Middle East and North Africa (MENA)

In March 2016, we entered into an agreement with Biologix FZCo, or Biologix, to register and commercialize VASCEPA in several Middle Eastern and North African countries. VASCEPA was launched in Lebanon in June 2018 and in United Arab Emirates in February 2019, respectively. VASCEPA was approved in Qatar in January 2020 and in Bahrain in December 2020.

Canada

In September 2017, we entered into an agreement with HLS Therapeutics Inc., or HLS, to register, commercialize and distribute VASCEPA in Canada. In March 2019, HLS received formal confirmation from Health Canada that the Canadian regulatory authority has granted priority review status for the upcoming New Drug Submission, which was filed in April 2019, for VASCEPA. In December 2019, HLS received formal confirmation from Health Canada that the Canadian regulatory authority has granted approval for VASCEPA to reduce the risk of cardiovascular events (cardiovascular death, non-fatal myocardial infarction, non-fatal stroke, coronary revascularization or hospitalization for unstable angina) in statin-treated patients with elevated triglycerides, who are at high risk of cardiovascular events due to: established cardiovascular disease, or diabetes, and at least one other cardiovascular risk factor. In January 2020 HLS obtained a regulatory exclusivity designation. Commercial launch in Canada began in February 2020 on a limited scale with subsequent expansion intended. An important step in growing the potential use of therapeutics in Canada, as is true in other countries, is gaining reimbursement coverage by the applicable payers. In July 2020, the Canadian Agency for Drugs and Technologies in Health recommended that VASCEPA be reimbursed by participating public drug plans for statin-treated patients with

established cardiovascular diseases and elevated triglycerides. HLS also received notification by the Patented Medicines Price Review Boards that, further to its review, VASCEPA's price did not trigger the investigation criteria for excessive pricing. While coverage of patients with established cardiovascular disease represents a substantial portion of VASCEPA's approved label in Canada.

Rest of World

We plan to also assess other potential partnership opportunities for licensing VASCEPA to partners in other parts of the world. While we believe that there is medical need and opportunity for VASCEPA elsewhere in the world, our current priorities are the geographies described above.

Research and Development

Since its inception in 2011, conduct of the REDUCE-IT cardiovascular outcomes study of VASCEPA has been the centerpiece of our research and development. Most of our other research and development during this period also pertained to VASCEPA, including study of the mechanism of action of the single active ingredient in VASCEPA, icosapent ethyl. The REDUCE-IT study was conducted based on a special protocol assessment, or SPA, agreement with the FDA. Based on the final positive results of REDUCE-IT, we sought additional indicated uses for VASCEPA in the United States and continued to pursue approval for VASCEPA around the world. We also anticipate continuing to publish additional details of the REDUCE-IT study to address scientific interest beyond the primary results of this study derived from the over 35,000 patient years of study experience which were accumulated in the REDUCE-IT study. The REDUCE-IT study topline results were made public in September 2018, and the primary results of the REDUCE-IT study were presented at the 2018 Scientific Sessions of the AHA on November 10, 2018 with such results concurrently published in *The New England Journal of Medicine*. The total (first and subsequent) cardiovascular events results of the REDUCE-IT study were presented at the American College of Cardiology's 68th Annual Scientific Session in March 2019 and concurrently published in the *Journal of the American College of Cardiology.* Potential additional research and development opportunities beyond REDUCE-IT will be prioritized after giving priority to securing regulatory approval for VASCEPA based on the REDUCE-IT results in various geographies internationally, including pursuit of approval for VASCEPA in Europe and in countries where we have commercialization partners for VASCEPA.

The FDA granted Priority Review designation to our March 2019 sNDA seeking an expanded indication for VASCEPA in the United States based on the positive results of the REDUCE-IT study. The FDA grants Priority Review designation to applications for drugs that, if approved, have the potential to offer significant improvements in the effectiveness and safety of the treatment of serious conditions when compared to standard applications. In November 2019, FDA held an EMDAC meeting to review the REDUCE-IT sNDA. The EMDAC voted unanimously (16-0) to recommend approval of an indication and label expansion for VASCEPA to reduce cardiovascular events in high-risk patients based on the REDUCE-IT results. On December 13, 2019, the FDA approved a new indication and related label expansion based on REDUCE-IT. VASCEPA is the first and only drug approved by the FDA as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated TG levels (≥150 mg/dL) and either established cardiovascular disease or diabetes mellitus and two or more additional risk factors for cardiovascular disease. Reflecting the robust results of the clinical development program for VASCEPA, no additional post-approval clinical study or other special post-approval requirement (as often seen with other drug approvals) was requested by the FDA in conjunction with its approval of VASCEPA.

In June 2018, we entered into a multi-faceted collaboration with Mochida Pharmaceutical Co. Ltd., or Mochida, related to the development and commercialization of drug products and indications based on the active pharmaceutical ingredient in VASCEPA, the omega-3 acid, EPA. Among other terms in the agreement, we obtained an exclusive license to certain Mochida intellectual property to advance our interests in the United States and certain other territories. In addition, the parties will collaborate to research and develop new products and indications based on EPA for our commercialization in the United States and certain other territories. The potential new product and indication opportunities contemplated under this agreement are currently in early stages of development. Upon closing of the collaboration agreement, we made a non-refundable, non-creditable upfront payment of approximately $2.7 million. In addition, the agreement provides for milestone payments from us upon the achievement of certain product development milestones and royalties on net sales of future products arising from the collaboration, if any. We exercised certain rights under the agreement, resulting in payments of $1.0 million in January 2020 and December 2020, respectively, to Mochida.

Based on our current understanding of the biological effects of a COVID-19 infection, including that patients at high risk of cardiovascular disease are at higher risk of mortality and severe effects from a COVID-19 infection, and based on data related to the mechanism of action and effects of VASCEPA in lowering cardiovascular risk in certain high-risk patients, we believe that VASCEPA could play a beneficial clinical role in helping patients infected by the virus. We are currently supporting investigator initiated studies by providing study drug product and limited financial support to investigators in multiple pilot studies designed to better understand the potential of VASCEPA and its potentially beneficial role. On December 12, 2020, we announced at the National Lipid Association Scientific Sessions 2020 positive clinical results from the first study of VASCEPA in COVID-19 infected outpatients, CardioLink-9. If the results of the other pilot studies are positive, we will evaluate whether additional studies will be

appropriate. The clinical effects of VASCEPA are multi-factorial. Multiple mechanisms of action associated with VASCEPA from clinical and mechanistic studies support the rationale to study its effects in patients with the COVID-19 infection. Additional postulated mechanisms that might play a role in the use of VASCEPA in the patients infected with COVID-19 include potential antiviral/antimicrobial effects, fibrosis and cardiac damage mitigation in animal models and anti-inflammatory effects (acute) in pulmonary/lung tissue.

The final results of the Effect of VASCEPA on Improving Coronary Atherosclerosis in People with High Triglycerides Taking Statin Therapy trial, or EVAPORATE, were presented at the European Society of Cardiology on August 29, 2020. A total of 80 patients were enrolled in the randomized, double-blind, placebo-controlled EVAPORATE trial. Patients had to have coronary atherosclerosis as documented by multidetector computed tomography, or MDCT, with 1 or more angiographic stenoses with ≥20% narrowing, be on statin therapy, and have persistently elevated TG levels (mean TG at baseline was 259.1 mg/dL [+/- 78.1]). Patients underwent an interim scan at nine months and a final scan at 18 months. The prespecified primary endpoint was a comparison of change in low attenuation plaque, or LAP, volume at 18 months between icosapent ethyl and placebo. EVAPORATE was not powered for long-term outcomes. The final results showed a significant reduction in the primary endpoint; icosapent ethyl reduced LAP plaque volume by 17% from baseline to the 18-month scan, whereas there was a progression of LAP plaque volume in the placebo group. There were significant differences between icosapent ethyl and placebo at study end for secondary endpoints of other types of plaque volume changes, including and sequentially total, total non-calcified, fibrofatty, and fibrous plaque volumes. All regressed in the icosapent ethyl group and progressed in the placebo group ($p<0.01$ for all). The only secondary endpoint which did not achieve a significant difference between groups in multivariable modeling was dense calcium ($p=0.053$). More study is needed to demonstrate the effects of VASCEPA on coronary plaque to determine the relationship of such effects, if any, on cardiovascular risk reduction.

During the Transcatheter Cardiovascular Therapeutics, or TCT, Connect 2020 Best of Abstracts session by Benjamin E. Peterson, M.D., Brigham and Women's Hospital Heart & Vascular Center and Harvard Medical School, which was held virtually from October 14 – October 18, 2020, the Company presented new REDUCE-IT PCI, or Percutaneous Coronary Intervention, analysis. The REDUCE-IT PCI analysis looked at 3,408 (41.7%) of patients enrolled in REDUCE-IT who had undergone a prior PCI. These patients were randomized a median of 2.9 years after PCI. Baseline characteristics were similar among patients randomized to VASCEPA versus placebo. Post hoc exploratory analyses of the subgroup of 3,408 patients with a prior PCI showed that, for the primary composite endpoint of 5-point MACE, time to first event was significantly reduced with VASCEPA versus placebo by 34% ($p<0.0001$) and total (first and subsequent) events were also reduced by 39% ($p<0.0001$). For the key secondary composite endpoint of 3-point MACE, time to first event was reduced by 34% ($p<0.0001$) in the subgroup of patients with a prior PCI. Administration of VASCEPA resulted in robust absolute risk reductions of 8.5% and 5.4% and numbers needed to treat, or NNT, of 12 and 19, respectively, for both primary and key secondary (hard MACE) composite endpoints in post hoc exploratory subgroup analyses.

Commercial and Clinical Supply

We manage the manufacturing and supply of VASCEPA internally and have done so since we began clinical development of VASCEPA prior to the drug's marketing approval by FDA in 2012. We rely on contract manufacturers in each step of our commercial and clinical product supply chain. These steps include active pharmaceutical ingredient, or API, manufacturing, encapsulation of the API, product packaging and supply-related logistics. Our approach to product supply procurement is designed to mitigate risk of supply interruption and maintain an environment of cost competition through diversification of contract manufacturers at each stage of the supply chain and lack of reliance on any single supplier. We have multiple FDA-approved international API suppliers, encapsulators and packagers to support the VASCEPA commercial franchise. The amount of supply we seek to purchase in future periods will depend on the level of growth of VASCEPA revenues and minimum purchase commitments with certain suppliers. While our current supply chain is scalable, we continue efforts to expand, diversify and further enhance it.

Impact of COVID-19

As the COVID-19 pandemic continues to spread and impact global populations and economies, we continue to evaluate its effect on patients, distributors, customers and our employees, as well as on our operations and the operations of our business partners and communities. Given the importance of supporting patients, we are diligently working with our suppliers, customers, distributors and other partners to provide patients with access to VASCEPA, while taking into account regulatory, institutional, and government guidance, policies and protocols. Given the uncertainties regarding the scope and impact of COVID-19 on our sales, supply, research and development efforts and operations, and on the operations of our customers, suppliers, distributors, other partners and patients, particularly as COVID-19 protocols and resources have restricted or discouraged patient access to hospitals, clinics, physicians' offices and other administration sites and caused a reprioritization of health care services, the impact of COVID-19 could impact our current performance and continues to represent a risk to our future performance.

Our ability to directly promote VASCEPA to healthcare professionals has been limited due to appropriate social distancing practices associated with COVID-19 and by patients electing to forego visiting their doctors for non-urgent medical examinations and/or choose not to get blood tests which test results provide useful information to the treatment of cardiovascular risk. These

limitations have had a significant impact on slowing VASCEPA prescription and revenue growth. While COVID-19 continues to impact our promotion of VASCEPA, we have seen signs of improvement. We resumed on a limited basis field-based, face-to-face interactions with healthcare providers beginning in June 2020. During the late part of the summer, substantially all of our field force personnel were able to resume face-to-face customer interactions, in a manner consistent with guidelines from local, state and government health officials in the United States. In the fourth quarter of 2020, the impact of COVID-19 worsensed in much of the United States with some physicians again limiting access to face-to-face interactions with our field force personnel. Such access remains variable and challenging due to COVID-19. In July 2020 we launched our first television-based promotion of VASCEPA emphasizing that it is the first and only U.S. FDA approved drug for the cardiovascular risk reduction indication. As the impact of COVID-19 on much of the United States worsened in the fourth quarter of 2020, we suspended television-based promotion of VASCEPA judging that the cost was not sufficiently justified. We anticipate that at-risk patients will increasingly resume visiting their doctors for non-urgent medical care after they are vaccinated for COVID-19. As COVID-19 protocols ease and ordinary course activities resume, we will seek to adjust our promotional initiatives accordingly, including pursuing increased face-to-face interactions with health care professionals and expanding various forms of direct-to-consumer promotion.

Thus far, COVID-19 has not materially impacted our ability to secure and deliver supply of VASCEPA. And, thus far, COVID-19 is not known to have significantly impacted ongoing clinical trials of VASCEPA.

The ultimate impacts of COVID-19 on our business are unknown; however, we are actively monitoring the situation and may take precautionary and preemptive or reactive actions that we determine are in the best interests of our business. We cannot predict the effects that such actions may have on our business or on our financial results, in particular with respect to demand for or access to VASCEPA.

We believe that the overall morale of Amarin employees is positive despite the challenges associated with COVID-19. While we have experienced modest employee turnover, the turnover level is generally consistent with the pre-COVID-19 era. As a result of COVID-19 and its limitations on our promotion of VASCEPA in the United States, we have intentionally slowed the hiring of replacements for our open positions which resulted from ordinary turnover. As we witness our sales representatives increasingly able to resume direct interactions with healthcare professionals, we continually evaluate our needs and it is our intention to fill a significant number of these positions, provided such replacement is appropriate to meet our business needs.

Financial Operations Overview

Product revenue, net. All of our product revenue is derived from product sales of 1-gram and 0.5-gram size capsules of VASCEPA, net of allowances, discounts, incentives, rebates, chargebacks and returns. In the United States, we sell product to a limited number of major wholesalers, as well as selected regional wholesalers and specialty pharmacy providers, or collectively, our distributors or our customers, who resell the product to retail pharmacies for purposes of their reselling the product to fill patient prescriptions. Revenues from product sales are recognized when the Distributor obtains control of our product, which occurs at a point in time, typically upon delivery to the Distributor. Outside of the United States, currently all our product revenue is derived from the sales of VASCEPA to our commercial partners based on the net price for VASCEPA established in our contracts with such partners. These commercial partners then resell the product in their agreed commercial territory. Revenues from product sales to our international commercial partners are recognized when the commercial partners obtain control of our product, which occurs at a point in time, typically upon delivery to the commercial partner. The net price of VASCEPA sold by us to our customers where we directly sell VASCEPA is generally significantly higher than the net price of VASCEPA that we sell to commercial partners who then incur the cost of promoting and reselling the product in their territories. As a result, even when the net price of VASCEPA to patients is similar in various parts of the world, our gross margin on sales is higher where we sell VASCEPA directly. Currently the majority of our product revenue is derived from direct sales of VASCEPA in the United States.

Licensing and royalty revenue. Licensing and royalty revenue currently consists of revenue attributable to receipt of up-front, non-refundable payments, milestone payments and sales-based payments related to license and distribution agreements for VASCEPA outside the United States. We recognize revenue from licensing arrangements as we fulfill the performance obligations under each of the agreements.

Cost of goods sold. Cost of goods sold includes the cost of API for VASCEPA on which revenue was recognized during the period, as well as the associated costs for encapsulation, packaging, shipment, supply management, quality assurance, insurance, and other indirect manufacturing, logistics and product support costs. The cost of the API included in Cost of goods sold reflects the average cost method of inventory valuation and relief. This average cost reflects the actual purchase price of VASCEPA API. Our cost of goods sold is not materially impacted by whether we sell VASCEPA directly in a country or we sell VASCEPA to a commercial partner for resale in a country.

Selling, general and administrative expense. Selling, general and administrative expense consists primarily of salaries and other related costs, including stock-based compensation expense, for personnel in our sales, marketing, executive, business development,

finance and information technology functions. Other costs primarily include facility costs and professional fees for accounting, consulting and legal services.

Research and development expense. Research and development expense consists primarily of fees paid to professional service providers in conjunction with independent monitoring of our clinical trials and acquiring and evaluating data in conjunction with our clinical trials, fees paid to independent researchers, costs of qualifying contract manufacturers, services expenses incurred in developing and testing products and product candidates, salaries and related expenses for personnel, including stock-based compensation expense, costs of materials, depreciation, rent, utilities and other facilities costs. In addition, Research and development expenses include the cost to support current development efforts, costs of product supply received from suppliers when such receipt by us is prior to regulatory approval of the supplier, as well as license fees related to our strategic collaboration with Mochida. We expense research and development costs as incurred.

Interest and other (expense) income, net. Interest expense consists of interest incurred under our December 2012 royalty-bearing instrument financing arrangement, which was calculated based on an estimated repayment schedule and was paid in full in 2020. Interest income consists of interest earned on our cash and cash equivalents, as well as our short term and long-term investments. Other (expense) income, net, consists primarily of foreign exchange losses and gains.

Income tax (provision) benefit. Income tax (provision) benefit, deferred tax assets and liabilities, and reserves for unrecognized tax benefits reflect management's best assessment of estimated future taxes to be paid. We are subject to income taxes in both the United States and foreign jurisdictions. In applying guidance prescribed under ASC 740 and based on present evidence and conclusions around the realizability of deferred tax assets, we determined that any tax benefit related to the pretax losses generated for the year-ended December 31, 2020 and 2019 are not more likely than not to be realized. On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act, or CARES Act, was enacted in the United States. Among other provisions, the CARES Act allows businesses to carry back net operating losses arising in years 2018 to 2020 to the five prior tax years.

Critical Accounting Policies and Significant Judgments and Estimates

Our discussion and analysis of our financial condition and results of operations is based on our consolidated financial statements and notes, which have been prepared in accordance with accounting principles generally accepted in the United States. The preparation of these financial statements requires us to make estimates and judgments that affect the reported amounts of assets, liabilities, revenue and expenses. On an ongoing basis, we evaluate our estimates and judgments. We base our estimates on historical experience and on various market-specific and other relevant assumptions that we believe to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates under different assumptions or conditions. Estimates are assessed each period and updated to reflect current information. A summary of our critical accounting policies, significant judgments and estimates is presented in Note 2—Significant Accounting Policies to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K. We believe the following critical accounting policies affect our more significant judgments and estimates used in the preparation of our consolidated financial statements.

Revenue Recognition—In accordance with GAAP, under Accounting Standards Codification, or ASC, Topic 606, *Revenue from Contracts with Customers*, which we adopted on a modified retrospective basis effective January 1, 2018, we recognize revenue when our distributors obtain control of promised goods or services, in an amount that reflects the consideration which we expect to receive in exchange for those goods or services. To determine revenue recognition for arrangements that we determine are within the scope of Topic 606, we perform the following five steps: (i) identify the contract(s) with a Distributor; (ii) identify the performance obligations in the contract; (iii) determine the transaction price; (iv) allocate the transaction price to the performance obligations in the contract; and (v) recognize revenue when (or as) we satisfy a performance obligation. We apply the five-step model to contracts only when it is probable that we will collect the consideration we are entitled to in exchange for the goods or services we transfer to the Distributor. At contract inception, once the contract is determined to be within the scope of Topic 606, we assess the goods or services promised within each contract, determine those that are performance obligations and assess whether each promised good or service is distinct. We then recognize as revenue the amount of the transaction price that is allocated to the respective performance obligation when (or as) the performance obligation is satisfied. We recognized Total revenue, net of $614.1 million and $429.8 million during the years ended December 31, 2020 and 2019, respectively. For a complete discussion of our accounting for net product revenue and licensing and royalty revenues, which make up Total revenue, net, see Note 2—Significant Accounting Policies.

We sell VASCEPA principally to a limited number of distributors that in turn resell VASCEPA to retail pharmacies that subsequently resell it to patients and healthcare providers.

We began recognizing revenue from the sale of VASCEPA following our commercial launch in the United States in January 2013. Prior to 2013, we recognized no revenue from VASCEPA sales. In accordance with GAAP, we recognize revenue when the Distributor obtains control of our product, which occurs at a point in time, typically upon delivery to the Distributor. We recognized Product revenue, net of $607.0 million and $427.4 million based on sales to distributors during the years ended December 31, 2020 and 2019, respectively.

We have written contracts with our distributors, and transfer of control typically occurs upon delivery of our product to the Distributor. We evaluate the creditworthiness of each of our distributors to determine whether revenues can be recognized upon delivery, subject to satisfaction of the other requirements, or whether recognition is required to be delayed until receipt of payment. We calculate gross product revenues based on the wholesale acquisition cost that we charge our distributors for VASCEPA. We estimate our Product revenue, net by deducting from our gross product revenues (a) trade allowances, such as invoice discounts for prompt payment and distributor fees, (b) estimated government and private payor rebates, chargebacks and discounts, such as Medicaid reimbursements, (c) reserves for expected product returns and (d) estimated costs of incentives offered to certain indirect customers, including patients. The gross to net deductions are estimated based on available actual information, historical data, known trends, and levels of inventory in the distribution channel. We rely on resale data provided by our distributors as well as prescription data provided by Symphony Health and IQVIA in estimating the level of inventory held in the distribution channel. A hypothetical 5% change in estimated aggregate bottles of channel inventory would result in a change of less than 1% in net product revenues reported during each of the three and twelve months ended December 31, 2020 and 2019.

When evaluating licensing arrangements, we perform the following steps: (i) identification of the promised goods or services in the contract; (ii) determination of whether the promised goods or services are performance obligations including whether they are distinct in the context of the contract; (iii) measurement of the transaction price, including the constraint on variable consideration; (iv) allocation of the transaction price to the performance obligations; and (v) recognition of revenue when (or as) we satisfy each performance obligation. In determining performance obligations, we evaluate whether the license is distinct from the other performance obligations with the collaborative partner based on the consideration of the relevant facts and circumstances for each arrangement. Factors considered include the stage of development of the license delivered, research and development capabilities of the partner and the ability of partners to develop and commercialize VASCEPA independent of us.

If the license to our intellectual property is determined to be distinct from the other performance obligations identified in the arrangement, we recognize revenues from non-refundable, up-front fees allocated to the license when the license is transferred to the Distributor and the Distributor is able to use and benefit from the license. For licenses that are bundled with other promises, we utilize judgment to assess the nature of the combined performance obligation to determine whether the combined performance obligation is satisfied over time or at a point in time and, if over time, the appropriate method of measuring progress for purposes of recognizing revenue from non-refundable, up-front fees. We evaluate the measure of progress each reporting period and, if necessary, adjust the measure of performance and related revenue recognition.

At the inception of each arrangement that includes development, regulatory and commercial milestone payments, we evaluate whether the milestones are considered probable of being reached and estimate the amount to be included in the transaction price using the most likely amount method. If it is probable that a significant revenue reversal would not occur, the associated milestone value is included in the transaction price. Milestone payments that are not within our control or the control of the licensee, such as regulatory approvals, are not considered probable of being achieved until those approvals are received. We evaluate factors such as the scientific, clinical, regulatory, commercial and other risks that must be overcome to achieve the respective milestone as well as the level of effort and investment required. The transaction price is then allocated to each performance obligation on a relative stand-alone selling price basis, for which we recognize revenue as or when the performance obligations under the contract are satisfied. At the end of each subsequent reporting period, we re-evaluate the probability of achievement of such development, regulatory and commercial milestones and any related constraint, and if necessary, adjust its estimate of the overall transaction price. Any such adjustments are recorded on a cumulative catch-up basis, which would affect licensing revenues and earnings in the period of adjustment.

We receive payments from our customers based on billing schedules established in each contract. Up-front payments and fees are recorded as deferred revenue upon receipt or when due and may require deferral of revenue recognition to a future period until we perform our obligations under these arrangements. Amounts are recorded as accounts receivable when our right to consideration is unconditional. We do not assess whether a contract has a significant financing component if the expectation at contract inception is such that the period between payment by the customer and the transfer of the promised goods or services to the customer will be one year or less.

Income Taxes—Deferred tax assets and liabilities are recognized for the future tax consequences of differences between the carrying amounts and tax bases of assets and liabilities and operating loss carryforwards and other attributes using enacted rates expected to be in effect when those differences reverse. Valuation allowances are provided against deferred tax assets that are not more likely than not to be realized.

We provide reserves for potential payments of tax to various tax authorities or do not recognize tax benefits related to uncertain tax positions and other issues. Tax benefits for uncertain tax positions are based on a determination of whether a tax benefit taken by us in our tax filings or positions is more likely than not to be realized, assuming that the matter in question will be decided based on its technical merits. Our policy is to record interest and penalties in the provision for income taxes.

We assess our ability to realize deferred tax assets at each reporting period. The realization of deferred tax assets depends on generating future taxable income during the periods in which the tax benefits are deductible or creditable. When making our assessment about the realization of our deferred tax assets as of December 31, 2020, we considered all available evidence, placing particular weight on evidence that could be objectively verified. The evidence considered included the (i) historical taxable profitability of our U.S. operations, (ii) historical pre-tax book loss position, (iii) sources of future taxable income, giving weight to sources according to the extent to which they can be objectively verified, (iv) the provisions of the Tax Cuts and Jobs Act enacted in 2017 and their impact on our future taxable income, and (v) the risks to our business related to the commercialization and development of VASCEPA. Based on our assessment, we concluded that all of our net deferred tax assets are not more likely than not to be realizable as of both December 31, 2020 and 2019. Changes in historical earnings performance, future earnings projections, and changes in tax laws and tax rates, among other factors, may cause us to adjust our valuation allowance on deferred tax assets in the future, which would impact our income tax expense in the period in which we determine that these factors have changed. We intend to maintain the valuation allowance until sufficient positive evidence exists to conclude that it is more likely than not that our deferred tax benefits will be realized. We will continue to monitor the need for valuation allowances in each jurisdiction and may adjust our positions in the future.

Excess tax benefits and deficiencies that arise upon vesting or exercise of share-based payments are recognized as an income tax benefit and expense, respectively, in the consolidated statement of operations.

Recent Accounting Pronouncements

For a discussion of recent accounting pronouncements, see Note 2—Significant Accounting Policies in the accompanying Notes to Consolidated Financial Statements in this Annual Report on Form 10-K.

Effects of Inflation

We believe the impact of inflation on operations has been minimal during the past three years.

Results of Operations

Comparison of Fiscal Years Ended December 31, 2020 and December 31, 2019

Total revenue, net. We recorded total revenue, net, of $614.1 million and $429.8 million during the years ended December 31, 2020 and 2019, respectively, an increase of $184.3 million, or 43%. Total revenue, net consists primarily of revenue from the sale of VASCEPA in the United States. In addition to the United States, VASCEPA is currently available by prescription in Canada, Lebanon and the United Arab Emirates through collaborations with third-party companies.

Product revenue, net. We recorded product revenue, net, of $607.0 million and $427.4 million during the years ended December 31, 2020 and 2019, respectively, an increase of $179.6 million, or 42%. This increase was driven primarily by volume of VASCEPA sales to our customers in the United States. Orders by such customers were supported by an increase in estimated normalized total VASCEPA prescriptions in the United States. Based on data provided by Symphony Health and IQVIA, estimated normalized total VASCEPA prescriptions in the United States increased in 2020 by approximately 1,255,000 and 1,194,000, respectively, over the year ended December 31, 2019, representing growth of 39% and 41%, respectively. In addition, we recognized net product revenue of approximately $8.9 million and $0.7 million as of December 31, 2020 and 2019, respectively for VASCEPA sales outside of the United States.

All of our Product revenue, net, in the United States, in the years ended December 31, 2020 and 2019 was derived from product sales of 1-gram and 0.5-gram size capsules of VASCEPA, net of allowances, discounts, incentives, rebates, chargebacks and returns. The U.S. FDA-approved dosing for VASCEPA continues to be 4 grams per day and, as expected, the majority of new and existing patients taking VASCEPA continue to be prescribed the 1-gram size VASCEPA capsules. Timing of shipments to wholesalers, as used for revenue recognition, and timing of prescriptions as estimated by third-party sources such as Symphony Health and IQVIA may differ from period to period.

During the years ended December 31, 2020 and 2019, our Product revenue, net included adjustment for co-pay mitigation rebates provided by us to commercially insured patients. Such support is intended for offset for a portion of the out-of-pocket expense that patients are required to pay for VASCEPA based upon the benefit design of their prescription drug coverage. Our cost for these co-payment support payments during the years ended December 31, 2020 and 2019 was up to $150 and $110, respectively per 30-day prescription filled and, up to $450 and $330, respectively per 90-day prescription filled.

As is typical for the pharmaceutical industry, the majority of VASCEPA sales in the United States are to major commercial wholesalers which then resell VASCEPA to retail pharmacies.

In March 2020, COVID-19 became widespread in the United States and other geographies around the globe. In recognition of guidance from public health officials, we announced on March 15, 2020 a temporary suspension of in-person promotional activities. We resumed on a limited basis field-based, face-to-face interactions with healthcare providers beginning in June 2020. During the late part of the summer, substantially all of our field force personnel were able to resume face-to-face customer interactions, in a manner consistent with guidelines from local, state and government health officials in the United States. In the fourth quarter of 2020, the impact of COVID-19 worsened in much of the United States, with some physicians again limiting access to face-to-face interactions with our field force personnel. For a U.S. FDA-approved drug like VASCEPA to be prescribed, historically physicians need to have met with their patients for an examination and have received blood test results prior to prescribing the drug to the patient. Public reports from IQVIA showed patient visits to medical offices for non-emergency medical care were down approximately 70% in April 2020 during the height of the COVID-19 related social distancing, with visits steadily increasing thereafter. However, as a result of a recent spike in COVID-19 cases, patient visits in December 2020 have again decreased to approximately 50% of pre-COVID-19 levels. Also reported in April 2020 was a significant drop in the number of routine lab tests likely due to patients not seeking medical care for non-urgent medical needs and resources of the medical community shifting focus to address the COVID-19 pandemic. As a result, while VASCEPA prescription levels in the twelve months ended December 31, 2020 grew over the prior year, we witnessed a slowing of new patients being prescribed VASCEPA resulting in year over year growth which was considerably slower than the growth rate reported in the three months ended March 31, 2020 when we first launched VASCEPA for its cardiovascular risk reduction indication and before COVID-19. In addition, in November 2020, a generic version of VASCEPA was launched in the U.S. which resulted in an approximately 6.7% impact on our normalized prescriptions for the remainder of the year. Despite the launch of a generic and the ongoing impact of COVID-19, in December 2020, weekly normalized prescriptions reached levels consistent with, or slightly higher, than pre-COVID-19 levels. We cannot predict the duration of this pandemic and we cannot quantify the impact of COVID-19 or the impact of the generic launch on our business beyond December 31, 2020.

We are confident that the patient need for VASCEPA remains high and that a significant portion of the slowing of VASCEPA growth was COVID-19 related. While we are optimistic that the worst of the COVID-19 impact is behind us regarding the levels of patients seeking ordinary course doctor visits and lab tests, we expect that COVID-19 will continue, at least in the near term, to impact the level of VASCEPA prescriptions and the degree and timing to which we can, if at all, reaccelerate VASCEPA growth, particularly if there are resurgences in the spread of the infection in various geographies and a reinforcement of social distancing and other protocols. In addition, as patients, pharmacies and payers adjust to the availability, pricing and label of generic competition variability is expected. As a result of the uncertainty of the extent of COVID-19, the impact of generic competition and regarding the approval and market access in Europe, we have suspended providing revenue guidance until there is greater clarity on the impact of these issues.

Licensing and royalty revenue. Licensing and royalty revenue during the years ended December 31, 2020 and 2019 was $7.0 million and $2.4 million, respectively, an increase of $4.7 million, or 198%. Licensing and royalty revenue relates to the recognition of amounts received in connection with the following VASCEPA licensing agreements:

- Edding – a $15.0 million up-front payment received in February 2015 and a $1.0 million milestone payment achieved in March 2016.
- HLS – a $5.0 million up-front payment which was received upon closing of the agreement in September 2017, a $2.5 million milestone payment that was received following achievement of the REDUCE-IT trial primary endpoint in September 2018, a $2.5 million milestone payment that was received following FDA approval of a new indication and label expansion in December 2019, and a $3.8 million milestone payment that was received as a result of obtaining a regulatory exclusivity designation in January 2020.

The up-front and milestone payments are being recognized over the estimated period in which we are required to provide regulatory and development support pursuant to the agreements. The amount of licensing and royalty revenue is expected to vary from period to period based on timing of milestones achieved and changes in estimates of the timing and level of support required.

As part of our licensing agreements with certain territories outside of the United States, we are entitled to a percentage of revenue earned based on sales by our partners. The royalty payments are being recognized as earned based on revenue recognized by our current partners.

Cost of goods sold. Cost of goods sold during the years ended December 31, 2020 and 2019 was $131.4 million and $96.0 million, respectively, an increase of $35.4 million, or 37%. Cost of goods sold includes the cost of API for VASCEPA on which revenue was recognized during the period, as well as the associated costs for encapsulation, packaging, shipment, supply management, insurance and quality assurance. The cost of the API included in cost of goods sold reflects the average cost of API included in inventory. This average cost reflects the actual purchase price of VASCEPA API.

The API included in the calculation of the average cost of goods sold during the years ended December 31, 2020 and 2019 was sourced from multiple API suppliers. These suppliers compete with each other based on cost, consistent quality, capacity, timely delivery and other factors. In the future, we may see the average cost of supply change based on numerous potential factors including increased volume purchases, continued improvement in manufacturing efficiency, the mix of purchases made among suppliers, currency exchange rates and other factors. We currently anticipate API average cost in 2021 to be similar to or modestly lower than 2020. The average cost may be variable from period to period depending upon the timing and quantity of API purchased from each supplier.

Our gross margin on product sales for the years ended December 31, 2020 and 2019 was 78% in both periods.

Selling, General and Administrative Expense. Selling, general and administrative expense for the years ended December 31, 2020 and 2019 was $463.3 million and $323.6 million, respectively, an increase of $139.7 million, or 43%. Selling, general and administrative expenses for the years ended December 31, 2020 and 2019 are summarized in the table below:

	Year Ended December 31,	
In thousands	**2020**	**2019**
Selling expense (1)	$ 350,648	$ 242,716
General and administrative expenses (2)	73,419	54,605
Non-cash stock-based compensation expense (3)	39,245	26,302
Total selling, general and administrative expense	$ 463,312	$ 323,623

(1) Selling expense for the years ended December 31, 2020 and 2019 was $350.6 million and $242.7 million, respectively, an increase of $107.9 million, or 44%. This increase is primarily due to personnel costs related to the U.S. sales force expansion in 2020 as well as an increase in promotional activities and direct-to-consumer promotion following the launch of VASCEPA in early 2020 for the new indication and expanded label approved based on the REDUCE-IT results.

(2) General and administrative expense for the years ended December 31, 2020 and 2019 was $73.4 million and $54.6 million, respectively, an increase of $18.8 million, or 34%. This increase is primarily a result of an increase in personnel and related costs, predominantly associated with preparing for our expansion into Europe, as well as insurance premiums.

(3) Non-cash stock-based compensation expense for the years ended December 31, 2020 and 2019 was $39.2 million and $26.3 million, respectively, an increase of $12.9 million, or 49%. Non-cash stock-based compensation expense represents the estimated costs associated with equity awards issued to internal personnel supporting our selling, general and administrative functions. The increase is due primarily to an increase in the number of employees receiving equity awards as a result of the growth of our sales force and an increase in the underlying fair value of the equity awards.

We anticipate our selling, general and administrative expenses to increase in 2021 primarily due to the costs associated with preparing VAZKEPA for commercial launch in Europe and subject to regulatory approval and market access, launching VAZKEPA in one or more countries in Europe during 2021. We currently have approximately 50 professionals involved with pre-approval and pre-launch planning and other commercial activities in Europe, with plans to expand to approximately 200 professionals by the end of 2021. As we work to increase revenue from VASCEPA, we continuously evaluate all of our spending commitments and priorities and we plan to adjust our level of education and promotional activities based on various factors, including the impact of COVID-19 and generic competition.

Research and Development Expense. Research and development expense for the years ended December 31, 2020 and 2019 was $39.0 million and $34.4 million, respectively, an increase of $4.6 million, or 13%. Research and development expenses for the years ended December 31, 2020 and 2019 are summarized in the table below:

In thousands	Year Ended December 31, 2020	2019
REDUCE-IT study (1)	$ 10,777	$ 10,680
Regulatory filing fees and expenses (2)	2,651	1,502
Internal staffing, overhead and other (3)	18,963	17,595
Research and development expense, excluding non-cash expense	32,391	29,777
Non-cash stock-based compensation expense (4)	6,568	4,615
Total research and development expense	$ 38,959	$ 34,392

(1) In September 2018, we announced landmark positive topline results of the REDUCE-IT cardiovascular outcomes trial. The increase in expenses is primarily driven by costs beyond the conduct of the study to further analyze samples collected from REDUCE-IT patients as well as the support of various publications and scientific presentations relating to REDUCE-IT.

(2) The regulatory filing fees included annual FDA fees for maintaining manufacturing sites. Such fees primarily represent fees to support international regulatory review of VASCEPA, particularly in Europe, qualification of new suppliers, including increasing capacity capabilities, and fees for sites used for the manufacture of product used in the REDUCE-IT clinical outcomes study.

(3) Internal staffing, overhead and other research and development expenses primarily relate to the costs of our personnel employed to manage research, development and regulatory affairs activities and related overhead costs including consulting and other professional fees that are not allocated to specific projects. Also included are costs related to qualifying suppliers. We also exercised certain rights under our strategic collaboration agreement with Mochida, resulting in payments of $1.0 million in each of January 2020 and December 2020, respectively. Also included are costs associated with various other investigations, including other costs in collaboration with Mochida and pilot studies regarding VASCEPA.

(4) Non-cash stock-based compensation expense represents the estimated costs associated with equity awards issued to personnel supporting our research and development and regulatory functions.

We anticipate our research and development expenses to remain consistent in 2021 with the current year. We continuously evaluate all of our spending commitments and priorities and we plan to adjust our level of research and development activities based on various factors, including the impact of COVID-19 and generic competition.

Interest Income, net. Net interest income for the years ended December 31, 2020 and 2019 was $2.3 million and $1.9 million, respectively, an increase of $0.4 million, or 23%. Net interest income for the years ended December 31, 2020 and 2019 is summarized in the table below:

In thousands	Year ended December 31, 2020	2019
Debt from royalty-bearing instrument (1):		
Cash interest	(1,614)	(4,381)
Non-cash interest	(635)	(1,643)
Total debt from royalty-bearing instrument interest expense	(2,249)	(6,024)
Other interest expense	(356)	(602)
Total interest expense	(2,605)	(6,626)
Interest income (2)	4,901	8,499
Total interest income, net	$ 2,296	$ 1,873

(1) Cash and non-cash interest expense related to the December 2012 royalty-bearing instrument for the years ended December 31, 2020 and 2019 was $2.2 million and $6.0 million, respectively. In November 2020, the Company made the final payment on its royalty-bearing instrument and, as a result, no further interest from this instrument is expected to be recorded beyond 2020. The decrease in cash and non-cash interest in 2020 as compared to 2019 is a result of the decrease in the outstanding balance of the royalty-bearing instrument during 2020.

(2) Interest income for the years ended December 31, 2020 and 2019 was $4.9 million and $8.5 million, respectively. Interest income represents income earned on cash and investment balances. As a result of COVID-19 and the related economic conditions, interest rates have decreased as compared to the prior year, resulting in a decrease in interest income.

Other income (expense), net. Other income (expense), net, for the year ended December 31, 2020 and 2019 was income of $0.1 million and expense of $0.1 million, respectively. Other income (expense), net, in the years ended December 31, 2020 and 2019 primarily consists of gains and losses on foreign exchange transactions.

Provision for income taxes. Provision for income taxes for the year ended December 31, 2020 and 2019 was $0.7 million and $0.2 million, respectively. The provision for each year is the result of losses generated by our U.S. and non-U.S. operations for which no tax benefit has been recognized based on our position that deferred tax benefits are not more likely than not to be realized based on available evidence.

The provisions for income taxes for the years ended December 31, 2020 and 2019 include excess tax benefits of $3.7 million and $17.2 million, respectively, arising from share-based payments as a result of adopting ASU No. 2016-09, *Compensation—Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting,* which requires that excess tax benefits and deficiencies that arise upon vesting or exercise of share-based payments be recognized as an income tax benefit and expense in the income statement.

Comparison of Fiscal Years Ended December 31, 2019 and December 31, 2018

Product Revenue, net. We recorded product revenue, net, of $427.4 million and $228.4 million during the years ended December 31, 2019 and 2018, respectively, an increase of $199.0 million, or 87%. This increase was driven primarily by volume of VASCEPA sales to our customers in the United States. Orders by such customer were supported by an increase in estimated normalized total VASCEPA prescriptions in the United States. Based on data provided by Symphony Health and IQVIA, estimated normalized total VASCEPA prescriptions in the United States increased in 2019 by approximately 1,412,000 and 1,274,000, respectively, over the year ended December 31, 2018, representing growth of 78% and 77%, respectively. In addition, we recognized net product revenue of approximately $0.7 million and $0.1 million as of December 31, 2019 and 2018, respectively for VASCEPA sales outside of the United States.

All of our product revenue in the years ended December 31, 2019 and 2018 was derived from product sales of 1-gram and 0.5-gram size capsules of VASCEPA, net of allowances, discounts, incentives, rebates, chargebacks and returns. The FDA-approved dosing for VASCEPA continues to be 4 grams per day and, as expected, the majority of new and existing patients taking VASCEPA continue to be prescribed the 1-gram size VASCEPA capsules. Timing of shipments to wholesalers, as used for revenue recognition, and timing of prescriptions as estimated by third-party sources such as Symphony Health and IQVIA may differ from period to period.

During the years ended December 31, 2019 and 2018, our Product revenue, net included adjustment for co-pay mitigation rebates provided by us to commercially insured patients. Such rebates are intended to offset the differential for patients of VASCEPA not covered by commercial insurers at the time of launch on Tier 2 for formulary purposes, resulting in higher co-pay amounts for such patients. Our cost for these co-payment mitigation rebates during the years ended December 31, 2019 and 2018 was up to $70 per 30-day prescription filled and, beginning in March 2017, included up to $140 per 90-day prescription filled. Since launch, certain third-party payors have added VASCEPA to their Tier 2 coverage, which results in lower co-payments for patients covered by these third-party payors. In connection with such Tier 2 coverage, we have agreed to pay customary rebates to these third-party payors on the resale of VASCEPA to patients covered by these third-party payors.

As is typical for the pharmaceutical industry, the majority of VASCEPA sales are to major commercial wholesalers which then resell VASCEPA to retail pharmacies.

Licensing and royalty revenue. Licensing and royalty revenue during the years ended December 31, 2019 and 2018 was $2.4 million and $0.8 million, respectively, an increase of $1.5 million, or 180%. Licensing and royalty revenue relates to the recognition of amounts received in connection with the following VASCEPA licensing agreements:

- Edding – a $15.0 million up-front payment received in February 2015 and a $1.0 million milestone payment achieved in March 2016.
- HLS – a $5.0 million up-front payment which was received upon closing of the agreement in September 2017, a $2.5 million milestone payment that was received following achievement of the REDUCE-IT trial primary endpoint in September 2018 and a $2.5 million milestone payment that was received following FDA approval of a new indication and label expansion in December 2019.

The up-front and milestone payments are being recognized over the estimated period in which we are required to provide regulatory and development support pursuant to the agreements. The amount of licensing and royalty revenue is expected to vary from period to period based on timing of milestones achieved and changes in estimates of the timing and level of support required. We do not anticipate significant revenues from international sources in 2020.

Cost of Goods Sold. Cost of goods sold during the years ended December 31, 2019 and 2018 was $96.0 million and $54.5 million, respectively, an increase of $41.5 million, or 76%. Cost of goods sold includes the cost of API for VASCEPA on which revenue was recognized during the period, as well as the associated costs for encapsulation, packaging, shipment, supply management, insurance and quality assurance. The cost of the API included in cost of goods sold reflects the average cost of API included in inventory. This average cost reflects the actual purchase price of VASCEPA API.

The API included in the calculation of the average cost of goods sold during the years ended December 31, 2019 and 2018 was sourced from multiple API suppliers. These suppliers compete with each other based on cost, consistent quality, capacity, timely delivery and other factors. In the future, we may see the average cost of supply change based on numerous potential factors including increased volume purchases, continued improvement in manufacturing efficiency, the mix of purchases made among suppliers, currency exchange rates and other factors.

Our gross margin on product sales for the years ended December 31, 2019 and 2018 was 78% and 76%, respectively, reflecting modestly lower API average cost in 2019 compared to 2018 reflecting multiple factors including efficiencies associated with economies of expanded scale.

Selling, General and Administrative Expense. Selling, general and administrative expense for the years ended December 31, 2019 and 2018 was $323.6 million and $227.0 million, respectively, an increase of $96.6 million, or 43%. Selling, general and administrative expenses for the years ended December 31, 2019 and 2018 are summarized in the table below:

	Year Ended December 31,	
In thousands	**2019**	**2018**
Selling, general and administrative expense (1)	$ 297,321	$ 164,267
Co-promotion fees (2)	—	46,821
Non-cash stock-based compensation expense (3)	26,302	15,908
Total selling, general and administrative expense	$ 323,623	$ 226,996

(1) Selling, general and administrative expense, excluding co-promotion fees and non-cash compensation charges for stock compensation, for the years ended December 31, 2019 and 2018 was $297.3 million and $164.3 million, respectively, an increase of $133.1 million, or 81%. This increase is due primarily to increased commercial and other promotional spend as well as costs for sales force expansion in preparation for the launch of VASCEPA in early 2020 for the new indication and expanded label approved based on the REDUCE-IT results. Partially offsetting this increase is a payment of $2.0 million made in connection with the settlement agreement reached with Teva Pharmaceuticals USA, Inc. in May 2018.

(2) Co-promotion fees payable to Kowa Pharmaceuticals America, Inc. were nil and $46.8 million in the years ended December 31, 2019 and 2018, respectively, a decrease of $46.8 million, or 100%. Amarin and Kowa Pharmaceuticals America, Inc. intentionally designed the co-promotion agreement to naturally end as of December 31, 2018 and mutually agreed not to renew the agreement.

(3) Non-cash stock-based compensation expense for the years ended December 31, 2019 and 2018 was $26.3 million and $15.9 million, respectively, an increase of $10.4 million, or 65%. Non-cash stock-based compensation expense represents the estimated costs associated with equity awards issued to internal personnel supporting our selling, general and administrative functions. The increase is due primarily to an increase in the number of employees receiving equity awards as a result of the growth of our sales force and an increase in the underlying fair value of the equity awards resulting from the increase in the price of our stock.

Research and Development Expense. Research and development expense for the years ended December 31, 2019 and 2018 was $34.4 million and $55.9 million, respectively, a decrease of $21.5 million, or 38%. Research and development expenses for the years ended December 31, 2019 and 2018 are summarized in the table below:

	Year Ended December 31,	
In thousands	**2019**	**2018**
REDUCE-IT study (1)	$ 10,680	$ 38,098
Regulatory filing fees and expenses (2)	1,502	1,052
Internal staffing, overhead and other (3)	17,595	13,852
Research and development expense, excluding non-cash expense	29,777	53,002
Non-cash stock-based compensation expense (4)	4,615	2,898
Total research and development expense	$ 34,392	$ 55,900

The decrease in research and development expenses for the year ended December 31, 2019, as compared to the prior year period, is primarily due to timing of REDUCE-IT and related costs.

(1) In September 2018, we announced landmark positive topline results of the REDUCE-IT cardiovascular outcomes trial. We managed the study through a contract research organization, or CRO, through which all costs for the conduct of this outcomes study were incurred with the exception of costs for clinical trial material, or CTM, and costs for internal management. The decrease in expenses is primarily driven by a decline in REDUCE-IT related costs after the successful REDUCE-IT results. Following the completion of the REDUCE-IT trial, costs consisted primarily of the clinical study's wrap-up activities, regulatory support and publications.

(2) The regulatory filing fees in each of the years ended December 31, 2019 and 2018 included annual FDA fees for maintaining manufacturing sites. Such fees primarily represent fees for qualification of new suppliers, including increasing capacity capabilities, and fees for sites used for the manufacture of product used in the REDUCE-IT clinical outcomes study.

(3) Internal staffing, overhead and other research and development expenses primarily relate to the costs of our personnel employed to manage research, development and regulatory affairs activities and related overhead costs including consulting and other professional fees that are not allocated to specific projects. Also included are costs related to qualifying suppliers. The increase in costs is primarily drive by an increase in support of publishing results of the REDUCE-IT study and preparation for sNDA submission based on the result of the REDUCE-IT study and in support of the FDA review process which led to FDA approval in December 2019 of an expanded indication for VASCEPA in the United States. Such costs also include costs for supporting VASCEPA approval in December 2019 by Health Canada and submission of VASCEPA for approval in the European Union. Partially offsetting this increase, is a non-refundable, non-creditable upfront payment made during the year ended December 31, 2018 of $2.7 million related to our strategic collaboration with Mochida Pharmaceutical Co., Ltd.

(4) Non-cash stock-based compensation expense represents the estimated costs associated with equity awards issued to internal staff supporting our research and development and regulatory functions.

Interest Income (Expense), net. Net interest income (expense) for the years ended December 31, 2019 and 2018 was income of $1.9 million and expense of $7.8 million, respectively, an increase of $9.7 million, or 124%. Net interest income (expense) for the years ended December 31, 2019 and 2018 is summarized in the table below:

	Year ended December 31,	
In thousands	**2019**	**2018**
Exchangeable senior notes (1):		
Amortization of debt discounts	$ —	$ (186)
Contractual coupon interest	—	(881)
Total exchangeable senior notes interest expense	—	(1,067)
Long-term debt from royalty-bearing instrument (2):		
Cash interest	(4,381)	(5,646)
Non-cash interest	(1,643)	(1,997)
Total long-term debt from royalty-bearing instrument interest expense	(6,024)	(7,643)
Other interest expense	(602)	(162)
Total interest expense	(6,626)	(8,872)
Interest income (3)	8,499	1,074
Total interest income (expense), net	$ 1,873	$ (7,798)

(1) Cash and non-cash interest expense related to the exchangeable senior notes, which were fully exchanged and retired for equity in November 2018, for the years ended December 31, 2019 and 2018 was nil and $1.1 million, respectively.

(2) Cash and non-cash interest expense related to the December 2012 royalty-bearing instrument for the years ended December 31, 2019 and 2018 was $6.0 million and $7.6 million, respectively. These amounts reflect the assumption that our VASCEPA net revenue levels will not be high enough to support repayment in accordance with the contractual repayment schedule without the optional reduction which is allowed to be elected by us if the threshold revenue levels are not achieved. To date, our revenues have been below the contractual threshold amount each quarter such that each payment reflects the calculated optional reduction amount as opposed to the contractual threshold payments for each quarterly period.

(3) Interest income for the years ended December 31, 2019 and 2018 was $8.5 million and $1.1 million, respectively. Interest income represents income earned on cash balances, which cash balances were on average higher in 2019 than in 2018.

Other Expense, net. Other expense, net, for the year ended December 31, 2019 and 2018 was $0.1 million and $0.3 million, respectively. Other expense, net, in the years ended December 31, 2019 and 2018 primarily consists of gains and losses on foreign exchange transactions.

Provision for Income Taxes. Provision for income taxes for the year ended December 31, 2019 and 2018 was $0.2 million and $0.1 million, respectively. The provision for each year is the result of losses generated by our U.S. and non-U.S. operations for which no tax benefit has been recognized based on our position that deferred tax benefits are not more likely than not to be realized based on available evidence.

The provisions for income taxes for the years ended December 31, 2019 and 2018 include excess tax benefits of $17.2 million and $7.7 million, respectively, arising from share-based payments as a result of adopting ASU No. 2016-09, *Compensation—Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting,* which requires that excess tax benefits and deficiencies that arise upon vesting or exercise of share-based payments be recognized as an income tax benefit and expense in the income statement.

Liquidity and Capital Resources

Our aggregate sources of liquidity as of December 31, 2020 are in excess of $550.0 million, with no debt. Our aggregate sources of liquidity include cash and cash equivalents and restricted cash of $190.9 million, short-term investments of $314.0 million and long-term investments of $62.5 million. Our cash and cash equivalents primarily include checking accounts and money market funds with original maturities less than 90 days. Our short-term investments consist of held-to-maturity securities that will be due in one year or less. Our long-term investments consist of held-to-maturity securities that will be due in more than one year. We invest cash in excess of our immediate requirements, in accordance with our investment policy, which limits the amounts we may invest in any one type of investment and requires all investments held by us to maintain minimum ratings from Nationally Recognized Statistical Rating Organizations so as to primarily achieve our goals of liquidity and capital preservation. Our cash flows from operating, investing and financing activities, as reflected in the consolidated statements of cash flows, are summarized in the following table:

	Year Ended December 31,		
In millions	**2020**	**2019**	**2018**
Cash (used in) provided by:			
Operating activities	$ (21.7)	$ (9.4)	$ (94.7)
Investing activities	(377.0)	(2.5)	(0.1)
Financing activities	(58.9)	409.6	271.3
(Decrease) increase in cash and cash equivalents and restricted cash	$ (457.6)	$ 397.7	$ 176.5

Net cash used in operating activities during 2020 compared to 2019 increased primarily as a result of higher collections due to an increase in product sales and partially offset by costs associated with expanding our United States-based sales force, as well as increased costs of promotional activities following the new indication and expanded label of VASCEPA.

Net cash used in investing activities during the year ended December 31, 2020, compared to the same period in 2019 increased as a result of our purchasing approximately $678.7 million investment-grade interest bearing instruments during 2020, partially offset by $302.0 million in proceeds from the maturity and sale of securities.

Net cash used in financing activities during the year ended December 31, 2020 primarily reflects an increase in the payments made on our royalty-bearing instrument with CPPIB, with the final payment made in the fourth quarter of 2020. In December 2012, we entered into a financing agreement with BioPharma. Under this agreement, we granted to BioPharma a security interest in future receivables and all related rights to VASCEPA, in exchange for $100.0 million received at the closing of the agreement which occurred in December 2012. In December 2017, BioPharma assigned all rights under this agreement to CPPIB. In the fourth quarter of 2020, we have repaid the remaining amounts outstanding of the agreed upon $150.0 million.

Net cash provided by financing activities during the year ended December 31, 2019 is primarily due to completing a public offering of 22,222,223 ADS with each ADS representing one ordinary share at a price of $18.00 per ADS, $17.235 per ADS after commission, on July 18, 2019. In addition, we granted the underwriters a 30-day option to purchase up to an additional 3,333,333 ADS at the same price per ADS. On July 29, 2019, the underwriters exercised the full option. This public offering, including the exercised option, resulted in net proceeds of $440.1 million, after deducting customary commissions and offering expenses. Net cash provided by financing activities during the year ended December 31, 2018 is primarily due to completing a public offering in February 2018 of 19,178,082 ADSs and, in March 2018, we issued an additional 1,438,356 ADSs upon the underwriter's partial exercise of a 30-day option to purchase additional shares. The underwriter purchased the ADSs from us at a price of $3.41 per ADS after commission, resulting in net proceeds to us of approximately $70.0 million, after deducting customary commissions and offering expenses. In November 2018, we completed a public offering of 11,111,112 ADSs. The underwriters purchased the ADSs from us at a

price of $17.575 per ADS after commission, resulting in net proceeds to us of approximately $194.8 million, after deducting customary commissions and offering expenses.

As of December 31, 2020, we had net accounts receivable of $154.6 million and inventory of $188.9 million. We have incurred annual operating losses since our inception and, as a result, we had an accumulated deficit of $1.4 billion as of December 31, 2020. We anticipate that quarterly net cash outflows in future periods will continue to be variable as a result of the timing of certain items, including our purchases of API and expanded VASCEPA promotional activities from approval by the U.S. FDA for the cardiovascular risk reduction indication and the impact from COVID-19 on our operations and those of our customers, the generic competition in the United States as a result of our ANDA litigation and commercialization of VASCEPA in Europe. For Europe, we commenced 2021 with approximately 50 professionals involved with pre-approval and pre-launch planning and other commercial preparation activities, with plans to expand to approximately 200 professionals by the end of 2021.

We believe that our cash and cash equivalents of $187.0 million as of December 31, 2020 together with our short-term investments of $314.0 million as of December 31, 2020, will be sufficient to fund our projected operations for at least twelve months and is adequate to achieve positive cash flow from VASCEPA based on our current plans. We have based this estimate on assumptions that may prove to be wrong, including as a result of the risks discussed under Part II, Item IA, “Risk Factors”, and we could use our capital resources sooner than we expect or fail to achieve positive cash flow.

We do not have any special purpose entities or other off-balance sheet arrangements.

Item 7A. ***Quantitative and Qualitative Disclosures about Market Risk***

We are exposed to market risks, which include changes in interest rates. We do not use derivative financial instruments in our investment portfolio, and we do not enter into foreign exchange contracts. Our investments meet high credit quality and diversification standards, as specified in our investment policy.

Foreign Currency Exchange Risk. Our results of operations and cash flows are subject to fluctuations due to changes in the Euro, Sterling, Swiss Franc and Yen. The majority of cash and cash equivalents, investments, and the majority of our vendor relationships are denominated in U.S. dollars. We therefore believe that the risk of a significant impact on our operating income from foreign currency fluctuations is not substantial. All of our investments are held in U.S. dollars. From time to time, we maintain a small amount of our cash and cash equivalents in Euro and Pound Sterling. We purchase a portion of our supply from Novasep based on a U.S. dollar to Euro exchange rate and, as such, remain subject to currency fluctuation risk for such purchases. Based on the size of our international operations and the amount of our expenses denominated in foreign currencies, currency fluctuation would not have a material effect on our financial position or results of operations.

Interest Rate Risk. We believe that we are not exposed to significant interest rate risk through market value fluctuations of balance sheet items (i.e., price risk) or through changes in interest income or expenses (i.e., re-financing or re-investment risk). Interest rate risk mainly arises through interest bearing liabilities and assets. Our portfolio of held-to-maturity investments as of December 31, 2020 was composed of U.S. Treasury securities, commercial paper, corporate, CD and asset-backed securities and other government-related securities. At December 31, 2020 the Company had short-term investments and long-term investments of $376.4 million. We did not have any held-to-maturity investments in 2019. We invest funds to have a continuous inflow of cash from diversified short-term and long-term investments, consisting primarily of investment grade securities. A hypothetical 10 percent change in interest rates would not result in a material decrease or increase in the fair value of our securities due to the balance and diversified investment portfolio.

Credit Risk. We monitor our investments with our investment managers with the objective of minimizing concentrations of credit risks. Our short-term investments consist of held-to-maturity securities that will be due in one year or less. Our long-term investments consist of held-to-maturity securities that will be due in more than one year. We invest cash in excess of our immediate requirements, in accordance with our investment policy, which limits the amounts we may invest in any one type of investment and requires all investments held by us to maintain minimum ratings from Nationally Recognized Statistical Rating Organizations so as to primarily achieve our goals of liquidity and capital preservation. Additionally, our investment policy is to invest only in institutions that meet high credit quality and diversification standards and established limits on the amount and time to maturity of investments.

Item 8. ***Financial Statements and Supplementary Data***

Our consolidated financial statements are annexed to this report beginning on page F-1.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures

We maintain disclosure controls and procedures that are designed to ensure that information required to be disclosed in the reports that we file or submit under the Securities Exchange Act of 1934, as amended, or the Exchange Act, is (1) recorded, processed, summarized, and reported within the time periods specified in the SEC's rules and forms and (2) accumulated and communicated to our management, including our Principal Executive Officer and Principal Financial Officer, to allow timely decisions regarding required disclosure.

As of December 31, 2020, or the Evaluation Date, our management, with the participation of our Principal Executive Officer and Principal Financial Officer, evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act). Our management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives, and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Our Principal Executive Officer and Principal Financial Officer have concluded based upon the evaluation described above that, as of the Evaluation Date, our disclosure controls and procedures were effective at the reasonable assurance level.

Management's Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting for our company. Internal control over financial reporting is defined in Rules 13a-15(f) and 15(d)-15(f) promulgated under the Exchange Act as a process designed by, or under the supervision of, our Principal Executive Officer and Principal Financial Officer and effected by our board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles and includes those policies and procedures that:

- pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and disposition of our assets;
- provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles;
- provide reasonable assurance that our receipts and expenditures are being made only in accordance with authorization of our management and directors; and
- provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of our assets that could have a material effect on the financial statements.

Because of inherent limitations, internal controls over financial reporting may not prevent or detect misstatements. Projections of any evaluation of effectiveness to future periods are subject to the risks that controls may become inadequate because of changes in conditions or that the degree of compliance with the policies or procedures may deteriorate.

Our management, including our Principal Executive Officer and Principal Financial Officer, has conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2020. In conducting this evaluation, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission, or COSO, in *Internal Control-Integrated Framework (2013)*.

Based upon this evaluation and those criteria, management has concluded that, as of December 31, 2020, our internal controls over financial reporting were effective.

Ernst & Young LLP, our independent registered public accounting firm, has audited our consolidated financial statements and the effectiveness of our internal control over financial reporting as of December 31, 2020. This report appears below.

Changes in Internal Control over Financial Reporting

There were no changes in our internal control over financial reporting during the fourth quarter of 2020 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Shareholders and the Board of Directors of Amarin Corporation plc

Opinion on Internal Control over Financial Reporting

We have audited Amarin Corporation plc's internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Amarin Corporation plc (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on the COSO criteria**.**

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2020 and 2019, the related consolidated statements of operations, stockholders' equity (deficit) and cash flows for each of the three years in the period ended December 31, 2020, and the related notes and our report dated February 25, 2021 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP
Iselin, New Jersey
February 25, 2021

Item 9B. ***Other Information***

Entry into Rule 10b5-1 Trading Plans

Our policy governing transactions in our securities by our directors, officers and employees permits our officers, directors and certain other persons to enter into trading plans complying with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Consistent with such regulation, our policy permits such plans to be entered into only when that person confirms they are not in possession of material non-public information. Our policy also requires a waiting period after a trading plan is created before shares can be traded under the plan. Our open trading windows are established in consultation with legal counsel. We have been from time to time advised that a number of our directors and employees, including members of our senior management team, and investment funds associated with such persons, have entered into trading plans in accordance with Rule 10b5-1 and our policy governing transactions in our securities. It is not our policy to publicly disclose the terms of these private trading plans. We undertake no obligation to update or revise the information provided herein, including for revision or termination of an established trading plan.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

The information required by this item will be contained in our definitive proxy statement, which will be filed with the SEC in connection with our 2021 Annual General Meeting of Shareholders. Such information is incorporated herein by reference.

Code of Ethics

Our Board of Directors has adopted a code of business conduct and ethical responsibility that applies to our directors, officers and employees. There have been no material modifications to, or waivers from, the provisions of such code. This code is available on the corporate governance section of our website (which is a subsection of the investor relations section of our website) at the following address: www.amarincorp.com. You may also request a printed copy of the code, without charge, by writing to us at Amarin Pharma, Inc., 440 Route 22, Bridgewater, NJ 08807, Attention: Investor Relations. In addition, should any changes be made to our code of business conduct and ethical responsibility, we intend to disclose within four business days on our website (or in any other medium required by law or the NASDAQ): (a) the date and nature of any amendment to our code of business conduct and ethical responsibility that applies to our principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions and (b) the nature of any waiver, including an implicit waiver, from a provision of our code of business conduct and ethical responsibility that is granted to one of these specified officers, the name of such person is granted the waiver, and the date of the waiver.

Item 11. ***Executive Compensation***

The information required by this item will be contained in our definitive proxy statement, which will be filed with the SEC in connection with our 2021 Annual General Meeting of Shareholders. Such information is incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

The information required by this item will be contained in our definitive proxy statement, which will be filed with the SEC in connection with our 2021 Annual General Meeting of Shareholders. Such information is incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

The information required by this item will be contained in our definitive proxy statement, which will be filed with the SEC in connection with our 2021 Annual General Meeting of Shareholders. Such information is incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

The information required by this item will be contained in our definitive proxy statement, which will be filed with the SEC in connection with our 2021 Annual General Meeting of Shareholders. Such information is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

Exhibit Number	Description	Incorporated by Reference Herein	
		Form	Date
3.1	Articles of Association of the Company	Quarterly Report on Form 10-Q, File No. 0-21392, as Exhibit 3.1	August 8, 2013
4.1	Form of Amended and Restated Deposit Agreement, dated as of November 4, 2011, among the Company, Citibank, N.A., as Depositary, and all holders from time to time of American Depositary Receipts issued thereunder	Annual Report on Form 10-K for the year ended December 31, 2011, File No. 0-21392, as Exhibit 4.1	February 29, 2012
4.2	Form of Ordinary Share certificate	Annual Report on Form 20-F for the year ended December 31, 2002, File No. 0-21392, as Exhibit 2.4	April 24, 2003
4.3	Form of American Depositary Receipt evidencing ADSs	Annual Report on Form 10-K for the year ended December 31, 2011, File No. 0-21392, as Exhibit 4.4	February 29, 2012
4.4	Form of Series A Preference Share Terms	Current Report on Form 8-K dated March 5, 2015, File No. 0-21392, as Exhibit 4.1	March 11, 2015
4.5	Preferred Share Deposit Agreement by and among the Company, Citibank, N.A., as depositary, and all holders and beneficial owners of restricted ADSs issued thereunder	Current Report on Form 8-K dated March 30, 2015, File No. 0-21392, as Exhibit 4.1	March 30, 2015
4.6	Form of American Depositary Receipt evidencing restricted ADSs representing Series A Preference Shares	Current Report on Form 8-K dated March 30, 2015, File No. 0-21392, as Exhibit 4.2	March 30, 2015
4.7	Description of Registrant's Securities	Annual Report on Form 10-K for the year ended December 31, 2019, File No. 0-21392, as Exhibit 4.7	February 27, 2020
10.1	The Company 2002 Stock Option Plan*	Annual Report on Form 20-F for the year ended December 31, 2006, File No. 0-21392, as Exhibit 4.17	March 5, 2007
10.2	The Company 2011 Stock Option Plan*	Quarterly Report on Form 10-Q for the period ended June 30, 2011, File No. 0-21392, as Exhibit 10.4	August 9, 2011
10.3	Amendment No. 1 to 2011 Stock Option Incentive Plan*	Quarterly Report on Form 10-Q for quarterly period ended June 30, 2012, File No. 0-21392, as Exhibit 10.1	August 8, 2008
10.4	Amendment No. 2 to 2011 Stock Option Incentive Plan*	Quarterly Report on Form 10-Q for quarterly period ended June 30, 2012, File No. 0-21392, as Exhibit 10.2	August 8, 2008
10.5	Amendment No. 3 to 2011 Stock Option and Incentive Plan*	Annual Report on Form 10-K for the year ended December 31, 2012, File No. 0-21392, as Exhibit 10.5	February 28, 2012
10.6	Amendment No. 4 to 2011 Stock Option and Incentive Plan*	Quarterly Report on Form 10-Q for quarterly period ended June 30, 2015, File No. 0-21392, as Exhibit 4.1	August 6, 2015

Exhibit Number	Description	Incorporated by Reference Herein	
		Form	Date
10.7	Amendment No. 5 to 2011 Stock Option and Incentive Plan*	Quarterly Report on Form 10-Q for quarterly period ended June 30, 2015, File No. 0-21392, as Exhibit 4.2	August 6, 2015
10.8	Amarin Corporation plc Management Incentive Compensation Plan*	Annual Report on Form 10-K for the year ended December 31, 2010, File No. 0-21392, as Exhibit 10.44	March 16, 2011
10.9	Form of Incentive Stock Option Award Agreement*	Annual Report on Form 10-K for the year ended December 31, 2011, File No. 0-21392, as Exhibit 10.3	February 29, 2012
10.10	Form of Non-Qualified Stock Option Award Agreement*	Annual Report on Form 10-K for the year ended December 31, 2011, File No. 0-21392, as Exhibit 10.4	February 29, 2012
10.11	Form of Restricted Stock Unit Award Agreement*	Annual Report on Form 10-K for the year ended December 31, 2011, File No. 0-21392, as Exhibit 10.5	February 29, 2012
10.12	Letter Agreement, dated November 15, 2010, between the Company and John F. Thero*	Annual Report on Form 10-K for the year ended December 31, 2010, File No. 0-21392, as Exhibit 10.42	March 16, 2011
10.13	Letter Agreement with Joseph Kennedy, dated December 13, 2011*	Current Report on Form 8-K dated December 23, 2011, File No. 0-21392, as Exhibit 10.5	December 23, 2011
10.14	Letter Agreement with John Thero, dated December 23, 2011*	Current Report on Form 8-K dated December 23, 2011, File No. 0-21392, as Exhibit 10.1	December 23, 2011
10.15	Letter Agreement with Steve Ketchum, dated February 8, 2012*	Current Report on Form 8-K dated February 16, 2012, File No. 0-21392, as Exhibit 10.1	February 16, 2012
10.16	Letter Agreement with John Thero, dated January 10, 2014*	Current Report on Form 8-K dated January 8, 2014, File No. 0-21392, as Exhibit 10.1	January 10, 2014
10.17	Amendment, dated July 6, 2015, to Letter Agreement with Joseph Kennedy, dated December 13, 2011*	Quarterly Report on Form 10-Q for the period ended June 30, 2015, File No. 0-21392, as Exhibit 10.1	August 6, 2015
10.18	Amendment, dated July 6, 2015, to Letter Agreement with Steven Ketchum, dated February 8, 2012*	Quarterly Report on Form 10-Q for the period ended June 30, 2015, File No. 0-21392, as Exhibit 10.2	August 6, 2015
10.19	Amendment, dated July 6, 2015, to Letter Agreement with John Thero, dated December 23, 2011*	Quarterly Report on Form 10-Q for the period ended June 30, 2015, File No. 0-21392, as Exhibit 10.3	August 6, 2015
10.20	2011 Long Term Incentive Award with Joseph Kennedy dated December 16, 2011*	Form S-8, File No. 333-180180, as Exhibit 4.1	March 16, 2012
10.21	2012 Long Term Incentive Award with Steven Ketchum dated March 1, 2012*	Form S-8, File No. 333-180180, as Exhibit 4.2	March 16, 2012
10.22	Employment Agreement dated November 5, 2009 with John F. Thero*	Registration Statement on Form F-1, File No. 333-163704, as Exhibit 4.104	December 14, 2009
10.34	API Commercial Supply Agreement, dated May 25, 2011, between Amarin Pharmaceuticals Ireland Ltd. and Chemport Inc. ††	Quarterly Report on Form 10-Q for the period ended June 30, 2011, File No. 0-21392, as Exhibit 10.2	August 9, 2011

Exhibit Number	Description	Incorporated by Reference Herein	
		Form	Date
10.35	Amendment to API Commercial Supply Agreement by and between Amarin Pharmaceuticals Ireland Ltd and Chemport Inc., dated April 4, 2012 ††	Quarterly Report on Form 10-Q for quarterly period ended June 30, 2012, File No. 0-21392, as Exhibit 10.6	August 8, 2008
10.36	Second Amendment to API Commercial Supply Agreement by and between Amarin Pharmaceuticals Ireland Ltd. and Chemport Inc., dated July 19, 2012††	Quarterly Report on Form 10-Q for quarterly period ended September 30, 2012, File No. 0-21392, as Exhibit 10.1	November 8, 2012
10.37	Purchase and Sale Agreement, dated December 6, 2012, by and between Amarin Corporation plc, Amarin Pharmaceuticals Ireland Limited and BioPharma Secured Debt Fund II Holdings Cayman LP††	Annual Report on Form 10-K for the year ended December 31, 2012, File No. 0-21392, as Exhibit 10.76	February 28, 2012
10.38	Co-Promotion Agreement dated March 31, 2014, by and among the Company and Kowa Pharmaceuticals America, Inc. ††	Quarterly Report on Form 10-Q for quarterly period ended March 31, 2014, File No. 0-21392, as Exhibit 10.1	May 9, 2014
10.39	Development, Commercialization and Supply Agreement dated February 26, 2015, by and between Amarin Pharmaceuticals Ireland Limited, Amarin Pharma, Inc. and Eddingpharm (Asia) Macao Commercial Offshore Limited††	Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2015, File No. 0-21392, as Exhibit 10.1	May 8, 2015
10.40	Securities Subscription Agreement dated March 5, 2015, by and among Amarin Corporation plc, 667, L.P., Baker Brothers Life Sciences, L.P., Stonepine Capital, L.P. and Broadfin Healthcare Master Fund	Current Report on Form 8-K dated March 5, 2015, File No. 0-21392, File No. 0-21392, as Exhibit 10.1	March 11, 2015
10.41	Securities Subscription Agreement dated March 30, 2015, by and between Amarin Corporation plc and Sofinnova Venture Partners VII, L.P.	Current Report on Form 8-K dated March 30, 2015, File No. 0-21392, as Exhibit 10.1	March 30, 2015
10.42	Letter Agreement, dated May 9, 2016, by and between Amarin Corporation plc and Michael Kalb*	Current Report on Form 8-K dated June 30, 2016, File No. 0-21392, as Exhibit 10.1	June 30, 2016
10.43	Amendment No. 6 to 2011 Stock Incentive Plan*	Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2017, File No. 0-21392, as Exhibit 4.1	August 2, 2017
10.44	2017 Employee Stock Purchase Plan*	Annual Report on Form 10-K for the year ended December 31, 2017, File No. 0-21392, as Exhibit 10.64	February 27, 2018
10.45	First Amendment to the Co-Promotion Agreement of March 31, 2014 dated July 25, 2017, by and among Amarin Pharmaceuticals Ireland Limited, Amarin Pharma, Inc., and Kowa Pharmaceuticals America, Inc. ††	Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2017, File No. 0-21392, as Exhibit 10.1	August 2, 2017
10.46	Consent and Waiver, dated December 20, 2017, by and among Amarin Pharmaceuticals Ireland Limited, Amarin Corporation PLC, BioPharma Secured Debt Fund II Holdings Cayman LP and Pharmakon Advisors LP	Annual Report on Form 10-K for the year ended December 31, 2017, File No. 0-21392, as Exhibit 10.66	February 27, 2018

Exhibit Number	Description	Incorporated by Reference Herein	
		Form	Date
10.47	Distribution Agreement, dated March 8, 2016, by and among Biologix FZCo, Amarin Pharmaceuticals Ireland Limited and Amarin Pharma, Inc. ††	Annual Report on Form 10-K for the year ended December 31, 2017, File No. 0-21392, as Exhibit 10.67	February 27, 2018
10.48	Development, Commercialization and Supply Agreement, dated September 25, 2017, by and among Amarin Pharmaceuticals Ireland Limited, Amarin Pharma, Inc. and HLS Therapeutics Inc. ††	Annual Report on Form 10-K for the year ended December 31, 2017, File No. 0-21392, as Exhibit 10.68	February 27, 2018
10.49	Lease Agreement, dated February 5, 2019, by and between 440 Route 22 LLC and Amarin Pharma, Inc.	Annual Report on Form 10-K for the year ended December 31, 2018, File No. 0-21392, as Exhibit 10.69	February 27, 2019
10.50	Employment Agreement, dated April 20, 2018, by and between Amarin Pharma Inc. and Aaron Berg*	Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2019, File No. 0-21392, as Exhibit 10.1	May 1, 2019
10.51	Sixth Amendment to Lease Agreement, dated April 1, 2019, by and between Amarin Pharma, Inc. and Bedminster 2 Funding, LLC	Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2019, File No. 0-21392, as Exhibit 10.1	July 31, 2019
10.52	Online Office Agreement, dated as of April 12, 2019, by and between Amarin Pharmaceuticals Ireland Limited and Regus CME Ireland Limited	Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2019, File No. 0-21392, as Exhibit 10.2	July 31, 2019
10.53	Office Service Agreement, dated as of April 12, 2019, by and between Amarin Pharmaceuticals Ireland Limited and Regus CME Ireland Ltd.	Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2019, File No. 0-21392, as Exhibit 10.3	July 31, 2019
10.54	Online Office Agreement, dated as of July 3, 2019, by and between Amarin Pharmaceuticals Ireland Limited and Regus CME Ireland Ltd.	Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2019, File No. 0-21392, as Exhibit 10.4	July 31, 2019
10.55	Online Office Renewal Agreement dated as of October 1, 2020, by and between Amarin Pharamecueticals Ireland Limited and Regus CME Irelnad Limited	Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2020, File No. 0-21392, as Exhibit 10.7	November 5, 2020
10.56	Online Office Renewal Agreement dated as of September 14, 2020, by and between Amarin Pharmaceuticals Ireland Limited and Regus CME Ireland Limited	Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2020, File No. 0-21392, as Exhibit 10.8	November 5, 2020
10.57	Online Office Renewal Agreement dated as of February 1, 2020, by and between Amarin Pharmaceuticals Ireland Limited and Regus CME Ireland Limited	Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2020, File No. 0-21392, as Exhibit 10.1	April 30, 2020
10.58	Form of Incentive Stock Option Award Agreement*	Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2020, File No. 0-21392, as Exhibit 10.2	November 5, 2020
10.59	Form of Non-Qualified Stock Option Award Agreement*	Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2020, File No. 0-21392, as Exhibit 10.3	November 5, 2020
10.60	Form of Restricted Stock Unit Award Agreement*	Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2020, File No. 0-21392, as Exhibit 10.4	November 5, 2020

Exhibit Number	Description	Incorporated by Reference Herein	
		Form	Date
10.61	Form of Non-Qualified Stock Option for Non-Employee Director Award Agreement*	Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2020, File No. 0-21392, as Exhibit 10.5	November 5, 2020
10.62	Form of Deferred Restricted Stock Unit for Non-Employee Director Award Agreement*	Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2020, File No. 0-21392, as Exhibit 10.6	November 5, 2020
21.1	List of Subsidiaries	Filed herewith	
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith	
24.1	Power of Attorney	Included on the signature page(s) hereto	
31.1	Certification of President and Chief Executive Officer (Principal Executive Officer) pursuant to Section 302 of Sarbanes-Oxley Act of 2002	Filed herewith	
31.2	Certification of Senior Vice President and Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer) pursuant to Section 302 of Sarbanes-Oxley Act of 2002	Filed herewith	
32.1	Certification of President and Chief Executive Officer (Principal Executive Officer) and Senior Vice President and Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer) pursuant to Section 906 of Sarbanes-Oxley Act of 2002	Furnished herewith	
101.INS	Inline XBRL Instance Document	Filed herewith	
101.SCH	Inline XBRL Taxonmy Extension Schema Document	Filed herewith	
101. CAL	Inilne XBRL Taxonomy Extension Calculation Linkbase Document	Filed herewith	
101. DEF	Inline XBRL Taxanomy Extension Defintiion Linkbase Document	Filed herewith	
101. LAB	Inline XBRL Taxanomy Extension Lable Linkbase Document	Filed herewith	
101. PRE	Inline XBRL Taxanomy Extension Presentation Linkbase Document	Filed herewith	
104	Cover Page Interactive Data File (formatted as inline XBRL with applicable taxonomy extension information contained in Exhibits 101.)	Filed herewith	

†† Confidential treatment has been granted with respect to portions of this exhibit pursuant to an application requesting confidential treatment under Rule 24b-2 of the Securities Exchange Act of 1934. A complete copy of this exhibit, including the redacted terms, has been separately filed with the Securities and Exchange Commission.

* Management contract or compensatory plan or arrangement.

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

Financial Statement Schedules:

Financial statement schedules have been omitted for the reason that the required information is presented in the consolidated financial statements or notes thereto, the amounts involved are not significant or the schedules are not applicable.

Item 16. ***Form 10-K Summary***

Not applicable.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

AMARIN CORPORATION PLC

By: /s/ John F. Thero
John F. Thero
President and *Chief Executive Officer*
(Principal Executive Officer)

Date: February 25, 2021

We, the undersigned officers and directors of the Registrant hereby severally constitute and appoint John F. Thero, Michael W. Kalb and Joseph Kennedy, and each of them singly, our true and lawful attorneys, with full power to them and each of them singly, to sign for us in our names in the capacitities indicated below, all amendments to this report, and generally to do all things in our names and on our behalf in such capacities to enable the Registrant to comply with the provisions of the Securities Exchange Act of 1934, as amended, and all requirements of the Securities and Exchange Commission.

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the date indicated.

Signature	Title	Date
/s/ John F. Thero John F. Thero	Director, President and Chief Executive Officer (Principal Executive Officer)	February 25, 2021
/s/ Michael W. Kalb Michael W. Kalb	Senior Vice President and Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer)	February 25, 2021
/s/ Lars Ekman, M.D., Ph.D. Lars Ekman, M.D., Ph.D.	Director	February 25, 2021
/s/ Patrick O'Sullivan Patrick O'Sullivan	Director	February 25, 2021
/s/ Kristine Peterson Kristine Peterson	Director	February 25, 2021
/s/ David Stack David Stack	Director	February 25, 2021
/s/ Jan van Heek Jan van Heek	Director	February 25, 2021
/s/ Joseph Zakrzewski Joseph Zakrzewski	Director	February 25, 2021

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Shareholders and the Board of Directors of Amarin Corporation plc

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Amarin Corporation plc (the Company) as of December 31, 2020 and 2019, the related consolidated statements of operations, stockholders' equity (deficit) and cash flows for each of the three years in the period ended December 31, 2020, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 25, 2021 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective or complex judgments. The communication of the critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the account or disclosure to which it relates.

Product Return Reserve Estimate

Description of the Matter

At December 31, 2020, the Company recorded a liability for product returns totaling $7.8 million. As discussed in Note 14 of the financial statements, the Company sells its product to distributors that in turn resell the product to retail pharmacies for subsequent sale to patients and healthcare providers. The Company estimates variable consideration resulting from product returns based on quantitative and qualitative data from various internal and external sources.

Auditing management's estimate of product returns was complex and judgmental due to the significant estimation required to determine inventory in the distribution channel that will not ultimately be sold to patients and healthcare providers and will be returned. Sales into the distribution channel could exceed market demand.

How We Addressed the Matter in Our Audit	We obtained an understanding, evaluated the design and tested the operating effectiveness of the controls over the Company's estimation process for product returns including inventory in the distribution channel. These procedures included controls over management's review of the inputs used and assumptions applied in the returns reserve calculation and channel inventory analysis. To test the estimated product return reserve, we performed audit procedures that included, among others, testing management's historical return rate calculation and testing the completeness and accuracy of sales and returns data used in the calculation. We also compared product expiration dates in the calculation to the related quality control documentation. We assessed the historical accuracy of management's estimate and performed analytical procedures to assess the correlation of monthly sales to distributors and monthly patient prescriptions. In addition, we assessed the Company's quarterly analysis of inventory held at various stages in the distribution channel. We confirmed prescription data directly with a third party, confirmed contract terms directly with significant customers, and tested credit memos issued subsequent to year-end for recording in the proper period. We read significant customer contracts and performed direct inquiries with management including the sales, legal, and contracting departments to identify any terms or conditions not included in customer contracts that could impact the estimate of product returns.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2014.

Iselin, New Jersey
February 25, 2021

AMARIN CORPORATION PLC

CONSOLIDATED BALANCE SHEETS
(in thousands, except share amounts)

	December 31, 2020	December 31, 2019
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 186,964	$ 644,588
Restricted cash	3,915	3,907
Short-term investments	313,969	—
Accounts receivable, net	154,574	116,430
Inventory	188,864	76,769
Prepaid and other current assets	30,947	13,311
Total current assets	879,233	855,005
Property, plant and equipment, net	2,016	2,361
Long-term investments	62,469	—
Operating lease right-of-use asset	8,054	8,511
Other long-term assets	432	1,074
Intangible asset, net	13,817	15,258
TOTAL ASSETS	$ 966,021	$ 882,209
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Accounts payable	$ 105,876	$ 49,950
Accrued expenses and other current liabilities	198,641	139,826
Debt from royalty-bearing instrument	—	50,130
Current deferred revenue	2,926	2,342
Total current liabilities	307,443	242,248
Long-Term Liabilities:		
Long-term deferred revenue	15,706	18,504
Long-term operating lease liability	9,153	9,443
Other long-term liabilities	6,214	3,751
Total liabilities	338,516	273,946
Commitments and contingencies (Note 8)		
Stockholders' Equity:		
Series A Convertible Preferred Stock, £0.05 par, unlimited authorized; nil shares issued and nil outstanding at December 31, 2020 and 289,317,460 shares issued and outstanding at December 31, 2019 (equivalent to 28,931,746 ordinary shares upon future consolidation and redesignation at a 10:1 ratio)	—	21,850
Common stock, £0.50 par, unlimited authorized; 398,425,000 issued, 392,538,081 outstanding at December 31, 2020; 365,014,893 issued, 360,103,901 outstanding at December 31, 2019	290,115	269,173
Additional paid-in capital	1,817,649	1,764,317
Treasury stock; 5,886,919 shares at December 31, 2020; 4,910,992 shares at December 31, 2019	(51,082)	(35,900)
Accumulated deficit	(1,429,177)	(1,411,177)
Total stockholders' equity	627,505	608,263
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 966,021	$ 882,209

See the notes to the consolidated financial statements.

AMARIN CORPORATION PLC

CONSOLIDATED STATEMENTS OF OPERATIONS
(in thousands, except per share amounts)

	Year Ended December 31,		
	2020	2019	2018
Product revenue, net	$ 607,025	$ 427,391	$ 228,371
Licensing and royalty revenue	7,035	2,364	843
Total revenue, net	614,060	429,755	229,214
Less: Cost of goods sold	131,444	96,019	54,543
Gross margin	482,616	333,736	174,671
Operating expenses:			
Selling, general and administrative	463,312	323,623	226,996
Research and development	38,959	34,392	55,900
Total operating expenses	502,271	358,015	282,896
Operating loss	(19,655)	(24,279)	(108,225)
Interest income	4,901	8,499	1,074
Interest expense	(2,605)	(6,626)	(8,872)
Other income (expense), net	104	(75)	(326)
Loss from operations before taxes	(17,255)	(22,481)	(116,349)
Provision for income taxes	(745)	(164)	(96)
Net loss	(18,000)	(22,645)	(116,445)
Loss per share:			
Basic	$ (0.05)	$ (0.07)	$ (0.39)
Diluted	$ (0.05)	$ (0.07)	$ (0.39)
Weighted average shares outstanding:			
Basic	381,759	342,538	297,237
Diluted	381,759	342,538	297,237

See the notes to the consolidated financial statements.

AMARIN CORPORATION PLC

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY (DEFICIT)
(in thousands, except share amounts)

	Preferred Shares	Common Shares	Treasury Shares	Preferred Stock	Common Stock	Additional Paid-in Capital	Treasury Stock	Accumulated Deficit	Total
December 31, 2017	**328,184,640**	**272,719,044**	**(1,697,033)**	**$ 24,364**	**$ 208,768**	**$ 977,866**	**$ (4,229)**	**$ (1,271,869)**	**$ (65,100)**
Cumulative-effect adjustment	—	—	—	—	—	—	—	(218)	(218)
January 1, 2018	**328,184,640**	**272,719,044**	**(1,697,033)**	**$ 24,364**	**$ 208,768**	**$ 977,866**	**$ (4,229)**	**$ (1,272,087)**	**$ (65,318)**
Issuance of common stock, net of transaction costs	—	31,727,550	—	—	21,744	243,096	—	—	264,840
Issuance of common stock under employee stock purchase plan	—	312,257	—	—	203	840	—	—	1,043
Exchange of exchangeable senior notes, net of transaction costs	—	7,716,046	—	—	5,011	24,358	—	—	29,369
Conversion of Series A Convertible Preferred Stock, net	(38,867,180)	3,886,718	—	(2,514)	2,514	(39)	—	—	(39)
Exercise of stock options	—	8,138,305	—	—	5,309	21,093	—	—	26,402
Vesting of restricted stock units	—	4,610,943	(1,563,817)	—	3,114	(3,114)	(6,184)	—	(6,184)
Stock-based compensation	—	—	—	—	—	18,662	—	—	18,662
Loss for the period	—	—	—	—	—	—	—	(116,445)	(116,445)
December 31, 2018	**289,317,460**	**329,110,863**	**(3,260,850)**	**$ 21,850**	**$ 246,663**	**$ 1,282,762**	**$ (10,413)**	**$ (1,388,532)**	**$ 152,330**
Issuance of common stock, net of transaction costs	—	25,555,556	—	—	15,879	424,229	—	—	440,108
Issuance of common stock under employee stock purchase plan	—	123,031	—	—	79	2,086	—	—	2,165
Issuance of common stock for milestone payment	—	257,713	—	—	173	6,043	—	—	6,216
Exercise of stock options	—	5,997,919	—	—	3,876	20,602	—	—	24,478
Vesting of restricted stock units	—	3,969,811	(1,650,142)	—	2,503	(2,503)	(25,487)	—	(25,487)
Stock-based compensation	—	—	—	—	—	31,098	—	—	31,098
Loss for the period	—	—	—	—	—	—	—	(22,645)	(22,645)
December 31, 2019	**289,317,460**	**365,014,893**	**(4,910,992)**	**$ 21,850**	**$ 269,173**	**$ 1,764,317**	**$ (35,900)**	**$ (1,411,177)**	**$ 608,263**
Conversion of Series A Convertible Preferred Stock, net	(289,317,460)	28,931,746	—	(21,850)	18,020	3,326	—	—	(504)
Issuance of common stock under employee stock purchase plan	—	347,153	—	—	225	1,732	—	—	1,957
Exercise of stock options	—	1,623,460	—	—	1,062	4,096	—	—	5,158
Vesting of restricted stock units	—	2,507,748	(975,927)	—	1,635	(1,635)	(15,182)	—	(15,182)
Stock-based compensation	—	—	—	—	—	45,813	—	—	45,813
Loss for the period	—	—	—	—	—	—	—	(18,000)	(18,000)
December 31, 2020	**—**	**398,425,000**	**(5,886,919)**	**$ —**	**$ 290,115**	**$ 1,817,649**	**$ (51,082)**	**$ (1,429,177)**	**$ 627,505**

See the notes to the consolidated financial statements.

AMARIN CORPORATION PLC

CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)

	Year Ended December 31,		
	2020	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net loss	$ (18,000)	$ (22,645)	$ (116,445)
Adjustments to reconcile net loss to net cash provided by (used in) operating activities:			
Depreciation and amortization	597	180	23
Amortization of investments	1,602	—	—
Stock-based compensation	45,813	30,917	18,806
Amortization of debt discount and debt issuance costs	635	1,644	2,183
Amortization of intangible asset	1,441	679	646
Changes in assets and liabilities:			
Accounts receivable, net	(38,144)	(49,907)	(21,205)
Inventory	(112,095)	(18,967)	(27,542)
Prepaid and other current assets	(17,636)	(10,366)	510
Other long-term assets	642	(900)	—
Interest receivable	(1,329)	—	—
Accrued interest payable	(428)	(210)	(310)
Deferred revenue	(2,214)	136	1,656
Accounts payable, accrued expenses and other current liabilities	114,741	65,913	37,602
Other long-term liabilities	2,629	(5,840)	9,373
Net cash used in operating activities	(21,746)	(9,366)	(94,703)
CASH FLOWS FROM INVESTING ACTIVITIES:			
Sale and maturities of securities	301,989	—	—
Purchases of securities	(678,700)	—	—
Purchases of furniture, fixtures and equipment	(252)	(2,478)	(58)
Net cash used in investing activities	(376,963)	(2,478)	(58)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from issuance of common stock, net of transaction costs	—	440,108	264,840
Proceeds from issuance of common stock under employee stock purchase plan	1,957	2,165	1,043
Proceeds from exercise of stock options, net of transaction costs	5,158	24,478	26,402
Payment of transaction costs for conversion of preferred stock	(504)	—	(39)
Payment on debt from royalty-bearing instrument	(50,336)	(31,652)	(14,690)
Transaction costs related to exchange of exchangeable senior notes	—	—	(121)
Taxes related to stock-based awards	(15,182)	(25,487)	(6,184)
Net cash (used in) provided by financing activities	(58,907)	409,612	271,251
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS AND RESTRICTED CASH	(457,616)	397,768	176,490
CASH AND CASH EQUIVALENTS AND RESTRICTED CASH, BEGINNING OF PERIOD	648,495	250,727	74,237
CASH AND CASH EQUIVALENTS AND RESTRICTED CASH, END OF PERIOD	$ 190,879	$ 648,495	$ 250,727
Supplemental disclosure of cash flow information:			
Cash paid during the year for:			
Interest	$ 2,043	$ 4,591	$ 21,527
Income taxes	$ 207	$ 67	$ 850
Supplemental disclosure of non-cash transactions:			
Laxdale milestone	$ —	$ 8,457	$ —
Initial recognition of operating lease right-of-use asset	$ —	$ 8,995	$ —
Exchange of exchangeable senior notes into common stock	$ —	$ —	$ 29,490
Conversion of Series A Convertible Preferred Stock into common stock	$ 18,020	$ —	$ 2,514

See the notes to the consolidated financial statements.

(1) Nature of Business and Basis of Presentation

Nature of Business

Amarin Corporation plc, or Amarin, or the Company, is a pharmaceutical company focused on the commercialization and development of therapeutics to improve cardiovascular health and reduce cardiovascular risk.

The Company's lead product, VASCEPA® (icosapent ethyl), was first approved by the United States Food and Drug Administration, or FDA, in July 2012 for use as an adjunct to diet to reduce triglyceride, or TG, levels in adult patients with severe (≥500 mg/dL) hypertriglyceridemia. In January 2013, the Company launched 1-gram size VASCEPA in the United States, or U.S., and in October 2016, introduced a smaller 0.5-gram capsule size. On December 13, 2019, the FDA approved a new indication and label expansion for VASCEPA based on the results of the Company's long-term cardiovascular outcomes trial, REDUCE-IT®, or Reduction of Cardiovascular Events with EPA – Intervention Trial. VASCEPA is approved by the FDA as an adjunct to maximally tolerated statin therapy for reducing persistent cardiovascular risk in select high risk patients. VASCEPA is also available for sale by prescription only in Canada, Lebanon and the United Arab Emirates through collaborations and is also in development in other jurisdictions.

On March 30, 2020, the United States District Court for the District of Nevada, or the Nevada Court, ruled in favor of two generics companies in Amarin's patent litigation related to its abbreviated new drug applications, or ANDAs, that seek FDA approval for sale of generic versions of VASCEPA for the original indication of VASCEPA as an adjunct to diet to reduce TG levels in adult patients with severe (≥500 mg/dL) hypertriglyceridemia. On May 22, 2020 and August 10, 2020, the two generics companies, Hikma Pharmaceutical USA Inc., or Hikma, and Dr. Reddy's Laboratories, Inc., or Dr. Reddy's, respectively, received FDA approval to market its generic versions of VASCEPA. On September 3, 2020, the U.S. Court of Appeals for the Federal Circuit, or the Federal Circuit, upheld the March ruling by the Nevada Court in favor of the two generics companies. On October 2, 2020, the Company filed a combined petition for panel rehearing or rehearing *en banc*. On November 4, 2020, the Company's rehearing and *en banc* petitions were denied. On February 11, 2021, Amarin filed a petition for a writ of certiorari with the United States Supreme Court to ask the Court to hear the Company's appeal in this litigation.

In August 2020, the Company announced plans to launch icosapent ethyl under the brand name VAZKEPA®, hereinafter along with the U.S. brand name VASCEPA, collectively referred to as VASCEPA, in major markets in Europe through the Company's new European sales and marketing teams. On January 29, 2021, the Committee for Medicinal Products for Human Use, or CHMP, of the European Medicines Agency, or EMA, adopted a positive opinion, recommending that a marketing authorization be granted to icosapent ethyl in the European Union, or EU, for the reduction of risk of cardiovascular events in patients at high cardiovascular risk. The CHMP recommendation is now expected to be reviewed by the European Community, or EC, with a decision expected to take place within 67 days of the CHMP opinion.

In November 2020, the Company announced topline results from the Phase 3 clinical trial of VASCEPA conducted by the Company's partner in China. On February 9, 2021, the Company announced that regulatory review processes for approval of VASCEPA in Mainland China and Hong Kong have commenced. The Chinese National Medical Products Administration, or NMPA, has accepted for review the new drug application for VASCEPA based on the results from the Phase 3 clinical trial and the results from the Company's prior studies of VASCEPA. The Hong Kong Department of Health is evaluating VASCEPA based on current approvals in the United States and Canada.

The Company currently has strategic collaborations to develop and commercialize VASCEPA in select territories outside the United States. Amarin is responsible for supplying VASCEPA to all markets in which the product is sold, including in Canada, Lebanon and the United Arab Emirates where the drug is promoted and sold via collaboration with third-party companies that compensate Amarin for such supply. Amarin is not responsible for providing any generic company with drug product. The Company operates in one business segment.

Basis of Presentation

The consolidated financial statements included herein have been prepared by the Company in accordance with accounting principles generally accepted in the United States and pursuant to the rules and regulations of the Securities and Exchange Commission, or the SEC.

The consolidated financial statements reflect all adjustments of a normal and recurring nature that, in the opinion of management, are necessary to present fairly the Company's financial position, results of operations and cash flows for the periods indicated. The preparation of the Company's consolidated financial statements in conformity with U.S. Generally Accepted Accounting Principles, or

GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. The results of operations for the years ended December 31, 2020, 2019 and 2018 are not necessarily indicative of the results for any future period. Certain numbers presented throughout this document may not add precisely to the totals provided due to rounding. Absolute and percentage changes are calculated using the underlying amounts in thousands. The consolidated financial statements include the accounts of the Company and its wholly-owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation.

The accompanying consolidated financial statements of the Company and subsidiaries have been prepared on a basis which assumes that the Company will continue as a going concern, which contemplates the realization of assets and the satisfaction of liabilities and commitments in the normal course of business, as well as the current global pandemic, COVID-19.

At December 31, 2020, the Company had Total assets of $966.0 million, of which $563.4 million consisted of cash and liquid short-term and long-term investments. More specifically, the Company had Current assets of $879.2 million, including Cash and cash equivalents of $187.0 million, Short-term investments of $314.0 million, Accounts receivable, net, of $154.6 million and Inventory of $188.9 million. In addition, at December 31, 2020, the Company had Long-term investments of $62.5 million. At December 31, 2020, the Company had no debt outstanding.

(2) Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of the Company and its wholly-owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

Accounting estimates are based on historical experience and other factors that are considered reasonable under the circumstances. Estimates are used in determining such items as provisions for sales returns, rebates and incentives, chargebacks, and other sales allowances; depreciable/amortizable lives; asset impairments; valuation allowance on deferred taxes; probabilities of achievement of performance conditions for certain equity awards; amounts recorded for licensing revenue; contingencies and accruals; and valuations of derivative and long-term debt instruments. Because of the uncertainties inherent in such estimates, actual results may differ from these estimates. Management periodically evaluates estimates used in the preparation of the consolidated financial statements for continued reasonableness.

Use of Forecasted Financial Information in Accounting Estimates

The use of forecasted financial information is inherent in many of the Company's accounting estimates including, but not limited to, determining the estimated fair values of derivatives, debt instrument and intangible assets, evaluating the need for valuation allowances for deferred tax assets, and assessing the Company's ability to continue as a going concern. Such forecasted financial information is comprised of numerous assumptions regarding the Company's future revenues, cash flows, and operational results. Management believes that its financial forecasts are reasonable and appropriate based upon current facts and circumstances. Because of the inherent nature of forecasts, however, actual results may differ from these forecasts. Management regularly reviews the information related to these forecasts and adjusts the carrying amounts of the applicable assets prospectively, if and when actual results differ from previous estimates.

Revenue Recognition

In accordance with Accounting Standards Codification, or ASC, Topic 606, *Revenue from Contracts with Customers*, or Topic 606, the Company recognizes revenue when its customer obtains control of promised goods or services, in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. To determine revenue recognition for arrangements that an entity determines are within the scope of Topic 606, the entity performs the following five steps: (i) identify the contract(s) with a customer; (ii) identify the performance obligations in the contract; (iii) determine the transaction price; (iv) allocate the transaction price to the performance obligations in the contract; and (v) recognize revenue when (or as) the entity satisfies a performance obligation. The Company only applies the five-step model to contracts when it is probable that the entity will collect the consideration it is entitled to in exchange for the goods or services it transfers to the customer. At contract inception, once the contract is determined to be within the scope of Topic 606, the Company assesses the goods or services promised within each contract and determines those that are performance obligations and assesses whether each promised good or service is distinct. The Company then recognizes as revenue the amount of the transaction price that is allocated to the respective performance obligation when (or as) the performance obligation is satisfied. For a complete discussion of accounting for net product revenue and licensing revenue, see Note 14—Revenue Recognition.

Distribution Costs

The Company records distribution costs related to shipping product to its customers, primarily through the use of common carriers or external distribution services, in Cost of goods sold.

Cash and Cash Equivalents and Restricted Cash

Cash and cash equivalents consist of cash, deposits with banks and short-term highly liquid money market instruments with remaining maturities at the date of purchase of 90 days or less. Restricted cash represents cash and cash equivalents pledged to guarantee repayment of certain expenses which may be incurred for business travel under corporate credit cards held by employees.

Accounts Receivable, net

Accounts receivable, net, comprised of trade receivables, are generally due within 30 days and are stated at amounts due from customers. The Company recognizes an allowance for losses on accounts receivable in an amount equal to the estimated probable losses net of any recoveries. The allowance is based primarily on assessment of specific identifiable customer accounts considered at risk or uncollectible, as well as an analysis of current receivables aging and expected future write-offs. The expense associated with the allowance for doubtful accounts is recognized as Selling, general, and administrative expense. The Company has not historically experienced any significant credit losses. All customer accounts are actively managed and no losses in excess of amounts reserved are currently expected; however, the Company is monitoring the potential negative impact of COVID-19 on the Company's customers' ability to meet their financial obligations.

The following table summarizes the impact of accounts receivable reserves on the gross trade accounts receivable balances at December 31, 2020 and 2019:

In thousands	December 31, 2020	December 31, 2019
Gross trade accounts receivable	$ 203,875	$ 149,567
Trade allowances	(36,242)	(29,261)
Chargebacks	$ (12,114)	(3,876)
Allowance for doubtful accounts	(945)	—
Accounts receivable, net	$ 154,574	$ 116,430

Inventory

The Company states inventories at the lower of cost or net realizable value. Cost is determined based on actual cost using the average cost method. Net realizable value is the estimated selling price in the ordinary course of business, less reasonably predictable costs of completion, disposal, and transportation. An allowance is established when management determines that certain inventories may not be saleable. If inventory cost exceeds expected net realizable value due to obsolescence, damage or quantities in excess of expected demand, changes in price levels or other causes, the Company will reduce the carrying value of such inventory to net realizable value and recognize the difference as a component of cost of goods sold in the period in which it occurs. The Company capitalizes inventory purchases of saleable product from approved suppliers while inventory purchases from suppliers prior to regulatory approval are included as a component of research and development expense. The Company expenses inventory identified for use as marketing samples when they are packaged. The average cost reflects the actual purchase price of VASCEPA active pharmaceutical ingredient, or API.

Long-Lived Asset Impairment

The Company reviews its long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of such assets may not be recoverable. Recoverability of these assets is determined by comparing the forecasted undiscounted net cash flows of the operation to which the assets relate to their carrying amount. If impairment is indicated, the assets are written down to fair value. Fair value is determined based on discounted forecasted cash flows or appraised values, depending on the nature of the assets.

Intangible Asset, net

Intangible asset, net consists of milestone payments to the former shareholders of Laxdale Limited, or Laxdale, related to the 2004 acquisition of the rights to VASCEPA, which is the result of VASCEPA receiving marketing approval in the U.S. for the first indication in 2012 and the expanded label in 2019 and is amortized over its estimated useful life on a straight-line basis. See Note 8—Commitments and Contingencies for further information regarding other obligations related to the acquisition of Laxdale Limited.

Costs for Patent Litigation and Legal Proceedings

Costs for patent litigation or other legal proceedings are expensed as incurred and included in Selling, general and administrative expense.

Research and Development Costs

The Company charges research and development costs to operations as incurred. Research and development expenses are comprised of costs incurred by the Company in performing research and development activities, including: salary and benefits; stock-based compensation expense; laboratory supplies and other direct expenses; contractual services, including clinical trial and pharmaceutical development costs; commercial supply investment in its drug candidates; and infrastructure costs, including facilities costs and depreciation expense. In addition, research and development costs include the costs of product supply received from suppliers when such receipt by the Company is prior to regulatory approval of the supplier, as well as license fees related to the Company's strategic collaboration with Mochida Pharmaceutical Co., Ltd., or Mochida.

Selling, General and Administrative Costs

The Company charges selling, general and administrative costs to operations as incurred. Selling, general and administrative costs include salaries and benefits, stock-based compensation expense, and costs of programs and infrastructure necessary for the general conduct of the Company's business, including those incurred as a result of the commercialization of VASCEPA in the United States as well as co-promotion fees to Kowa Pharmaceuticals America, Inc. which in 2018 included costs for accrual of tail co-promotion fees.

Income Taxes

Deferred tax assets and liabilities are recognized for the future tax consequences of differences between the carrying amounts and tax bases of assets and liabilities and operating loss carryforwards and other tax attributes using enacted rates expected to be in effect when those differences reverse. Valuation allowances are provided against deferred tax assets that are not more likely than not to be realized. Deferred tax assets and liabilities are classified as non-current in the consolidated balance sheet.

The Company provides reserves for potential payments of tax to various tax authorities and does not recognize tax benefits related to uncertain tax positions and other issues. Tax benefits for uncertain tax positions are based on a determination of whether a tax benefit taken by the Company in its tax filings or positions is more likely than not to be realized, assuming that the matter in question will be decided based on its technical merits. The Company's policy is to record interest and penalties in the provision for income taxes, as applicable.

The Company regularly assesses its ability to realize deferred tax assets. Changes in historical earnings performance, future earnings projections, and changes in tax laws, among other factors, may cause the Company to adjust its valuation allowance on deferred tax assets, which would impact the Company's income tax expense in the period in which it is determined that these factors have changed.

Excess tax benefits and deficiencies that arise upon vesting or exercise of share-based payments are recognized as an income tax benefit and expense, respectively, in the statement of operations. Excess income tax benefits are classified as cash flows from operating activities and cash paid to taxing authorities arising from the withholding of shares from employees are classified as cash flows from financing activities.

The Company's and its subsidiaries' income tax returns are periodically examined by various tax authorities, including the Internal Revenue Service, or IRS, and states. The Company is currently under audit by the IRS for the Company's 2018 U.S. income tax return and by the New Jersey Department of Treasury for the years 2012 to 2015. Although the outcome of tax audits is always uncertain and could result in significant cash tax payments, the Company does not believe the outcome of these audits will have a material adverse effect on its consolidated financial position or results of operations.

Loss per Share

Basic net loss per share is determined by dividing net loss by the weighted average shares of common stock outstanding during the period. Diluted net loss per share is determined by dividing net loss by diluted weighted average shares outstanding. Diluted weighted average shares reflects the dilutive effect, if any, of potentially dilutive common shares, such as common stock options calculated using the treasury stock method and convertible notes using the "if-converted" method. In periods with reported net operating losses, all common stock options are deemed anti-dilutive such that basic net loss per share and diluted net loss per share are equal.

The Company's preferred stock is entitled to receive dividends on an as-if-converted basis in the same form as dividends actually paid on common shares. Accordingly, the preferred stock is considered a participating security and the Company is required to apply the two-class method to consider the impact of the preferred stock on the calculation of basic and diluted earnings per share. The

Company is currently in a net loss position and is therefore not required to present the two-class method, however, in the event the Company is in a net income position, the two-class method must be applied by allocating all earnings during the period to common shares and preferred stock based on their contractual entitlements assuming all earnings were distributed.

The calculation of net loss and the number of shares used to compute basic and diluted net loss per share for the years ended December 31, 2020, 2019, and 2018 are as follows:

In thousands	2020	2019	2018
Net loss—basic and diluted	$ (18,000)	$ (22,645)	$ (116,445)
Weighted average shares outstanding—basic and diluted	381,759	342,538	297,237
Net loss per share—basic and diluted	$ (0.05)	$ (0.07)	$ (0.39)

For the years ended December 31, 2020, 2019 and 2018, the following potentially dilutive securities were not included in the computation of net loss per share because the effect would be anti-dilutive:

In thousands	2020	2019	2018
Stock options	16,664	15,619	19,263
Restricted stock and restricted stock units	7,710	6,921	9,633
Preferred stock (if converted)	—	28,932	28,932

Stock options are anti-dilutive during periods of net earnings when the exercise price of the stock options exceeds the market price of the underlying shares on the last day of the reporting period. Restricted stock and restricted stock units are anti-dilutive during periods of net earnings when underlying performance-based vesting requirements were not achieved as of the last day of the reporting period.

Debt Instruments

Debt instruments are initially recorded at fair value, with coupon interest and amortization of debt issuance discounts recognized in the consolidated statement of operations as interest expense each period in which such instruments are outstanding. The Company records debt issuance costs related to a recognized debt liability in the consolidated balance sheets as a direct deduction from the carrying amount of that debt liability and amortized to interest expense using the effective interest method over the expected term of the related debt. Unamortized debt issuance costs related to the extinguishment of debt are expensed at the time the debt is extinguished and recorded in Other income (expense), net, in the consolidated statements of operations. If the Company issues shares to discharge the liability, the debt obligation is derecognized and common stock and additional paid-in capital are recognized upon the issuance of those shares.

Stock-Based Compensation

Stock-based compensation cost is generally measured at the grant date, based on the fair value of the award, and is recognized as compensation expense over the requisite service period. For awards with performance conditions, if the achievement of the performance conditions is deemed probable, the Company recognizes compensation expense based on the fair value of the award over the estimated service period. The Company reassesses the probability of achievement of the performance conditions for such awards each reporting period. The Company estimates the level of forfeitures expected to occur based on its historical data and records compensation cost only for those awards that are ultimately expected to vest. See Note 11—Stock Incentive Plans and Stock-Based Compensation for further discussion.

Concentration of Credit Risk

Financial instruments that potentially subject the Company to credit risk consist primarily of cash and cash equivalents, short-term and long-term investments, and accounts receivable. The Company maintains substantially all of its cash and cash equivalents in financial institutions believed to be of high-credit quality.

A significant portion of the Company's sales are to wholesalers in the pharmaceutical industry. The Company monitors the creditworthiness of customers to whom it grants credit terms and has not experienced any credit losses. The Company does not require collateral or any other security to support credit sales. Three customers individually accounted for 10% or more of the Company's gross product sales. Customers A, B, and C accounted for 38%, 29%, and 25%, respectively, of gross product sales for the year ended December 31, 2020 and represented 31%, 18%, and 37%, respectively, of the gross accounts receivable balance as of December 31, 2020. Customers A, B, and C accounted for 36%, 29% and 25%, respectively, of gross product sales for the year ended December 31, 2019 and represented 35%, 20%, and 37%, respectively, of the gross accounts receivable balance as of December 31, 2019. The Company has not experienced any significant write-offs of its accounts receivable.

Concentration of Suppliers

The Company has contractual freedom to source the API for VASCEPA and to procure other services supporting its supply chain and has entered into supply agreements with multiple suppliers. The Company's supply of product for commercial sale and clinical trials is dependent upon relationships with third-party manufacturers and suppliers.

The Company cannot provide assurance that its efforts to procure uninterrupted supply of VASCEPA to meet market demand will continue to be successful or that it will be able to renew current supply agreements on favorable terms or at all. Significant alteration to or disruption or termination of the Company's current supply chain, including as a result of COVID-19, or the Company's failure to enter into new and similar agreements in a timely fashion, if needed, could have a material adverse effect on its business, condition (financial and other), prospects or results of operations.

The Company currently has manufacturing agreements with multiple independent FDA-approved API manufacturers and several independent FDA-approved API encapsulators and packagers for VASCEPA manufacturing. Each of these companies has qualified and validated its manufacturing processes and is capable of manufacturing VASCEPA. There can be no guarantee that these or other suppliers with which the Company may contract in the future to manufacture VASCEPA or VASCEPA API will remain qualified to do so to its specifications or that these and any future suppliers will have the manufacturing capacity to meet anticipated demand for VASCEPA.

Foreign Currency

Monetary assets and liabilities denominated in a foreign currency are remeasured into U.S. dollars at period-end exchange rates. Gains and losses from the remeasurement are included in Other income (expense), net in the consolidated statements of operations. For transactions settled during the applicable period, gains and losses are included in Other income (expense), net in the consolidated statements of operations. Certain amounts payable pursuant to supply contracts are denominated in currencies other than the U.S. dollar.

Fair Value of Financial Instruments

The Company provides disclosure of financial assets and financial liabilities that are carried at fair value based on the price that would be received upon sale of an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements may be classified based on the amount of subjectivity associated with the inputs to fair valuation of these assets and liabilities using the following three levels:

Level 1—Inputs are unadjusted quoted prices in active markets for identical assets or liabilities that the Company has the ability to access at the measurement date.

Level 2—Inputs include quoted prices for similar assets and liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, inputs other than quoted prices that are observable for the asset or liability (i.e., interest rates, yield curves, etc.) and inputs that are derived principally from or corroborated by observable market data by correlation or other means (market corroborated inputs).

Level 3—Unobservable inputs that reflect the Company's estimates of the assumptions that market participants would use in pricing the asset or liability. The Company develops these inputs based on the best information available, including its own data.

The following tables present information about the estimated fair value of the Company's assets and liabilities as of December 31, 2020 and 2019 and indicate the fair value hierarchy of the valuation techniques the Company utilized to determine such fair value:

In thousands	December 31, 2020 Total	Level 1	Level 2	Level 3
Asset:				
Money Market Fund	$ 88,266	$ 88,266	$ —	$ —
U.S. Treasury Shares	48,356	48,356	—	—
Corporate Bonds	179,864	—	179,864	—
Commercial Paper	106,650	—	106,650	—
Agency Securities	20,782	—	20,782	—
Repo Securities	10,000	—	10,000	—
Asset Backed Securities	8,599	—	8,599	—
Certificate of Deposit	6,125	—	6,125	—
Non-US Government	5,240	—	5,240	—
Total	$ 473,882	$ 136,622	$ 337,260	$ —

In thousands	December 31, 2019 Total	Level 1	Level 2	Level 3
Asset:				
Money Market Fund	$ 10,078	$ 10,078	$ —	$ —

The carrying amount of the Company's cash and cash equivalents approximates fair value because of their short-term nature. The cash and cash equivalents consist of cash, deposits with banks and short-term highly liquid money market instruments with remaining maturities at the date of the purchase of 90 days or less.

The Company's held-to-maturity investments are stated at amortized cost, which approximates fair value. The Company does not intend to sell these investment securities and the contractual maturities are not greater than 24 months. Those with maturities greater than 90 days and less than twelve months are included in short-term investments on its consolidated balance sheet. Those with remaining maturities in excess of twelve months are included in long-term investments on its consolidated balance sheet.

Unrealized gains or losses on held-to-maturity securities are not recognized until maturity, except other-than-temporary unrealized losses which are recognized in earnings in the period incurred. The Company evaluates securities with unrealized losses to determine whether such losses are other than temporary. The unrealized gain for the year ended December 31, 2020 and 2019 was $0.5 million and nil, respectively. Interest on investments is reported in interest income.

The carrying amounts of accounts payable and accrued liabilities approximate fair value because of their short-term nature. The carrying amounts and the estimated fair values of the debt from royalty-bearing instrument as of December 31, 2020 and 2019 are as follows:

In thousands	December 31, 2020 Carrying Value	Estimated Fair Value	December 31, 2019 Carrying Value	Estimated Fair Value
Debt from royalty-bearing instrument	$ —	$ —	$ 49,702	$ 50,400

The estimated fair value of the debt from royalty-bearing instrument was calculated utilizing the same Level 3 inputs utilized in valuing the related derivative liability (see Derivative Liabilities below). The carrying value of the debt from royalty-bearing instrument was net of the unamortized debt discounts and issuance costs as of both December 31, 2020 and 2019.

Derivative Liabilities

Derivative financial liabilities are recorded at fair value, with gains and losses arising for changes in fair value recognized in the consolidated statement of operations at each period end while such instruments are outstanding. If the Company issues shares to discharge the liability, the derivative financial liability is derecognized and common stock and additional paid-in capital are recognized on the issuance of those shares.

Long-Term Debt Redemption Feature

The Company's December 2012 royalty-bearing instrument financing arrangement (discussed in Note 7—Debt) was repaid in quarterly increments from 2013 through 2020. After the quarterly payment in the fourth quarter of 2020, the instrument has been fully repaid. This royalty-bearing instrument contained a redemption feature whereby, upon a change of control, the Company would have

been required to repay $150.0 million, less any previously repaid amount. The Company determined this redemption feature was an embedded derivative, which was carried at fair value and was classified as Level 3 in the fair value hierarchy due to the use of significant unobservable inputs. The fair value of the embedded derivative was calculated using a probability-weighted model incorporating management estimates of future revenues and for a potential change in control, and by determining the fair value of the debt with and without the change in control provision included.

As of December 31, 2020, having fully repaid the royalty-bearing instrument, the fair value and carrying value are both nil. The fair value of this derivative liability was remeasured at each reporting period, with changes in fair value recognized in the consolidated statement of operations. As of December 31, 2019, the fair value of the derivative was determined to be nil based on underlying assumptions, and the debt was valued by comparing debt issues of similar companies with (i) remaining terms of between 1.9 and 7.3 years, (ii) coupon rates of between 6.0% and 11.5% and (iii) market yields of between 5.2% and 16.8%.

Segment and Geographical Information

Operating segments are defined as components of an enterprise about which separate financial information is available that is evaluated on a regular basis by the chief operating decision-maker, or decision-making group, in deciding how to allocate resources to an individual segment and in assessing performance of the segment. The Company currently operates in one business segment, which is the development and commercialization of VASCEPA. A single management team that reports to the Company's chief decision-maker, who is the Chief Executive Officer, comprehensively manages the business. Accordingly, the Company does not have separately reportable segments.

Recent Accounting Pronouncements

From time to time, new accounting pronouncements are issued by the Financial Accounting Standards Board, or FASB, and are early adopted by the Company or adopted as of the specified effective date.

In November 2018, the FASB issued ASU No. 2018-18, *Collaborative Arrangements (Topic 808)*, Clarifying the Interaction between Topic 808 and Topic 606, which clarified that in collaborative arrangements where the counterparty is a customer for a good or service that is a distinct unit of account is required to be accounted for under ASC 606. The Company adopted this standard effective January 1, 2020, which did not have an impact on the Company's consolidated financial statements.

In August 2018, the FASB issued ASU No. 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework—Changes to the Disclosure Requirements for Fair Value Measurement*, which eliminates, adds and modifies certain disclosure requirements for fair value measurements, including eliminating the requirement to disclose the amount of and reasons for transfers between Level 1 and Level 2 of the fair value hierarchy, and requiring disclosure of the range and weighted average used to develop significant unobservable inputs for Level 3 fair value measurements. The Company adopted this standard effective January 1, 2020, which did not have a material impact on the Company's consolidated financial statements.

In June 2016, the FASB issued ASU No. 2016-13, *Financial Instruments – Credit Losses (Topic 326), Measurement of Credit Losses on Financial Instruments*, which requires earlier recognition of credit losses on loans and other financial instruments held by entities, including trade receivables. The new standard requires entities to measure all expected credit losses for financial assets held at each reporting date based on historical experience, current conditions, and reasonable and supportable forecasts. The Company adopted this standard effective January 1, 2020, which did not have a material impact on the Company's consolidated financial statements.

The Company also considered the following recent accounting pronouncement which was not yet adopted as of December 31, 2020:

In December 2019, the FASB issued ASU No. 2019-12, *Income Taxes (Topic 740), Simplifying the Accounting for Income Taxes*, which simplifies the accounting for income taxes by eliminating certain exceptions to the guidance in ASC 740 related to the approach for intraperiod tax allocation, the methodology for calculating income taxes in an interim period, the recognition of deferred tax liabilities for outside basis differences, among other simplifications. The new guidance is effective for fiscal years beginning after December 15, 2020, including interim periods within those fiscal years. Early adoption of all amendments in the same period is permitted. The Company has evaluated the standard and does not expect it to have a material impact on the Company's consolidated financial statements.

The Company believes that the impact of other recently issued but not yet adopted accounting pronouncements will not have a material impact on the Company's consolidated financial position, results of operations, and cash flows, or do not apply to the Company's operations.

(3) Intangible Asset

Intangible asset consists of the historical acquisition cost of certain technology rights for VASCEPA. Upon approval by FDA on December 13, 2019 of a new indication of VASCEPA, a milestone for £5 million was achieved, which resulted in the Intangible asset increasing by $8.5 million. Refer to Note 9 — Equity for further discussion of the milestone payment. The Intangible asset has an estimated weighted-average remaining useful life of 9.6 years. The carrying value as of December 31, 2020 and 2019 is as follows:

In thousands	December 31, 2020	December 31, 2019
Technology rights	$ 20,081	$ 20,081
Accumulated amortization	(6,264)	(4,823)
Intangible asset, net	$ 13,817	$ 15,258

Amortization expense for the years ended December 31, 2020 and 2019 was $1.4 million and $0.7 million, respectively. Estimated future amortization expense, based upon the Company's intangible asset, as of December 31, 2020 is as follows:

In thousands	
Year Ending December 31,	Amount
2021	$ 1,442
2022	1,442
2023	1,442
2024	1,442
2025	1,442
Thereafter	6,607
Total	$ 13,817

(4) Inventory

The Company capitalizes its purchases of saleable inventory of VASCEPA from suppliers that have been qualified by the FDA. Inventories as of December 31, 2020 and 2019 consist of the following:

In thousands	December 31, 2020	December 31, 2019
Raw materials	$ 50,657	$ 19,455
Work in process	30,388	12,031
Finished goods	107,819	45,283
Inventory	$ 188,864	$ 76,769

(5) Property, Plant and Equipment

Property, plant and equipment as of December 31, 2020 and 2019 consist of the following:

In thousands	Useful Life (in years)	December 31, 2020	December 31, 2019
Furniture and fixtures	5	$ 1,699	$ 1,636
Leasehold improvements	lesser of useful life or lease term	1,026	714
Software	3 - 5	617	617
Computer equipment	3 - 5	290	290
Construction in progress		—	123
Property, plant and equipment		3,632	3,380
Accumulated depreciation and amortization		(1,616)	(1,019)
Property, plant and equipment, net		$ 2,016	$ 2,361

The Company provides for depreciation and amortization using the straight-line method by charges to operations in amounts that depreciate the cost of the fixed asset over its estimated useful life. Depreciation expense for the years ended December 31, 2020, 2019, and 2018 were $0.6 million, $0.2 million, and less than $0.1 million, respectively. Upon retirement or sale of assets, the cost of the assets disposed and the related accumulated depreciation are removed from the consolidated balance sheet and any resulting gain or loss is credited or expensed to operations. Repairs and maintenance costs are expensed as incurred.

(6) Accrued Expenses and Other Current Liabilities

Accrued expenses and other current liabilities consist of the following as of December 31, 2020 and 2019:

In thousands	December 31, 2020	December 31, 2019
Payroll and payroll-related expenses	$ 22,772	$ 21,204
Sales and marketing accruals	6,220	8,221
Accrued revenue allowances	140,863	93,815
All other	28,786	16,586
Accrued expenses and other current liabilities	$ 198,641	$ 139,826

(7) Debt

Debt from Royalty-Bearing Instrument—December 2012 Financing

On December 6, 2012, the Company entered into a Purchase and Sale Agreement with BioPharma Secured Debt Fund II Holdings Cayman LP, or BioPharma. Under this agreement, the Company granted to BioPharma a security interest in future receivables associated with the VASCEPA patent rights, in exchange for $100.0 million received at the closing of the agreement which occurred in December 2012. In the agreement, the Company agreed to repay BioPharma up to $150.0 million with such repayment based on a portion of net revenues and receivables generated from VASCEPA. On December 20, 2017, BioPharma assigned all rights under this agreement to CPPIB Credit Europe S.à r.l., or CPPIB.

As of December 31, 2020, the $150.0 million was repaid in full to CPPIB and as such, the Company has no outstanding debt. During the year ended December 31, 2020, the Company made repayments under the agreement of $52.4 million to CPPIB, with the final payment owed to CPPIB being made in November 2020 for $9.6 million.

During the year ended December 31, 2020, the Company recorded cash and non-cash interest expense of $1.6 million and $0.6 million, respectively, in connection with the royalty-bearing instrument. During the year ended December 31, 2019, the Company recorded $4.4 million and $1.6 million of cash and non-cash interest expense, respectively, in connection with the royalty-bearing instrument.

(8) Commitments and Contingencies

Litigation

On February 22, 2019, a purported investor in the Company's publicly traded securities filed a putative class action lawsuit against Amarin Corporation plc, the chief executive officer and chief scientific officer in the U.S. District Court for the District of New Jersey, *Debendra Sharma v. Amarin Corporation plc, John F. Thero and Steven Ketchum*, No. 2:19-cv-06601 (D.N.J. Feb. 22, 2019). On March 12, 2019, another purported investor filed a substantially similar lawsuit captioned *Richard Borghesi v. Amarin Corporation plc, John F. Thero and Steven Ketchum*, No. 3:19-cv-08423 (D.N.J. March 12, 2019). On May 14, 2019 the court consolidated the cases under the caption *In re Amarin Corporation PLC Securities Litigation*, No. 3:19-cv-06601 and appointed two other purported shareholders, Dan Kotecki and the Gaetano Cecchini Living Trust, as Co-Lead Plaintiffs.

Co-Lead Plaintiffs filed a consolidated amended complaint, or Amended Complaint, on July 22, 2019 that adds as defendants the Company's current chief medical officer and the Company's former chief executive officer, who is a current director. The Amended Complaint alleges that from September 24, 2018 to November 9, 2018 the Company misled investors by releasing topline results for the REDUCE-IT study without disclosing data on biomarker increases in the placebo group as compared with baseline measurement. The Amended Complaint alleges that these data suggest that the mineral oil placebo used in the REDUCE-IT study may have interfered with statin absorption in the placebo group, which they allege may have increased adverse outcomes in the placebo group. The Amended Complaint further alleges that these purported misrepresentations and omissions inflated the share price. Based on these allegations, the suit asserts claims under the Securities Exchange Act of 1934 and seeks unspecified monetary damages and attorneys' fees and costs.

A court determination on the Company's motion to dismiss this litigation is pending. The Company believes that it has valid defenses and will vigorously defend against the claims, but cannot predict the outcome. The Company is unable to reasonably estimate the loss exposure, if any, associated with these claims. The Company has insurance coverage that is anticipated to cover any significant loss exposure that may arise from this action after payment by the Company of the associated deductible obligation.

In September and October 2016, the Company received paragraph IV certification notices from four companies contending to varying degrees that certain of its patents are invalid, unenforceable and/or will not be infringed by the manufacture, use, sale or offer for sale of a generic form of VASCEPA as described in those companies' ANDAs. The Company filed patent infringement lawsuits against three of these four ANDA applicants. In October 2016, Amarin filed a lawsuit against Roxane Laboratories, Inc. and related parties (collectively, "Roxane") in the Nevada Court. The case against Roxane was captioned *Amarin Pharma, Inc. et al. v. Roxane*

Laboratories, Inc. et al., Civ. A. No. 2:16-cv-02525 (D. Nev.). According to a stipulation filed with the Nevada Court, in December 2016, Roxane transferred its ANDA to West-Ward Pharmaceuticals International Limited, which then designated West-Ward Pharmaceuticals Corp. (or together with West-Ward Pharmaceuticals International Limited, West-Ward) as its agent for FDA communications. In view of the ANDA transfer, in February 2017, West-Ward replaced Roxane and related parties as Defendants in the above-referenced case. The case against West-Ward was then captioned *Amarin Pharma, Inc. et al. v. West-Ward Pharmaceuticals Corp. et al.*, Civ. A. No. 2:16-cv-02525 (D. Nev.). In November 2016, the Company filed a lawsuit against Dr. Reddy's Laboratories, Inc. and Dr. Reddy's Laboratories, Ltd. (collectively, "DRL") in the U.S. District Court for the District of Nevada. The case against DRL is captioned *Amarin Pharma, Inc. et al. v. Dr. Reddy's Laboratories, Inc. et al.*, Civ. A. No. 2:16-cv-02562 (D. Nev.). In November 2016, the Company filed a lawsuit against Teva Pharmaceuticals USA, Inc. and Teva Pharmaceuticals Industries Limited (collectively, "Teva") in the Nevada Court. The case against Teva was captioned *Amarin Pharma, Inc. et al. v. Teva Pharmaceuticals USA, Inc. et al.*, Civ. A. No. 2:16-cv-02658. In all three lawsuits, the Company sought, among other remedies, an order enjoining each defendant from marketing generic versions of VASCEPA before the last to expire of the asserted patents in 2030.

The fourth ANDA applicant referenced above is Apotex Inc., or Apotex, which sent the Company a paragraph IV certification notice in September 2016. The notice reflected that Apotex made a paragraph IV notice as to some, but not all, of the patents listed in the Orange Book for VASCEPA.

In October 2016, the Company introduced to the market a 0.5-gram dose strength of VASCEPA. In August 2017, as anticipated, the Company received a paragraph IV certification notice from Teva contending that certain of its patents are invalid, unenforceable and/or will not be infringed by the manufacture, use, sale or offer for sale of a generic form of the 0.5-gram dose strength of VASCEPA, as described in the Teva ANDA. This Teva ANDA was filed as an amendment to the 1-gram Teva ANDA and is related to patents already at issue in the 1-gram VASCEPA patent litigation. This certification followed the related listing in the Orange Book of patents associated with the 0.5-gram product in June 2017. This June 2017 listing was within the five-year, post NDA-approval period during which the Hatch-Waxman Amendments require a paragraph IV certification of patent invalidity or non-infringement under the Hatch-Waxman, five-year, NCE regulatory scheme. Accordingly, in October 2017, the Company filed a patent infringement lawsuit against Teva in the U.S. District Court for the District of Nevada. The case was captioned *Amarin Pharma, Inc. et al. v. Teva Pharmaceuticals USA, Inc. et al.,* Civ. A. No. 2:17-cv-2641 (D. Nev.). In this lawsuit, the Company sought, among other remedies, an order enjoining Teva from marketing generic versions of the 0.5-gram dose strength of VASCEPA before the last to expire of the asserted patents in 2030.

On May 24, 2018, the Company entered into a settlement agreement with Teva that resolved its ANDA patent litigation as it relates to Teva's as amended ANDA for both the 1-gram and 0.5-gram dose strengths of VASCEPA. As part of the settlement agreement, Teva may, subject to procurement of product supply, sell a generic version of VASCEPA in the United States now that the U.S. Federal Circuit Court of Appeals issued its mandate following our Nevada Court trial appeal lost at the level. The settlement agreement with Teva also substantially resolved litigation with Teva that could have ensued related to the December 2019 cardiovascular risk reduction indication of VASCEPA based on the REDUCE-IT study.

In July 2018, as anticipated, the Company received a paragraph IV certification notice from DRL contending that certain of its patents are invalid, unenforceable and/or will not be infringed by the manufacture, use, sale or offer for sale of a generic form of the 0.5-gram dose strength of VASCEPA, as described in the DRL ANDA. This DRL ANDA was filed as an amendment to the 1-gram DRL ANDA and is related to patents already at issue in the 1-gram VASCEPA patent litigation. This certification followed the related listing in the Orange Book of patents associated with the 0.5-gram product in June 2017. This June 2017 listing was within the five-year, post NDA-approval period during which the Hatch-Waxman Amendments require a paragraph IV certification of patent invalidity or non-infringement lawsuit against DRL in the U.S. District Court for the District of Nevada. The case is captioned *Amarin Pharma, Inc. et al. v. Dr. Reddy's Laboratories, Inc. et al.,* Civ. A. No. 2:18-cv-01596 (D. Nev.). In this lawsuit, the Company is sought, among other remedies, an order enjoining DRL from marketing generic versions of the 0.5-gram dose strength of VASCEPA before the last to expire of the asserted patents in 2030. In light of the overlap between the cases, DRL and the Company have stipulated that the final judgment on the merits of the parties' contentions in the consolidated 1-gram action shall also be binding in the 0.5-gram case.

The trial for the ANDA patent litigation against defendants DRL and Hikma, and certain of their respective affiliates, or the Defendants, took place in the Nevada Court (case no.: 2:16-cv-02525-MMD-NJK (consolidated with 2:16-cv=02562=MMD-NJK). Following conclusion of the trial in late January 2020, the Nevada Court, on March 30, 2020, decided in favor of the Defendants, ruling that the relevant patents are invalid due to obviousness. Amarin appealed this decision to the Federal Circuit (case no.: 20-1723).

In June 2020, the Company entered into a settlement agreement with Apotex that resolved patent litigation that was expected to result from the ANDA filed by Apotex with the FDA, which ANDA was amended in May 2020, seeking approval of a generic form of VASCEPA capsules based on the MARINE study. As part of the settlement agreement, Apotex may, subject to FDA approval of its ANDA and procurement of product supply, sell a generic version of VASCEPA with MARINE indication labeling in the United

States now that the U.S. Federal Circuit Court of Appeals issued its mandate following our Nevada Court trial appeal loss at the level (the same such date provided for under the 2018 settlement agreement with Teva). The settlement agreement with Apotex also substantially resolved litigation with Apotex that could have ensued related to the December 2019 cardiovascular risk reduction indication of VASCEPA based on the REDUCE-IT study. Apotex may amend its label under our settlement agreement to include the REDUCE-IT indication after expiration of the associated Hatch-Waxman Act regulatory exclusivity expires in December 2022.

On September 3, 2020, the U.S. Court of Appeal for the Federal Circuit upheld the March 2020 trial ruling by the Nevada Court in favor of Hikma and DRL. On October 2, 2020, the Company filed a combined petition for panel rehearing or rehearin *en banc* (case no.: 20-1723-1901), which was denied. On February 11, 2021, the Company filed a petition for a writ of certiorari with the United States Supreme Court to ask the Supreme Court to hear the appeal in this litigation (case no.: 20-1119). That petition is pending.

In November 2020, the Company filed a new patent infringement lawsuit against Hikma in the United States District Court in Delaware. The complaint alleges that Hikma has induced the infringement of VASCEPA-related cardiovascular risk reduction U.S. Patent Nos. 9,700,537 (Composition for preventing the occurrence of cardiovascular event in multiple risk patient), 8,642,077 (Stable pharmaceutical composition and methods of using same), and 10,568,861 (Methods of reducing the risk of a cardiovascular event in a subject at risk for cardiovascular disease) by making, selling, offering to sell and importing generic icosapent ethyl capsules in or into the United States. The Company is seeking remedies including a permanent injunction against Hikma's unlawful inducement of infringing uses of its generic product to reduce cardiovascular risk and monetary damages in an amount sufficient to compensate the Company for such infringement.

In January 2021, the Company expanded the scope of the VASCEPA CV risk reduction patent infringement lawsuit against Hikma to include a health care insurance provider in the United States, Health Net, LLC. Through insurance coverage and economic incentives the Company alleges that Health Net, LLC has actively induced pharmacies to dispense, and patients to use, Hikma generic icosapent ethyl capsules in infringement of the related patents. In the complaint, the Company is seeking remedies including a permanent injunction against the unlawful inducement by Hikma and Health Net, LLC of infringing uses of the Hikma generic product, i.e., uses to reduce cardiovascular risk as detailed in the patents, and monetary damages in an amount sufficient to compensate the Company for such infringement. The Company is considering its legal options against parties similarly situated to Health Net, LLC and Hikma and acting in concert with either by making or selling any drug product or component thereof covered by the subject patents, or inducing others to do the same.

The Company intends to vigorously enforce its intellectual property rights relating to VASCEPA, but cannot predict the outcome of these lawsuits or any subsequently filed lawsuits.

In June 2020, the Company received a civil investigative demand, or CID, from the U.S. Department of Justice, or the DOJ, informing the Company that the DOJ is investigating whether aspects of its promotional speaker programs and copayment waiver program during the period from January 1, 2015 to the present violated the U.S. Anti-Kickback Statute and the U.S. False Claims Act in relation to the sale and marketing of VASCEPA by the Company and its previous co-marketing partner, Kowa Pharmaceuticals America, Inc. The CID requires the Company to produce documents and answer written questions, or interrogatories, relevant to the specified time period. Amarin is cooperating with the DOJ and cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on the Company's business.

In addition to the above, in the ordinary course of business, the Company is from time to time involved in lawsuits, claims, investigations, proceedings, and threats of litigation relating to intellectual property, commercial arrangements and other matters.

Milestone and Supply Purchase Obligations

The Company entered into long-term supply agreements with multiple FDA-approved API suppliers and encapsulators. Certain supply agreements require annual minimum volume commitments by the Company and certain volume shortfalls may require payments for such shortfalls.

These agreements include requirements for the suppliers to meet certain product specifications and qualify their materials and facilities with applicable regulatory authorities including the FDA. The Company has incurred certain costs associated with the qualification of product produced by these suppliers.

Pursuant to the supply agreements, there is a total of approximately $326.1 million that is potentially payable over the term of such agreements based on minimum purchase obligations. The Company continues to meet its contractual purchase obligations.

Under the 2004 share repurchase agreement with Laxdale upon receipt of marketing approval in Europe for the first indication for VASCEPA (or first indication of any product containing intellectual property acquired from Laxdale in 2004), the Company must make an aggregate stock or cash payment to the former shareholders of Laxdale (at the sole option of each of the sellers) of £7.5 million (approximately $10.2 million as of December 31, 2020). Also under the Laxdale agreement, upon receipt of a marketing

approval in Europe for a further indication of VASCEPA (or further indication of any other product acquired from Laxdale in 2004), the Company must make an aggregate stock or cash payment (at the sole option of each of the sellers) of £5.0 million (approximately $6.8 million as of December 31, 2020) for the potential market approval.

The Company has no provision for any of the obligations above since the amounts are either not paid or payable as of December 31, 2020.

Marketing Obligations

As of December 31, 2020, the Company had certain marketing commitments, consisting of communication costs related to the direct-to-consumer activities, totaling approximately $7.3 million.

(9) Equity

Preferred Stock

As of December 31, 2020, the Company had no preferred stock outstanding.

On March 5, 2015, the Company entered into a subscription agreement with four institutional investors, or the Purchasers, including both existing and new investors, for the private placement of 352,150,790 restricted American Depositary Shares, each representing one (1) share of Amarin's Series A Convertible Preference Shares, par value £0.05 per share, in the capital of the Company, or Series A Preference Shares, resulting in gross proceeds to the Company of $52.8 million, before deducting estimated offering expenses of approximately $0.7 million. For each restricted American Depositary Share, the Purchasers paid a negotiated price of $0.15 (equating to $1.50 on an as-if-converted-to-ordinary-shares basis). The closing of the private placement occurred on March 30, 2015. As of December 31, 2020, all such Series A Preference Shares, as well as the Series A Preference Shares issued in the second private placement as discussed below, had been converted to ordinary shares at the request of the holders such that none remain outstanding.

Each ten (10) Series A Preference Shares were able to be consolidated and redesignated as one (1) ordinary share, par value £0.50 per share, in the capital of the Company, each ordinary share to be represented by American Depositary Shares, or ADSs, provided that consolidation would be prohibited if, as a result, the holder of such Series A Preference Shares and its affiliates would beneficially own more than 9.9% (increased from 4.99% effective March 2020) of the total number of Amarin ordinary shares or ADSs outstanding following such redesignation, or the Beneficial Ownership Limitation. By written notice to the Company, a holder was able to from time to time increase or decrease the Beneficial Ownership Limitation to any other percentage not in excess of 19.9% specified in such notice; provided that any such increase would not be effective until the sixty-first (61st) day after such notice was delivered to the Company. This consolidation and redesignation was able to be effected by a holder of Series A Preference Shares following the first to occur of the resale of the ADSs representing the ordinary shares being registered for resale under the Securities Act pursuant to an effective registration statement, following any sale of the ADSs representing the ordinary shares pursuant to Rule 144 under the Securities Act, or if such ADSs representing the ordinary shares were eligible for sale under Rule 144, following the expiration of the one-year holding requirement under Rule 144.

Except as otherwise provided in the Series A Preference Share Terms or as required by applicable law, the Series A Preference Shares had no voting rights. However, as long as any Series A Preference Shares were outstanding, the Company could not, without the approval of the holders of seventy-five percent (75%) of the then outstanding Series A Preference Shares, alter or change adversely the powers, preferences or rights attaching to the Series A Preference Shares or enter into any agreement with respect to the foregoing.

Holders of the Series A Preference Shares were entitled to receive, and the Company was required to pay, dividends (other than dividends in the form of ordinary shares) on the Series A Preference Shares equal (on an as-if-converted-to-ordinary-shares basis) to and in the same form as dividends (other than dividends in the form of ordinary shares) actually paid on ordinary shares when, as and if such dividends (other than dividends in the form of ordinary shares) were paid on the ordinary shares.

The restricted American Depositary Shares and Series A Preference Shares were sold in a transaction exempt from the registration requirements under the Securities Act of 1933, as amended, or the Securities Act. The Company filed a registration statement with the SEC covering the resale of the restricted American Depositary Shares and the ADSs representing ordinary shares created by the consolidation and redesignation of the Series A Preference Shares' or the Registrable Securities, on April 9, 2015, which was declared effective by the SEC on May 1, 2015. In addition, the Company agreed to use its commercially reasonable best efforts to keep the registration, and any qualification, exemption or compliance under state securities laws which the Company determines to obtain, continuously effective, and to keep the Registration Statement free of any material misstatements or omissions, until the earlier of (a) March 11, 2017 or (b) the date on which all Registrable Securities held by Purchasers may be sold or transferred in compliance with Rule 144 under the Securities Act, without any volume or manner of sale restrictions.

On March 30, 2015, in connection with the closing of the private placement, and pursuant to a pre-existing contractual right to participate in certain private placement transactions effected by the Company, the Company entered into a separate subscription agreement with an existing investor, Sofinnova Venture Partners VII L.P., or Sofinnova, for the purchase of an additional $5.8 million

of restricted American Depositary Shares, each representing one (1) share of the Company's Series A Preference Shares, at the same price per share and otherwise on substantially the same terms as the initial private placement, or the Second Private Placement. In accordance with applicable marketplace rules of the NASDAQ Stock Market, the consummation of the Second Private Placement was conditioned upon approval by the Company's shareholders at a future meeting of the Company's shareholders. Such approval was received at the Company's Annual General Meeting of Shareholders on July 6, 2015 and as a result, the closing of the Second Private Placement occurred on July 10, 2015. The Company issued 38,867,180 restricted ADSs, each representing one Series A Preference Share, which could be consolidated and redesignated from time to time up to a maximum of 3,886,718 ordinary shares, each ordinary share to be represented by one ADS. For each restricted ADS, Sofinnova paid a negotiated price of $0.15 (equating to $1.50 on an as-if-converted-to-ordinary-shares basis) resulting in gross proceeds to the Company of $5.8 million.

The Company filed another registration statement with the SEC covering the resale of these restricted American Depositary Shares and the ADSs representing ordinary shares created by the consolidation and redesignation of the Series A Preference Shares, or the Sofinnova Registrable Securities, on July 24, 2015, which was declared effective by the SEC on August 7, 2015. In addition, the Company agreed to use its commercially reasonable best efforts to keep the registration, and any qualification, exemption or compliance under state securities laws which the Company determines to obtain, continuously effective, and to keep the registration statement free of any material misstatements or omissions, until the earlier of (a) July 10, 2017 or (b) the date on which all Sofinnova Registrable Securities held by Sofinnova may be sold or transferred in compliance with Rule 144 under the Securities Act, without any volume or manner of sale restrictions.

During the years ended December 31, 2020, 2018, and 2015, the Company issued 28,931,746, 3,886,718, and 6,283,333 ADSs, respectively, upon consolidation and redesignation of Series A Preference Shares at the request of the holders, such that no Series A Preference Shares remained outstanding as of December 31, 2020.

Common Stock

During the year ended December 31, 2020, other than as described elsewhere in this Annual Report on Form 10-K, including in the Notes to Consolidated Financial Statements, the Company did not engage in any transactions involving its common stock. Refer to *Preferred Stock* above for discussion of the consolidation and redesignation of Series A Preference Shares which resulted in the issuance of ordinary shares. Refer to *Incentive Equity Awards below* for discussion of ordinary shares issued as a result of stock option exercises and restricted stock unit vestings. Refer to Note 11—Stock Incentive Plans and Stock Based Compensation for discussion of shares issued under the Company's employee stock purchase plan.

On December 13, 2019, in connection with approval by the FDA for a new indication of Vascepa, the Company was required to make an aggregate milestone payment of £5 million (in either stock or cash at the sole option of each of the sellers) to Laxdale's former shareholders. One of the shareholders' elected to receive payment in stock, resulting in the issuance of 257,713 shares at a price of $24.12 per share. The Company recorded a liability of $2.2 million in Accrued expenses and other current liabilities on the consolidated balance sheet as of December 31, 2019.

On July 18, 2019, the Company completed a public offering of 22,222,223 ADSs with each ADS representing one ordinary share of the Company, at a price of $18.00 per ADS, $17.235 per ADS after commission. In addition, the Company granted the underwriters a 30-day option to purchase up to an additional 3,333,333 ADSs at the same price per ADS. On July 29, 2019, the underwriters exercised the full option. This public offering, including the exercised option, resulted in gross proceeds of approximately $460.0 million and, after deducting customary commissions and offering expenses, net proceeds to the Company of approximately $440.1 million.

On November 29, 2018, the Company completed a public offering of 11,111,112 ADSs, with each ADS representing one ordinary share of the Company. The underwriters purchased the ADSs from the Company at a price of $17.575 per ADS after commission, resulting in net proceeds to the Company of approximately $194.8 million, after deducting customary commissions and offering expenses.

On February 1, 2018, the Company completed a public offering of 19,178,082 ADSs, with each ADS representing one ordinary share of the Company. The Company also granted the underwriters a 30-day option to purchase an additional 2,876,712 ADSs, which was partially exercised on March 5, 2018 for issuance of 1,438,356 ADSs. The underwriters purchased the ADSs from the Company at a price of $3.41 per ADS after commission, resulting in net proceeds to the Company of approximately $70.0 million, after deducting customary commissions and offering expenses.

Incentive Equity Awards

The Company issues incentive equity awards, including incentive and non-qualified stock options and restricted stock units, under the Amarin Corporation plc 2020 Stock Incentive Plan, or the 2020 Plan, which is the successor to the Amarin Corporation plc 2011 Stock Incentive Plan, as amended, or the 2011 Plan, and the Amarin Corporation plc 2002 Stock Option Plan, as amended, or the 2002

Plan, and together with the 2020 Plan and 2011 Plan, the Plans. Refer to Note 11—Stock Incentive Plans and Stock Based Compensation for further information regarding the Company's incentive equity plans and awards.

As of December 31, 2020, there were an aggregate of 16,664,260 stock options and 7,710,388 restricted stock units, or RSUs, outstanding, representing approximately 4% and 2%, respectively, of outstanding shares on a fully diluted basis.

During the years ended December 31, 2020 and 2019, the Company issued 1,623,460 and 5,997,919 shares, respectively, as a result of the exercise of stock options, resulting in gross and net proceeds of $5.2 million during the year ended December 31, 2020 and $24.5 million during the year ended December 31, 2019.

During the years ended December 31, 2020 and 2019, the Company issued 2,507,748 and 3,969,811 common shares, respectively, related to the vesting of RSUs of which 975,927 and 1,650,142 shares, respectively, were retained as treasury shares as settlement of employee tax obligations. Of these shares issued during the year ended December 31, 2020, in connection with the achievement of certain regulatory and sales performance conditions associated with the REDUCE-IT clinical trial and subsequent revenue growth, the Company issued 1,240,584 common shares upon vesting of performance-based RSUs granted in 2017 and 2018, of which 514,784 shares were retained as treasury shares as settlement of employee tax obligations. These performance-based RSUs will continue to vest ratably monthly through August 2021.

During the years ended December 31, 2020 and 2019, the Company granted a total of 2,890,450 and 2,589,400 stock options, respectively, and 1,811,470 and 782,802 RSUs, respectively, to employees under the Plans. The RSUs typically vest annually over a three-year period and the stock options typically vest quarterly over a four-year period. Also during 2020 and 2019, the Company granted a total of 1,483,400 and 645,000 RSUs, respectively, to employees under the Plans that vest upon the achievement of specified performance conditions.

In addition, during the years ended December 31, 2020 and 2019, the Company granted a total of 210,764 and 58,721 stock options, respectively, and 164,657 and 45,163 RSUs, respectively, to members of the Company's Board of Directors under the Plans. The RSUs vest in equal installments over a three-year period upon the earlier of the anniversary of the grant date or the Company's annual general meeting of shareholders in such anniversary year. The stock options vest in full upon the earlier of the one-year anniversary of the grant date or the Company's annual general meeting of shareholders in such anniversary year. Upon termination of service to the Company or upon a change of control, each director shall be entitled to a payment equal to the fair market value of one share of Amarin common stock per award vested or granted, respectively, which is required to be made in shares.

(10) Income Taxes

Interest and penalties related to any uncertain tax positions have historically been insignificant. The Company recognizes interest and penalties related to uncertain tax positions within the provision for income taxes. The total amount of unrecognized tax benefits that would affect the Company's effective tax rate if recognized is $5.6 million and nil as of December 31, 2020 and 2019, respectively.

The following is a reconciliation of the total amounts of unrecognized tax benefits for the years ended December 31, 2020, 2019 and 2018:

In thousands	2020	2019	2018
Beginning uncertain tax benefits	$ 26,743	$ 6,815	$ 1,734
Prior year—increases	2,428	295	296
Prior year—decreases	(5,391)	—	(762)
Current year—increases	254	19,633	5,547
Ending uncertain tax benefits	$ 24,034	$ 26,743	$ 6,815

The Company files income tax returns in the United States, Ireland and United Kingdom, or UK. The Company remains subject to tax examinations in the following jurisdictions as of December 31, 2020:

Jurisdiction	Tax Years
United States—Federal	2017-2020
United States—State	2012-2020
Ireland	2016-2020
United Kingdom	2019-2020

The Company does not expect any gross liabilities to expire in 2021 based on statutory lapses or audits.

The components of loss from operations before taxes were as follows for the years ended December 31, 2020, 2019 and 2018:

In thousands	2020	2019	2018
United States	$ 14,915	$ 10,269	$ (13,583)
Ireland and United Kingdom	(32,170)	(32,750)	(102,766)
	$ (17,255)	$ (22,481)	$ (116,349)

The provision for income taxes shown in the accompanying consolidated statements of operations consists of the following for fiscal 2020, 2019 and 2018:

In thousands	2020	2019	2018
Current:			
United States—Federal	$ 45	$ —	$ 4
United States—State	700	164	92
Total current	$ 745	$ 164	$ 96
Deferred:			
United States—Federal	1,972	1,777	(1,968)
United States—State	1,956	(914)	(1,325)
Ireland and United Kingdom	(26,793)	1,278	(5,435)
Change in valuation allowance	22,865	(2,141)	8,728
Total deferred	$ —	$ —	$ —
Provision for income taxes	$ 745	$ 164	$ 96

The provision for income taxes differs from the amount computed by applying the statutory income tax rate to income before taxes due to the following for fiscal 2020, 2019 and 2018:

In thousands	2020	2019	2018
Benefits from taxes at statutory rate	$ (4,314)	$ (5,620)	$ (29,087)
Rate differential	128	3,009	9,796
Change in valuation reserves	22,865	(2,141)	8,728
Derivative liabilities	—	—	337
Nondeductible employee compensation	6,122	5,472	3,058
Stock option/RSU windfall	(3,262)	(14,342)	(7,684)
ISO Disqualifying Disposition Windfall	(253)	(2,849)	—
Research and development credits	(6,225)	(1,607)	(1,438)
Tax return to provision adjustments	(138)	(3,222)	6,736
Net Operating Loss Carryback	(2,465)	—	—
Cumulative translation adjustment	(10,852)	2,025	5,711
Permanent and other	(4,283)	(443)	(404)
Non-deductible interest expense	—	—	267
Tax reserves	3,422	18,799	4,956
Corscianto Liquidation	—	1,727	—
Long-term debt from royalty-bearing instrument	—	(644)	(880)
Provision for income taxes	$ 745	$ 164	$ 96

The Company is subject to a corporate tax rate in Ireland of 25% for non-trading activities and 12.5% for trading activities. For the years ended December 31, 2020, 2019, and 2018, the Company applied the statutory corporate tax rate of 25% for Amarin Corporation plc, reflecting the non-trading tax rate in Ireland. However, for Amarin Pharmaceuticals Ireland Limited, a wholly-owned subsidiary of Amarin Corporation plc, the Company applied the 12.5% Irish trading tax rate. In the table above, the Company used Amarin Corporation plc's 25% tax rate as the starting point for the reconciliation since it is the parent entity of the business.

On March 27, 2020, the Coronavirus Aid, Relief and Economic Security Act, or CARES Act, was enacted in the United States. Among other provisions, the CARES Act allows businesses to carry back net operating losses arising in years 2018 to 2020 to the five prior tax years. We recorded an income tax benefit of $2.5 million for the year ended December 31, 2020 as a result of these loss carrybacks and an income tax benefit of nil for the years ended December 31, 2019 and 2018, respectively.

In April 2016, the Company adopted ASU No. 2016-09, *Compensation-Stock Compensation (Topic 718): Improvements to Share-Based Payment Accounting* which changes the accounting for certain aspects of share-based payments to employees. One aspect of the standard requires that excess tax benefits and deficiencies that arise upon vesting or exercise of share-based payments be recognized as an income tax benefit and expense in the income statement. Previously, such amounts were recognized as an increase and decrease in additional paid-in capital. This aspect of the standard was adopted prospectively, and accordingly the provisions for income taxes for the years ended December 31, 2020, 2019 and 2018 includes $3.7 million, $21.9 million and $7.7 million of excess tax benefits, respectively, arising from share-based payments during the period.

The income tax effect of each type of temporary difference comprising the net deferred tax asset as of December 31, 2020 and 2019 is as follows:

In thousands	December 31, 2020	December 31, 2019
Deferred tax assets:		
Net operating losses	$ 125,859	$ 118,220
Stock-based compensation	7,565	7,111
Tax credits	14,690	9,149
Lease Liability	2,219	2,715
Other reserves and accrued liabilities	14,702	5,580
Gross deferred tax assets	165,035	142,775
Less: valuation allowance	(160,841)	(137,976)
Total deferred tax assets	4,194	4,799
Deferred tax liabilities:		
Depreciation and amortization	(2,399)	(2,544)
Lease Asset	(1,784)	(2,242)
Other liabilities	(11)	(13)
Total deferred tax liabilities	(4,194)	(4,799)
Net deferred tax assets	$ —	$ —

The Company assesses whether it is more-likely-than-not that the Company will realize its deferred tax assets. The Company determined that it was more-likely-than-not that the Irish, U.S., UK, and Israeli net operating losses and the related deferred tax assets would not be realized in future periods and a full valuation allowance has been provided for all periods.

The following table reflects the activity in the valuation allowance for the years ended December 31, 2020 and 2019:

In thousands	2020	2019
Beginning valuation allowance	$ 137,976	$ 140,117
Increase (decrease) as reflected in income tax expense	12,453	(114)
Cumulative translation adjustment	10,412	(2,027)
Ending valuation allowance	$ 160,841	$ 137,976

During 2020, the Company recorded adjustments to its deferred tax accounts related to the impact of foreign exchange rate changes and to reconcile the financial statement accounts to the amounts expected to result in future income and deductions under local law, primarily as it relates to Irish net operating losses and deferred taxes for stock compensation. These adjustments were fully offset with valuation allowances based on the Company's position with respect to the realizability of its recorded deferred tax assets.

The Company has combined U.S., Irish, UK, and Israeli net operating loss carryforwards of $900.5 million, which do not expire. The total net operating loss carryforwards increased by approximately $38.7 million from the prior year primarily as a result of current year losses generated by the Company's U.S. and Irish subsidiaries, the impact of foreign exchange rate changes, and adjustments to reconcile the financial statement accounts to the amounts reported on the filed 2019 foreign tax returns. In addition, the Company has U.S. Federal tax credit carryforwards of $13.0 million and state tax credit carryforwards of $4.0 million. These amounts exclude the impact of any unrecognized tax benefits and valuation allowances. These carryforwards, which will expire between 2024 and 2040, may be used to offset future taxable income, if any.

As of December 31, 2020, there are no earnings that have been retained indefinitely for reinvestment by foreign subsidiary; therefore, no provision has been made for income taxes that would be payable upon the distribution of such earnings or the recovery of the Company's investment in its subsidiaries as the amount of the related unrecognized deferred income tax liability is zero.

The Company's and its subsidiaries' income tax returns are periodically examined by various taxing authorities. The Company is currently under audit by the IRS for the Company's 2018 U.S. income tax return and by the New Jersey Department of Treasury for

the years 2012 to 2015. Although the outcome of tax audits is always uncertain and could result in significant cash tax payments, the Company does not believe the outcome of these audits will have a material adverse effect on the Company's consolidated financial position or results of operations.

(11) Stock Incentive Plans and Stock-Based Compensation

On March 16, 2020, the Company's Board of Directors, upon the recommendation of the Remuneration Committee, adopted, subject to shareholder approval, the 2020 Stock Incentive Plan, or 2020 Plan, which was subsequently approved by the Company's shareholders on July 13, 2020 at the Annual General Meeting of Shareholders. The 2020 Plan is the successor to the Company's 2011 Stock Option Plan, as amended, or the 2011 Plan, which was set to expire on July 12, 2021, and the Company's 2002 Stock Option Plan, as amended, or the 2002 Plan, and together with the 2020 Plan and 2011 Plan, the Plans.

The maximum number of the Company's Ordinary Shares of £0.50 each or any ADS's, as to be issued under the 2020 Plan shall not exceed the sum of (i) 20,000,000 shares and (ii) the number of Shares that remained available for grants under the Company's 2011 Plan as of July 13, 2020. If any award over shares granted and outstanding under the Plans expires or is forfeited, surrendered, canceled or otherwise terminated, the shares may be made available for subsequent grants under the Plan. The award of stock options (both incentive and non-qualified options) and restricted stock units, and awards of unrestricted shares to Directors are permitted. The 2020 Plan is administered by the Remuneration Committee of the Company's Board of Directors and expires on July 13, 2030.

Stock Options

Under the terms of the Plans, stock options typically vest over a four-year period, expire after a ten-year term and are granted at an exercise price equal to the closing price of the Company's American Depositary Shares on the grant date. The following table summarizes all stock option activity for the year ended December 31, 2020:

In thousands (except per share amounts and years)	Number of Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding as of January 1, 2020	15,619	$ 6.43		
Granted	3,101	14.43		
Forfeited	(403)	15.53		
Expired	(30)	13.82		
Exercised	(1,623)	3.18		
Outstanding as of December 31, 2020	16,664	8.00	6.5 years	$ 23,174
Exercisable as of December 31, 2020	11,533	5.46	5.6 years	$ 22,110
Vested and expected to vest as of December 31, 2020	16,408	$ 7.91	6.5 years	$ 23,121
Available for future grant as of December 31, 2020	21,885			

The weighted average grant date fair value of stock options granted during the years ended December 31, 2020, 2019, and 2018 was $14.43, $17.07, and $7.82, respectively. The total grant date fair value of options vested during the years ended December 31, 2020, 2019, and 2018 was $22.5 million, $14.5 million, and $7.7 million, respectively.

During the years ended December 31, 2020, 2019 and 2018, the Company received proceeds from the exercise of options of $5.2 million, $24.5 million, and $26.4 million, respectively. The total intrinsic value of options exercised during the years ended December 31, 2020, 2019, and 2018 was $9.0 million, $90.5 million, and $69.7 million, respectively, calculated as the difference between the quoted stock price of the Company's common stock as of the reporting date and the exercise prices of the underlying awards.

As of December 31, 2020, there was $45.6 million of unrecognized stock-based compensation expense related to unvested stock option share-based compensation arrangements granted under the Company's stock award plans. This expense is expected to be recognized over a weighted-average period of approximately 2.5 years. The Company recognizes compensation expense for the fair values of those awards which have graded vesting on a straight-line basis.

The fair value of stock options on the date of grant was estimated using the Black-Scholes option pricing model. Use of a valuation model requires management to make certain assumptions with respect to selected model inputs. Expected stock price volatility was calculated based on the historical volatility of the Company's common stock over the expected life of the option. The expected life was determined using the simplified method based on the term and vesting period. The risk-free interest rate is based on zero-coupon U.S. Treasury securities with a maturity term approximating the expected life of the option at the date of grant. No dividend yield has been assumed as the Company does not currently pay dividends on its common stock and does not anticipate doing so in the foreseeable future. Estimated forfeitures are based on the Company's historical forfeiture activity.

Employee stock options generally vest over a four-year service period and all stock options are settled by the issuance of new shares. Compensation expense recognized for all option grants is net of estimated forfeitures and is recognized over the awards' respective requisite service periods. The vesting of certain stock options is contingent upon the attainment of performance criteria. The probability that such criteria will be achieved is assessed by management and compensation expense for such awards is only recorded to the extent that the attainment of the performance criteria is deemed to be probable. The Company recorded compensation expense in relation to stock options of $22.4 million, $16.3 million, and $8.2 million for the years ended December 31, 2020, 2019, and 2018, respectively.

For 2020, 2019, and 2018, the Company used the following assumptions to estimate the fair value of share-based payment awards:

	2020	2019	2018
Risk-free interest rate	0.33% - 1.74%	1.55% - 2.95%	2.18% - 3.00%
Expected dividend yield	0.00%	0.00%	0.00%
Expected option life (years)	6.25	6.25	6.25
Expected volatility	84% - 99%	92% - 94%	71% - 92%

Restricted Stock Units

The Plans also allow for granting of restricted stock unit awards under the terms of the Plans. The restricted stock units vest based upon a time-based service condition, a performance condition, or both. The probability that any performance criteria will be achieved is assessed by management and compensation expense for such awards is only recorded to the extent that the attainment of the performance criteria is deemed to be probable. Restricted stock units are recorded as compensation expense based on fair value, representing the market value of the Company's common stock on the date of grant. The fair value of restricted stock units is amortized on a straight-line basis through the statement of operations over the service period until the shares have vested. The following table presents the restricted stock unit activity for the years ended December 31, 2020 and 2019:

In thousands (except per share amounts)	Shares	Weighted Average Grant Date Fair Value
Outstanding as of January 1, 2020	6,921	6.34
Granted	3,460	13.12
Vested	(2,508)	5.12
Forfeited	(163)	11.72
Outstanding as of December 31, 2020	7,710	$ 9.67

The Company recorded compensation expense in relation to restricted stock units of $23.4 million, $14.6 million, and $10.6 million for the years ended December 31, 2020, 2019, and 2018 respectively.

The following table presents the stock-based compensation expense related to stock-based awards for the years ended December 31, 2020, 2019, and 2018:

In thousands	2020	2019	2018
Research and development	$ 6,568	$ 4,615	$ 2,898
Selling, general and administrative	39,245	26,302	15,908
Stock-based compensation expense	$ 45,813	$ 30,917	$ 18,806

Employee Stock Purchase Plan

On March 13, 2017, the Board adopted, subject to shareholder approval, the Amarin Corporation plc 2017 Employee Stock Purchase Plan, or the ESPP, which was approved by the Company's shareholders on May 15, 2017. The ESPP is intended to qualify as an "employee stock purchase plan" within the meaning of Section 423 of the Internal Revenue Code. The maximum fair market value of stock which can be purchased by a participant in a calendar year is $25,000. Under the ESPP, an aggregate of 3,000,000 ordinary shares (each ordinary share to be represented by one ADS) are reserved and available for issuance, which were registered with the SEC on August 2, 2017, for sale to eligible employees. Subject to certain exclusions, any employee of the Company's U.S. subsidiary, Amarin Pharma, Inc., who works at least 20 hours per week and has been employed for at least six months as of the first day of the applicable offering period is eligible to participate in the ESPP. Eligible employees may authorize payroll deductions of up to 15 percent of their base pay to be withheld to purchase ordinary shares, subject to terms and limitations of the plan, at a price equal to 85 percent of the lower of the fair market values of the Company's ordinary shares as of the beginning or the end of six-month offering periods.

For the offering periods ended on the last business day on or before each of May 31, 2020 and November 30, 2020, the Company issued 123,608 shares and 223,545 shares, respectively, at a purchase price of $5.83 per share and $4.22 per share, respectively. For the offering periods ended on the last business day on or before each of May 31, 2019 and November 30, 2019, the Company issued 47,358 shares and 75,673 shares, respectively, at a purchase price of $15.02 per share and $14.92 per share, respectively. As of December 31, 2020, 2,217,559 shares were reserved for future issuance under the ESPP.

(12) Defined Contribution Plan

The Company makes available a 401(k) plan for its U.S. employees. Under the 401(k) plan, employees may make contributions which are eligible for a discretionary percentage match, in cash, as defined in the 401(k) plan and determined by the Board of Directors. The Company recognized $1.7 million, $1.1 million and $0.7 million of related compensation expense for the year ended December 31, 2020, 2019 and 2018, respectively.

(13) Co-Promotion Agreement

On March 31, 2014, the Company entered into a Co-Promotion Agreement, or the Agreement, with Kowa Pharmaceuticals America, Inc. related to the commercialization of VASCEPA capsules in the United States. The Company and Kowa Pharmaceuticals America, Inc. intentionally designed the Agreement to naturally end as of December 31, 2018 and mutually agreed not to renew the Agreement.

During 2018, which was the last year of the co-promotion of VASCEPA by Kowa Pharmaceuticals America, Inc., the Company incurred expense for co-promotion tail payments which are calculated as a percentage of the 2018 co-promotion fee, which was eighteen and a half percent (18.5%) of VASCEPA gross margin in 2018. The accrued tail payments are paid over three years with declining amounts each year. Kowa Pharmaceuticals America, Inc. was eligible to receive $17.8 million in co-promotion tail payments, the present value of which $16.6 million, was fully accrued as of December 31, 2018.

As of December 31, 2020 and 2019, a net payable to Kowa Pharmaceuticals America, Inc. of $3.8 million and $10.0 million, respectively, of which $3.2 million and $6.5 million, respectively, was classified as current on the consolidated balance sheets, representing the remaining accrued co-promotion tail payments.

(14) Revenue Recognition

The Company sells VASCEPA principally to a limited number of major wholesalers, as well as selected regional wholesalers and specialty pharmacy providers in the United States, or collectively, its distributors or its customers, that in turn resell VASCEPA to retail pharmacies for subsequent resale to patients and healthcare providers. Patients are required to have a prescription in order to purchase VASCEPA. In addition to distribution agreements with distributors, the Company enters into arrangements with health care providers and payors that provide for government-mandated and/or privately-negotiated rebates, chargebacks and discounts with respect to the purchase of the Company's product.

Revenues from product sales are recognized when the distributor obtains control of the Company's product, which occurs at a point in time, typically upon delivery to the distributor. Payments from distributors are generally received 30-60 days from the date of sale. The Company evaluates the creditworthiness of each of its distributors to determine whether revenues can be recognized upon delivery, subject to satisfaction of the other requirements, or whether recognition is required to be delayed until receipt of payment. The Company calculates gross product revenues generally based on the wholesale acquisition cost that the Company charges its distributors for VASCEPA.

Reserves for Variable Consideration

Revenues from product sales are recorded at the net sales price (transaction price), which includes estimates of variable consideration for which reserves are established and which result from (a) trade allowances, such as invoice discounts for prompt pay and distributor fees, (b) estimated government and private payor rebates and chargebacks and discounts, such as Medicaid reimbursements, (c) reserves for expected product returns and (d) estimated costs of incentives that are offered within contracts between the Company and its distributors, health care providers, payors and other indirect customers relating to the Company's sales of its product. These reserves are based on the amounts earned or to be claimed on the related sales and are classified as reductions of accounts receivable (if the amount is payable to the distributor) or as a current liability (if the amount is payable to a party other than a distributor). Where appropriate, these estimates take into consideration a range of possible outcomes which are probability-weighted for relevant factors such as the Company's historical experience, current contractual and statutory requirements, specific known market events and trends, industry data and forecasted customer buying and payment patterns. Overall, these reserves reflect the Company's best estimates of the amount of consideration to which it is entitled based on the terms of the contract. The amount of variable consideration which is included in the transaction price may be constrained, and is included in the net sales price only to the extent that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. Actual amounts of consideration ultimately received may differ from the Company's estimates. If actual results in the future vary from the Company's estimates, the Company adjusts these estimates, which would affect net product revenue and earnings in the period such variances become known.

Trade Allowances: The Company generally provides invoice discounts on VASCEPA sales to its distributors for prompt payment and fees for distribution services, such as fees for certain data that distributors provide to the Company. The payment terms for sales to distributors generally include a 2% discount for prompt payment while the fees for distribution services are based on contractual rates agreed with the respective distributors. Based on historical data, the Company expects its distributors to earn these discounts and fees, and deducts the full amount of these discounts and fees from its gross product revenues and accounts receivable at the time such revenues are recognized.

Rebates, Chargebacks and Discounts: The Company contracts with Medicaid, Medicare, other government agencies and various private organizations, or collectively, Third-party Payors, so that VASCEPA will be eligible for purchase by, or partial or full reimbursement from, such Third-party Payors. The Company estimates the rebates, chargebacks and discounts it will provide to Third-party Payors and deducts these estimated amounts from its gross product revenues at the time the revenues are recognized. The Company estimates these reserves based upon a range of possible outcomes that are probability-weighted for the estimated payor mix. These reserves are recorded in the same period the revenue is recognized, resulting in a reduction of product revenue and the establishment of a current liability, which is included in accrued expenses and other current liabilities on the consolidated balance sheets. For Medicare, the Company also estimates the number of patients in the prescription drug coverage gap for whom the Company will owe an additional liability under the Medicare Part D program. The Company estimates the rebates, chargebacks and discounts that it will provide to Third-party Payors based upon (i) the Company's contracts with these Third-party Payors, (ii) the government-mandated discounts applicable to government-funded programs, (iii) information obtained from the Company's distributors and (iv) information obtained from other third parties regarding the payor mix for VASCEPA. The Company's liability for these rebates consists of invoices received for claims from prior quarters that have not been paid or for which an invoice has not yet been received, estimates of claims for the current quarter, and estimated future claims that will be made for product that has been recognized as revenue, but remains in the distribution channel inventories at the end of each reporting period.

Product Returns: The Company's distributors have the right to return unopened unprescribed VASCEPA during the 18-month period beginning six months prior to the labeled expiration date and ending twelve months after the labeled expiration date. The expiration date for VASCEPA 1-gram and 0.5-gram size capsules is currently four years and three years, respectively, after being converted into capsule form, which is the last step in the manufacturing process for VASCEPA and generally occurs within a few months before VASCEPA is delivered to distributors. The Company estimates future product returns on sales of VASCEPA based on: (i) data provided to the Company by its distributors (including weekly reporting of distributors' sales and inventory held by distributors that provided the Company with visibility into the distribution channel in order to determine what quantities were sold to retail pharmacies and other providers), (ii) information provided to the Company from retail pharmacies, (iii) data provided to the Company by a third-party data provider which collects and publishes prescription data, and other third parties, (iv) historical industry information regarding return rates for similar pharmaceutical products, (v) the estimated remaining shelf life of VASCEPA previously shipped and currently being shipped to distributors and (vi) contractual agreements intended to limit the amount of inventory maintained by the Company's distributors. These reserves are recorded in the same period the related revenue is recognized, resulting in a reduction of product revenue and the establishment of a current liability which is included in accrued expenses and other current liabilities on the consolidated balance sheets.

Other Incentives: Other incentives that the Company offers to indirect customers include co-pay mitigation rebates provided by the Company to commercially insured patients who have coverage for VASCEPA and who reside in states that permit co-pay mitigation programs. The Company's co-pay mitigation program is intended to reduce each participating patient's portion of the financial responsibility for VASCEPA's purchase price to a specified dollar amount. Based upon the terms of the program and information regarding programs provided for similar specialty pharmaceutical products, the Company estimates the average co-pay mitigation amounts and the percentage of patients that it expects to participate in the program in order to establish its accruals for co-pay mitigation rebates. These reserves are recorded in the same period the related revenue is recognized, resulting in a reduction of product revenue and the establishment of a current liability which is included in accrued expenses and other current liabilities on the

consolidated balance sheets. The Company adjusts its accruals for co-pay mitigation rebates based on actual redemption activity and estimates regarding the portion of issued co-pay mitigation rebates that it estimates will be redeemed.

The following tables summarize activity in each of the net product revenue allowance and reserve categories described above for the years ended December 31, 2020 and 2019:

In thousands	Trade Allowances	Rebates, Chargebacks and Discounts	Product Returns	Other Incentives	Total
Balance as of January 1, 2019	**$ 19,495**	**$ 41,634**	**$ 2,948**	**$ 1,167**	**$ 65,244**
Provision related to current period sales	92,378	403,865	2,430	47,169	545,842
Provision related to prior period sales	—	(324)	—	—	(324)
Credits/payments made for current period sales	(63,288)	(312,790)	5	(43,416)	(419,489)
Credits/payments made for prior period sales	(19,324)	(41,388)	(804)	(1,200)	(62,716)
Balance as of December 31, 2019	**29,261**	**90,997**	**4,579**	**3,720**	**128,557**
Provision related to current period sales	132,881	621,937	3,543	64,452	822,813
Provision related to prior period sales	—	(3,872)	—	—	(3,872)
Credits/payments made for current period sales	(96,834)	(482,254)	—	(58,911)	(637,999)
Credits/payments made for prior period sales	(29,066)	(85,608)	(324)	(3,677)	(118,675)
Balance as of December 31, 2020	**$ 36,242**	**$ 141,200**	**$ 7,798**	**$ 5,584**	**$ 190,824**

Such net product revenue allowances and reserves are included within accrued expenses and other current liabilities within the consolidated balance sheets, with the exception of trade allowances and chargebacks, which are included within accounts receivable, net as discussed below.

Licensing Revenue

The Company enters into licensing agreements which are within the scope of Topic 606, under which it licenses certain rights to VASCEPA for uses that are currently commercialized and under development by the Company. The terms of these arrangements typically include payment to the Company of one or more of the following: non-refundable, up-front license fees; development, regulatory and commercial milestone payments; payments for manufacturing supply services the Company provides through its contract manufacturers; and royalties on net sales of licensed products. Each of these payments results in licensing revenues.

In determining the appropriate amount of revenue to be recognized as it fulfills its obligations under each of its agreements, the Company performs the following steps: (i) identification of the promised goods or services in the contract; (ii) determination of whether the promised goods or services are performance obligations including whether they are distinct in the context of the contract; (iii) measurement of the transaction price, including the constraint on variable consideration; (iv) allocation of the transaction price to the performance obligations; and (v) recognition of revenue when (or as) the Company satisfies each performance obligation.

In determining performance obligations, management evaluates whether the license is distinct from the other performance obligations with the collaborative partner based on the consideration of the relevant facts and circumstances for each arrangement. Factors considered in the determination include the stage of development of the license delivered, research and development capabilities of the partner and the ability of partners to develop and commercialize VASCEPA independent of the Company.

Licenses of intellectual property: If the license to the Company's intellectual property is determined to be distinct from the other performance obligations identified in the arrangement, the Company recognizes revenues from non-refundable, up-front fees allocated to the license when the license is transferred to the customer and the customer is able to use and benefit from the license. For licenses that are bundled with other promises, the Company utilizes judgment to assess the nature of the combined performance obligation to determine whether the combined performance obligation is satisfied over time or at a point in time and, if over time, the appropriate method of measuring progress for purposes of recognizing revenue from non-refundable, up-front fees. The Company evaluates the measure of progress each reporting period and, if necessary, adjusts the measure of performance and related revenue recognition.

Milestone Payments: At the inception of each arrangement that includes development, regulatory and commercial milestone payments, the Company evaluates whether the milestones are considered probable of being reached and estimates the amount to be included in the transaction price using the most likely amount method. If it is probable that a significant revenue reversal would not occur, the associated milestone value is included in the transaction price. Milestone payments that are not within the control of the Company or licensee, such as regulatory approvals, are not considered probable of being achieved until those approvals are received. The Company evaluates factors such as the scientific, clinical, regulatory, commercial and other risks that must be overcome to achieve the respective milestone as well as the level of effort and investment required. The transaction price is then allocated to each

performance obligation on a relative stand-alone selling price basis, for which the Company recognizes revenue as or when the performance obligations under the contract are satisfied. At the end of each subsequent reporting period, the Company re-evaluates the probability of achievement of such development, regulatory and commercial milestones and any related constraint, and if necessary, adjusts its estimate of the overall transaction price. Any such adjustments are recorded on a cumulative catch-up basis, which would affect licensing revenues and earnings in the period of adjustment.

The Company receives payments from its customers based on billing schedules established in each contract. Up-front payments and fees are recorded as deferred revenue upon receipt or when due, and may require deferral of revenue recognition to a future period until the Company performs its obligations under these arrangements. Amounts are recorded as accounts receivable when the Company's right to consideration is unconditional. The Company does not assess whether a contract has a significant financing component if the expectation at contract inception is such that the period between payment by the customer and the transfer of the promised goods or services to the customer will be one year or less.

(15) Development, Commercialization and Supply Agreements

In-licenses

Mochida Pharmaceutical Co., Ltd.

In June 2018, the Company entered into a collaboration with Mochida related to the development and commercialization of drug products and indications based on the active pharmaceutical ingredient in VASCEPA, the omega-3 acid, EPA, or eicosapentaenoic acid. Among other terms in the agreement, the Company obtained an exclusive license to certain Mochida intellectual property to advance the Company's interests in the United States and certain other territories and the parties will collaborate to research and develop new products and indications based on EPA for the Company's commercialization in the United States and certain other territories. The potential new product and indication opportunities contemplated under this agreement are currently in early stages of development.

Upon closing of the collaboration agreement, the Company made a non-refundable, non-creditable upfront payment of approximately $2.7 million. In addition, the agreement provides for the Company to pay milestone payments upon the achievement of certain product development milestones and royalties on net sales of future products arising from the collaboration, if any.

In January 2020 and December 2020, the Company exercised certain rights under the agreement, resulting in payments of $1.0 million, respectively, to Mochida, which were recorded as Research and development expense in the consolidated statement of operations.

Out-licenses

Eddingpharm (Asia) Macao Commercial Offshore Limited

In February 2015, the Company entered into a Development, Commercialization and Supply Agreement, or the DCS Agreement, with Eddingpharm (Asia) Macao Commercial Offshore Limited, or Edding, related to the development and commercialization of VASCEPA in Mainland China, Hong Kong, Macau and Taiwan, or the China Territory. Under the terms of the DCS Agreement, the Company granted to Edding an exclusive (including as to the Company) license with right to sublicense to develop and commercialize VASCEPA in the China Territory for uses that are currently commercialized and under development by the Company based on the Company's MARINE, ANCHOR and REDUCE-IT clinical trials of VASCEPA.

Under the DCS Agreement, Edding is solely responsible for development and commercialization activities in the China Territory and associated expenses. The Company provides development assistance and is responsible for supplying finished and later bulk drug product at defined prices under negotiated terms. The Company retains all VASCEPA manufacturing rights. Edding agreed to certain restrictions regarding the commercialization of competitive products globally and the Company agreed to certain restrictions regarding the commercialization of competitive products in the China Territory.

The Company and Edding agreed to form a joint development committee to oversee regulatory and development activities for VASCEPA in the China Territory in accordance with a negotiated development plan and to form a separate joint commercialization committee to oversee VASCEPA commercialization activities in the China Territory. Development costs are paid by Edding to the extent such costs are incurred in connection with the negotiated development plan or otherwise incurred by Edding. Edding is responsible for preparing and filing regulatory applications in all countries of the China Territory at Edding's cost with the Company's assistance. The DCS Agreement also contains customary provisions regarding indemnification, supply, record keeping, audit rights, reporting obligations, and representations and warranties that are customary for an arrangement of this type.

The term of the DCS Agreement expires, on a product-by-product basis, upon the later of (i) the date on which such product is no longer covered by a valid claim under a licensed patent in the China Territory, or (ii) the twelfth (12th) anniversary of the first commercial sale of such product in Mainland China. The DCS Agreement may be terminated by either party in the event of a

bankruptcy of the other party and for material breach, subject to customary cure periods. In addition, at any time following the third anniversary of the first commercial sale of a product in Mainland China, Edding has the right to terminate the DCS Agreement for convenience with twelve months' prior notice. Neither party may assign or transfer the DCS Agreement without the prior consent of the other party, provided that the Company may assign the DCS Agreement in the event of a change of control transaction.

Upon closing of the DCS Agreement, the Company received a non-refundable $15.0 million up-front payment. In March 2016, Edding submitted its clinical trial application, or CTA, with respect to the MARINE indication for VASCEPA to the Chinese regulatory authority. Following the CTA submission, the Company received a non-refundable $1.0 million milestone payment. In March 2017, the CTA was approved by the Chinese regulatory authority, and, in December 2017, Edding commenced a pivotal clinical trial aimed to support the regulatory approval of the first indication of VASCEPA in a patient population with severe hypertriglyceridemia in Mainland China. In November 2020, the Company announced statistically significant topline results from the Phase 3 clinical trial of VASCEPA conducted by Edding, which is being used to seek regulatory approval in Mainland China.

In addition to the non-refundable, up-front and regulatory milestone payments described above, the Company is entitled to receive certain regulatory and sales-based milestone payments of up to an additional $153.0 million as well as tiered double-digit percentage royalties on net sales of VASCEPA in the China Territory escalating to the high teens. The regulatory milestone events relate to the submission and approval of certain applications to the applicable regulatory authority, such as a clinical trial application, clinical trial exemption, or import drug license application. The amounts to be received upon achievement of the regulatory milestone events relate to the submission and approval for three indications, and range from $2.0 million to $15.0 million for a total of $33.0 million. The sales-based milestone events occur when annual aggregate net sales of VASCEPA in the territory equals or exceeds certain specified thresholds, and range from $5.0 million to $50.0 million for a total of $120.0 million. Each such milestone payment shall be payable only once regardless of how many times the sales milestone event is achieved. Each such milestone payment is non-refundable and non-creditable against any other milestone payments.

The Company assessed this arrangement in accordance with Topic 606 and concluded that the contract counterparty, Edding, is a customer. The Company identified the following performance obligations at the inception of the DCS Agreement: (1) the exclusive license to develop and commercialize VASCEPA in the China Territory for uses that are currently commercialized and under development by the Company, (2) the obligation to participate in various steering committees, and (3) ongoing development and regulatory assistance. Based on the analysis performed, the Company concluded that the identified performance obligations are not distinct and therefore a combined performance obligation.

The transaction price includes the $15.0 million up-front consideration received and the $1.0 million milestone payment received related to the successful submission of the CTA for the MARINE indication. None of the other clinical or regulatory milestones have been included in the transaction price, as all milestone amounts are fully constrained. As part of its evaluation of the constraint, the Company considered numerous factors, including that receipt of the milestones is outside the control of the Company and contingent upon success in future clinical trials and the licensee's efforts. Any consideration related to sales-based milestones (including royalties) will be recognized when the related sales occur and therefore have also been excluded from the transaction price. The Company will re-evaluate the transaction price in each reporting period and as uncertain events are resolved or other changes in circumstances occur.

During the years ended December 31, 2020 and 2019, the Company recognized $3.0 million and $0.3 million, respectively, as licensing revenue related to the up-front and milestone payments received in connection with the Edding agreement. From contract inception through December 31, 2020 and 2019, the Company recognized $6.1 million and $3.0 million, respectively, as licensing revenue under the DCS Agreement concurrent with the input measure of support hours provided by Amarin to Edding in achieving the combined development and regulatory performance obligation, which in the Company's judgment is the best measure of progress towards satisfying this performance obligation. The remaining transaction price of $10.8 million and $13.0 million is recorded in deferred revenue as of December 31, 2020 and 2019, respectively, on the consolidated balance sheets and will be recognized as revenue over the remaining period of 14 years.

Biologix FZCo

In March 2016, the Company entered into an agreement with Biologix FZCo, or Biologix, a company incorporated under the laws of the United Arab Emirates, to register and commercialize VASCEPA in several Middle Eastern and North African countries. Under the terms of the distribution agreement, the Company granted to Biologix a non-exclusive license to use its trademarks in connection with the importation, distribution, promotion, marketing and sale of VASCEPA in the Middle East and North Africa territory. Upon closing of the agreement, the Company received a non-refundable up-front payment, which will be recognized as revenue over 10 years commencing upon first marketing approval of VASCEPA in the territory. The Company is entitled to receive all payments based on total product sales and pays Biologix a service fee in exchange for its services, whereby the service fee represents a percentage of gross selling price which is subject to a minimum floor price.

The Company received approval of VASCEPA as a prescription medication for use in Lebanon in March 2018, in United Arab Emirates in July 2018, in Qatar in January 2020 and in Bahrain in December 2020 as an adjunct to diet to reduce triglyceride levels in adult patients with severe hypertriglyceridemia. VASCEPA was launched in Lebanon in June 2018 and in United Arabe Emirates in February 2019.

The Company recognized net product revenue of approximately $0.5 million and $0.7 million as of December 31, 2020 and 2019, respectively, related to sales to Biologix.

HLS Therapeutics, Inc.

In September 2017, the Company entered into an agreement with HLS Therapeutics Inc., or HLS, a company incorporated under the laws of Canada, to register, commercialize and distribute VASCEPA in Canada. Under the agreement, HLS will be responsible for regulatory and commercialization activities and associated costs. The Company is responsible for providing assistance towards local filings, supplying finished product under negotiated supply terms, maintaining intellectual property, and continuing the development and funding of REDUCE-IT related activities.

Upon closing of the agreement, the Company received one-half of a non-refundable $5.0 million up-front payment, and received the remaining half on the six-month anniversary of the closing. Following achievement of the REDUCE-IT trial primary endpoint, which was announced in September 2018, the Company received a non-refundable $2.5 million milestone payment. Following approval from Health Canada in December 2019, the Company received a non-refundable milestone payment of $2.5 million in February 2020. In addition, in January 2020 HLS obtained regulatory exclusivity from the Office of Patented Medicines and Liaison, or OPML, as a result the Company received a non-refundable $3.8 million milestone payment. In addition to the non-refundable, up-front and regulatory milestone payments just described, the Company is entitled to receive certain sales-based milestone payments of up to an additional $50.0 million, as well as tiered double-digit royalties on net sales of VASCEPA in Canada.

The Company assessed this arrangement in accordance with Topic 606 and concluded that the contract counterparty, HLS, is a customer. The Company identified the following performance obligations at the inception of the contract: (1) license to HLS to develop, register, and commercialize VASCEPA in Canada, (2) support general development and regulatory activities, and (3) participate in various steering committees. Based on the analysis performed, the Company concluded that the identified performance obligations in the agreement are not distinct and therefore a combined performance obligation.

The transaction price includes the $5.0 million up-front consideration, the $2.5 million milestone related to the achievement of the REDUCE-IT trial primary endpoint, the $2.5 million milestone related to obtaining approval from Health Canada and $3.8 million milestone related to obtaining regulatory exclusivity from the OPML. Any consideration related to sales-based milestones (including royalties) will be recognized when the related sales occur and therefore have also been excluded from the transaction price. The Company will re-evaluate the transaction price in each reporting period and as uncertain events are resolved or other changes in circumstances occur.

During the years ended December 31, 2020 and 2019, the Company recognized $3.9 million and $2.1 million, respectively, as licensing revenue related to up-front and milestone payments received in connection with the HLS agreement. From the contract's inception through December 31, 2020 and 2019, the Company has recognized $6.6 million and $2.9 million, respectively, as licensing revenue is recognized under the agreement concurrent with the input measure of support hours provided by Amarin to HLS in achieving this performance obligation, which in the Company's judgment is the best measure of progress towards satisfying the combined development and regulatory performance obligation. The remaining transaction price of $7.1 million and $7.1 million is recorded in deferred revenue as of December 31, 2020 and 2019, respectively, on the consolidated balance sheets and will be recognized as revenue over the remaining period of 10 years.

The following table presents changes in the balances of the Company's contract assets and liabilities for years ended December 31, 2020 and 2019:

In thousands	Balance at Beginning of Period	Additions	Deductions	Balance at End of Period
Year ended December 31, 2020:				
Contract assets	$ —	$ —	$ —	$ —
Contract liabilities:				
Deferred revenue	$ 20,846	$ 4,608	$ (6,822)	$ 18,632
Year ended December 31, 2019:				
Contract assets	$ —	$ —	$ —	$ —
Contract liabilities:				
Deferred revenue	$ 20,710	$ 2,500	$ (2,364)	$ 20,846

During the years ended December 31, 2020 and 2019, the Company recognized the following revenues as a result of changes in the contract asset and contract liability balances in the respective periods:

In thousands	Twelve Months Ended December 31,	
Revenue recognized in the period from:	2020	2019
Amounts included in contract liability at the beginning of the period	$ 4,705	$ 1,633
Performance obligations satisfied in previous periods	$ 1,262	$ 299

(16) Leases

The Company leases office space under operating leases. The lease liability is initially measured at the present value of the lease payments to be made over the lease term. Lease payments are comprised of the fixed and variable payments to be made by the Company to the lessor during the lease term minus any incentives or rebates or abatements receivable by the Company from the lessor or the owner. Payments for non-lease components do not form part of lease payments. The lease term includes renewal options only if these options are specified in the lease agreement and if failure to exercise the renewal option imposes a significant economic penalty for the Company. As there are no significant economic penalties, renewal cannot be reasonably assured and the lease terms for the office space do not include any renewal options. The Company has not entered into any leases with related parties. The Company accounts for short-term leases (i.e., lease term of 12 months or less) by making the short-term lease policy election and will not apply the recognition and measurement requirements of ASC 842.

The Company has determined that the rate implicit in the lease is not determinable and the Company does not have borrowings with similar terms and collateral. Therefore, the Company considered a variety of factors, including the Company's credit rating, observable debt yields from comparable companies with a similar credit profile and the volatility in the debt market for securities with similar terms, in determining that 11.5% was reasonable to use as the incremental borrowing rate for purposes of the calculation of lease liabilities and a change of 1% would not result in a material change to the Company's consolidated financial statements.

On February 5, 2019, the Company entered into a lease agreement for office space in Bridgewater, New Jersey, or the Lease. The Lease commenced on August 15, 2019, or the Commencement Date, for an 11-year period, with two five-year renewal options. Subject to the terms of the Lease, Amarin will have a one-time option to terminate the agreement effective on the first day of the ninety-seventh month after the Commencement Date upon advance written notice and a termination payment specified in the Lease. Under the Lease, the Company pays monthly rent of approximately $0.1 million for the first year following the Commencement Date, and such rent will increase by a nominal percentage every year following the first anniversary of the Commencement Date. In addition, Amarin receives certain abatements subject to the limitations in the Lease. The operating lease liability is $10.6 million and the operating lease right-of-use asset is $8.1 million, as of December 31, 2020. The operating lease liability was $9.8 million and the operating lease right-of-us asset was $8.5 million, as of December 31, 2019. The lease expense for the twelve months ended December 31, 2020, December 31, 2019 and December 31, 2018 is approximately $1.6 million, $1.5 million and $0.8 million, respectively.

The table below depicts a maturity analysis of the Company's undiscounted payments for its operating lease liabilities and their reconciliation with the carrying amount of lease liability presented in the statement of financial position as of December 31, 2020:

		Undiscounted lease payments ($000s)
2021	$	1,475
2022		1,774
2023		1,808
2024		1,842
2025		1,876
2026 and thereafter		9,112
Total undiscounted payments	$	17,887
Discount Adjustments	$	(7,259)
Current operating lease liability		1,475
Long-term operating lease liability	$	9,153

EXHIBIT 21.1

Subsidiaries of the Registrant as of December 31, 2020

Name	Jurisdiction
Amarin Pharmaceuticals Ireland Limited	Ireland
Amarin Pharma, Inc.	United States
Ester Neurosciences Limited	Israel
Amarin Switzerland GmbH	Switzerland
Amarin Germany GmbH	Germany
Amarin France SAS	France
Amarin UK Limited	United Kingdom
Amarin Italy S.r.l	Italy

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement on Form F-1 No. 333-163704 of Amarin Corporation plc,
(2) Registration Statements on Form S-8 Nos. 333-146839, 333-143358, 333-132520, 333-110704, 333-101775, 333-168055, 333-168054, 333-176877, 333-183160, 333-205863, 333-219644, 333-180180, 333-84152 and 333-240321 of Amarin Corporation plc; and
(3) Registration Statements on Form S-3 Nos. 333-216384, 333-216385 and 333-236670 of Amarin Corporation plc;

of our reports dated February 25, 2021, with respect to the consolidated financial statements of Amarin Corporation plc, and the effectiveness of internal control over financial reporting of Amarin Corporation plc, included in this Annual Report (Form 10-K) of Amarin Corporation plc for the year ended December 31, 2020.

/s/ Ernst & Young LLP

Iselin, New Jersey
February 25, 2021

EXHIBIT 31.1

CERTIFICATION

I, John F. Thero, certify that:

1. I have reviewed this Annual Report on Form 10-K of Amarin Corporation plc;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
    b. Designed such internal controls over financial reporting, or caused such internal controls over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2021

/s/ John F. Thero

John F. Thero
President and Chief Executive Officer
(Principal Executive Officer)

EXHIBIT 31.2

CERTIFICATION

I, Michael W. Kalb, certify that:

1. I have reviewed this Annual Report on Form 10-K of Amarin Corporation plc;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2021

/s/ Michael W. Kalb
Michael W. Kalb
Senior Vice President and Chief Financial Officer
(Principal Financial Officer and Principal Accounting Officer)

EXHIBIT 32.1

STATEMENT PURSUANT TO 18 U.S.C. § 1350

Pursuant to the requirement set forth in Rule 13a-14(b) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and Section 1350 of Chapter 63 of Title 18 of the United States Code (18 U.S.C. §1350), John F. Thero, President and Chief Executive Officer (Principal Executive Officer) of Amarin Corporation plc (the "Company"), and Michael W. Kalb, Senior Vice President and Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer) of the Company, each hereby certifies that, to the best of his knowledge:

(1) The Company's Annual Report on Form 10-K for the period ended December 31, 2020, to which this Certification is attached as Exhibit 32.1 (the "Annual Report") fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Annual Report fairly presents, in all material respects, the financial condition and results of operations of the Company at the end of such year.

/s/ John F. Thero

Date: February 25, 2021

John F. Thero
President and Chief Executive Officer (Principal Executive Officer)

/s/ Michael W. Kalb

Date: February 25, 2021

Michael W. Kalb
Senior Vice President and Chief Financial Officer
(Principal Financial Officer and Principal Accounting Officer)

This certification accompanies the Form 10-K to which it relates, is not deemed filed with the Securities and Exchange Commission and is not incorporated by reference into any filing of Amarin Corporation plc under the Securities Exchange Act of 1934, as amended (whether made before or after the date of the Form 10-K), irrespective of any general incorporation language contained in such filing.